Mentoring...

How does it address nurses' learning needs?

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Abstract:

Mentoring is regarded as a valuable process to support development in a variety of practice orientated disciplines, and nursing is no exception. The diversity of mentoring required within the clinical and academic context provides challenges for the nursing profession. The New Zealand Nursing Council [NZNC] requires nurses to develop a mentoring relationship to support postgraduate study. Learning and development can be supported both personally and professionally, I believe, through sound mentoring relationships.

This study offers insights into mentoring experiences of nurses, seeking to understand the impact of mentoring on learning. The cohort is a group of New Zealand Registered Nurses who completed a Postgraduate Speciality Nursing Practice programme.

A qualitative interpretive research design was employed using interpretive phenomenology, to explore nurses' experiences of the mentoring phenomenon. A review of the literature supported by data collection using focus group conversations during late 2006 and early 2007 provided the basis for data generation.

Nursing education has been in transition over the past decade. Training programs have moved from the hospital base into the polytechnics and universities. This transitional process has resulted in a diverse mix of nurses in current practice bringing different views and perspectives to the practice setting and their educational pursuits and therefore provides challenges for mentoring relationships. Transition theory was integrated to understand the relationship of learning during times of transition and change.

Findings indicate the mentoring process is complex and highly individual, often ill defined and confusing. This study illuminates some of the issues and complexities seeking to identify areas for future initiatives.

Acknowledgement:

This thesis has challenged my thinking about nursing and nursing practice, helping me to understand the supporting roles that provide nurses with many opportunities for advancement and professional development. There are many people, some nurses, some not who have travelled this journey with me, it is difficult to know where to start with acknowledgements.

Firstly thanks to my supervisors, Dr Marg Gilling and Gloria Slater who shared their extensive knowledge and expertise regarding education and research. Marg you provided the light when I was in darkness, thank you.

To all the nurses who have shared in my life (past and present) including working colleagues (clinical and educational), research participants, Graduate and Postgraduate students, I thank you for your time and sharing. Your passion, insights and perspectives have added to my learning and knowledge and have contributed to the wider nursing knowledge base.

To Myra, mentor, dearest friend, business partner and colleague, you constantly offered support and encouragement. Your positive outlook is awesome and inspiring! Thank you for making this difficult journey possible by providing the physical and mental space to achieve the result.

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And finally to my dear Dad, my first and most powerful mentor, his incredible enthusiasm and keen interest in my life and passions has been exceptional and inspirational. Sadly he passed away before the completion of this project. This work is a tribute to him.

Just a Nurse

By Susanne Gordon

I'm *just a nurse.* I just make the difference between life and death.

I'm *just a nurse.* I just have the educated eyes that prevent medical errors, injuries, and other catastrophes.

I'm *just a nurse.* I just make the difference between healing and coping, and despair.

I'm *just a nurse.* I just make the difference between pain and comfort.

I'm *just a nurse.* I'm just a nurse researcher who helps nurses and doctors give better, safer, and more effective care.

I'm *just a nurse.* I'm just a professor of nursing who educates future generations of nurses.

I'm *just a nurse.* I just work in a major teaching hospital managing and monitoring patients who are involved in cutting-edge experimental research.

I'm *just a nurse.* I just educate patients and families about how to maintain their health.

I'm *just a nurse.* I'm just a geriatric nurse practitioner who makes a difference between an elderly person staying in his own home or going to a nursing home.

I'm *just a nurse.* I just make the difference between dying in agony and dying in comfort and with dignity.

I'm *just a nurse.* I'm just the real bottom-line in health care.

Wouldn't you like to be *just a nurse,* too?

Mentoring...

How does it address nurses learning needs?

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'Come to the edge', he said.

They said, 'We are afraid'.

'Come to the edge', he said.

They came.

He pushed them.....

And they flew!

Giullaume Apollinaire

Cited in Cooper-Morton & Palmer (2000 Pg 35)

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Chapter One - Introduction

1.1 Overview

Mentoring and nursing are both complex and dynamic. They involve relationships and the interconnectedness and complexities associated with one's life, career and professional development. The nursing profession is one of privilege and with privilege comes responsibility, not only to our patients but to each other. As nurses we are obliged to form unique relationships with patients, often at a deep personal level during vulnerable times associated with illness. I believe nurses need to form the same deep and personal relationship with fellow nurses in order for successful mentoring to occur.

Mentoring is a support role appearing in the health context and nursing discipline and in a variety of other contexts and disciplines. Within the nursing profession, mentoring, I believe is at the heart of professional growth and development as nurses work towards developing true expertise from the starting point of novice practitioner. Professional growth and development is essential within the clinical context but also greatly enhanced by the pursuit of postgraduate education. Mentoring, therefore, is about people and relationships and how the interconnectedness has the potential to provide value for both parties. Mentoring has the power to be a catalyst for change and ultimately empowerment, not only for the mentee, but also the mentor, and potentially impacting on the wider nursing profession.

The practice world of nursing is diverse and unpredictable, not easily contained or controllable, and therefore provides a challenging environment for both mentor and mentee. Nursing is a practice discipline, and therefore requires a certain level of "on the job training". Learning from others in this

context can have advantages, however, there is potential for disadvantages and the creation of barriers to learning and development. The working and learning environment of the Registered Nurse must be explored and understood to address the research question...

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My focus is the Postgraduate Registered Nurse and the impact of mentoring on and for this group because, I believe they have been neglected. The literature regarding supporting roles for practice development from the postgraduate student perspective is scarce. The literature is rich with information supporting the new nursing graduates (i.e. those nurses registered within the last 12-24 months). The nursing profession has identified the need for supporting this group of nurses as they integrate their educational preparation into the practice world.

The complexity of the mentoring role is highlighted by the variety of ways it occurs within the nursing context, for example informal mentoring whereby peers support each other in complex and challenging clinical situations, or when a senior nurse supports the development of a less experienced member of the nursing care team. According to Morton-Cooper and Palmer (2000), classical mentoring occurs where the partnership is one of mutual trust and the two individuals are drawn together naturally as a result of personal characteristics, attitudes and common values. Formal mentoring, on the other hand, is a structured, time focused process often experienced within a learning context, for example, during an undergraduate or postgraduate study programme.

Mentoring can also be described from the perspective of the context in which it occurs, for example, within the clinical practice world, when support for learning is focused on clinical issues such as the application of knowledge and skill development and the integration of evidence based practice. Clinical mentoring requires development of reflection, and critical thinking through the exposure of a variety of clinical situations so that nurses are able

to develop expertise through experience. In contrast, academic mentoring at undergraduate and postgraduate level occurs when support is needed for the development of information literacy, information retrieval and academic writing skills, so that learning can be integrated with clinical knowledge in order for evidence based practice to occur.

Mentoring occurs, or can occur, whenever and wherever the need arises. Sometimes mentoring occurs spontaneously, not necessarily sought by the mentee. Certain forms of mentoring lend themselves to timeframes as already mentioned, for example, formal and academic mentoring during study time frames. There are many challenges for the mentor and mentee within the clinical learning environment, such as the patient population, the expectations of the mentee and experience of mentor, all of which impact on a structured, time focused mentoring relationship. Clinical mentoring requires exposure to a variety of situations and experiences so that learning, knowledge integration and skill development can occur.

Historically the 'senior' nurse with many years of clinical expertise, referred to as the 'wise' practitioner, would be matched with the 'junior/less experienced' nurse to develop the skills and knowledge required to manage the complex clinical situations of daily practice. This was referred to as the 'buddy system'. In some situations, the most qualified person (in terms of years of clinical experience) may not necessarily be the most appropriate practitioner for the mentoring role. Nowadays the senior and wise practitioners are a scarce commodity, with senior often referring to a Registered Nurse who graduated within the past twelve months, and therefore brings less than one year of experience to this important clinical support role.

The aging nursing workforce provides challenges for both senior and junior nurses as they struggle to bridge the gaps associated with different training programmes and different expectations about how nursing 'should' be. Changes to nursing education have also impacted on the role requirements and expectations of mentor and mentee. Supporting roles, in some situations

have reversed with the junior nurse (i.e. Registered Nurses with less than 5 years of clinical experience) supporting the senior nurse to embrace life-long learning and return to postgraduate study. The assumption is that the junior nurse, recently graduated from an academic institution, has the skills to offer support and guidance to the senior practitioner with such challenges as information literacy, information retrieval, and academic writing development, all of which are essential components of contemporary nursing education and practice.

In order for successful mentoring relationships to occur the mentee must form a bond with the mentor and vice versa, and because of this relationship, merely being a senior staff member does not guarantee such qualities. The reverse is true for the recently Registered Nurse, whereby completing a nursing qualification does not guarantee the ability to support the development of reflection and evidence based practice.

The complexity of mentoring means that matching the mentor and mentee becomes challenging and in fact may be totally inappropriate. Nowadays the term 'senior' nurse may apply to a nurse who registered within the past year or so, however they may be the most 'senior' staff nurse on the ward due to high staff turnover and attrition. It is important for the nursing profession and the organisations that nurses work in to be mindful of overburdening the 'good' mentors. Equally important is an acute awareness of the multiple challenges associated with the mentoring role for the less experienced Registered Nurse and overloading them at times when they might need to consolidate their own learning is less than ideal. There is an expectation within nursing that nurses can and will multi-task. This is in part because of the flexible and capable nursing ethos of working in a variety of diverse and adaptable ways. Nurses frequently demonstrate this capability by working in situations requiring a 'roll your selves up and get on with it' mentality. The expectation for nurses to multi task these support roles, for example, mentor and assessor may also be less than ideal. Issues associated with the same nurse performing the role of clinical assessor and mentor begs further discussion and a clear understanding of what each role entails helps to clarify

this issue. Nursing needs to look closely at the appropriateness of combining these important roles and the expectation that the same nurse should perform both.

The role of the mentor today is just as important as it was historically, both for the individual nurse and for the nursing profession. I believe, potentially even more important. One must ask, "Who cares for those who provide the care? How is that care offered and is it enough?" To understand the impact of mentoring for the future of nursing and the quality of that mentorship requires a closer look into the experiences of the nurses involved. Questions arise as to what makes a mentoring relationship work. More importantly, work well? Who does it work well for, and who says?

Today's health care environment requires nurses to be responsible for more complex clinical situations, and advances in technology, plus an aging population which has resulted in sicker patients with more advanced care requirements have all impacted on the nursing profession. Internet access and the world wide web has resulted in an informed and questioning patient population which further adds to the nursing challenge. The Health Practitioners Competency Assurance Act [HPCA] (2003) and the New Zealand Nursing Council [NZNC] (2007b) requirements for Annual Practising Certificates have further impacted on the nursing work force with requirements to provide care that is both current and evidence based. At the time of application for their annual practising certificates, nurses are required to sign a declaration acknowledging their fitness to practice for the forthcoming year. Nurses are required to develop a professional portfolio with a collection of evidence to demonstrate proof of their competency and fitness to practice.

There are challenges associated with modern day nursing and for many senior nurses with years of clinical experience and expertise much is foreign to them, including the language of academia, the requirements to demonstrate their practice level through Professional Development Programmes, and the demographic of the new graduate nursing work force.

There are also issues for the new graduate nurse, many of whom experience the challenges associated with 'integration' and 'socialisation' into the clinical world beyond their preceptor time. The importance of integration of theory and practice during undergraduate study cannot be underestimated and is integral to the development of skills, knowledge and clinical competency. Nursing students need exposure to a variety of clinical situations as they prepare to become Registered Nurses and the mentor role is crucial.

One cannot underestimate the value of looking globally. However, as nurses, we must look and act locally, hence, the significance of the local context. This research involves Registered Nurses who completed a one year postgraduate certificate in peri operative speciality nursing. The participants were sought from previous postgraduate study programmes run between 2000 and 2005.

Doing research with this group of New Zealand nurses to explore their mentoring experiences, particularly at postgraduate level, provided an opportunity to shed some light on what is done well, what could be done better, or differently and what role education providers have as part of this process. This research holds a special interest to me, as a clinical practitioner and also an educationalist.

1.2 Background

Nursing in New Zealand has evolved from the apprenticeship model of training from the 60's through the 80's to the academic preparation of today provided by Universities and Polytechnic Institutes. However, that is not to say that mentoring is less important today than it was 20 years ago; some may argue that it is more important in the nursing and health care climate of today. This is highlighted by the increasing complexity of contemporary health care. A large percentage of the nursing population (both nationally and internationally) trained prior to 1990. Within New Zealand, 42% are hospital

trained, 28% diploma graduates, and 28% bachelor degree, according to the 2007 nursing workforce break down supplied by the NZNC (2007a). New Zealand demographics indicate that 67.9% of the nursing workforce is aged between 40 and 49 years, highlighting the complexity associated with diverse ideas about mentoring and education. Pravikoff, Tanner and Pierce (2005) report that the average age of nurses in the United States is 40 years and 70% graduated prior to 1990. The implications of the historical mentoring perspective may be vastly different from the perspective of today's nurses, however, these demographics do not include postgraduate qualifications which may in fact provide another perspective of mentoring.

Historically the clinical environment was less complex, with a greater emphasis on socialisation within the hospital environment, including little emphasis on academic mentorship and questioning of practice predating the evidence based paradigm. Merely being with a registered nurse does not guarantee learning according to Burnard (cited in Andrews and Wallis, 1999). Nursing is a practice discipline, and therefore requires support from peers to socialise into the clinical and health care environments (Andrews and Wallis, 1999; Morton-Cooper and Palmer, 2000). Historically clinical nurses and academics have valued different things as highlighted by Elkan and Robinson; Millar (cited in Andrews and Wallis, 1999).

This research project is an exploration of mentoring and its relationship to nursing education. The study has developed from a sense of concern for the development of nursing practice within the academic framework of speciality nursing. The advancement of the nursing professional is reliant on the development of academic scholarship and the integration of theory into clinical practice and vice versa, particularly as the nurse develops the skills of critical reflection and evidence based practice.

1.3 Justification for the research

The NZNC (2007b) and the New Zealand Nurses Organisation [NZNO] (n.d.) have highlighted the need for educational programmes to demonstrate the ways they support students during academic programmes. Educational programmes must demonstrate how support for students occurs during academic programmes, and the ways in which new knowledge is incorporated into the complex world of clinical practice. Mentoring, Precepting and clinical supervision offer frameworks for this development. These relationships provide the nurse with opportunities to incorporate new knowledge and understanding safely into the complex world of clinical practice. There is an expectation by NZNC (2007b) that nursing education will support the development of learning and expertise, thereby bridging gaps with theory and practice. There are expectations within the clinical and academic environments that student support will be provided, not only within the academic institution but also within the clinical context to support the integration of theory and practice, in an attempt to advance 'evidence based nursing'. Nurses are accountable for their practice development and ongoing learning. NZNC (2007b) requires nurses to demonstrate their competence to practice in order to receive their annual practicing certification as a result of the HPCA, (2003).

The literature is weighted with agreement that mentoring is a valuable process to support learning and development at undergraduate level, however, there is limited literature exploring the postgraduate cohort. There is a need to understand how mentoring will support the transition and integration of theory into practice and whether this is in fact the reality for nurses involved in postgraduate study. The intent of the researcher was to offer a deeper understanding of the nurses' reality and lived experiences, specifically, but not exclusively from a postgraduate perspective.

The study highlights key themes and concepts that have the potential to impact on future educational and nursing initiatives. Mentoring can play an

integral part in the advancement of nursing practice, both clinically and academically. The effectiveness of the mentoring process requires organizational involvement and commitment to develop nursing practice and academic scholarship for the advancement of the nursing profession.

Mentoring can take many forms, both formal and informal and is reliant on the building of sound relationships for the benefit of all parties, not least of all the patients. The NZNC (2007b) does require nurses to demonstrate their competence to practice, both through practice hours and professional development hours in order to receive their annual practicing certification. Postgraduate study has been embraced by many nurses and goes beyond the requirements of the HPCA Act (2003) for 60 professional development hours over a three year period.

1.4 Personal Information and Comments

My nursing passion is shared between the clinical practice world and the academic world. I am a lecturer and a practising clinical nurse. I teach two Postgraduate Certificate Programs, both at Masters Level 8 on the Nursing Council Education Framework. One of the programmes is the Postgraduate Certificate in Perioperative Specialty Nursing from which the research participants were sought for this study. This second programme supports the Graduate Nurse, that is, the nurse who has just completed their nursing qualification and is embarking on their first clinical practice placement as a New Zealand Registered Nurse. I am also responsible for the delivery of a variety of one day seminars to support nurses meeting the 60 hours of professional development mandated by the HPCA Act (2003), and regulated by the NZNC (2007b). I see my position as one of broker in bridging the gaps between the academic and practice worlds for nurses.

I chose to explore the concept of mentoring for my thesis because I believe it holds value and significance for many practicing nurses, including me. My goals were to talk with nurses about their mentoring experiences with a focus on the impact of mentoring during their one year of postgraduate study. My

intent was to understand if mentoring supported learning needs and encouraged professional growth and development, both individually and collectively.

I am extremely committed to nursing practice and education but also to career development and life-long learning. My time is divided between clinical practice and education, and I continue to enjoy the pleasures and frustrations of both camps! My nursing career has been shaped and influenced by many great nurses who I believe have offered 'mentoring' support in diverse and varying ways. I believe that although the clinical context is complex it is an essential learning environment for the novice practitioner in order for true expertise to be developed. This is partly because it was the environment in which I did my initial nursing education and where my learning and development of clinical practice took place.

The mentoring process is complex; it involves relationships, engagement, power and risk. My assumptions prior to the commencement of this study included...

Mentoring does support and encourage nursing development and learning
Mentoring is complex, and difficult to "pin down"
Good mentoring experiences will result in producing good, if not great future mentors
It is beneficial to have the same mentor for the entire academic year of post graduate study, with specific reference to the research participants who had all completed a Postgraduate Certificate in Perioperative Nursing at Speciality Practice Level over a one year time frame
There is a rich and available resource to postgraduate students within the clinical context to support their learning and translation of theory into practice
Students (mentees) will source an appropriate mentor to meet their specific learning needs
Students (mentees) will contact the tutor and/or their mentor when there is a requirement for help or support
Postgraduate qualifications would secure quality mentorship.

As a researcher and reflective clinical practitioner, my nursing career, spans more than 30 years and includes a variety of diverse clinical and academic experiences, both nationally and internationally. I recall nurses who assisted my development, pointed me in the direction of future development and showed faith in my ability to achieve clinically and academically, often at times when I was unable to see this for myself. I am reminded of the comment placed on one of my first baccalaureate nursing (BN) assignments at a time when I was unsure about completing my BN let alone achieving further academic pursuits..... *I look forward to reading your thesis!*

Caring, for me, is fundamental to nursing. There is an appropriate fit between the caring nurse's offer to their patients and the caring required in being an effective mentor. Theoretically, this caring translates to the advancement of practice and critical thinking and in addition to supporting practice development provides an opportunity for nurses to achieve and realise their potential. However, one must question, is this in fact the reality? Although we think of ourselves as a caring profession, the culture of nursing does not always support and nurture nurses and their practice, and we are not exempt from the negative culture attributes and challenges such as horizontal violence and oppression.

1.5 Structure

In this first chapter I have highlighted some of the issues associated with the mentoring role, for example the complexity associated with role definition, expectations and the challenges associated with academic and clinical mentoring relationships. The background to the study and the justification for this research offer an historical perspective and the complexities associated with the process of transition. Personal information and comments have provided the reader with knowledge of the nurse, the researcher and the educationalist within the project.

The second chapter provides a review of the literature. The definition of mentoring, the mentor role, the characteristics of 'good' mentoring and

'poor' mentoring are explored. Distinctions between the supporting roles of mentoring, preceptoring and clinical supervision are explored. An overview of the theoretical frameworks incorporated within the study is also provided. The literature is also explored with regard to reflective practice and evidence based nursing, both of which are significant components of lifelong learning and career development.

Chapter three describes the methodology used to explore the question "How does mentoring address nurses' learning needs?" A qualitative interpretive approach was employed to talk with nurses about their experiences, in order to understand the reality and challenges associated with postgraduate education and the integration of theory into practice through the role of mentoring. Qualitative research can be described as "messy and complex" and my intention was to unpack some of the complexities and explore the messiness using the transition theory lens.

Chapter four presents the data and discussion. Data sharing occurred via focus group conversations that were taped and immediately followed by researcher note taking. Tapes were transcribed by the researcher to highlight key themes and similarities experienced by the participants. Differences and inconsistencies were also explored to offer a deeper understanding of meaning.

Chapter five explores research findings, and provides discussion and clarity of themes and issues, with literature integrated throughout the discussion.

Chapter six offers recommendations and is followed by conclusions and insights gained from the study. Limitations are identified and recommendations discussed, with suggestions for further research highlighted.

Chapter Two – Literature Review

2.1 Transition Theory

This literature review is an exploration of mentoring and its relationship to the advancement of clinical nursing practice. This review is aimed at supporting the study to further understand and interpret the data that questions the role of mentoring in addressing the learning needs of nurses. The world of the nurse and nursing is evolutionary and in a perpetual state of change. Changes including health care reforms, education reforms, increased patient acuity and technological advances all of which have impacted on the nursing profession, the individual nurse and the ways that nurses practice today as opposed to historically.

It is important to understand the difference between change and transition. The literature highlights clear distinctions by some authors regarding the similar but very different meanings associated with these two words. Change is inevitable whereas transition is optional. ".....before we can expect an organisational cultural change we must first effect an attitudinal change in the individual clinician" (Courtney, 2005, p.136). Here in lies the true challenge for the nursing profession and educational providers. Change occurs as a result of a given situation, for example, the revision of the Nurses Act (1977) resulting in the HPCA Act (2003) and the requirement to demonstrate evidence of competence in order to practice as a New Zealand Registered Nurse. Transition however, requires psychological engagement. It involves internalisation and coming to terms with the new situation brought about by the change. According to Bridges (2003) "Getting people through the transition is essential if the change is actually to work as planned" (p.3).

Transition theory provides a useful lens to explore the question of mentoring and how it addresses nurses learning needs. The world of nursing involves the world of change, but more importantly these changes for nurses must be accompanied by transitions, of themselves and their practice. I believe in order for learning needs to be addressed, ultimately enhancing and developing clinical practice, the transitional process must be completed.

Our profession has and is changing and along with that our nursing workforce is changing due to local and international forces. The nursing workforce is aging, recruitment and retention of nurses is a constant challenge. Another challenge for the nursing profession is encouraging young school leavers to consider nursing as a career. Our patients are changing with high acuity, complex conditions and new technology all impacting on treatment advances and options, and providing additional challenges for nurses to keep up to date with practice. Bridges (2003) refers to three distinct phases involved in the transition process; the ending, the neutral zone and the new beginning. All three phases are integral to the transition process.

Firstly the ending phase, whereby we have to let go of what is. One must give something away in order for the transition process to begin. The postgraduate nursing student has to give away the old nursing traditions and ways of knowing in order to start the transition process to postgraduate thinking, learning and knowing. Secondly there is the neutral zone. This is the stage when it would be tempting to abandon the transition process, for example it would be highly possible for nurses to give up on the program of study during this phase. Abandonment of the neutral phase would compromise the change BUT in doing so we lose a great opportunity. The neutral phase is both a dangerous and opportune place, according to Bridges (2003), and is core to the transition process. Bridges (2003) describes this phase as where the repatterning takes place. Emergence from the neutral phase is the new beginning. Because of the degree of 'overlapping' Bridges (2003) describes the transition in terms of processes rather than phases.

Nursing education has changed with movement from the hospital based apprentice model to the academic institutions, to secure a Registered Nurse qualification. The nurse who trained prior to 1980 must make transitions similar to that of the graduate nurses of today, if they choose to embark on a postgraduate qualification. The literature frequently refers to the transitions of the graduate nurse into the practice world (Benner, Tanner and Chelsea, 1996; Chang and Daly, 2001; Flynn and Slack, 2006) however the postgraduate nursing student must also make transitions and develop the skill of critical reflection and the integration of evidence into daily practice. The nursing profession requires an understanding of the relationship between change and transition and the impact for nurses, whether that is within the practice setting or the academic learning situation.

This understanding is essential for the nursing profession if these nurses are to support the junior/novice practitioner's development ensuring the links are made between critical reflection, the integration of evidence and the relationship to clinical practice. Nurses are required to make transitions whether they embrace postgraduate study or not. Lifelong learning has become part of everyday practice and nurses are bound by the HPCA Act (2003) and by the NZNC (2007a and 2007b) regulations in order to receive their annual practising certificates. Nurses therefore, have to embrace the new ethos, which involves reflection and evidence based practice, both of which are integral for continued registration.

The diversity of the nursing role has also impacted on the nursing profession and the term "nurse" continues to evolve, as the profession keeps pace with the health care needs of a growing and aging population. In an attempt to keep pace with the changing needs of the patient population nurses have had to adapt and reinvent themselves in multiple and diverse ways. The evolution of advanced practice roles is just one example of this adaptation by the nurse. Role development and specific responsibilities are required for the nurse specialist, advanced nurse practitioner and nurse prescriber. (Brown and Olshansky, 1997; Glen and Waddington, 1998; Rosser, Rice, Campbell and Jack, 2004).

The technological age has also impacted on the clinical and educational environment of the nursing work force. This impact has affected both the clinical practitioner and the postgraduate nursing student. Technology for nursing is far greater than the use of equipment and computers to support clinical practice; it includes the interrelationships between equipment (Chang and Daly, 2001).

Development of practice and the advancement of clinical expertise requires the nurse to embrace change, and in doing so to make transitions from old ways of thinking and doing to new ways of skill and knowledge development. According to Bridges (2003) "Because transition is a process by which people unplug from an old world and plug into a new world, we can say that transition starts with an ending and finishes with a beginning" (p.5).

2.2 Mentoring

The nursing profession, as well as many other practice orientated disciplines, has embraced the concept of mentoring. There is much in the literature regarding the role of mentoring in the advancement and development of various disciplines, particularly regarding business, sport, education, and more recently appearing in the secondary school environment (Kram, 1988; Schatz, Bush-Zurn, Ceresa and Caldwell Freeman, 2003; Timmons, 2007; Wikipedia, 2008). There are reports in the literature that Florence Nightingale provided mentorship to matrons; however, traditionally mentorship was not a feature of nursing according to McCloughen, O'Brien and Jackson (2006). Nursing literature associated with mentoring started to appear in the early 80's and by the 1990's there was a wealth of published material (Andrews and Wallis, 1999; Firtko, Stewart and Knox 2005; Yonge, Billay, Myrick and Luhanga, 2007). Mentoring within the New Zealand nursing context remains relatively new and according to McCloughen et al (2006), mentoring within the Australian context has only appeared in the nursing literature over the past 10-15 years.

Despite the nursing profession valuing the mentoring role, certain forms of mentoring are still in their infancy within nursing. Many have written on the virtues of mentoring as a support system for the development and advancement of nursing practice from novice to expert, student to graduate, and to a lesser degree graduate to postgraduate nurse (Sheehan, 1993; Benner, Tanner and Chelsea, 1996; Zachary, 2000; Tomka, 2001; Beecroft, Santer, Lacy, Kunzman, and Dorey, 2006; McMurtrie, 2006). Despite this, there appears to be confusion around role definition and role responsibilities, with the terms of mentor and preceptor used interchangeably, and more recently the role of clinical supervision appearing in the nursing literature, potentially adding to the confusion regarding the supporting role for nurses. Hagerty (cited in Andrews and Wallis, 1999), refers to this as a "definition quagmire", highlighting the need for consensus and clarity of not only role definition but also role responsibilities.

Although there are many similarities between the roles of mentor, preceptor and clinical supervisor, these terms should not be used interchangeably. Confusion exists when these terms are used to describe similar roles and characteristics and the literature is not always helpful in this regard. The emotional and personal connection seen with the mentoring relationship is not as overt or necessarily an essential component for the preceptor and clinical supervisor, in order for these roles to be successful. According to Yonge, Billay, Myrick and Luhanga (2007) "This evolves into a close relationship with personal and emotional bonds" (p.3). Another distinguishing feature of the roles is that of the mutually beneficial relationship occurring between the mentor and mentee. This is not so obvious within the relationship of preceptor and preceptee or within the role of clinical supervision.

The impact of the global nursing shortage is becoming an ever increasing issue for the health care industry and the nursing profession must not only appreciate this but work towards supporting and valuing this scarce nursing resource (Block, Claffey, Korow and McCaffrey, 2005; Wilson, Woodard Leners, Fenton and Conner, 2005; Mills and Mullins, 2008). The nursing profession and the organisations that employ and represent nurses must be

aware of the implications of the nursing shortage and the aging nursing workforce. Sound mentoring relationships have the potential to offer nurses emotional support, encouragement and guidance for career development and lifelong learning. The nursing profession and the organisations employing this valuable resource can capitalise on mentoring to not only maintain but also retain the nursing work force.

There is a requirement for engagement between the nurse and the patient, therefore mentoring through transition and mentoring for transition are key to the development of clinical and academic practice so that nurses can confidently and competently serve their patients. Nurses need help and support to deal with the transitions required through all stages of their nursing careers, including student nurse to Registered Nurse, from New Entry to Practice Registered Nurse to competent Staff Nurse and ultimately from competent Staff Nurse to Postgraduate Registered Nurse. This success goes beyond the mere process of making a change. Bridges (2003) highlights that "only people, like you, can recognise that change works only if it is accompanied by transition" (p. 9).

Although the nursing profession remains predominately white, middle class and female it is challenged by the relationships of the 'older' and 'younger' nursing work force, referring to levels of nursing experience and seniority as opposed to the actual age of the individual nurse. Maori refer to mentoring relationships involving the older and younger person highlighting these relationships, also referring to seniority rather than actual age. 'Tuakana' refers to senior and 'Teina' refers to junior. (Adair and Dixon 1998). According to Maori, a Tuakana Teina relationship results in the junior learning the right way to do things from the senior, and the senior learns tolerance from the junior (University of Otago n.d.). The young/novice nurse certainly learns from the senior/expert nurse. However, one wonders if the senior nurses are taking the opportunities to learn from their junior colleagues.

Debate also exists as to whether the mentor should be responsible for clinical assessment of the mentee (Firtko et al, 2005; Block, Claffey, Korow and McCaffrey, 2005; Murray and Main, 2005; Kilcullen, 2007). Clearly the

mentor would be well placed to assess the progress of the mentee, but one wonders if this is appropriate. Consideration needs to be given to whether the mentor role and clinical assessor role can or should be performed by the same nurse. The Whitireia Mentors Handbook (2008) developed by the Postgraduate Nursing Tutorial staff addresses the issues of role definitions and responsibilities.

As the profession builds capacity for these supporting roles, this dual responsibility may not be an issue. Clarity of role definition and responsibilities is essential for mentor, mentee, and clinical assessor. To avoid confusion, whenever inconsistency occurs clarity must be sought. Although the mentor would have the necessary skills and knowledge to make the assessment judgements necessary for the mentee, assessment should be performed independently, which is consistent with current literature (Busen and Engebretson, 1999; Thornby and Pettrey, 2005; Block, Claffey, Korrow and McCaffrey, 2005; Whitireia Mentors Handbook, 2008). These roles should be separate; the mentor offers support and guidance that should be unconditional, without the added complications associated with assessment. I acknowledge the difficulties associated with the limited resource pool and access to appropriate and skilled nurses who have the experience and expertise to perform both the role of mentor and assessor as highlighted by Andrews and Wallis (1999).

There is literature referring to the mentoring relationship as a structured, systematic process and clearly this offers extensive value to the mentee. Several research participants made reference to nurses who had provided a catalyst for their professional development. The participants referred to those nurses who had "shoulder tapped" and made suggestions that they could embark on a programme of postgraduate study, often when the nurse themselves doubted their ability. Bridges (2004) refers to this as the ending stage, when we have to let go of the past, in order to move forward.

How does mentoring support nurses learning needs? The practice world is diverse and unpredictable, not easily contained or controllable, therefore making a challenging environment for both mentor and mentee. According to Morgan and Johns (cited in Johns and Freshwater, 2005) "If the world is essentially chaotic, then the process of learning 'chaotically' is central to

realising desirable practice. So, in response, the guide resists any urge to 'fix it' for the practitioner. The guide must let go of learnt teacher mode to flow within the pattern of unfolding dialogue, to become a guiding light and resource" (p.117). This diverse environment provides challenges for learning from each other that has both advantages and disadvantages and there is potential for the creation of barriers to learning and development. According to Schon (1987) "Students learn by practicing the making or performing at which they seek to become adept, and they are helped to do so by senior practitioners who – again, in Dewey's terms – initiate them into the traditions of practice" (p. 17).

Does the nursing profession have sufficient and appropriate nurses within this environment to provide the learning and support required? And if so, are such nurses willing and prepared for the challenge?

Defining Mentoring

The mentoring role within the nursing context involves many different terms including friend, colleague, senior and wise practitioner, role model, clinical coach, and expert. There are many processes employed by nurses to develop clinical and academic practice including clinical judgement, evidence based practice, reflection *on* and *in* practice, exemplar writing and academic expression. These developmental processes are supported in the following ways through supervision, role modelling, preceptoring and mentoring.

The mentoring role requires the mentor to not only support and guide, but also to develop the mentee. The mentor needs visionary skills to support the mentee through the initial phase of the transition process, that is, the letting go of the past. The mentor must provide a safe and supportive environment for the mentee so that they are able to make the transition through the neutral phases of learning and development. This is the time when the mentor must be offering support, guidance, encouragement, enthusiasm and allowing questioning and reflection to assist in practice development. The mentor has to be intuitive to the mentee's needs during this phase of development, mindful of providing anything that the mentee requires to help them through

the "transition" of what they are attempting to achieve. According to Chang and Daly (2001) "Mentors will need to facilitate learning rather than direct it" (p. 286).

Mentoring for nurses takes many forms including, clinical and academic, formal, informal, and classical, senior practitioners working with junior practitioners and colleagues supporting colleagues. Within the context of postgraduate nursing education, one practitioner may be offering support to another, even though they may be at the same level of practice development, for example both proficient nurses or postgraduate students. This is described as "peer mentoring". Chang and Daly (2001) state that "Another type of support that you could utilise during transition is a support network made up of your peers" (p. 88).

Mentoring occurs, or can occur, whenever, and wherever a need arises for guidance, support, and development. Informal or classical mentoring relationships develop from individual needs identified either by the mentor, who sees a need to support the new nurse, or the by the mentee who seeks the skills, knowledge and experience of a more senior colleague or peer. Informal mentoring is a natural part of the socialisation into the practice world of nursing. Within the clinical practice world this can be on a daily basis as nurses are faced with many challenging clinical and ethical decisions. According to Chang and Daly (2001) "Informal mentoring will continue to happen as it always has" (p. 281). The academic perspective, however, may take a very different form as the mentoring support required for the transition through postgraduate education offers different challenges for the mentor and mentee. The mentoring support may be intense and constant especially during times of assignment development and write up as a deadline for completion draws closer. Mentoring requirements during these times may include keeping the mentee on track and focused towards the assignment due date, but also supporting the mentee through the challenges associated with academic expression and the integration of the literature within the assignment framework and the guideline of the assessment criteria.

Mentoring for the nursing profession can occur within multiple contexts and at all levels of practice both within the diverse clinical practice setting and academically. The process can be a formal or an informal one depending on the situation and requirements of the relationship. Some relationships are prescriptive, and set by the academic staff particularly at undergraduate level and within a programme of study, whereby there is a requirement for the pairing of mentor and mentee. Evidence in support of matching mentor and mentee remains insufficient (Morton-Cooper and Palmer, 2000). Evans (cited in Kochan and Pascarelli, 2003) suggests "The success of any mentoring relationship depends to a large extent on the appropriateness of the 'fit' between mentor and mentee, and the quality of the relationship that develops between them" (p.15.)

Nursing is a 'practice' discipline and therefore practice development occurs over time and with exposure to many and varied clinical situations. The nursing profession and practice world is complex and unpredictable and requires learning and development to occur within the reality of the clinical context. According to Chang and Daly (2001) "Nurses gain expertise by virtue of their knowledge, their ability to observe, reflect upon and analyse the essence of nursing care" (p.248). Integration from the academic into the clinical practice world requires sound clinical assessment and observation, reflective practice and the integration of the best available evidence into the practice environment to support the clinical decision making process.

This diverse and challenging practice world provides a difficult environment for learning and support, one in which nurses are required to support each other in addition to providing safe, efficient and evidence based patient care. Given this backdrop one must acknowledge the potential for tension and conflict. It would be naive to think that this environment is free from tension and challenge and therefore the potential for negativity cannot be ignored. The nursing literature is rich regarding bullying, horizontal violence and the impact associated with 'toxic' mentoring relationships (Busen and Engebretson, 1999; Morton-Cooper and Palmer, 2000; Wilson, 2000; Newton and McKenna, 2007; Dellasega, 2009). There are tensions associated with the new graduate socialising into the clinical world of practice. Further tensions exist as senior and experienced nurses embrace the

new paradigms of lifelong learning, evidence based practice and postgraduate study. Have we learnt from our past experiences? Do we support each other more today than we used to? Historically, the nursing profession was known for "eating our young". Wilson (2000) writes, "there is no doubt there are a lot of nurses who have left the system because of abuse or because their positions were disestablished" (p. 24). Dellasega (2009) states "Relational aggression is a type of bullying typified by various forms of psychological (rather than physical) abuse" (p. 52). The experienced nurse who trained within the hospital based and early polytechnic programs of the 80's speak a different language to the new nurse of today which may provide a threat to the senior practitioner. On the other hand the junior nurse wants to 'fit in' and become part of the clinical team. There are potential tensions as the two groups try to work together, with major issues around power and control. Who holds the knowledge? Who holds the power? And who has the control? According to Dellasega (2009) relational aggression reflects actual or perceived power imbalances resulting in conflict between peers.

The development of the Nursing Council educational framework attempts to address these issues encouraging nurse's to return to the learning environment to advance and develop, joining the movement towards evidence based practice and lifelong learning. This process requires both change and ultimately transition, in an attempt to improve the culture and environment that nurse's work in. Does the engagement in postgraduate study translate into bridging the gaps and relieving the tensions? And does it translate to continued and future support of nurses and nursing? If these nurses make the transition to lifelong learning do they then support and develop other nurse?

The Research Question

Mentoring...

How does it address nurses learning needs?

To explore the research question from the interpretive phenomenological perspective I offer an individual definition for each word used in the research question. According to the Reader's Digest Word Power Dictionary (2001)...

MENTOR:

An experienced and trusted advisor

An experienced person in an organisation or institution who trains and counsels new employees or students

HOW:

In what way or by what means

To what extent or degree

ADDRESS:

Apply oneself to, attend to, see to, tackle

NURSE (Postgraduate Student):

A person studying at a university or other place of higher education

Denoting someone who is studying to enter a particular profession

A person who takes a particular interest in a subject

LEARNING:

Knowledge or skills acquired through study or by being taught

NEEDS:

Require (something) because it is essential or very important

Expressing necessity or obligation

Circumstances in which a thing or course of action is require

Mentoring Quality

The literature frequently refers to mentoring quality and how this is fundamental to the mentoring relationship. The quality is reliant on a partnership based approach involving mutual respect. Other components for a sound mentoring relationship include the personal characteristics and interpersonal skills of the mentor. Effective mentoring requires a sound relationship between the mentor and mentee. May, Meleis and Winstead-Fry (cited in Andrew and Wallis 1999) summarise the relationship as "An intense relationship calling for a high degree of involvement between a novice in a discipline and a person who is knowledgeable and wise in that area" (p. 203). There are discrepancies as to whether this relationship should be personal with emotional involvement, or a more formal alliance (Andrew and Wallis, 1999).

As with any human relationship, another significant aspect integral to the quality of the mentoring relationship, is trust. This trust is required by both the mentor and mentee. The mentee has to trust that the mentor will facilitate their learning and development and trust their judgement in knowing when to let them "go". Veugelers (cited in Kochan & Pascarelli, 2003) states, "The Mentor is more than role model: His message is not "be as I am", but "be as you can be" (p. 40). The mentee must trust their judgement in their choice of mentor that indeed this person will offer them the support and guidance needed to develop. The mentor has to trust that the mentee is indeed ready for the challenges they face and that the patients are safe in the care of the mentee. This trusting relationship results in learning and development for both parties and therefore provides mutual benefits for both.

All relationships have phases, from the initial attraction, followed by the main part of the relationship, which is often described as the open and relaxed period, and finally the ending of the relationship or the breaking up phase. The mentoring relationship involves the transition phases including an initial settling in period, followed by a more open and relaxed phase before establishing the friendship and trust, all of which should be positive and when the relationship works well, mutually beneficial to both parties.

According to Andrews and Wallis (1999) some mentoring relationships become lasting friendships.

The Dalton/Thompson Model of Career Development (cited in Andrews and Wallis, 1999) offers a means of identifying the four discrete stages of the mentoring process. Considering the changes necessary for professional growth and development and the transitional process of learning required by nurses this model is a useful tool for nursing. The model identifies four distinct stages of development, including initial dependence, equal relationship between mentor and mentee, then moving to less dependence on direct supervision and finally the ability for the nurse to not only be responsible for direct patient care, but simultaneously supporting the less experienced practitioner. Not moving beyond the equal relationship stage of mentor and mentee, namely progression to assuming mentoring responsibilities, limits the potential for future nursing development. It is encouraging to note that there are those nurses who go on to become mentors themselves, developing the ability to supervise and support others. Ultimately there are those nurses who manage complex patient loads plus support and supervise other nurses simultaneously (Andrews & Wallis, 1999). This is one of the challenges for nursing and postgraduate education. The future of nursing requires nurses to reach beyond their own capabilities and support the practice development of others.

Benner (1984) developed a similar model for practice development known as the novice to expert model. Her model describes the development of clinical practice as a nurse makes the transition from novice to expert practitioner. Benner (1984) defines an "expert" as a nurse who not only demonstrates the ability to manage complex patient loads, but also has the capacity to support and supervise other nurses while doing so.

Several authors, both within nursing and other disciplines define the qualities required for effective mentoring (Waters, Clarke, Ingall and Dean-Jones, 2003; McClougen, O'Brien and Jackson, 2006; Yonge, Billay, Myrick and Luhanga, 2007; Mills, Lennon and Francis, 2007). These qualities share many parallels with the qualities required for effective leadership and include

approachability, effective interpersonal skills, positive teaching role model, attentiveness to learning requirements, providing supervisory support and professional development (Mahaffey, Kaplan and Klauer Triolo, 1998; Andrews and Wallis, 1999; Schatz, Bush-Zurn, Ceresa and Caldwell Freeman, 2003). The Darling Model of Mentor Potential developed in the early 90's (cited in Andrews and Wallis 1999) was used as a means of measuring mentor potential, identifying absolute requirements including mutual attraction, mutual respect and subscription of time and energy. This model also highlights three basic mentoring roles as inspirer, inventor and supporter. Yonge et al. (2007) describe the core activities of mentorship and make distinctions between the role of mentor and preceptor by describing the mentoring role as one of facilitator, guide, advisor, counsellor, supporter and role model.

2.3 Reflection

Nursing as a discipline has embraced the concept of reflection and there are many models available for development of this concept and its relationship to clinical and academic practice. The relationship between reflective practice and advancement of clinical practice cannot be overlooked as it is integral to nursing practice development. Experiential learning occurs over time as nurses develop reflective practice skills based on exposure to a variety of clinical situations in which to build their practice base experience. What role do mentors play in the development of reflective practice? What role does academia play with regard to reflective practice development? How should reflection be developed clinically and academically? How do nurses teach each other to reflect?

"We do not learn by doing, we learn by doing and realising what cause came of what we did" John Dewy (1929).

Reflection becomes a component in the development of lifelong learning, which is essential for nurses working in the delivery of health care today and indeed this is mandated by the HPCA Act (2003) and the NZNC (2007b). Nurses need to understand the way they practice and the way that their learning shapes their practice (Benner, 1994; Tanner, 2006; Beckett, Gilbertson and Greenwood, 2007). Nurses need to appreciate how they integrate knowledge and skills into practice development and have an understanding of how the two intertwine for true transformation to occur, and expert practice to become reality (Benner, 1994; Benner, Tanner and Chelsea, 1996; Lindsay, 2008). The process of transition requires the development of reflection in order to move successfully through the change process. There is also a requirement for nurses to look within themselves and develop an understanding of where they have come from, where they are now, and where they are going. Atkins and Murphy (1993) summarize by saying "Reflection, therefore, must involve the self and must lead to a changed perspective" (p.1191).

A lack of understanding as to the true value of reflection by senior practitioners can provide challenges for both junior and senior nurses. Clearly there are potential barriers to the development of reflective practice particularly for those nurses less experienced in the process. The senior nurses have the experience to share clinical expertise but not necessarily the ability to unpack the meaning behind decisions made and actions taken, therefore making it difficult for less experienced staff to understand the clinical decision making process. According to Tanner (2006) "Each situation is an opportunity for clinical learning, given a supportive context and nurses who have developed the habit and skill of reflection-on-action" (p.209). The reality of the practice world differs greatly from the academic learning environment and for the new entry to practice nurse this challenge requires translation of what they learnt in nursing school to the reality of what they confront in the practice world. Attempts to make these transitions through reflective practice will be more fruitful if the senior practitioners supporting them understand the processes involved with reflection.

Reflective practice has not escaped the critics and it is important to acknowledge the imitations and challenges associated with its application, and its place in clinical practice and education. The nursing literature has responded to such criticisms and according to Taylor (2006) "In spite of the concerns and critiques, clinicians, educators and researchers tend to agree that although reflective practice has its limitations, and requires time, effort and ongoing commitment, it is nevertheless worth the effort to bring about deeper insights and changes in practice, leadership, clinical supervision and education" (p.15).

2.4 Evidence Based Practice

Literature referring to evidence based practice began around 1996 and the development of evidence based practice for nursing followed on from the development of evidence based medicine (Sackett, Rosenbeerg, Gray, Haynes and Richardson, 1996). Sackett, Straus and Richardson, et al. offer one of the most cited definitions of evidence-based practice...

> The conscientious, explicit and judicious use of current best evidence in making the decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available clinical evidence from systematic reviews (cited in Osborne and Gardner, 2004, p19).

Development of clinical expertise requires experience, but also critical reflective practice and academic learning so that practice decisions are indeed based on the integration of evidence, and, most importantly the patients' values. Integral to this process of linking evidence with clinical decisions is an appreciation of the evidence (the science) and the patient values (the art). According to DePalma (2002) the principle of evidence based practice is to establish best practice within the healthcare environment. Courtney (2005) acknowledges the definition for evidence based practice has evolved and now includes not only the judicious use of current best evidence

but also the integration of clinical expertise and patient values as the bases for the clinical decision making process.

Evidence based practice requires questioning and questioning requires reflection. Questioning practice can challenge current viewpoints and assist the nurse to make transformations to new ways of thinking and knowing. To explore the question of mentoring and how it addresses nurses learning needs one must look to the literature on evidence based practice and the role it plays in today's health care setting. According to DiCenso and Cullum (1998) "Evidence from research can help to perfect the expertise but cannot do the examination or sort through the myriad of quantitative and qualitative information that nurses collect during the clinical encounter" (p.39).

The development of clinical expertise and evidence based practice requires nursing to embrace sound mentoring processes to support nurses to not only identify, but also achieve their learning needs so that patients benefit from the knowledge and skills gained. This may be best achieved by nurses pursuing some form of academic preparation for true expertise to be enhanced and developed. However, merely attending and completing a postgraduate study programme does not guarantee the development of reflective and evidence based practice. According to DiCenso and Cullum (1998) "Clinical expertise is the crucial element that separates evidence-based nursing from cookbook nursing and the mindless application of rules and guidelines" (p. 39).

Nursing must move away from the ritualistic practices of the past into the modern day world of evidence based practice. Nursing must make the changes from the old ways of learning and knowing, letting go of the old and embracing transition. Clearly there must be a paradigm shift not only for the individual nurse but for the nursing profession and the health care organisations, to develop a culture of inquiry. As part of a multi disciplinary team nursing works alongside other health care disciplines, for example, medicine, pharmacy, physiotherapy, and occupational therapy, to support patient care through sound nursing practice initiatives. Courtney (2005) describes a culture of inquiry as one of organisational involvement encouraging interrogation of practice, formulation of research questions, searching for and evaluating the answers. She goes on to say such a culture

tolerates diversity and promotes true collaboration in the decision making process relevant to patient care. The modern day nurse must engage in evidence based practice to support and indeed practice in the modern nursing environment, but to achieve this must work within organisations that support the culture of inquiry. Nowadays nurses should be critiquing the literature, asking the difficult questions...What is the relevance of this research to my practice? How does it fit with what I do? Will this new evidence enhance the care delivery to my patient? Do I need to change my practice? As providers of education to advance nursing practice our role must question our teaching methods. Are we teaching nurses what evidence is, how to source and critique evidence and most importantly how to integrate evidence findings into practice? Are we developing a culture of inquiry so that, not only the patient, but also the nursing profession benefits from the new and current knowledge gained?

This chapter provides an overview of the issues associated with defining mentoring within the nursing context. It highlights the complexity associated with the mentoring role and responsibilities for those who take on the challenge of mentoring, irrespective of the context. Transition theory is explained and provides a useful framework to explore the research question. Reflection and evidence based practice have been explored to provide an understanding of their relationship to the mentoring role and the impact of learning for nurses. Chapter three describes the research methods employed to explore the question...how does mentoring address nurses learning needs?

Chapter Three – Research Methods

This chapter outlines the research methods employed to explore the research question "Mentoring.....How it addresses nurses' learning needs?" An interpretive approach was required to understand nurse's experiences with the process of mentoring and the impact this may or may not have on their learning. This qualitative study follows the naturalistic paradigm and uses an epistemological approach whereby the researcher "interacts with those being researched; findings are the creation of the interactive process" (Polit, Beck and Hunger, 2001, p.13). The methodological process is a combination of naturalistic assumptions, using inductive processes with a holistic focus. This inductive process seeks to identify patterns, commonalities, relationships (Polit, Beck and Hungler, 2001, p. 13).

This chapter covers the following and outlines the framework for the research study:

3.1 Establishing the Research Question

The NZNC (2007b) and the NZNO (n.d.) identify the need for professional support structures as an integral part of the learning process for nurses. The literature highlights that the nursing profession values mentoring as a learning support system and indeed the data collection suggests that individual nurses perceive mentoring to be of value to them, both personally and professionally. However, one cannot assume that this value is transparent and consistent, especially in today's constant changing health care delivery system. Literature suggests that specific elements need to be in place for successful mentoring to occur (Andrews and Wallis, 1999; Morton-Cooper and Palmer, 2000). This project was designed to explore the experiences of nurses during a one year post graduate study programme, to understand the reality of mentoring for them, highlighting positive experiences and identifying gaps and inconsistencies. What were the similarities experienced by the participants in comparison with the literature reviewed? What were the differences? Did these factors influence the support and learning for the students? What lessons can be learnt to support nursing education and the advancement of clinical practice to ultimately improve patient care and ultimately, what does it all mean?

The nursing literature reviewed was heavily embedded in the academic world and sometimes lacking the reality of the clinical environment. Historically the focus for student learning support has been at undergraduate level, with little, if any attention given to postgraduate students. Nurses are now required to demonstrate competence in order to practice (Health Practitioners Competency Assurance Act, [HPCA] 2003), and therefore a paradigm shift has occurred whereby nursing has become a profession of life-long learning. Nurses must demonstrate fitness to practice when applying for their annual practising certificates. This project sought to explore the role of mentoring and the implications associated with the clinical world from the perspective of post graduate nurses, who had chosen to embrace nursing education by returning to study. How does mentoring support learning in the environment where nurses not only perform their nursing work but integrate their

learning, through the development of evidence based practice, critical thinking, and reflection?

3.1.1 Subsequent Research Questions

I was conscious of the fact that I did not wish to influence the research participants by asking too many questions that could detract from the data collection process. My intention was to let the participants share their stories and experiences and then try to interpret shared meanings and understanding, supported by the literature and my own experiences.
Probes, rather than questions can be directed to individual participants or the group as a whole, in an attempt to explore the question, "How does mentoring support nurses learning needs?" This allowed an opportunity for participants to reflect on contributions and clarify meanings and interpretations; either their own, or those of the group. (Litoselliti, 2003).

During the focus group conversation sessions the following probes required further exploration...

- What are the qualities of a "good" nursing mentor?
- What were "good" mentoring and learning experiences?
- How much does the culture of the organisation influence these learning experiences and mentoring interactions?
- Did you always enjoy positive mentoring experiences?
- How could things have been different?
- Better for you?
- How have these experiences shaped your nursing practice?
- How have these experiences shaped the way you provide support to other nurses?

3.2 Research Participants

The research participants were all New Zealand Registered Nurses and came from a variety of clinical settings and different hospital environments. Access to potential research participants was sought by the researcher via a letter to Whitireia Community Polytechnic (Refer Appendix One) requesting permission to access the database of previous students. Approval was granted and all students between 2000 and 2005 were contacted in writing and invited to participate in the study.

Participant characteristics were identified as:
Registered Nurses who had undertaken the Post Graduate Programme in Perioperative Speciality Nursing Practice. This programme is clinically focused and includes academic requirements. One of the challenges for students is integrating learning into their clinical practice. Many students were already practicing at a "senior" level within their clinical working environments, prior to the commencement of study and therefore shared views to mentoring from recent and historical perspectives as well as mentor and mentee experiences.

A total of 24 letters were sent out.
There were eleven responses, of these nine agreed to partake in the study. There were two respondents who did not partake in the study, because one had moved to another city and the other was overseas during the data collection process.

There were no exclusion criteria. All those who agreed to participate were included in the study. As a courtesy, the Directors of Nursing of all the organisations who employed the participants were contacted and informed of this research project and that staff members within their organisations had been invited to participate in the study. (Refer Appendix Two). The Directors of Nursing were keen to be included in the reporting and outcome findings of the project and positive support for this project was unanimous.

3.2.1 Participant Demographics

Gender:

8 Female; 1 Male

Age Range:

30-40 years 3 participants

40-50 years 3 participants

50-60 years 2 participants

Over 60 years 1 participant

Range of Years of Registered Nurse Experience:

5-10 years 3 participants

10-20 years 3 participants

Over 25 years 3 participants

Preparation to Practice:

Hospital Trained New Zealand - 3

Hospital Trained United Kingdom - 2

Diploma in Nursing New Zealand Polytechnic - 3

Bachelor of Nursing New Zealand – 1

Nursing Position Held:

Staff Nurses - 4

Nursing Managers - 4

Clinical Nurse Educator – 1

3.3 Research Process

- Focus Group Conversations
- 3 in total

There was some confusion as to how many sessions participants needed to attend, although this was outlined in the information sheet. There was a total of three focus group sessions and participants were invited to attend all three, alternatively they could attend what would be realistically manageable.

The same venue was used for each focus group session and the same time slot, but the researcher made the point of scheduling the sessions on different days of the week, in an attempt to make allowances for the shift work component of nursing work, and acknowledging the time commitment of the participants. Light refreshments were provided to enhance the socially interactive, group conversation process.

The researcher had a clear sense that participants wanted to provide the data required and wanted the researcher to achieve the end product. The researcher audio taped the focus group conversations to ensure maximum data retrieval for the process of transcription and interpretation.

Some participants offered to meet with the researcher on a one-to-one interview basis, if this was required and the researcher was grateful for this level of support and endorsement. The researcher did not get the sense that participants did not want to share, and contributions were made by all present at various times during the conversation process. Inevitably, some participants had more to say than others, which is acknowledge as an issue with the focus group process. The potential for some participants to dominate the group also requires consideration and therefore the researcher must be mindful of the power dynamics of the group and ensure that everyone has the opportunity to share. Participants were reminded of the

ground rules at the beginning of each focus session and I did not have a sense that those who wished to speak were not given the opportunity to do so.

Breakdown of session attendance was as follows:

Session One: 7 participants
Session Two: 5 participants
Session Three: 2 participants

Breakdown of participant attendance at each session:

3 participants attended the first session only.
3 participants attended the first and second sessions.
1 attended the first and third session.
1 attended the second and third session.
1 participant attended the second session only.

Attendance at the focus group sessions was variable for many reasons and the researcher acknowledges the significant time commitment associated with attendance at all three sessions. Most participants managed to attend at least two of the sessions and this helped to clarity and consolidation of data. Due to the timing of data collection, occurring soon after Christmas during the summer and school holiday break there were issues affecting attendance including family commitments, annual leave and those who were out of town.

Three participants offered to meet and do individual interviews highlighting the commitment of the research participants and the desire to contribute to this research project. The researcher thanked participants for this level of commitment to the project, but was unable to meet with individual participants on a one-to-one basis, due to time constraints. Consideration will be given to a follow up study using mixed methodology of focus groups and individual interviews to extend research findings and understanding.

One must ponder this offer to meet on a one-to-one basis and the possibility that the participants were uncomfortable with the dynamics of the focus group process and therefore not willing to share stories with others but rather with the researcher, in private. Two participants, not necessarily uncomfortable with the focus group process were only available to attend one session and highlighted other commitments on the preset dates and times. The third participant was possibly uncomfortable with the focus group forum, however, they did not allude to why they were unable to attend on the preset dates and times and the researcher did not pry.

The meetings were spread over a 3 month period and scheduled on different days of the week, on the same evening and held at the same venue, in an attempt to make meeting easier for the participants. I was conscious of the problems associated with nursing shift work and various schedules including shifts covering the day, evening and night rosters, and so attempted to factor this into the planning of meeting times and dates.

The participants attended the sessions that they could manage and engaged in the conversation process enthusiastically. They were willing to share their mentoring experiences, and for this the researcher was extremely grateful. The sharing of mentoring stories by participants included recent experiences but also their previous experiences with support roles common to nursing, for example, Preceptorship. The diversity and complexity of mentoring experiences shared highlights the challenges associated with exploring this topic and interpretation of meaning.

The researcher assured all participants that information shared would remain confidential and not identifiable through the final write up phase of the project. The focus group forum results in sharing private thoughts, feelings and experiences with others in the group and therefore one cannot assume that the data collection process suits all who agreed to participate. Initially there were those who expressed thoughts and feelings more openly than others and although at times I felt that not all participants were making contributions as I listened, and listened and listened to the tapes it was clear

that all participants made contributions. This is evident in the analysis chapter and highlighted by pseudonym initials used to demonstrate individual research participant's contributions. The larger number of research participants, that is a total of seven attending the first session allowed for the discussion process and sharing of ideas with reflections on individual experiences and acknowledgement of one's thoughts and beliefs. However, one must acknowledge the obvious limitations with this research method including ethical considerations of each research participant, and their ability to share personal stories within the group dynamic process. Do they feel safe to share stories? Whose voice is heard and who is silent? What is the meaning of the silence? What are the issues of power? The role of the moderator in focus group work is significant and potentially problematic when the researcher is extremely well known to all the research participants, as was the case with this project, albeit, as a previous lecturer and nursing colleague.

I must acknowledge the complex relationship I shared with this group, aside from my role as researcher. I was a previous nursing tutor to all research participants. I worked in the same organisation as five of the participants and of these five I worked in the same clinical practice area with three of the research participants. My challenge as researcher was to make all participants feel comfortable and safe in the focus group environment; to listen intently and avoid any signals that may be interpreted as judgemental. This was an extremely challenging part of the research gathering process. To listen intently, in a non-judgemental manner, with a supportive, interested persona whilst attempting to absorb the conversations, the behaviour and the mannerisms. Clough and Nutbrown (2002) refer to this as radical listening. Interpretation of meaning develops from hearing the literal voice as well as the voices within the literature. The changing dynamic of the researcher/participant relationship as opposed to tutor/student, or nursing colleagues can have both positive and negative implications. On the one hand the participants may be comfortable in sharing their stories because they know and respect me, as I do them. On the other hand they may be

reluctant to share stories and experiences for fear of what I may think of them or what others in the group may think.

Triangulation was achieved by the integration of current nursing literature, with the data from focus group conversations and the researcher's experiences and interpretation. The goal of triangulation is to use a combination of research strategies within a single piece of research, in an attempt to strengthen the work. (Speziale & Carpenter, 2007). According to Speziale and Carpenter (2007) "Proponents of triangulation recognise that application of multiple approaches to an investigation can improve the reliability and validity of data because the strengths of one method may help to compensate for the weaknesses of another" (p.380).

The researcher acknowledges the value of external checking to establish the credibility of the inquiry. The researcher used peer debriefing as a means of external checking. The process of peer debriefing described by Polit, Beck & Hungler (2001) involves sessions held with objective peers to review and explore aspects of the research project. The researcher explored searching questions with other postgraduate nurses familiar with the mentoring process, either as mentors or mentees. Workshop sessions with postgraduate students has become an ongoing process to source information related to defining mentoring, exploring the characteristics of good mentors and highlighting mentoring needs for postgraduate nurses to support the integration of theory to practice.

3.3.1 Focus Group Research

Focus group research involves different stages and is referred to by Litoselliti (2003) as forming, storming, norming, performing and adjourning. This project involved these stages and each focus group session included the forming stage with an introduction at the first session and then recapping of information shared from previous sessions at subsequent sessions. Storming occurred as participants shared stories and reflected on their experiences as they explored the research question, "Mentoring, how does it address nurses

learning needs". The norming phase occurs as the group moves towards problem-solving, and acknowledging other view points. If the group moves beyond this phase to the performing phase they become more productive and interactive and debate and redefine the issues. This was the biggest challenge of this project for the researcher because not all participants attended all sessions, making it difficult to build on previous sessions. The final stage is the adjourning, when the group has an opportunity for reflection and recapping of what was said as the session draws to an end (Litoselliti, 2003).

Another aspect of this form of data collection is the potential for domination by certain research participants over others within the group, especially those who are quiet and shy. Individual interviewing with nurses on a one-to-one basis to explore the research question of how mentoring addresses nurses learning needs may have highlighted additional research data and addressed the issues associated with the shy and private nurses within the group, but was not possible for the researcher to achieve. Rethinking the data collection process the researcher acknowledges the value of a combination approach for collection of data in order to answer the research question, and would consider individual interviews and also survey questionnaires for future work. Ideally, and warranting further consideration for future projects, the participants could be invited to chose the forum for data collection, based on personal preference, that is, individual interviews and/or focus group conversations.

The value of an observer in addition to the researcher is highlighted as beneficial. Litoselliti (2003) refers to the value of an observer and moderator in addition to the researcher; however one must acknowledge that this may in fact detract from the conversations and intimidate some of the research participants, therefore limiting the data sharing process. The researcher acknowledges the value of an additional pair of ears and eyes as participants share mentoring stories and experiences providing an opportunity for observation and transcription at the time of conversation however, this project involved the researcher performing all three of these roles herself.

One could argue that the presence of additional people during the focus group conversations would detract from the data process and inhibit the free flow of discussion. Obviously it would depend on who the additional people were and their relationship to the research participants. One of my objectives during this project was, as much as possible, to put the research participants at ease. This was achieved by the unique relationship I have with the group and a deep understanding of the topic under exploration.

The focus group highlighted diversity and complexity, in much the same way that phenomenological research seeks to understand the whole being rather than the parts as separate processes. Narrative in nursing is common practice and many nurses have the ability to share stories as a means of exploring and reflecting on their practice world. Interpretive phenomenology became an obvious choice to explore mentoring experiences for postgraduate nursing students. Advantages associated with access to more participants at one time and therefore potentially more data, as well as the advantage of focus group methodology included the timeframes for data collection, and the ability to gain a variety of perspectives to explore the question. I felt this data collection process of discovering the meaning of nurse's stories by using focus group conversation would indeed suit this group, the researcher and the research project.

This project was in part a reflection of the nurse's experiences during their year of post graduate study. Triangulation was achieved by integration of current and historical literature on mentoring, and the impact of supporting roles on nursing practice development. Litoselliti (2003) highlights the benefits of focus group research including discovering new information and consolidating old knowledge, obtaining a number of different perspectives and gaining views, attitudes, beliefs, responses, motivations and perceptions on the same topic. In addition to the ability to examine shared understanding, brainstorming and generating ideas, gaining insights through the process of group dynamics and exploring complex issues such as mentoring and its impact on nurses learning and development during postgraduate study.

3.4 Ethics

Qualitative research requires a close and personal relationship between the researcher and the participants, with special attention to the safety of all, particularly those sharing experiences and perspectives, and giving "voice" to the phenomenon under study. According to Polit, Beck and Hungler, (2001) "Research participants enter a special relationship with the researcher" (p.75). A qualitative research project requires engagement with the participants in much the same way as one engages with patients in practice or students in learning environments, either, the novice/expert nurse, the teacher/student, or mentor/mentee relationship. I acknowledge my position with the participants as previous tutor and in some cases nursing colleague, and realise the implications of the relationship dynamics entering into a researcher/participant partnership. I believe I have built rapport over time in a variety of situations with the research participants but was mindful that this may be one of my assumptions. As the researcher and previous tutor to this group I was well known to each of the research participants and therefore this rapport had the potential to have both positive and negative implications for the research process.

The researcher acknowledges the potential for participants to tell me what I wanted to hear, rather than their actual experiences and stories. Researcher bias was an issue because the researcher had been in a relationship with each and every research participant during their post graduate study year, however, no research participants were current students. In the absence of monitoring the mentoring process and following the traditions of adult educational processes, the educators relied on the students embracing this process, sourcing mentors and engaging in the mentoring process, as outlined in the student handbook. The researcher did not have any preconceived ideas regarding individual mentoring experiences, rather wished to explore experiences to understand what was happening? And if so what was the impact on the overall outcome?

Ethical considerations are extremely important with any research study but particularly so with qualitative research regarding nursing practice but also because focus group methodology was used to retrieve data. Ethical Practice is core to the Nursing Profession and provides a framework to guide our behaviour, actions and decisions (NZNO Codes of Ethics, 2001). I was extremely conscious of my role as previous educator to all of the research participants and the personal and professional relationship I had shared with all in the group. I was also aware that this could have a bearing on the focus group dynamics and the ability of participants to share their stories and experiences. At times during the focus group interviews I did have a sense that the participants were checking with me, that indeed, they were telling me what I wanted to hear, as they made their contributions. On more than one occasion this was verbalised, and by more than one of the research participants. During conversations participants would look to me, as researcher and nursing colleague for validation of their contributions.

Ethical approval was sought and gained from the Massey University Human Ethics Committee [MUHEC] (HEC: Southern A, Application - 06/48). The Health and Disability Ethics Committee was also informed of the research project and acknowledged the approval from MUHEC highlighting that this was sufficient for the project to proceed and that further ethical approval from their perspective was not required.

Ethical approval took longer than was originally anticipated, and this delayed the data collection process significantly. MUHEC highlighted the need for consideration regarding the conflict of mentor and mentee participants attending the same focus group, and the researcher's ability to manage this potential conflict. The researcher acknowledges that the data collection may have been limited due to the potential mentor/mentee relationship issues. There was dialogue between the researcher, the supervisor and the ethics committee to provide assurance that this project upheld the principles of beneficence and non-maleficence (Taylor, Kermode and Roberts 2006). The mentor/mentee dynamic, where both may be present in the same focus group was managed by identification of the potential and stated clearly on the

information sheet distributed to potential participants. Each participant identified availability to attend focus group sessions and the researcher identified if mentor/mentees would be attending the same sessions. Two participants had shared a mentor/mentee relationship and both indicated that they did not have any issues with attending the same focus group to share stories and experiences with each other and the group.

As researcher I was conscious of the possibility of individual research participants requiring follow up should distress be caused during focus group conversations. Should this potential be realised, participant support would be provided, appropriate to the individual situation and specific participant needs. The course of action would include discussion with the participant in the first instance who would then be encouraged and supported, by the researcher, to seek necessary council to resolve issues and feel safe. The information sheet provided to each research participant,
detailed other contacts should this be preferred, including the supervisor of the research and the Massey University Ethics Committee.

All participants were informed in writing and verbally that they could withdraw from the study at anytime up until the data analysis phase of the project. Focus group confidentiality is not possible because of the nature of sharing stories within the conversation context, however, protection of each research participant and acknowledgment of their contributions was paramount. The researcher and the participants clarified the "ground rules" at the beginning of each and every focus group session. This was an attempt to provide a comfortable and safe environment for data collection, sharing of information and exchange of ideas and experiences, but also to offer the participants a sense of confidentially through the data sharing process.

These "ground rules" included:

- Everyone's contribution is valued and therefore listened too without interruptions.
- One person speaks at a time, without interruptions.
- Everything shared stays within the room.
- Participants had the opportunity to leave at any time during the sessions and withdraw their contributions at any time up until the data analysis phase of the project.
- Participants were informed of the time commitment for each of the focus group interviews prior to the commencement of the study and reminded at the beginning of each of the interview sessions that we would keep to the allocated time schedule.

Confidentiality regarding data was achieved by each participant identifying a unique name for their contribution, which was used by the researcher for transcription and the final write up stage. The data collected was limited to the researcher and supervisor; no other persons would have access to the transcripts. The decision was made to feed into each focus group the findings from the previous sessions as a starting point, however, the participants were not offered a transcript nor did they request one. Tapes have been transcribed by the researcher and will be kept for a period of five years in a locked filing cabinet and destroyed as per the standard recommendations of Massey University.

3.5 Qualitative Research

Fundamental to the qualitative research approach are six significant characteristics including, multiple realities exist, the application of the most appropriate approach to understand the phenomenon studied, the importance of the participant's views, conducting the inquiry with minimal disruption to the natural context, and acknowledgement of participants, including their rich contributions when reporting the literary style (Speziale and Carpenter, 2007). Qualitative research involves shared interpretations, multiple realities and an inclusionary process. Making meaning from the experiences of

situations is always challenging and requires the researcher to interpret the meaning of the inquiry. Exploring the "taken for granted" as it relates to nursing and the mentoring process is an essential part of the interpretive research process. At face value is it so obvious that it doesn't need to be questioned? Clough and Nutbrown (2002) suggest four characteristics for radical inquiry; radical looking, radical listening, radical reading and radical questioning.

Highlighting assumptions is integral to the qualitative research process, but not so with the interpretive phenomenology process. My assumptions include that mentoring is in the most part a positive experience, providing multiple learning opportunities for the mentee, given certain conditions.

Another assumption is that the mentor can also have a positive experience from the mentoring process and therefore grow personally and professionally. My assumption is that mentoring offers challenges to the mentor and mentee, especially within the health care context, and that learning and development is also challenging within the health care context. That said, these challenges are not insurmountable and can be used in positive ways for creative learning situations. My assumption is that one can learn and grow from negative experiences if critical reflection is developed and enhanced, and one has the ability to move forward, leaving the past behind, via a process of transition, in order for true professional development to occur. The ability to leave the past behind may be more challenging for the senior practitioner as they grapple with the complexities and multiplicities of the many changes they confront, as opposed to the recent nursing graduate who at least has had the exposure to academic preparation, information retrieval, evidence based practice and reflection as part of their undergraduate programme of study.

3.6 Interpretive Phenomenology

Phenomenological research can be descriptive or interpretive. This project follows an interpretive process, and a naturalistic paradigm with underpinning assumptions including emphasis on entirety of phenomenon, and the holistic approach grounded in the nurse's experiences. Phenomenology is congruent with nursing because of the value of humanistic knowledge and is a process that helps nursing reveal the nature of the human experience (Watson, McKenna, Cowman, and Keady, 2008). This project is heavily context bound, including the contextual world of clinical practice, but also the contextual issues around adult learning and nursing education. A holistic approach is at the centre of this research project drawing a parallel with the practice world of nursing. "Holistic care and avoidance of reductionism are at the centre of professional nursing practice" (Speziale and Carpenter, 2007, p.91). Broadly speaking, interpretive phenomenology is a process whereby the researcher explores the lived experience of the participants, for example... *"Being a student" "Being a mentor" "Being mentored".*

Lincoln and Guba (cited in Speziale and Carpenter, 2007) believe that "Interpretive frameworks within phenomenology are used to search out the relationships and meanings that knowledge and context have for each other" (p.88). The researcher must move from specific pieces of information (data) to abstractions that synthesize and give structure to what is observed. The data is used to interpret the reality, bearing in mind that this reality is not only multiple it is merely a snapshot of the experiences. According to Speziale and Carpenter (2007) "Because phenomenological inquiry requires that the integrated whole is explored, it is a suitable method for the investigation of phenomena important to nursing practice, education and administration" (p. 92). The science of interpretation involves a hermeneutic circle whereby individual parts of the experience are explored as well as the whole experience. Interpretation develops from moving back and forth from the individual parts to the whole experience again and again to increase depth

of understanding and the meaning associated with the words and text. Watson et al.(2008) found that the interpretive process is achieved by a hermeneutic circle, exploring not only the parts of the experiences but also the whole experience.

The researcher's contribution and experiences are part of the interpretive process and cannot be extracted from the research process, and therefore are an essential contribution to the interpretive process. Bracketing is rejected because the researcher cannot be extracted from "being-in-the-world". Watson et al. (2008) believe that interpretive phenomenology does not require the research to bracket assumptions and preconceptions; instead these are integrated into the research findings.

3.7 Data Analysis

Thematic Analysis provided the framework for the qualitative data analysis. The data was transcribed by the researcher verbatim from the tape interviews and become time consuming, but necessary to highlight individual experiences and "clusters" of themes and ideas. It was necessary to refer back to the tapes on many times to understand the meaning of the nurse's stories and experiences and to interpret what they were saying from the words they used to express themselves. The process of thematic analysis aims to tease out key themes from the raw data and code, in an attempt to make sense of the participant's contributions. My intention was to interpret the conversations shared to understand the experiences of mentoring both from the individual experiences and the shared meanings offered by the group.

Watson et al.(2008) believe that data analysis using interpretive phenomenology recognises that the researcher's preconceptions and background are integrated in the data analysis process. Speziale and Carpenter (2007) agree that interpretive phenomenology does not require the researcher to bracket assumptions; however, it is important to acknowledge one's assumptions so as not to cloud the analysis and provide a clear and "true" interpretation of the participant's experiences. Interpretive analysis

becomes a blend of the meaning that the researcher places on what is heard and what is said by the research participants (Watson et al.2008).

The data analysis becomes a process of my interpretation of what each individual nurse was saying, but also the interpretation of the group thinking. Interpretive phenomenology requires the researcher to use interpretation throughout the interpretive process, at all stages of analysis. Speziale and Carpenter (2007) state that "phenomenology of essences involves probing through the data to search for common themes or essences and establishing patterns of relationships shared by particular phenomena" (2007, p. 86). One wonders if I got it right, or at least did it justice!

Integration of transition theory to enhance analysis of the data presented was useful to gain insight and understanding and therefore interpretation of what was said by individual nurses as well as the shared understanding from the group. This chapter has described the methodological process used in this study. The next chapter offers the contributions of the participants who shared their mentoring experiences to explore the research question...Mentoring, how does it address nurses' learning needs?

Chapter Four – Analysis and Discussion

4.1 Background

The aim of this chapter is an analysis of the research data obtained during focus group conversations. Data was collected from three focus group sessions and includes the researcher's notes during or immediately following each group meeting. The participants arrived at the research venue having received an information sheet which included details of the research project, the focus group process, including number of sessions and approximate time commitment associated with each session and a consent form.

The research participants shared a mixture of experiences and interpretations of what mentoring means to them. This group of Registered Nurses had all experienced mentoring in various forms and in a variety of clinical and learning contexts. There was diversity associated with preparation to practice, length of nursing service, nursing experience and level of seniority within the group. The clinical context was diverse and unique to individual research participants and included both Public and Private Hospital settings. Another complexity associated with the clinical context was the diversity of clinical expertise of the research participants and included the following practise settings... Cardiothoracic, General Surgery, Gynaecology, Intensive Care, and Orthopaedics.

The common phenomenon the group shared was they had all participated in and completed a postgraduate nursing qualification at Speciality Practice within a Masters Level programme during an academic year. A requirement of this programme is student's sourcing a mentor to support them during this year of study. The initial focus group session commenced as a form of a

reunion for the students, some had not had contact with each other since their postgraduate study year. Participants engaged in the research process and conversations enthusiastically and appeared keen and willing to share their stories and views in exploring the question "Mentoring...how does is address nurses learning needs?"

Each focus group session commenced with a welcome and introduction, and included an overview of the research project. I invited the group to consider the following and used this as an introductory statement asking them to share their experiences of mentoring...

"*Anything about mentoring and the mentoring process... your thoughts, feelings, ideas and experiences*".

I asked the group to talk about mentoring in any way they understood it. I wanted to know about their experiences of mentoring particularly during their postgraduate study year.

As probes, I asked the following...

- *Have you had mentors?*
- *Have they been appropriate?*
- *Have they supported you in your learning?*
- *Is there a difference between a clinical and academic mentor?*
- *What are the differences and have you separated them out?*
- *Who decided who your mentor was?*

In order to secure confidentiality the participants provided pseudonym names and I have used the pseudonym initials to present the raw data.

Participant comments will be presented in italic font.

If I were to tackle this project again, I would begin by sharing an understanding and a clear definition of a mentor, particularly within the nursing context, if indeed that is possible. Research participants would be given information and definitions from the literature to help them formulate a shared definition. My first question as part of the introduction would be to challenge the group to define a nursing mentor.

4.2 Key Themes

Themes are identified and further subdivided into categories relevant to that particular theme in an effort to clarify meaning and address the question of...

"Mentoring... How does it address nurses learning needs?"

Key themes and subheadings from the data analysis have been categorised as follows:

Mentor Qualities

- Respect, mutual respect and trust
- Approachable, knowledgeable and role model
- Leadership and personality

Relationships

- Matching mentor and mentee
- Mentoring relationships other than nurse to nurse
- Peer relationships
- Student/Tutor relationships
- Relationships with mangers

Encouragement and Confidence

- Brief encounters... taking the first step
- Continuing on the learning journey
- Giving and receiving confidence
- Supporting others to learn and develop

Questioning and Culture

- Critical reflection of self and practise
- Culture of inquiry and organisational culture

Role Training and Development

The significance of ethics and power within this project, for mentoring and for nursing cannot be overstated and both are interwoven and overlapping throughout this research project. Neither are listed as individual themes or separated out from the body of work, as both concepts overlap all themes and form part of the discussion and conclusion chapters.

4.2.1 Mentor Qualities

The participants shared views on what constituted mentor qualities in an attempt to explore the research question and offer a definition of a nursing mentor. It is important to address the qualities required to be a mentor in order to understand who is suitable for this major responsibility. There was rich discussion regarding the qualities of a 'good' mentor, and included a brainstorming session to highlight these qualities.

4.2.2 Respect, Mutual Respect & Trust

"Someone you respect, you are keen to follow" V explained.
Respect was highlighted as an important quality of the mentor. The brainstorming session revealed the following when the group was asked what qualities they thought were important for a mentor to have...
J started... *"Respect... You respect their knowledge... You respect their ability"*.
V added... *"And you trust their ability, as well"*.
K said... *"And patient towards the person they are mentoring; they've got time"*.
"Personality... it's no use looking for a mentor and thinking, I can't stand that person!" said V laughing... *"You wouldn't pick her as a mentor; no, you'd pick someone you liked... someone you'd get along with"*.
J agreed... *"No. That's right; you'd pick someone you liked and would get along with and also someone who would be helpful to you"*.
L added... *"And also somebody who respects you, even though you might not be as knowledgeable as them, they still respect you as a person"*.
"And that they believe in you" said K.

M said... *"It's about trust; it's about supporting each other and it's about resources".*

The word respect was mentioned first, almost without hesitation. General agreement from the group was they would respect the mentor for their level of knowledge, but they would also respect for their ability, adding the importance of trust within the relationship. The concept of respect was one of a reciprocal process whereby the mentee would seek a mentor who they respected, but it was also important for the mentor to respect the mentee as mentioned by L.

M summarised this way... *"Also, I think, a mentor is someone that (pause)... a mentor is someone who grows with their student, very much, you know. And that the student isn't the only person learning, it's alright for the mentor to perhaps make a mistake, because you're both on a learning curve".*

4.2.3 Approachable, Knowledgeable & Role Model

There was general agreement that the mentor had to be approachable and knowledgeable but also act as a role model. Two participants talked of approachability as simply the way they would welcome new staff onto the ward. L explained it this way... *"I remember having a student and there was a few of us who had students. And she (the student) said... I'll work with you, to me, because I'd said, Hello, I'm L, how's it going? Just really simple stuff".*

J added... *"'cause mentoring can be just as simple as that... you turn up and somebody saying... I'm so and so and I'll just show you around. And it's just a passing thing, but of course it's so important".*

The ability to be approachable as well as knowledgeable was summed when L said... *"And someone who is approachable... very approachable. Someone who knows what they are doing and why they are doing it".*

There was a difference highlighted between being approachable and being available. There are potential mentors who are 'available' but not approached if they are working clinically and have a patient workload. C explained it this way... *"I did find myself in a quandary at the time, because*

the patient was the focus NOT my assignment. I didn't want to impinge on that because you had the role of the nurse". Time with patients is sacred and not encroached upon by nurses for their own needs. This clinical time is perceived as exclusive for the patient. This discussion was endorsed by N when she said she never worked on assignments at work, or during work time; she said... *"Even if I had a quiet time to sit down and study and even though it was related to nursing I didn't feel I should be doing it... I might miss something important because I'm so engrossed in what I was reading, mentally... whereas some people think nothing of it!"*

Being knowledgeable was an important mentor quality. Mentors must be knowledgeable, but more importantly they must be able to share their knowledge. There was general agreement this knowledge had to be shared to be of value in a mentoring relationship. A mentor had to have knowledge, but also had to be able to share their knowledge. They had to be able to explain themselves. K said... *"You want to pick someone who is knowledgeable and has advanced knowledge".*

Role modelling was another important issue and included demonstrating that you were part of the nursing team. V mentioned that a mentor would be someone who would not be afraid to do the work themselves, and would not ask you to do something that they wouldn't do themselves. In other words, they would 'roll their sleeves up and get amongst it'. V stated... *"They'll do things, or set you tasks that they're not afraid to do as well. Like, stuck in the sluice room, all the time, they're not afraid to be in there as well".*
The description of a "good role model" was highlighted by J when she said... *"When I grow up I want to be like her".*

V reflected that when she was a student she felt it was important to be matched up with the right person. When I asked her who the 'right' person was she responded... *"I want to be like her; I want to do what she is doing... has a rationale for what they are doing... and it makes sense... and they explain themselves".*

L put it this way... *"But you do expect the mentor to be able to identify some of your learning needs, because they're more knowledgeable".*
N added... *"You know W is knowledgeable, whereas you might not know whether someone else has that level of knowledge".*

L highlighted that... *"Some people give you the impression they have lots of knowledge, as well as are approachable, but then you find out they don't know as much as they make out!"*

J added... *"Or they can't apply that knowledge to practise. Because knowing it from the book is completely different from being able to demonstrate it".*
This comment resulted in general agreement from the group with *"Yep, yep"* responses.
K summarised *"... Because you do need to be a good role model to be a mentor... but not all mentors are good role models".*

4.2.4 Leadership & Personality

There are parallels between mentor qualities and leadership ability. Highlighted was the personality of the mentor its significance in forming and continuing a mentoring relationship. Participants made reference to different personality traits and how these impacted on the establishing and sustaining of mentoring relationships. Participants made reference to the importance of the personality of the mentor, highlighting that certain personalities were more conducive to mentoring. The personality of the mentee was also significant to the relationship, especially if the relationship was to develop and benefit both parties.

M said... *"There is something different that makes you a mentor".*
K added... *"Perhaps the mentor needs to be a lateral thinker... needs to be an 'all rounder' ".*
L said... *"They might have a skill, but they don't have the personality. You know they know what they're doing (pretty much)... but you wouldn't want them as your mentor!"*

As part of a catalyst for conversation at the second focus group session I decided to use key words drawn from the data shared at the first session. I had place keys words onto coloured paper. One of these words was 'flexibility'. Discussion included the following... V felt that this meant... *"The mentor coming down to your level... so you know where to go to from there"*.
K interpreted flexibility of the mentor by stating *"My mentor had an open door policy"*.

4.3 Relationships

As human beings and nurses we form relationships with each other, the patients and all members of the multi-disciplinary team. Mentoring requires the forming of a relationship and the research participants shared a variety of situations and interactions they perceived fitted the definition of a mentoring relationship. These relationships included mentoring patients and their families, mentoring medical staff, mentoring nursing colleagues and mentoring students in both the clinical and academic environments.

4.3.1 Matching Mentor and Mentee

There are many situations when the nurse makes the choice as to who they would approach to mentor them. There are also those situations when mentors and mentees are paired together without the consideration of mutual attraction. Discussion covered historical perspectives with reference to the role of preceptor and preceptee, rather than that of mentor/mentee. This demonstrates the different relationship for the preceptor and preceptee whereby a new graduate is entering into the practise world and works with an experienced member of the nursing team. Two participants highlighted that they had no choice in the selection process, often the case with preceptor/preceptee relationships.

Two participants acknowledged that they didn't get along with their preceptors however; they also acknowledged that they did learn from these

experiences. C reflected that the person, who had precepted them in the early days of their nursing career, was in fact *"the wrong person for me"*. C explained... *"I remember when I first started nursing I was mentored with someone...I didn't have a choice who it was. I remember thinking, later on, that the person was the wrong person for me, and how they did things. Someone else would have been better to mentor me; you know...their style and their personal actions"*.
B said... *"The person that precepted me, I didn't get on with personally but their way of just being very matter-a-fact was great, as a new grad because I learnt everything right the first time, the right way, and she was just very good... 'cause you got it right or you got it wrong. And she told you exactly where you stood. I appreciated her honesty and direct approach, but certainly we were very different in the ways that we would have done things"*.

B's mentoring experience of the early days as a New Entry to Practice Nursing Graduate highlights the importance of a structured approach to integrate learning in the clinical environment and acknowledges the clarity of knowing the right and wrong ways of doing things. B did however say that she didn't get on with this person personally and that they were very different, which begs the question of the quality of the relationship and the quality of the learning situation.

Sharing ourselves is a requirement of being a nurse and mentor, and is also a requirement of being mentored. Mentoring relationships require nurses to share something of themselves with others. These relationships require flexibility by both the mentor and mentee, and this may be one of the distinguishing features for this relationship as opposed to the preceptor/preceptee and the clinical supervision relationship. Data shared highlighted issues associated with the formation of relationships and the process involved in sourcing a mentor to support the learning journey. Conversations included how nurses decide who would be the 'right' mentor for them and whether this person can offer them the support they need.

J made reference to those nurses who offer mentoring support within the clinical working environment explaining it this way... *"Someone to hold you up when you've fallen down or somebody to say... hey, hold on a bit, you're getting a little bit ahead of yourself".*

4.3.2 Mentoring Relationships... other than nurse to nurse

Participants highlighted that mentoring relationships are not always nursing colleague to nursing colleague, and although the context of this research was mentoring experiences during a year of postgraduate study I had asked the participants to share any and all of their mentoring experiences. I placed on limits on the conversations and experiences shared. Participants talked of those mentoring relationships other than nurse to nurse and included situations with student nurses, doctors, and also 'mentoring' patients.

Participants shared stories of mentoring situations with people other than nurses and the following comments illustrate these relationships...
K referred to the mentoring support she received from her father, especially as she developed her computer skills and summed it up...
"Mentors in a uniform as opposed to mentors NOT in a uniform".

K also referred to her role in the preassessment clinic as a form of mentoring the Medical staff stating... *"House Surgeons come in and don't know where to find things... and how things are meant to be done. They get thrown into the deep end a lot of the time. A lot of them don't stay (in the profession)... because of the stress, and no-one helps them!"*

C has a nursing role that involves mentoring patients.... *"The client is now the patient and I see my role as mentoring them individually, into lifestyle changes that are sustainable".* C also talked about the role of mentoring in the community... *" I look at my role sometimes, mentoring groups of people, you know, out in the community, exercise groups and I go and touch base with them... keep a face there... answers questions... offer support".*

J, M and V shared mentoring situations with student nurses... J said...
"Because I'm in this job and what I do, I teach a lot of students and a lot of staff coming through, I must admit, sometimes I feel overwhelmed... that people just keep coming back and coming back!"
M said... *"I worked with some students... nurses who thought they knew where they were at. When I looked at them, they were nowhere near where I thought they were at! And you have to 'gently' bring them back".*
V stated... *"We also had students... two 3rd year students... in the last six months of their training and you think, good they'll be able to do this and this... then you find out... this is their FIRST hospital placement!"*
L said... *"Which is funny because before I said I didn't mentor anybody, but I suppose I am in a way; you know, down in the clinic because we get Medical Students down there".*

4.3.3 Peer Relationships

Another dimension within the mentoring relationship is that of fellow students, often referred to as peer or horizontal mentoring within the literature (Jones, 2008). Clearly at postgraduate level and within the senior group of nursing practitioners this type of mentoring is well suited. Peer mentoring offers the Postgraduate nursing student support from colleagues as they develop academic expression, computer skills, and information literacy skills of searching and critiquing. J stated... *"But it wasn't just the mentor, the whole group around you, supporting you. And you become mentors to them; and they become mentors to you".*
Three participants highlighted the peer mentoring relationship they formed during their postgraduate study year, K, J and V.
"V had recently been learning...that's what I saw in her. I didn't have any problem asking V" J said.

J's shared her story of doing the postgraduate programme over two years as opposed to the recommended one year time frame, this occurred for a variety of reasons, beyond her control. J tells of the different experiences between the first year and the second year, specifically in relation to the support of

peers. She explained it this way... *"I did my study in two parts, as you know, and the first time I did it, I did feel quite alone, but thought I was supposed to be alone. Possibly I struggled a little bit because I found it difficult to ask for support and advice, or anything like that. But then... after I teamed up with V and K to do the next one, it was totally different, because I felt I had people to go too".*

Although these adult students bring with them many years of clinical experience they are entering the unknown and challenging academic world as students and learners, needing to achieve specific requirements to complete the postgraduate qualification. The research participants highlighted the support of fellow students as part of their postgraduate study year, and the support they gave and received from one another during the year. Some postgraduate groups develop this type of mentoring support more than other groups, highlighting that personality, approachability and availability are all interrelated parts of the process.

4.3.4 Student/Tutor Relationships

Participants identified a variety of people who offered 'mentoring' support to them. L shared that she did not have a *"named mentor"* as she puts it. She sourced the help and support she needed from one of the tutors. L said... *"Actually I went to F, so she was probably my main mentor. F for academic stuff really".*

C mentioned a situation where support came from tutorial staff. C said... *"We had presentations we had to do, and the course director assigned mentoring time with us. He was very approachable, he would come around, and he would just pop in. I found that really good because he 'went out of his way to come to us' to show he was available to us. He also provided clarity about how to write assignments".*

One participant described how the tutor had been the person who encouraged them to attempt postgraduate study. The relationship formed between tutor

and student can offer the support and encouragement before the programme commences, during the programme of study and upon completion of the course.

L said... *"I didn't have anybody like that in my work place. I did it (the course) on my own really. But, when I met F for the first time, I got the same from her (even though I'd never met her before) very quickly she sussed me out, knew where I was at... after a very short conversation and she just told me what my options were...and that I would be able to do it".*

M said... *"I think mentors have special qualities, because I have an Academic mentor now, he has an 'open door policy' which I'm grateful for and he lives in Wellington, which I'm also grateful for (some students are from all over the country!) I can ring him up and say... Hey I can't understand this! I haven't a clue! And he says, pop up. You can do it. You will do it. And if you fail then I'm not a very good teacher! I wouldn't say that all academic mentors are that way" M* added... *"They (mentors) have a responsibility and they need to take that responsibility VERY seriously".*
N mentioned a meeting with the tutors... *"I remember meeting for a cup of coffee one day... I found that great... the one to one time spent... it was great, just to talk about it (the assignment)".*

Apart from forming a mentoring relationship there is a commitment required by both the mentor and mentee for the continuation of the relationship. Personalities clearly impact on the approachability of the mentor; however, there is also a requirement for availability. As already mentioned the mentor may perceive themselves as approachable and available but the mentee may not have that same perception, especially if the mentor is working in a clinical capacity and has a patient work load. The availability of the mentor was complex and participants mentioned dilemmas associated with whether to approach the mentors and ask for help and support especially if the mentor was working in a clinical capacity. C shared a situation associated with role definition because of a management position but also because the person to offer the mentoring support was also the tutor and worked as a clinical

practitioner for this manager. C explained... *"I did find myself in a bit of a quandary being your manager at the time... the patient was the focus, not my assignment. I didn't want to impinge on that because you had the role of the nurse... I felt it was not appropriate to tell you all my problems".*
E's Unit Manager had done the course the year before and W (the tutor and clinical practitioner mentioned above) was also available. E said... *"I felt I was lucky because my manager at the time had just done the course and was into that 'mode' and I worked with W (one of the tutors) and I knew that I could come to you... I felt well supported".*

4.3.5 Relationships with Managers

Participants discussed relationships they formed with their managers, and how they perceived their managers as mentors to them. Some managers were also instrumental in encouraging nurses to embark on postgraduate study. K referred to her manager stating the following... *"My mentor was my manager, she was the one who got me onto the course in the first place; she told me I could do it".*

C mentioned that... *"The year that I did it (the course) mainly senior nurses did it. We were all managers. So I found I didn't have another nurse manager to go to as such... at the same time it was quiet good, supporting each other and knocking around ideas about what assignment topics we were thinking about".*

4.3.6 The Adult Student

There was in depth conversation regarding the adult student as mentee. J said... *"Isn't it just one adult supporting another?"*

Contradictions included adults are self directed learners who should be able to question, critique and ask for help if and when they need it. General consensus was that although postgraduate nurses are adults, they are also learners, students and protégés of the mentor and therefore one must not

make the assumption that they are all self directed and self sufficient. This is highlighted by the data suggesting the significance of encouragement and how powerful that was as a catalyst for embarking on postgraduate study. One must avoid assuming that adult nursing students do not need the help, support, encouragement and confidence building, or that their needs are different or less than the needs of more junior nursing students. Data highlighted the significance of all of these features for the adult nurse studying at postgraduate level.

M shared... *"Well a year ago I couldn't use a computer! My kids would be forever teaching me... now; I'm up with the play... I feel so great!"*
V added... *"I couldn't use a computer either, I mean I really only used it as a word processor. In the last year I've learnt to send emails... and pictures! Up until the last year, I couldn't send emails. I'm still not brilliant at it!"*
J agreed and said... *"And I needed to go to V and ask... what does this mean? What are they asking? Instead of the language they're using, you tell me in ordinary language".*

V also commented on the challenges for the adult student regarding assignment language saying... *"I spent hours with the dictionary going through those great big words... thinking... what does that mean?"*
L offered a different view point adding... *"I'm an adult, I knew the things I needed to know, and so I just went to the people... I've always done that. You just go to someone and you ask... someone you respect and someone you think knows".*
Adults will strive to make links of knowledge and its application, investing much time and energy into why they might need to learn something. The research participants shared a mixture of responses regarding this aspect of knowledge seeking. There were those who felt that because they were adults they could and would ask for help when they needed it. There is an assumption that adult learners are able to find out what we need to know, and ask for help if and when they need it.
L made the comment *"If I don't ask for help... people can't read my mind! My parents told me when I was at school that I must ask for help if I need it".*

4.4 Encouragement and Confidence

Another theme of significance for the research participants was encouragement and the ability of other nurses to not only have belief in your ability but also to see your potential to achieve. Insightful nursing mentors were those who were not only able to see your ability and potential, but were also able to support you to achieve that potential. Three participants highlighted those 'mentors' who had recognised qualities in them that they had not identified within themselves. M described a situation illustrating the role of encouragement and the impact it had for attempting postgraduate study saying... *"I'm absolutely sure that if that person hadn't made... (Pause)... what seemed like an innocent comment I would never have contemplated it (the course)"*

L reinforced the significance of encouragement and put it this way... *"It does just show how important encouragement is; and how not to under-rate it, really. How important to encourage other people around us... as well"*
M added... *"Encouragement makes you grow!"*
Other terms used to describe the process of encouragement included words such as *"helping and directing"* and *"she gave me the incentive"*.

4.4.1 Brief Encounters... Taking the first step

Mentoring experiences for the research participants included encounters with nurses who provided the catalyst for professional growth and development including career advancement and attempting postgraduate study. Are these people mentors? According to this group the answer is 'yes'. Stories shared to illustrate this included the one from K with reference to her manager and the fact that she did not complete the programme herself but offered support and encouragement for K to enrol.
K said... *"She encouraged me; even though she never completed it herself, she was so encouraging... and she believed in me"*.

At face value one might think that small comments and short interactions would not be influential, however, many participants highlighted situations that were clearly the catalyst for further professional development and perceived these situations as mentoring ones. It was demonstrated that brief interactions have the potential to have a lasting impact. Which begs the question; could this be classified as mentoring? And if this is the case what is the relationship between the mentor and mentee? Would the mentor know that these brief encounters resulted in such a big impact for the mentee and would the mentor know that they were perceived as mentors by these people? Clearly this influence is both potentially and actually affecting the direction of another's career or working life. Career development for some nurses involves postgraduate study and the research participants shared experiences of those who had a major influence on them, not only enrolling in postgraduate study but also achieving the qualification.

J said to one of the other research participants... *"You say you've identified some key people, but do they know that's what they are to you?"*
J questions... *"Does it have to be two people identified... or can it be one person thinking... Gosh! That person has shaped some of the things I do... and the person I am".*

4.4.2 Continuing on the learning journey

There was evidence from the research participants that postgraduate study had indeed encouraged and supported development of critical reflection and academic thinking. Conversations shared to illustrate this include...
K said... *"Well you know how to research now, whereas I never knew that before".*
V mentioned the importance of... *"The mentor believing in you...and saying you can do it, you can do it and you start to believe it yourself!"*
N said... *"And she was such a good mentor... she just carried you along with her... And she'd been doing it for 35 years! And it was still so new and fresh!"*

4.4.3 Giving and receiving confidence

It was clear from listening to the tapes that along with encouragement and forming a relationship the participants highlighted that their mentors gave them confidence. This confidence building process not only occurred from the perspective of the ability to realise their potential but also to enhance it and giving nurses the confidence to achieve goals set either by themselves or by their managers.

Mentors offered confidence building that allowed the mentees to not only believe that they were capable of completing the study programme but also that they were capable of integrating their new found knowledge and skills into daily clinical practice. This meant those students who had not formally studied since their original nursing training now had a level of confidence boosting them to believe they were indeed capable of keeping abreast of current practice trends.

J mentioned that... *"I did my training in '72 and had never come across* ***anything*** *like this before!"*
E asked J... *"Now that you've completed a postgraduate certificate and when you are mentoring... are you a lot more confident in your knowledge and education?"*
J responds... *"Most definitely! It just gave me that little extra boost... Oh yes! I do know a little bit!"*
C said... *"I had more confidence to stand up and talk... and to do literature searches".*

4.4.4 Supporting others to learn and develop

C recalled a story of working with a senior colleague while they were overseas and shared the following... *"... and we had a close relationship. She wanted me to become a Charge Nurse at night... She mentored me, in a way... I didn't think I was good enough to be in that role; I hadn't been there that long but you know it was just what she said to me that stuck in my*

head... You're calm, you talk the right words, and you know what you're doing".

L added... *"She saw leadership qualities in you, didn't she?"*
E said... *"That's the role of the mentor; she nurtured you".*
C reflects... *"She nurtured me into the role".*
J adds... *"She identified you as 'potential', and then gave you the support and encouragement to possibly step up to the role".*

4.5 Questioning and Culture

4.5.1 Critical reflection of self and practise

L shared that when she is working with students she is evaluating the process all the time; she said she is constantly asking herself... *"Are they getting it?"* Reflection as part of learning and gaining knowledge in the pursuit of practice development is integral to the nursing world, and has been endorsed by the nursing council and nursing educational institutes. Reflection *in* action and reflection *on* action are both important within the clinical practice setting. Reflective practice development is integral for nurses, not only within the world of clinical practice but also for academic scholarship.

Ethical questioning becomes a part of everyday practice, and J said there were many situations at work when she would ask colleagues...
"What is the right thing to do for my patient?"

There was general agreement from the research participants that in many clinical situations nurses draw on each other to sound off ideas and *'check in'* with each other that indeed they are doing the '*right thing'* for and with patients. Reflection is a powerful tool to evaluate knowledge gained and also explore skill development. Reflection offers a means of evaluating what one knows as well as what one does. The reflective process allows the mentor to evaluate their own practice but also to evaluate the learning they are providing to mentees.

L stated... *"We all do that... don't we? Nursing lends itself to reflection and critical reflection. The whole of your nursing career, you sound off with each other".*

M said... *"As a team we very much mentor each other. There are eight of us on nights and we work together, asking each other various questions throughout the night".*

V added that... *"Even during the day; we get surgical patients in the orthopaedic ward and we have to find out... Are they allowed to get up? Are they allowed to drink?"*

The ability to question and reflect on practice and learning are integral to the development of critical reflection, evidence based, advanced nursing practice and ultimately professional growth and development. Data analysis highlighted these links, with participants identifying the role of questioning and its significance to current nursing practice.

E shared... *"We, (nurses)... "Used to be task focused... today it's about looking at the research".*

As E reflected on her mentoring experiences when she was supporting another staff member into a new area of clinical practice she said... *"Should I be telling him how to do things my way?"*

There is an assumption that questioning practice has become far more acceptable nowadays. Indeed it is a requirement as we move into the world of evidence based practice. The expectation of today's nurse is one of reflective and questioning practitioner. Although we have started to value the process of questioning, C highlighted one of the barriers. The story shared involved two instructors during a prescriptive study course; C was one of the instructors and mentioned that the other instructor was incredibly knowledgeable and in fact this intimidated learners and impeded the questioning process. When a question was asked C stated that the instructor answered it... *"Straight out of the book!"* C commented... *" She answered the question straight out of the book! Verbatim, and I thought BEEP, BEEP, even I was scared! She had so much knowledge!* C reflected on this

experience and added... *"What it did show me was that, after that... there were no more questions, everyone was afraid to ask questions!"*

4.5.2 Culture... of inquiry and organisational culture

C added that... *"I think the key is that we are all scared about being asked a question... something... admitting that we don't know the answer".*
The participants highlighted the changing role of the senior nurses and there was no longer the expectation for the senior nurse to know everything.

Participants shared experiences of how the mentor and mentee could explore answers to questions together, and in fact, the senior colleagues would gain credibility by admitting that they do not know *'everything'*. There are times when mentor and mentee search together for answers to particular questions. J illustrated this when she said... *"And that makes you appear very human to them; I think, to go on that search together is very rewarding".*
The group highlighted the significance of searching for the answers together, so that both parties embrace knowledge seeking and *'the learning journey'* together. In this case, *both* parties develop during the relationship. E highlighted this point with reference to being questioned and challenged by mentees adding... *"And that's happened to me a few times also, and I could quite easily put my hand up and say...good question! (Laughing) Why don't we go and look that up!"*

This was followed by laughter within the group and acknowledged with the nodding of heads and the *"Yes" "Yes that's right"* responses to E's comments. Today it's important to admit when you don't know the answer and it's OK to search for answers together.
Seeking the answers to questions by searching together can be extremely positive and rewarding for both parties and forms the basis of what I refer to as *"the mutual learning journey"*. The ability of the mentor and mentee to work as a team and share the learning process was perceived as incredibly positive.

This was illustrated by E... *"As a mentor, as well, we do learn too, because we are being* ***challenged*** *and we're being* ***asked questions*** *because... we don't know everything do we?"* E went on to say... *"And to be able to go and access the resources to find out what they want to know.... you're learning in the process".*

C agreed by stating... *"Yes, I think that's true"*
The culture of inquiry was illustrated by L's comments... *"I learnt that as an 8 year old, if I needed help, I had to ask for it".* Contradictions occurred when V shared her experiences as a student nurse (albeit back in the late 70's and early 80's) being told (as her assignment was literally thrown back at her)... *"I don't know how you passed; you'll never make it as a nurse!"* V went on to say that these experiences affected her ability to ask questions, to ask for help. V stated she learnt... *"You don't ask the teacher for help!"* And also that *"I was always dumb! I've always lived my life as being a dumb person".*
The group discussed the process of evaluating their own clinical practice and also the support they provided to others nurses when engaged in mentoring. From the perspective of their clinical practice J made the comment... *"The whole of your nursing career you are sounding off with others... Am I doing this right?"* This highlights the significance associated with working as a team and working with other nurses in the clinical practice world. J shared how the practice world of nursing is about working with other nurses and how we *'check in'* with each other.

K stated... *"Even at top level you still need to ask (that's what I find) because everything is changing so much. Practise is changing SO fast!"*

Organisational Culture

The researcher took an opportunity to ask the group about power dynamics in an effort to explore nurse's experiences in relation to the mentoring process. J had said that... *"nurses can be cruel to each other"* however, the group felt that things had changed. Interestingly enough, there was general agreement

amongst the group that this is no longer an issue and that nurses are much *'nicer'* to each other nowadays. This was followed by reflection and discussion as to why things had changed. Another brainstorming session followed a probing question from the researcher as to why they felt things were different today as opposed to historically...

J started with... *"Why are nurses so cruel to each other? What is it? Is it competition? What is it?"*
E mentioned... *"Over there (in Saudi Arabia) there is a hierarchy system and the pay system is hierarchical also".*
J said (with regard to V having her assignments thrown back to her)... *"That would NEVER be tolerated today!"*
V and J felt there were several reasons as to why things are different today, sharing... *the older nursing student (many are in there 40's), they are paying for their nursing education today, whereas we were paid to work in the hospital, and our training was 'on the job' and student nurse are probably more savvy today.*
E felt we are... *"Just a bit more polite".*
C mentioned... *"There are still places where the stress of the workplace and environment creates... that poor attitude towards colleagues".*

This led onto the discussion of power (by the researcher) rather than by the research participants. Power was generally perceived in a positive way, which was extremely refreshing, given the potential for negativity. There was an assumption that the historical behaviour would not be tolerated today, and that nursing students were much more likely to stand up to colleagues if they felt they were being mistreated. One wonders why this group feels this way when the literature would clearly contradict this belief. Have these nurses, who have experienced negative behaviour, modified their own ways of teaching and supporting others and have learnt to oppose it? Have these nurses made a transition and left the past behind, letting go of the negativity and moving forward in positive ways? Are these nurses working in areas that truly do not tolerate this behaviour? Are these nurses working in organisations where this behaviour is not tolerated? Power and the culture of

the working environment are closely linked and my assumption is these nurses are working and learning in safe and positive environments that appear conducive to education and professional development. This is highlighted by the organisational support for these postgraduate nursing students and the resources committed to supporting nursing education.

The Organisation

Encouragement came from a variety of sources and participants shared experiences of the impact of the organisation, these encounters were also perceived as forms of mentoring. One participant shared her experiences of the email she received from the Director of Nursing and how she found it so encouraging not only to attempt the course, but also to ultimately achieve it. M stated that the email included such comments as... *"I'm so pleased you've decided to do the course. Well done! You'll be great, and you'll enjoy it! We're all here to support you"*

Initially the encouragement provided the catalyst for enrolling in postgraduate study, with participants stating that senior nursing personal such as the Nursing Managers and Directors of Nursing offered encouragement and belief they could actually attempt it and this was supported by ongoing encouragement so that they continued and achieved the qualification following completion and submission of the necessary course work. K said... *"If it wasn't for her, I not only wouldn't have started it, I never would have completed it!"*

There was general agreement that if tutors were passionate about the development of nursing practice and passionate about their roles as teachers, students become motivated and were encouraged to develop and complete the programme of study, but that it was also important to have, as M put it... *"... the organisation behind you"*.

4.6 Role Training and Development

Informal mentoring is a given within the nursing profession and will probably always be part of the clinical practice world of the nurse. Most research participants had been mentors at some stage during their nursing training and many of this group where in senior nursing positions, and therefore had experienced various forms of mentoring.

K referred to a nurse she had worked with and stated... *"... but she was a mentor; even though it wasn't labelled as that".*
E questioned... *"How do we know we are doing it right?"*

Although these nurses had been in mentoring roles there were concerns as to whether they had preformed these roles sufficiently. I was not aware of any formal training the research participants had received to support their mentoring roles. E mentioned... *"How do we know as mentors we are doing a good job? If they don't come to me to ask questions, am a failing as a mentor? Because they are not coming to me?"*

Debate and discussion around role training and development highlighted general consensus that there was an expectation of senior nurses to perform the role of mentor, irrespective of training to support them in this role.

Mentoring support is expected irrespective of the qualifications of the nurse. Caution must occur here, as highlighted by the participants, merely being a senior nurse within a clinical practice area may not directly translate to being the most suitable person to mentor others.

M stated... *"The mentor they get at that stage (is really important)... 'cause I've actually seen one new grad that had a mentor... and I'm absolutely sure she left nursing because of her!"*
M added that... *"Mentors can make or break new grads".*
E said... *"How do we know as mentors we are doing the right thing, if we haven't had any formal training in it? It's quite an art!"*

J rightfully stated... *"Not everyone is capable of being a mentor"*
K felt... *"It was a huge challenge, in our environment... our busy clinical environment"*.
K referred to a mentor in her workplace as *"awe inspiring"*. She went on to explain this comment in more detail, stating... *"They are just such fantastic people; they are almost 'God-Like' you know! They are just so nice to talk to, and they think you are wonderful and they really want to help you... and they are really special people"*.

The transition through ones nursing career requires different support at different stages of practice development as nurses integrate new skills and knowledge with evidence and reflection. Role training and development must consider these complexities. The profession must nurture and support those nurses willing and able to perform the role of mentor. This ability is dependent on a variety of factors, both personal and organisational. Although the role of the mentor may come 'naturally' to some, for others role training and development begs further exploration and discussion.

Multiple mentoring roles within the nursing profession requires further consideration for role training and development including the nurses role when mentoring patients, as opposed to mentoring medical staff. Although there are commonalities with mentoring nurses, either junior nursing staff or nursing students specific role training can be enhanced and developed by training programmes. The role of the mentor within the multi-disciplinary team also requires further consideration as many nurses are involved with physiotherapy, occupational therapy and medical personnel (both senior and junior doctors). While many of the principles and practicing will be similar one must acknowledge the uniqueness of each group and the specific needs of each.
As J said... *"Not everyone is capable of being a mentor"*.

The analysis presented reflects the complexity associated with mentoring for nurses and the diversity of the various forms it takes. All research participants had completed a postgraduate qualification, in addition to the

commonality of being students, they all shared experiences of being mentored and their experiences of mentoring others. Data highlighted experiences and perceptions of the research participants and the researcher collectively to illuminate key themes in exploring the role of mentoring to address nurses' learning needs. The following chapter provides discussion related to the analysis and makes links to the literature to confirm the interpretations.

Chapter Five – Discussion

This chapter provides discussion related to the data presented and its relationship to the analysis and key themes. A selection of literature reviewed has been integrated to support the discussion. Conceptualization of the data is presented under the following headings although complexities demonstrate areas of overlap and interconnectedness.

5.1 The Role of Mentoring

5.1.1 Personalities

5.1.2 Expectations

5.1.3 Training and development

5.2 Transition

5.2.1 Learning transition

5.2.2 Practice integration

5.2.3 Culture of inquiry

5.1 The Role of Mentoring

5.1.1 Personalities

A clear and concise definition of a nursing mentor remains elusive. Data highlighted many of the qualities perceived as ideal for the mentor. This information provides a useful framework for seeking those with 'mentor potential' to support nurses. Qualities required of a nursing mentor are multiple and parallel the qualities of nursing leaders. The research participants used the words trust, respect, knowledge, energetic, intuitive, and sound practitioner to describe mentor qualities. Data revealed that while all the above qualities are essential for good mentors the personality of the mentor was also significant. As Fawcett (cited Flynn and Stack, 2006)

indicated "effective mentors have the following characteristics: patience, enthusiasm, knowledge, a sense of humour, and the ability to engender respect" (p. 151). Conversations revealed the mentor had to be cheerful and pleasant, with a welcoming attitude towards all nursing staff, but specifically the mentee, if the relationship was to develop. Literature supported the relationship between mentor qualities and leadership qualities. Wilson, Woodard Leners, Fenton and Conner (2005) recognise that "mentorship is intrinsic to transformational leadership and foundational for professional nursing leadership" (p.45).

Distinctions can be made between the role of mentor and preceptor. According to Firtko, Stewart and Knox (2005) preceptoring does not occur outside working hours where as mentoring can be considered as a 24-hour responsibility. This level of commitment requires the mentor to be passionate. Nursing mentors must be passionate about nurses, and about nursing, whether that is in clinical practice, directly working with patients and families, or with education to support nursing practice development. The personality of the nursing mentor depends on many individual factors. Personal and professional experiences would impact on a nursing mentor's ability to develop clinical expertise and support the development of other nurses.

It is difficult to evaluate the personal characteristics of a mentor, except to say both mentor and mentee form a bond and the relationship develops from that point. There is an expectation that the mentee takes responsibility in deciding to form a bond. Apart from this initial formation of the bond the mentee must also assess the merits of the mentoring relationship and whether it works or not. The profession must be mindful of ensuring that the mentor/mentee relationship is beneficial to both. Destructive and 'toxic' mentoring relationships must be recognised and avoided and current literature suggests this remains problematic. The implications of these negative situations often go beyond the immediate mentor/mentee relationship. Our nursing work force is precious and must not be destroyed or lost as a result of negative teaching and learning experiences. Data highlighted situations that mentor relationships had resulted in nurses leaving the profession and there were historical views highlighting negative

comments and destructive behaviours potentially impacting on mentoring relationships. Recruitment and retention, job satisfaction and work productivity require positive working environments conducive to learning and development (Wagner, 2006; Clarke, 2007; Letvak and Buck, 2008). Organisational culture must ensure nurses work in safe, positive and blame free environments, conducive to learning and professional development. Knowledge development of the mentor and mentee was a significant finding from the data, again consistent with the literature reviewed. It is important for the mentor to attain a level of knowledge perceived by the mentee as expert, but also that the mentor is willing and able to share this knowledge. Stevens Barnum (cited in Flynn and Stack, 2006) observes that "teaching is content focused; mentoring is student focused" (p. 14). Mentors must develop a sound knowledge base within their area of clinical practice but more importantly have the skills required to share that knowledge in pursuit of mentee development. There would be value in assessing the quality of the mentoring relationships by evaluating the process of learning and knowledge integration from both the perspective of mentee and mentor.

One of my assumptions was that postgraduate qualifications would secure quality mentorship and while this may be true to a certain extent, clearly quality mentoring relationships go beyond whether a mentor has a Postgraduate qualification or not. The research participants mentioned the specific qualities required of "good" mentors and highlighted the importance of knowledge and 'advanced' knowledge but this was not explored further. If education initiatives are to support student development at Postgraduate level it would be useful for these mentors to have knowledge of the requirements and expectations of Postgraduate study. I don't believe we have the luxury to exclude good mentors without postgraduate qualifications from mentoring students. However, it would be valuable for these mentors to have access to student handbooks and a guide as to the expectations of the study programme and the potential mentee support required. Merely having a Postgraduate qualification does not translate to being a "good" mentor any more than having a particular number of years of clinical experience makes an expert practitioner. Experience according to Benner (1984) is not the

mere passage of time but theory development from multiple and various encounters of different clinical situations.

5.1.2 Expectations

My assumption that mentoring is complex and a difficult process to "pin down" is accurate. This is endorsed by Belcher (cited in Flynn and Stack, 2006) "Mentorship is a highly complex and developmentally important relationship" (p. 149). Data revealed that participants believed part of the mentoring role was one of socialization into the clinical practice world. There was discussion regarding the helping and directing aspects of the mentoring but also the importance of other staff members taking the time to show you around, often referred to by the group as "the simple stuff". Beyond this was an expectation that the mentor would take a personal interest in you and your needs.

J said... *"To me; it's just being a buddy, that's where it starts, the building of a tight relationship".*

As the focus group talked more and shared more experiences of mentoring it became clear that mentoring is far more than just simply the socialisation into the work environment and the need to be shown around and made to feel welcome. A study by Thomka (cited in Lloyd and Bristol, 2006) highlighted the importance of the mentoring relationship for graduate nurses in their first year of practice as part of the professional socialisation process. One participant summarised mentoring as "an art". Highlighting the complexities associated with art and the individual interpretations of various pieces of art. As the group drilled down to uncover the meaning of mentoring M shared the following comment...

"A mentor is someone who grows with their students BUT you do expect your mentor to identify some of your needs because they are more knowledgeable".

There are expectations for both the mentor and the mentee within a mentoring relationship. While it is important for the mentor to offer support and guidance it is also important for the mentee to seek support and guidance from their mentors. Data revealed several examples of nurses (perceived as mentors by the research participants) who realised and identified potential in them, often before they realised or appreciated it for themselves. The research participants regarded such situation as mentoring relationships. The nurses were perceived as mentors, because they provided a catalyst for change and growth, and are seen as part of the mentoring process. Bridges (2004) mentions "Genuine beginnings begin within us, even when they are brought to our attention by external opportunities" (p.169).

Questions arising from the data analysis indicate that the support and guidance for the mentee and the ongoing development of nursing practice must come from those nurses willing to share their skill, expertise and knowledge as well as themselves. "Expert clinicians understand reasoning in transitions because they are used to comparing directly one practical world with another in their clinical practice" (Benner, 1994, p.103). The appropriate nurse to do this may not always be the one readily available and accessible to the mentee. Another complexity is associated with the issue of who decides who the "appropriate" person is to provide the mentoring support. Where do we find these "super" nurses? How do we nurture and support them to nurture and support others? What qualities and qualifications do we require of these nurses who are willing to support Postgraduate development during a year of study? What expectations do we place on these mentors to support learning transition from Registered Nurse to Postgraduate student and then to Postgraduate practitioner?

There are expectations for adult nursing students. Assumptions include that because these nurses are adults they will ask for help, if and when they need it. Participants highlighted this was not always the case and as adult students they didn't want to appear stupid either amongst their peers or to the tutors.

Participants also shared that they felt scared and sometimes intimidated to ask despite the tutor's explicit communication that questions were encouraged and there was no such thing as a stupid question. Meaning that even with the best of intentions students do feel intimidated, stupid and scared. They leave the comfort of the known and familiar to enter the unknown and frightening. M referred to postgraduate study as a... *"Huge leap into a BLACK HOLE!"*

Consideration for the tutor and assuming that the tutor is "too busy" for students was apparent from the data. Dilemmas occur when there are discrepancies between the expectations of tutors and students. An assumption by tutors that adult students will ask for help when they require is problematic. Student assumptions are also potentially problematic especially when students assume that the teachers are too busy to provide help and support. There are situations when students do not approach teaching staff because of this assumption. Data identified this issue. Dialogue must occur between tutor and student if learning needs are to be identified and ultimately addressed.

Loneliness and isolation can impact on the ability of students to ask and seek help. J highlighted feeling alone but that she thought that was how she was supposed to feel. Clearly these feelings of loneliness would impact on the learning opportunities but also the opportunity to ask for help or question study information and unfamiliar content. The role of the mentor here would be instrumental in supporting the mentee to either seek help from the tutors or the mentor may be well placed to provide the help and support required. Expectations were highlighted with regard to achieving the programme and completing the qualification. There were students who shared that they were concerned about failing and the grades they would achieve for their assessments. One of the students shared her concerns about failing the programme and for this reason she had not attempted postgraduate study before. C shared... *"My biggest concern was failing it....and that's why I left it so long"*.

What then is the role of the mentor?

According to Taylor (2006) "You need courage to look at yourself and your practice, because it takes honesty and frankness to move outside your comfort zones" (p. 49). What can the mentor do to support the student through the transition to postgraduate study? What skills, knowledge and ability must they have to support students to achieve assignments? I believe ultimately it is the responsible of the individual nurse to achieve the assignment criteria and the postgraduate qualification; however, mentors have a key role during the learning journey. Academic mentorship offers challenges to the nursing profession as we build the capacity of postgraduate nurses and develop the ability to support learning through research activities and critical reflection. As Estabrooks (cited in Higgs, Richardson and Dahlgren, 2004) mentions "Nurses ranked their primary knowledge sources as experiential, institutional, medical, intuitive, traditional and finally, literature-based" (p.168).

The Reality

The reality may be that the nursing profession does not have the 'appropriate' nurses to assume the mentoring role. This may be especially true for the postgraduate nurse mentee seeking support from a mentor. Access to a nursing mentor to support the postgraduate student may be problematic. It may also depend on the clinical practice setting and the particular organisation the nurse works in.

There are inconsistencies with what we as a profession believe about mentoring and indeed what is happening in reality. Some would say that *"Mentoring is not about teaching "skills" it's much greater than that!"* and others would believe it's as simple as being *"nice"* to your colleagues. Nursing has major issues regarding recruitment and retention. Now more than ever, we must be mindful of systems and processes that support or impede nurses staying in the profession but also entering in the first place. There are distinct issues around recruitment and retention and many of these

have been highlighted within the nursing literature as we struggle to retain and recruit nurses in 2009 (Firtko, Stewart and Knox, 2005; Flynn and Stack, 2006). Rightly stated by E... *"We can 'make or break' new people by not treating them the right way!"*

Participants felt it was not appropriate to study at work and the working environment was exclusive to clinical practice for patient care. Nursing as a practice orientated discipline requires making links between theory and practice. Development of reflective practice and integration of evidence into practice occurs within the practice setting. Would it not be reasonable for theoretical learning to also occur in the practice setting? This is a challenge for practice as nurses work in busy and stressful clinical situations and may be unrealistic. Staffing levels, patient acuity, resource issues all impact on the ability for nurses to perform their day to day work, let alone find time within in their day to study! L commented... *"Didn't feel I could study at work... thought I might miss something important!"*

5.1.3 Training and Development

Simple and Complex:

The role of training and development was highlighted by the research participants. Training and development to support mentoring processes and student support were viewed by nurses as essential. Educational institutes have a key training role to support the engagement in mentoring relationships. Educational initiatives such as seminars and workshops would provide explicit role responsibilities and expectations to support those in mentoring positions. Exploring mentee expectations would provide role clarity and role expectations also. Sessions on mentoring to discuss role expectations and responsibilities would be useful.

Mentoring is both simple and complex. Stories shared involved the simplicity of establishing a relationship, of supporting, nurturing and checking in with work colleagues. This process was also seen as a means of establishing and maintaining a positive working culture. Many participants

felt that supporting and nurturing each other in the work environment was fundamental to everyday nursing practice. Nursing literature highlights the impact of negative culture, recruitment and retention issues and work productivity. (Firtko, Stewart, Knox, 2005; Wagner, 2006; Clarke, 2007; Letvak and Buck, 2008). Providing a positive environment, checking in with colleagues, and socialising new staff members to the work place were all seen as ways to promote an environment conducive to supporting mentoring processes. Peer mentoring is becoming more widely accepted as an appropriate support system for students. Of note particularly within schools and universities as an informal process providing support for imparting both knowledge and experience. (Kochan and Pascarelli, 2003).

L said *"... I would say... Hello, I'm L... welcome to the ward... real simple stuff and she would rather work with me because I introduced myself!"*
J added... *"Someone there to welcome you... that's where it starts"*

5.2 Transition

5.2.1 Learning Transition

The nursing profession relies on education, clinical practice development and experience to secure nursing expertise and advanced practice. "Nursing's patterns of knowing are interrelated and arise from the whole of the experience" (Chinn and Kramer, 1999, p.7). It is also reliant on nurses making the transition from novice to expert practitioner (Benner, 1984). This transition process requires nurses to become insightful, develop critical thinking skills and take risks. These risks include challenging themselves and their practice. Various strategies allow nurses to enhance their critical thinking skills including mentoring and role modelling. (Fincher, 2004; Murray and Main, 2005). The learning transition process can be supported by the development of leadership, research and education. According to Taylor (2006) "Some questions may remain puzzles to which you will always be seeking insights, and that is OK, because sometimes what you

learn in the search is more beneficial than what you find in the discovery" (p.79).

Central to these processes is the need for nursing support, guidance and counsel. This support can take various forms depending on the practice level of the student and the capabilities of the "guide". Mentoring, preceptoring and clinical supervision are processes that offer the nurse support and guidance at different stages of their nursing practice development. Support roles, I believe, are essential so that the transition of the learning process can be translated into the complex practice world, and the clinical practice world can be understood through education and research. Nursing mentors are those who are interested in sharing their knowledge and fostering leadership skills (Donner and Wheeler, 2007). Ideally this learning transition occurs throughout ones nursing career initially as nurses move from junior to senior nursing practitioners. Both junior and senior nurses throughout their careers require opportunities for ongoing learning and professional practice development.

According to Smit (cited in Kochan and Pascarelli, 2003) mentoring activity is between two people with different levels of experience, knowledge and skill working within the same organisation. They describe mentoring as an active and dynamic process.

Nursing in 2009, I believe, is driven by the complex practice world but also by Government initiatives and regulated by the New Zealand Nursing Council. An essential requirement for every New Zealand Registered Nurse is to provide evidence of currency and competency to practice through the development of a professional portfolio (Andre and Heartfield, 2007). We have moved into the "knowledge age". Butterworth (cited in Butterworth, Faugier and Burnard, 1997) observe that "nursing itself has undergone striking changes in the 1990s... new roles, structures, and demands for advanced practice have asked great things of the nurses" (p.1).
In order for quality learning opportunities to be available and developed the mentor and mentee must work together to enhance learning opportunities

both clinically and academically. The relationship must be one of mutual respect and trust as noted from the data and literature reviewed. Each must value the contribution of the other, to enhance the quality of the mentoring process, and the mentor typically becomes a friend. (Yonge, Billay, Myrick and Luhanga, 2007). Both mentor and mentee must be comfortable in allowing the learning process to provide opportunities for critically reflection of oneself and one's practice, and in doing so challenge thinking and current practice. The mentor/mentee relationship has the potential to support both parties, according to Duffy (2004) "Mentoring is not a one-way street" (p.1).

Nursing should celebrate diversity and enhance the strengths of different practitioners at different practice levels and expertise. The profession should realise that all nurses have something to offer and contribute to nursing. Nurses need to appreciate where they have come from, acknowledge the constant changing world they live and work in, celebrate success, acknowledge limitations, and offer support for further professional development. The role of senior nursing leadership and management is to recognise and strengthen the support structures for the nursing environments to meet the needs of mentoring relationships (Rosser, Rice, Campbell and Jack, 2004; Donner and Wheeler, 2007). Data highlighted nurses who were encouraged and supported by their nursing managers, their Directors of Nursing and also the organisations in which they worked. These organisations send a powerful message to nurses. This message is acknowledging the nurses contribution to the organisation and offers an appreciation of their valuable contribution to the organisation. Nurses working within these organisations feel valued and supported by their employers. One cannot underestimate the impact of a positive culture within the working environment to support nurses, essential to encouraging them to not only embrace lifelong learning but to achieve postgraduate qualifications.

How should we support nurses to choose an appropriate mentor to provide the learning and career development they need? My assumption is that a prescriptive matching of mentor and mentee may have negative implications and adversely affect the quality of the relationship. Nurses must have the

option to choose the nurse they perceive will provide them with the appropriate support and guidance. Issues may arise if education providers stipulate the matching process, I believe, particularly at Postgraduate level. There are difficulties associated with matching the mentor and mentee with the literature supporting mentoring relationships are not prescriptively matched (Rosser, Rice, Campbell and Jack, 2004; Yonge et al, 2007).

Participants shared experiences of how they sourced their mentors, and L acknowledged that the programme descriptor stated the organisation where she worked would provide a mentor. L stated *"... and I was waiting for them (the organisation) to provide one!"* There is merit in exploring this aspect of mentoring in more detail, either with this group of students or subsequent students to understand the expectations of the organisation but also the matching process of mentor and mentee. This was a limitation of the study. My assumption was that the research participants would benefit from the same mentor during the entire academic year as they worked to complete the study programme. Data indicated that students sourced multiple mentors during the year. This demonstrated a degree of creativity of the students (mentees) highlighting that the student will seek the support they need from the resource available to them. More importantly, it would be unrealistic to expect the mentee to stay with the same mentor the entire year if the relationship was inadequate and not of benefit to the mentee.

Another assumption was that the mentee, would source an appropriate mentor to meet their specific learning needs. This assumption relies on the students identifying their learning needs. This provides a challenge for students, particularly initial during the programme. New learning situations provide challenges for the nurse to decide what they need to know and there is always the potential of not knowing what you do not know. Students may or may not be able to identify specific learning needs and therefore the role of the mentor is vital to support this process. Data highlighted those nurses who had not perceived themselves as suitable for additional challenges, for example postgraduate study or advancement to a senior nursing position.

There are situations when we rely on others to "push" us beyond our comfort zone, and then support us through the process to achievement.

Changing World:

We live, work and learn in a changing world. These changes have impacted on individual nurses with mandates from the nursing profession and health care organisations to not only adapt but also survive in this changing environment. This was highlighted at the second focus group session by J. As a follow up from the first session J decided to explore mentoring and shared the following comment...
"Google Mentoring... and see how many hits!"

There was robust discussion and debate regarding the nursing culture and the environments in which nurse's work today as opposed to historically. This changing world for the nurse must be viewed from two perspectives. Firstly, from the perspective of the impact of this changing world for nurses, involving research appreciation, reflection, and the integration of theory into the complexities of this constantly changing practice world. "Insights raise awareness and raised awareness in turn raises the possibility of change" (Taylor, 2006).

Secondly nursing must explore how they have adapted, made transitions and changed within this world. The evolutionary process associated with these changes requires nurses to adapt to new technologies, increased patient acuity, organisational changes, policy changes and the changing demographics of the nurse and nursing education. The impact of technology was highlighted, not only within the clinical world of information retrieval and how that impacts on clinical practice, but also in terms of learning and studying. Participants responded with comments... *"Using the computer opens up a whole new world"* and *"When I finished the Postgraduate Certificate I got into this new world!"*

My assumption was that indeed mentoring supports the learning needs of the nurse. Clearly this cannot be taken for granted and requires systems and processes in place for achievement. Mentoring can support and encourage nursing development and learning, but again this cannot be taken for granted. My assumption is that good mentoring experiences will result in producing good, if not great future mentors, but again this is not a given and requires further exploration. The nurse offering support to other nurses must be both willing and able to do so. At certain times in ones career and learning life this may be achievable and ideal. At other times it may be unrealistic and less than ideal.

The role of intuition within nursing is well documented (Benner, 1984; Benner, 1994; Benner, Tanner & Chelsea, 1996). The intuition used in clinical practice to anticipate the changing needs of the patient can also be applied to colleagues (mentees) so the mentor becomes intuitive to the mentee learning needs. The mentor anticipates not only what the mentee needs to know but provides situations for development of theory into practice. The mentor must also anticipate when to provide support, how much support and when to pull back allowing the mentee to "fly solo". Mentors play an important role in supporting the integration of theory into the clinical practice world, by ensuring the safety of the mentees as well as the patient.

5.2.2 Practice Integration

Nursing is in transition. Nursing will always be a pragmatic profession, one of doing, but nursing is moving from a culture of doing to a culture of knowing and doing. Knowledge generation is becoming more complex. This knowledge transition means nurses must understand why and how they know what they know, but also why and how they do what they do. The explosion of information and technology has impacted on how nurse's source information to advance clinical practice and provide evidence based care, ultimately to improve patient outcomes. Mentors are integral in the process

of encouraging learners to integrate theory into practice and reflect on their practice to develop experiential learning.

The clinical practice environment for the nurse is a challenging one. This learning environment must be relevant and appropriate so that knowledge and skill development reflects in enhanced patient care delivery. Challenges for the mentor and mentee in the clinical learning environment require a degree of control to be positive and the integration of theory into practice. Issues around shift work and rosters provide yet another challenge for mentor and mentee. The potential being that mentor and mentee do not work together on the same shift or struggle to have time together to discuss issues and concerns. The uncontrollable and unpredictable clinical environment offers another challenge for learning and skill development.

Education has an obligation to support the learning in the classroom setting, however for nursing this learning must be translated into the clinical practice setting. One must ask how this can be successfully achieved. Who is qualified to be a nursing mentor? How do we decide what qualifications are required? Are nurses available, and prepared to fulfil the mentoring role and prepared for the responsibilities associated with this role?

There is the assumption that there is a rich resource available to Postgraduate students within the clinical context to support learning and translation of theory into practice. This may be true to some extent but the quality of the mentoring provided must be examined. Mentors must be current practitioners. Educators must ensure the mentors are supported to provide teaching opportunities that offer sound learning outcomes for mentees. The mentor is instrumental in supporting the mentee to source current, relevant information to support the process of evidence based practice. It is important for the mentee to gain knowledge and skill with the process critical reflection. Mentors can support mentees with the transition of knowledge and skill into the clinical practice environment.

Data highlighted the assumption that there is a rich resource available to postgraduate students may not be an automatic given, and that certain things needed to be in place for students to access this resource. Discussion highlighted even though the appropriate skilled and knowledgeable mentor was indeed *"right in my back pocket"* to quote C the perception was that this person was with the patient and therefore this clinical time was "off limits" to the mentee. The mentor was not even approached! There was no dialogue as to setting up a time to meet and discuss issues and concerns. From the perspective of the mentor, they were indeed available and most definitely approachable. This was not the perception of the mentee. My assumption was that the mentees will ask when they want to know something which in fact may not necessarily be the case. The data highlighted that indeed students (mentees) did not "ask or bother" the teachers when they needed help. There was a perception that the tutors were too busy, or had a clinical workload which has already been highlighted as a "taboo" area. Interestingly the research participants mentioned that although the tutors verbalised their availability (on several occasions) students still did not seek help and guidance from them. There is a concern that although the tutors say they are available the students do not find them approachable and accessible. How can tutors offer support to students in other (creative ways)? Clearly some students are more "needy" than others, however, we need to be mindful OF sending messages to students that we are "too busy" for them.

5.2.3 Culture of Inquiry

Clearly nursing must embrace the questioning ethos. According to Taylor (2006) "Systematic questioning is the basis of all the reflective processes" (p. 76). Challenges to ensure this becomes reality go beyond the individual nurse and their ability to question. The challenge is for organisational culture and the local culture of individual clinical practice area to change. The literature would suggest that indeed this is the case (DiCeenso and Cullum, 1998; Courtney, 2005). Data indicated that despite working and learning in 2009 nurses bring historical views to their learning experiences indicating that Bridges (2003) theory of letting go as a starting point before moving through

the transition is still challenging for some nurses. According to Chinn and Kramer (1999) "The values and resources that influence knowledge development are rooted in history and determine how knowledge in nursing is seen and how it develops" (p. 45).

Further discussion indicated mixed views and a dichotomy between those who had come from a culture of *"... don't ask questions, especially from the teacher"*, and those who shared *"... if I didn't ask for help, how will anyone know I needed it?"* The challenge for the profession is to support nurses to make the necessary transitions to move forward and develop questioning of self and practice. This questioning must be encouraged and indeed accepted as both common place and appropriate.

The challenge for the nursing profession and the individual practitioners lies with overcoming feelings of insecurities and defensiveness about questioning and challenging habitual and ritualistic practice. Nursing must move beyond this thinking and become 'comfortable' and encouraging of asking and answering questions. This is the way forward to develop expert clinical practitioners and advance evidence based practice by looking for the answers to difficult or obscure questions. According to Taylor (2006) "One of the most important parts of a reflective story is its emotional content, because if you can identify your feelings you can begin to reflect on why they are as they are, and what you can learn from them" (p. 65).

Development of the questioning ethos comes through reflection, and more importantly critical reflection. Critical reflection offers the ability to question and seek answers to the questions posed particularly if nurses engage with research literature to discover answers. Critical reflection offers a way for nurses to evaluate clinical decisions. The mentor and the mentee should be able to question each other and practise as they seek to explore practice issues and enhance the care delivery to their patients. Nurses must work towards the development of critical reflection and a culture of inquiry. The mentor can support this process by posing such questions as... How did that make you feel? Why did you react that way? What were the

patient's/family response to that? How or what would you do differently next time? Reflective practice development offers one way to start the questioning process, and "test the water" in the pursuit of experiential learning development.

Barriers to the development of a questioning ethos include the use of academic and research language. There is the potential for students not understanding the language used and therefore unsure as to what they need to ask and what they need to know. Issues associated with the classroom environment whereby some students would not want to be seen by colleagues as "inadequate" may also provide a barrier to learning and questioning.

Key to the development of a quality mentoring relationship is communication. Clear communication helps clarify the role expectations and abilities of what the mentor can offer the mentee. Communication is a two way process and must highlight the mentees learning requirements and expectations. Communicating feedback and feed forward is also useful for both the mentor and the mentee. The mentee will require feedback also, but possibly and more importantly they may require feed forward from the mentor. The mentor must provide challenges and "push" the mentee sometimes beyond what they believe they can achieve. The significance of the mentor to be insightful and intuitive to the needs of the mentee cannot be overstated especially as the relationship continues to evolve and develop, and the mentee requires more opportunities for autonomy and less intervention and support from the mentor.

Good communication is paramount to effective mentoring relationships. Specific goal setting highlighting expectations for both mentor and mentee would highlight barriers and limitations that either party may experience or identify. The mentee must have opportunities to voice concerns if they are uncomfortable with a particular challenge or learning opportunity offered by the mentor. Patient and staff safety remains paramount. The mentor must

communicate with the mentee practice issues and concerns. Safety of patients and staff must not be compromised.

According to Donner and Wheeler (2007) "Mentoring can be a powerful strategy to help nursing focus on developing a new generation of professionals who want to find their own ways to make a difference while also ensuring that we continue to value and hear the issues of our senior colleagues" (p.40). To truly understand the meaning of the experiences and stories shared by the research participants to explore the role of mentoring in supporting nurses learning needs I have reflected and pondered this process. I have learnt a great deal completing this thesis and in future when talking with nurses I plan to... talk less... pause more... and use one word to question. That word is... *Meaning?*

This chapter has provided discussion of the themes highlighted by the analysis of data. Selected literature supports the discussion. The focus group participants, the researcher and the literature have offered some explanations to the exploration of the research question. Contradictions have been highlighted and assumptions revisited adding to the discussion of the findings. Limitations to this research have been identified. The following chapter details conclusions and recommendations for future research to complement this work.

Mentoring...

How does it address nurses' learning needs?

Chapter Six – Conclusions and Recommendations

This thesis is about mentoring for nursing, but more specifically the impact of mentoring for the postgraduate nursing student. Mentoring as a support role for practice development, integration of reflection and evidence based nursing and differs from the support roles of preceptoring and clinical supervision.

The question "Mentoring... How does it address nurses' learning needs?" was asked of nurses who had experienced a variety of mentoring relationships. The aim of this project has been met. The role of mentoring has been explored and explained based on the data shared by the research participants, review of selected literature and the researcher experiences and interpretation.

The literature highlighted the complexity of the mentoring role and the confusion associated with definitions and this was consistent with the data (Andrews and Wallis, 1999; McCloughen et al, 2006; Yonge et al, 2007). Literature remains less than helpful in separating the terms of mentoring, preceptoring and clinical supervision. Current literature is attempting to extrapolate the distinctions with some success (Yonge et al, 2007). Confusion has occurred because these roles have been used interchangeably throughout the literature adding to definition confusion. The literature was heavily weighted exploring mentoring and other support roles within the context of the new nursing graduate/junior practitioner (Block et al, 2005; Sharples, 2007). Limited attention is given to the senior/postgraduate practitioner.

I believe the value of mentoring for nursing is underestimated and therefore potentially underutilised at all levels of practice. Nursing practitioners and

academic must continue debating and exploring its place within the nursing discipline. There are processes in place to support the practice development and integration of theory into practice for the new graduate nurse. To date these support systems elude senior nurses. These senior nurses make huge contributions to the nursing profession and support new graduates and less experienced staff with the complexities associated with contemporary nursing practice. Postgraduate study programmes are working towards addressing some of these issues. Resources and research will need to be injected to ensure value for money, not only for nurses but also for the organisations employing these nurses.

This project has highlighted multiple complexities. There are complexities associated with the clinical practice world as a teaching and learning environment. There are complexities associated with the changing practice and educational world of nurses. There are tensions and challenges associated with different preparation to practice and different expectations.

6.1 Personal Assumptions Revisited

Mentoring is by no means a 'one size fits all'. Data demonstrated the creativity and diversity of selection of mentors by the research participants. Mentor support was provided by senior nursing staff, nursing mangers, Directors of Nursing, peers and colleagues. The research question generated data suggesting that indeed mentoring does support nurses learning needs, but there are complexities associated with the process.

Some of my assumptions were correct while others remain inconclusive. It remains unclear as to whether good mentoring experiences will result in producing good, if not great, future mentors. Participants shared stories of their mentoring relationships in positive ways. Data revealed that although many mentoring experiences were positive and supportive for both mentor and mentee there are issues that need addressing regarding role training and development to ensure this valuable role provides maximum benefits.

The assumption that there is a rich and available resource to postgraduate students within the clinical context to support their learning and translation of theory into practice was challenged in this project. Data identified that while the rich resource may be available participants shared various reasons as to why the mentor was not approached.

The assumption that mentees will contact tutorial staff and/or their mentors when there is a requirement for help or support was also unfounded. There was a mixture of issues associated with this assumption and educational staff must be reminded about the pitfalls of assuming if students do not seek help then all is well.

The assumption that a postgraduate qualification would secure quality mentorship remains an unanswered question. This project offers a platform to explore this assumption through further research.

6.2 Research Process

This project involved focus group conversations with nurses who had experienced mentoring in various forms. The research participants had multiple variables including age, clinical practice experience, length of practice experience and preparation to practice. Focus group conversations were taped and then transcribed by the researcher followed by multiple sessions of listening. Thematic analysis provided the framework for interpretation of participant's voice and then conceptualisation of themes was identified.

6.3 Limitations of the study

As a researcher, I acknowledge the limitations of this research project. Firstly the number of research participants. The small sample size of nine participants limits the extent to which conclusions can be drawn. According to social researchers this number was appropriate for focus group research and made data sharing and interpretation to some extent a manageable

process. Limited participant numbers makes Generalisability problematic. Multiple method research may generate more data to build the body of knowledge regarding the complexities of mentoring relationships.

I must acknowledge this project was a snapshot but a useful piece of work for clinical practitioners and educationalists involved in supporting professional growth and development. The findings of this project will be shared with the nursing profession and especially those nurses and organisations that supported the research participants to achieve, not only a postgraduate qualification, but also this research project. This work provides an opportunity for discussion with the New Zealand Nursing Council to advance future development of educational frameworks and practice development initiatives.

6.4 Recommendations

The recommendations arise from the data analysis and the discussion supported by current literature. Informal mentoring for nursing will continue to support practice development and the integration of theory into clinical practice. The nursing profession must continue to explore and debate mentoring within the nursing and educational literature to enhance development of this valuable process. Formal mentoring processes need to be explored particularly at postgraduate level. There is clearly a place for formal mentor support during the study programmes. Research activity to evaluate the mentoring process provided to students will offer insights and understanding to advance further initiatives. There would be value in questioning student's experiences as mentees but also questioning mentors.

Didactic presentations, workshops and written material providing articles and background information to support formal and structured mentoring relationships may also prove useful. This work has already begun in nursing education at Whitireia Community Polytechnic in an attempt to address some of the issues already identified in the literature.

Study programmes may need to be resourced to include time to discuss issues for mentors and mentees and expectations of roles and responsibilities. Time and resources are devoted to clinical and academic assessment criteria, evidence based and reflective practice at postgraduate level, so why not mentoring relationships?

Course evaluations offer one way to access the quality of mentoring relationships. This may not be sufficient to illuminate areas of concern and identify areas for development. To discover issues and barriers early would provide opportunities to make changes. Our future challenges will include workforce diversity as we struggle to address recruitment and retention issues nationally and internationally.

The New Zealand Nursing Council (2007b) and the New Zealand Nurses Organisation (n.d.) must support initiatives to advance professional practice, the development of reflection and evidence based practice. Mentoring offers one way forward to support and advance these initiatives.

6.5 Suggestions for further research activity

Further research activities could include an evaluation of what constitutes mentor knowledge especially exploration of what nurses understand by the term "advanced knowledge". There would be value in nursing education and the profession exploring mentoring practice within a variety of postgraduate nursing programmes within the New Zealand. Crossing cultural boundaries to make comparisons, highlight similarities and address differences is always valuable and it would be reasonable to extend mentoring research in Australia and the South Pacific. This project offers an introduction to understanding some of the issues associated with mentoring. The research was embedded in the nursing practice world but offers insights for multiple practice disciplines including education, health care, business, sport and other health care disciplines such as dentistry, physiotherapy, occupational therapy and medicine.

I believe this project represents some of the issues associated with the complexity of mentoring. Despite the vast amount of work that has been done to support nursing practice and professional development, there is still much we need to achieve if mentoring is to maintain the value we place on it for the nursing profession. Mentoring within nursing is still in its infancy and further exploration through research and literature will add to the understanding of those key nurses responsible for providing and evaluating this important support role.

I'm just a nurse...
I want to make a difference for and in nursing.

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August 2006

Kathy Holloway
Programme Leader
Postgraduate Studies
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Wineera Drive
PORIRUA

Dear Kathy

I am presently undertaking a Master in Education (Adult) at Massey University. As part of this degree I plan to complete a Thesis, and have chosen to study the role of mentoring to support learning for postgraduate nursing students. This project is an exploratory study with data collection occurring through focus group conversations. I have attached an information sheet detailing the research project, and I would be happy to meet with you to discuss any questions you may have.

With your permission, I require access to the database of Wellington students, who completed the Postgraduate Certificate in Perioperative nursing during the past five years, as this group will be approached and invited to take part in the study. I am seeking approval for access to these students contact details.

I will make contact with you during September 2006, subject to ethics approval, to seek your support and with your approval to advance the project further.

Yours sincerely,

Mary Anne Johnson
Researcher

[redacted]

November 2006

Letter to Director's of Nursing

Dear

I am presently undertaking a Masters in Education (Adult) at Massey University. As part of this degree I plan to complete a Thesis, and have chosen to study the role of mentoring to support learning for postgraduate nursing students. I have attached an information sheet detailing the research project, and I would be happy to meet with you to discuss any questions you may have.

I would like to work with a small number of the nurses who completed the Postgraduate Certificate in Perioperative nursing during the past five years. This study is based around focus group conversations, and will require two or three meeting between January, February and March 2007.

I acknowledge your organizations commitment to professional development of nursing staff via the Postgraduate Perioperative programme and believe the contribution from staff via this research will provide valuable information to support the programme and future developments.

I look forward to working with the staff and respect their opinions and anticipated contributions to this project. I will make contact with you next week, to seek your support and with your approval to advance the project further. Massey University Human Ethics Committee has approved this project.

Yours sincerely,

Mary Anne Johnson
Researcher
[redacted]

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Exploring the mentoring role in nursing.....how does it address nurses learning needs?

Information Sheet

Thank you for considering participation in this research project, which aims to explore the mentoring role in postgraduate nursing education. The aim of this study is to identify any issues and key themes, which have the potential to provide future development of this process. It is anticipated that further research questions may emerge and critical review of the current status will grow the body of knowledge around this topic.

This information sheet has been complied to provide information on the research project, clarifying your rights as a research participant, and some indications of the time commitment required for your participation. Your contribution will involve being part of the focus group conversation.

Mary Anne Johnson is the researcher undertaking this project, under the supervision of Dr Marg Gilling and Gloria Slater. This thesis project is part of a Massey University Masters Degree in Education (Adult Education). Contact details for both the researcher and supervisors are provided at the end of this information sheet. If you have any questions or concerns, please contact the researcher directly. Please note that you will be required to sign a written consent form and return it to me prior to the commencement of the research project.

The participant recruitment method involves Wellington nurses who have completed the postgraduate certificate in perioperative nursing during the past five years through Whitireia Polytechnic. The total number of students

who will be approached is approximately 25-30, with anticipated numbers of 10-20 consenting to take part. There are no exclusion criteria. It is anticipated that there will be an initial focus group identifying potential need for splitting groups following initial data analysis. Follow up groups may include, for example, those who have assumed mentor roles, and those who have been mentored.

The persons with access to the data collection will be limited to the researcher and supervisors. Every effort will be make to ensure the confidentiality of individual research participants and their contributions, although it is acknowledge that information will be shared within the focus group conversation process.

Participants will provide their own unique identifier, such as a pseudonym, however, there will be no such identification in the research findings, or the final report/thesis.

Focus Group Conversations

Time Commitment

It is anticipated that there may be a large initial focus group highlighting key themes and issues. This may be followed by 2-3 smaller focus sessions depending on the data illuminated from the initial group meeting. Each focus group conversation will be approximately one to one and half hours and it may be necessary to meet 2 or 3 times.

The total time commitment will be approximately 4-5 hours.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/48.
If you have any concerns about the conduct of this research, please contact Professor John O'Neill, Chair,
Massey University Human Ethics Committee: Southern A,
Telephone 06 350 5799 X 8635,
Email *humanethicssoutha@massey.ac.nz*

Research Participants Rights:

- I understand that information regarding focus group conversations will be provided if I request it, to support my involvement with the project.
- I understand that the focus group conversations will occur within a mutually agreeable environment and at a mutually agreeable time.
- I understand that the researcher wishes to audio tape the conversations as well as take notes during the focus group conversations.
- I understand that I must not disclose anything discussed in the focus group.
- I understand that I can withdraw from the research project at any time prior to the analysis commencement.
- I understand the requirement to meet 2 or 3 times with the group and researcher, which will involve a maximum time commitment of 4-5 hours.
- I understand that the researcher will report back data recorded from previous conversations for clarity and enrichment of data collected.
- I understand that the researcher may need to contact me following my focus group participations to clarity information and provide further clarity to explore the question.

Time Commitment

It is anticipated that the duration of the focus group conversation will be approximately one to one and half hours, and that there will be 2 or 3 meetings during November, December 2006 and January 2007. This will result in a total time commitment of 4-5 hours.

Please complete the Consent Form attached, the return in the stamped and addressed envelope provided to:

Mary Anne Johnson
[redacted]

If you have any questions regarding any aspect of this research project, please contact either:

Mary Anne Johnson
Researcher
[redacted]

OR

Dr Marg Gilling
Supervisor
06 356 9099 extn 8851
Massey University
Hokowhitu Campus
Palmerston North
m.gilling@massey.ac.nz

Research Project

Exploring some insights into

"Mentoring……..How does it address nurses learning needs?"

CONSENT FORM:

This consent form will be held for a period of 5 years.

I have read the research information sheet and details of the research project have been explained to me, and are to my satisfaction. All my questions have been answered and further questions that may emerge I know I can ask at any time during the research project.

I understand the requirement for focus group conversation audiotaping and agree to have my conversations audio taped.

I agree not to disclose anything discussed in the focus group.

I agree to participate in this study under the conditions set out in the information sheet.

Signature:_____ **Date:**_____

Full Name: Printed:_____