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A Quasi-Experimental Study: Mentoring for the Novice Nurse in an Acute Care Setting

Jacqueline A. Witter[1], *Robert J. Manley*[2]
(1. Bronx Lebanon Hospital, New York, USA; 2. Dowling College, Shirley, New York, USA)

Abstract: Nurses who practice in today's healthcare environment must be experts and leaders who collaborate with other professionals in helping to address current issues and simultaneously shape reforms in the 21st century. Nurses are pivotal in the change process; newly hired nurses are expected to transition into new practice roles with a cursory orientation process and minimal support. This quasi-experimental study involved fifty medical surgical nurses from an acute care hospital in New York City (N = 25 registered nurses who were mentored, N = 25 registered nurses who were not mentored). Study participants with three years, or less, nursing experience volunteered to participate in an eight week mentorship program. Pre and post test questionnaire scores were used to compare participants with and without mentoring using identified variables. Nurses who were mentored showed significant correlation with their Willingness to Remain in the Nursing Profession on the dimensions of Clinical Decision Making, r = 0.61, $p < 0.01$; Commitment to Professional Nursing Standards with r = 0.48, p < 0.05; Positive Feelings about Nursing at this Hospital r = 0.75, $p < 0.01$. This research provided nursing faculty, hospital administrators, educators, nursing students, staff nurses with a better understanding of the importance of mentorship development for newly hired nurses.

Key words: mentoring; novice; medical surgical nurses

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1. Introduction

1.1 Mentoring

Mentoring is a two-way circular dance that provides opportunities for experience, giving and receiving each other's gift without limitations and fears (Huang, Huang, & Lynch, 1995). The literature offers several varying definitions of mentoring. In Greek Mythology, Odysseus left Mentor in charge of his son, Telemachus, while he went to fight in the Trojan War. Mentor was a trusted friend, a protector, and an adviser who supported the development of Telemachus (Bey & Holmes, 1990).

In ancient China, Taoism required leaders and rulers to be both teachers and learners, as they provided as well as received wisdom in their relationships. The Socratic method of mentoring continues to influence most mentoring relationships in the 21st century, as mentors are expected to coach and support mentees. Mentors guide, support, advise, and apply relevant examples from their experiences to facilitate the learning processes of their

Jacqueline A. Witter, Ed.D., FNP, MSN, RN, Bronx Lebanon Hospital; research area: quantitative, mentorship. E-mail: Jahwitter@aol.com.
Robert J. Manley, Ph.D., Full Professor, Dowling College; research areas: leadership, policy. E-mail: ManleyR@dowling.edu.

mentees (Podsen & Denmark, 2000).

1.2 Mentoring in Nursing

The medical education model is based on mentoring relationships built upon a hierarchal system between medical student, first through third-year resident, and finally, to attending physician (Oxyley, Fleming, Golding, Pask, & Steven, 2003). As developed by the early leaders in the nursing profession, nursing mirrored the medical education model by including components of the strict discipline the military model. In 1860, Florence Nightingale was the earliest proponent of orientation for nurses; she used modeling and mentorship to help nurses achieve the expectations of the profession (Cimino, 2009). In 1873, Linda Richards, the first American-trained nurse, was oriented to nursing education that patterned the Florence Nightingale Model. In the late 1870s, Richards was credited with bringing nursing education to the United States (Cimino, 2009).

According to Bally (2007), the nightingale model remained the hallmark for nursing education, using preceptors in the hospital-based training system during orientation of graduate nurses to the practice setting. When nursing education moved to the academic setting, this preceptor model evolved to the current system in which nursing students receive designated visits to clinical practice settings under the direct supervision of clinical instructors.

Similarly, within the practice setting, newly hired graduate nurses were assigned to preceptors for the duration of their orientation period. The preceptor's primary role was to assist the newly-hired nurse with development of competencies required to perform daily routines. Today, in most healthcare institutions, there has been a steady decline in the use of a designated mentorship/preceptorship system (Bally, 2007), and because of fiscal burdens associated with a non-revenue producing department, many hospitals have reduced staff, and gradually phased out the role of the nursing education department.

1.3 Mentorship

Zalenik (1981) observed that mentors fostered employee development through socialization as well as through support for mastery of skills. The development of a mentorship program with consistent input from mentors for extended periods might contribute significantly to the personal growth and professional development of new nurses, and reduce the attrition rate in hospital settings.

Angelini (1995) posited that mentoring was used inherently as a form of apprenticeship for men in the business sector and in medical training. Vance (1982) acknowledged that mentoring was beneficial; however, the majority of mentoring relationships were among men. For career-oriented women, mentoring was not addressed until the late 1970s and, it was more difficult to find mentoring relationships that addressed the factors that were central to the lives of women. In many disciplines, mentoring was a process in which students and teachers, novice and expert nurses, superiors and subordinates, and peers and colleagues could benefit (Vance & Olson, 1998). As a predominantly female profession, women in nursing face barriers, compounded by race and ethnicity, to achieve career elevation (O'Neill & Blake-Beard, 2002).

The National League of Nursing (NLN, 2004) endorsed the need for mentorship in terms of a socialization/development process whereby individuals learned the intricacies of the new role they would assume. New graduates in nursing benefitted from an orientation to their role and support that addressed assessment of patients, clinical decision-making, cultural competence, commitment to professional standards, and willingness to remain in the profession of nursing. Socialization into the nursing profession occurred through formal education, mentoring and on-the-job experiences (NLN, 2004).

1.4 Nurse Retention

In the healthcare setting, it was common to find new graduates or nurses in new roles fending for themselves

with only obligatory introduction and minimal support in their new milieu (Block, Claffey, Korow, & McCaffrey, 2005). Thus, nurses felt unwelcomed and unsupported in their new roles. Due to the lack of personal support for nurses, burnout syndrome and feelings of being overwhelmed contributed to the high attrition rate among novice nurses as they attempted to meet the unrealistic expectations of patients, employers, and colleagues. Nurses were leaving bedside nursing because of lack of job satisfaction, burnout, frustration, unsafe assignments/workload, and lack of respect or support (Block, Claffey, Korow, & McCaffrey, 2005).

The high rate of attrition among hospital nurses in the 21st century highlighted the need for structured mentorship programs in the practice of nursing. A strong fiscal commitment and accountability to develop and mentor nurses were needed to increase nursing satisfaction, improve retention, and ultimately care quality and patient satisfaction. The Health Resources and Services Administration (HRSA) projected that, absent aggressive intervention, the registered nurse (RN) workforce would decrease by 41 percent below requirements by 2020 (HRSA, 2010). Furthermore, these factors affected fiscal viability for healthcare institutions in an era when healthcare reform and the need for competent practitioners were in demand. It was imperative that mentoring programs be investigated to assist in the development and retention of a competent nursing workforce for the 21st century.

1.5 Nursing Practice

The core values of caring, integrity, diversity, and excellence should compel civic engagement in shaping public policies that affect everyone's quality of health and care (NLN, 2011). In 2001, the Institute of Medicine addressed the need to prepare the healthcare workforce for the complex environment of healthcare delivery systems of the 21st century. Clinical guidelines were developed by the National Institute of Health (NIH), and the Robert Wood Johnson Foundation (RWJ) created funds for interdisciplinary nursing research and improvement of nursing education and the quality of care (Finkelman & Kenner, 2007). The Robert Wood Johnson Foundation funded several initiatives related to transformations in health care delivery, workforce development, patient safety, and care quality.

According to Cronenwett, Sherwood, Barnstein, Disch, Johnson, Mitchell, Sullivan and Warren (2007), the goal of the Quality and Safety Education for Nurses (QSEN) was to “reshape the professional identity in nursing to include commitment to quality and safety competencies recommended by the Institute of Medicine” (p. 123). To accomplish this goal, six competencies were defined “the five competencies by the Institute of Medicine (IOM) (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, and informatics), and the QSEN competency of safety, which includes the knowledge, skills, and attitudes needed in pre-licensure nursing programs” (p. 124).

Pilot schools participated in the project that integrated and developed competencies for each goal (Cronenwett et al., 2007). The results were shared on the QSEN website (www.qsen.org). Additionally, the IOM (2010) recommendations addressed current educational practices and set a strategic plan for the accomplishment of following major goals by 2014:

(a) Encourage the widespread adoption of electronic health records;

(b) Interconnect clinicians so that data and information can be more easily shared;

(c) Personalize care using personal health records and telehealth;

(d) Improve public health through accessible information;

(e) Improve public health through accessible information (p. 6).

Congruent with the IOM initiatives, Joint Commission (JC) formerly known as Joint Commission for Accreditation of Hospital and Organization (JCAHO) regulatory agency mandated that healthcare settings meet standards to improve patient safety, avoid errors, and affect continuity of care. Healthcare institutions incorporated

consumer-driven health care initiatives, staff education, and competency program. The Institute of Medicine (IOM) reported that patients' safety issues were related to institutional system problems, the inability to integrate knowledge into practice, and the inadequate integration of new technology (Cronenwett et al., 2007).

The Joint Commission included annual national patient safety goals and benchmarked standards that could be measured in all healthcare institutions. The Commission of Medicare Services (CMS) delineated regulations that held institutions more accountable in the area of infection control, and restricted reimbursement for healthcare acquired infections. Therefore, it seems crucial for nurses and the healthcare team to develop more collaborative relationships that sustain optimal health for all patients (CMS, 2010).

Because of the complexity of disease processes and individualized needs of patients, mastery of competencies that related to physical assessment, clinical decision-making, cultural competence, and maintenance of professional standards were expectations for newly hired nurses. To achieve these expectations, a strong mentorship program and a curriculum tailored to the development of effective mentors for newly hired nurses seemed warranted at that time (Glass & Walter, 2000).

Fundamental to the nursing profession and integral to NLN core values was the principle that all individuals must have equitable access to comprehensive health care services. In addition, healthcare reform demanded a system that was evidence-based, cost-effective, and offered the highest quality of care. New models of care delivery must be innovative to attain these goals, and the team of health professionals providing this care must be highly educated and they must possess advanced skills (IOM, 2010).

This paradigm shift presented a unique opportunity for the nursing profession to educate nurses to fill new leadership positions. Registered Nurses (RNs) with the ability to practice to the full extent of their education, training, and scope of practice can influence nursing education, nursing leadership and nursing practice. The three key recommendations in the *Future of Nursing* report include the following:

(1) Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

(2) Nurses should be full partners with other healthcare professionals in redesigning health care in the United States.

(3) Effective workforce planning and policy-making require better data collection and an improved information infrastructure (IOM Report, 2010; ANA, 2010).

McKinley (2004) posited that a workforce with trained mentors who exchange relationships and skills with other workers might benefit the new graduate or mentee, the mentor, nurse manager, the interdisciplinary team, and the organization. McKinley also noted overall outcomes would likely be better patient satisfaction, staff satisfaction, staff retention, and ultimately financial viability. For McKinley, the benefits of mentoring extended to all parties involved and he stated that, "organizations, mentees, and mentors all gain from the mentoring experiences and future leaders are developed" (p. 208).

The United States Department of Health and Human Services (2002) predicted that the shortage of nurses would continue to increase over the next 20 years. Based on that report the national nursing shortfall is expected to be one million nurses (29%) by 2020. Therefore, urgent measures are needed to improve nurses' education, satisfaction, and retention (Block & Claffey et al., 2005).

Lenners, Wilson, Connor, & Fenton (2006) reported that increased low morale and lack of adequate staffing contributed to decreased job satisfaction in nurses who were already suffering from burnout. This quasi-experimental study of mentorship in an acute care setting laid the foundation for significant contribution to

the literature about the benefits of mentoring programs for novice medical surgical registered nurses.

2. Guiding Research Questions

How do novice medical surgical registered nurses, with and without mentoring, differ for their pre- and post-mentoring Assessment of Patients, Clinical Decision-Making, Cultural Competency, Commitment to Professional Nursing Standards, Positive Feelings about Nursing at this Hospital, and Willingness to Remain in the Nursing Profession?

For nurses, with and without mentoring, how do their scores on the post mentoring Assessment of Patients, Clinical Decision-Making, Cultural Competency, and Commitment to Professional Nursing Standards, Positive Feelings about Nursing at this Hospital predict their Willingness to Remain in the Nursing Profession?

3. Definition of Major Variables and Terms

3.1 Mentoring

Mentoring was defined as: "a formalized process whereby a more knowledgeable and experienced person takes on a supportive role of overseeing and encouraging reflection and learning (Roberts, 2000, p. 16).

3.2 Mentor

Mentor was defined as: "someone who serves as a career role model, and who actively advises, guides, and promotes another's career and training, with the relationship between mentor and trainee most inclusive and influential type of support" (Vance, 1982, p. 8).

3.3 Mentee

Mentee or protégé is typically a novice or neophyte who is usually younger, and less experienced than a mentor (Levinson, Darrow, Klein, & McKee, 1978, p. 475).

3.4 Nursing

The American Nurses Association (ANA) defined nursing as: "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (2003, p. 6).

3.5 Nursing Process

The nursing process was defined as: "the common thread uniting different types of nurses who work in varied areas and as an essential core of practice for the registered nurse to deliver holistic, patient-focused care" (ANA, 2011, p. 1).

For the purpose of this study, definitions for selected dimensions of the nursing process under investigation are presented below.

3.6 Clinical Decision-Making

Clinical decision-making was defined as a process that nurses use to gather information about patients, evaluate the processes, and make judgments that results in the provision of nursing care (Clark, 1996).

3.7 Cultural Competency

Cultural competency is an evolving concept. It is a new behavior expectation in nursing that has not been well defined or developed. Cultural competency is defined as a process for awareness, wisdom, skills, interactions, and empathy among caregivers, and the competent services they implement for their culturally diverse clients (St. Clair & McKenry, 1999).

For the purpose of this study, cultural competence is a construct of cultural awareness. Cultural awareness is defined as: "deliberate self-examination and in-depth exploration of individual personal biases, stereotypes, prejudices, and assumptions that are held about individuals who are different from each other" (As cited in Ambrosio-Mahwirter, 2010, p. 27, from Campinha-Bacote, 2003).

3.8 Assessment of Patients

Registered nurses utilize a systematic approach to collect and analyze data about patients in order to deliver holistic, patient-focused nursing care. Assessment is for not only physiological data, but also psychological, socio-cultural, spiritual, economic, and life-style components (ANA, 2010).

3.9 Nursing Professional Standards

Nursing professional standards and the nurses' scope of practice were defined by the American Nurses Association (ANA) and the Nurse Practice Act (NPA) as:

> The Nurse Practice Act was enacted by the legislature to define the scope and regulate the professional practice of nursing for the purpose of protecting the public. Self-regulation occurs when nurses remain accountable for maintaining current knowledge, skills, and abilities to practice competently (ANA, 2003).

The Nursing Social Policy Statement (2003) provides a description of nursing standards as:

> Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations. It is the expectation for all nurses whether experience or newly hired to uphold these professional standards (p. 6).

3.10 Commitment to Professional Nursing Standards

For the purpose of this study, commitment to professional nursing standards was defined operationally as a nurse's participation in professional education, adherence to professional standards, and enthusiasm to meet professional nursing standards.

3.11 Willingness to Remain in the Profession

For the purpose of this study, willingness to remain in the nursing profession was operationally defined as doing more than what is expected as a nurse, sharing knowledge, commitment and valuing the contribution by the nurse to the profession.

3.12 Medical Surgical Staff Nurse

3.12.1 Registered Nurse

A registered professional nurse (RN) was defined as a licensed health professional whose role is to provide independent, dependent and collaborative care of individuals of all ages, as well as families, groups and communities. A registered nurse role promotes patients' quality of life through medical diagnosis, nursing diagnosis and treatment modalities of their diseases and or illnesses (NYS Office of the Professions—State Education Department). A medical surgical registered nurse is a professional nurse who is currently employed to work in the specialty area of medicine and surgery.

3.12.2 Novice Nurse

A novice nurse was defined as a new nurse that is a recent graduate from a school of nursing. This period at the start of every nursing career is typically one that needs extra special care and guidance (Benner, 2000). For the purpose of this study, a novice nurse was one who was hired to work in the medical surgical unit within the last than three years.

3.12.3 Nurse with Mentoring

For this study, nurse with mentoring was operationally defined as one having formal, structural or peer group support to assist with the transition of the various phases of being a novice nurse to an expert nurse (Benner, 2000).

3.12.4 Nurse without Mentoring

For this study, nurse without mentoring was operationally defined as a novice nurse without any formal or structural guidance, support, and advice, for personal and professional mentorship relationship (Vance, 2011).

4. Methodology

4.1 Setting

Novice medical surgical staff nurses (mentees) for this study were from an acute care hospital in New York. The hospital had a bed capacity of 880, and provided services to geriatrics, adult, pediatric, and psychiatric patients among a lower socio-economic and ethnically diverse population.

4.2 Selection of Subjects

The participants in this study consisted of medical surgical registered nurses with five years or more of experience; novice medical surgical registered nurses with less than three years of experience. All participants were volunteers and the selection of the subjects was based on their willingness to participate in the mentor relationship for eight weeks. Fourteen experienced medical surgical nurses who volunteered to be mentors had five years or more of nursing experience. They were given the opportunity to be trained as mentors and to participate in the study. Nurse mentors were diverse in cultural backgrounds and work experience.

A mentorship curriculum was developed using the QSEN (2007) recommendations for competency of safety, knowledge, skills, and attitudes needed in clinical practice. The IOM (2010) recommendations for current educational curriculum were included with topics on patient-centered care, teamwork, collaboration, evidence-based practice, quality improvement, and informatics (Cronenwett et al., 2007). The curriculum to train registered nurses as mentors addressed issues specifically for hospital registered nurses. Mentors responded to questions that the new nurses (their mentees) posed to them. The mentors' specific roles were problem solving, guiding, redirecting, and nurturing the mentees.

The mentors assisted the mentees in the resolution of concerns in meeting their responsibilities in the acute care setting. Mentors conducted dialogues with their mentees about hospital procedures, training, and nurse responsibilities. They also helped new nurses to become comfortable and confident in their knowledge of hospital practices and expectations. Additionally, the following constructs were included in the curriculum: (1) purpose and time frame for the mentorship program; (2) differentiation of mentorship versus preceptorship; (3) responsibility and role expectations of the mentors and mentees; (4) cognitive and demonstrative skills of assessment; (5) clinical decision-making; (6) cultural competence; and (7) commitment to the nursing standards.

The target populations for this study were registered nurses on medical/surgical units in an acute care hospital. The mentees had three or less years of experience. According to Benner (1984), a novice nurse is one who had from zero to five years of experience. Benner also postulated that an advanced beginner would be proficient within five years of supervised experience. Mentees selected to participate in the mentor relationship for eight weeks. Fifty recently hired registered nurses with three or less years of experience at this hospital volunteered to participate in the 8-week mentorship program. Twenty-five registered nurses were assigned alternately to the mentor program and 25 were assigned to the control group, both groups completed the pre-and post-tests.

5. Data Gathering Procedure

All participants were informed of their rights to withdraw at any time during the study without any reprisal and there would not be any effect on their rights, responsibilities, services, or current employment. The research was conducted for 8 weeks. Research demographics and pre-treatment questionnaires were manually distributed and collected to all the mentees prior to the study. All post-treatment survey questionnaires were collected at the end of the 8-week study. A coding system was employed to maintain participants' confidentiality. At the end of the eight weeks, the mentors completed a post-mentorship evaluation of the strengths and weaknesses of their mentees.

5.1 Selection Criteria for Mentors

A convenient sample of participants who showed interest in mentoring and those who wanted to mentor was generated from the registered nurses in the acute care setting. Registered Nurses were selected as mentors according to the following inclusion and exclusion criteria.

For inclusion in the study staff nurse mentors were required to have:

(1) Five years or greater clinical nursing experience (N = 13) or extensive training as preceptors for three years (N = 1);

(2) Mentorship training eight hours designed for this study (Appendix C); and

(3) BSN or higher degree in nursing

5.2 Mentee and Non-Mentee Selection

Twenty-five Medical Surgical/Registered Nurses employed currently at the acute care hospital were chosen respectively for the mentoring group and the non-mentoring group. The fifty (50) participants were volunteers and they were placed in matched pairs for ethnicity and experience.

Selection Criteria for Mentees:

(1) RNs with three years or less of Medical/Surgical experience;

(2) BSN degree or higher; and

(3) Employed at the current acute care hospital.

5.3 Mentorship Training Curriculum

Fourteen registered nurses who volunteered were given eight hours of training in the role of a mentor. As part of the mentorship curriculum and training for the mentors, 7.5 continuing education contact hours were approved by the New York State Nurses Association and were awarded to all the mentors at the end of the study. Each mentor was assigned two or one mentees.

The mentorship curriculum included the following topics: Introduction to mentorship; History of mentorship; Roles and responsibilities of mentors and mentees; Phases of mentorship; Mentees' ability to establish and clarify goals; Role differentiation between mentorship and preceptorship; Nursing theory and mentorship; Mentoring relationship from Novice to Expert; Strategies for critical thinking and clinical decision making skills; Cultural awareness and diversity among patients and colleagues; Leadership qualities and sustainability towards improving nursing practice; Mentee learning process and ways to accomplish quality patient care outcomes; Processes to resolve actual or potentials problems; and Mapping and availability of resources for nurses.

5.4 Instrumentation

After factor analysis, the following items in the survey comprised each of dimensions under consideration in this study (See Table 1). Because of the factor analysis, a new construct, Positive Feelings towards Nursing at this Hospital, emerged. The new construct consisted of five items with an alpha coefficient of internal consistency

of .870. Items deleted from the dimensions after the factor analysis were items 22, 27, 30 from the dimension of Cultural Competency and reversal items 22 and 30.

The instruments used in this study were from several authors whose work contributed to how nurses practice. Cimino (2009) investigated 150 newly hired registered nurses as to whether their assessment abilities, critical thinking skills, self-efficacy, evaluation of orientation program, and sense of confidence in nursing assessments were influenced by simulation utilized in their hospital orientation program. A 5-point Likert scale was used to determine the level of newly hired nurses' self-efficacy and evaluation of the orientation program. Additionally, a 5-point Likert scale survey was used to measure the nurses' confidence in assessment ability and in critically thinking skills after clinical simulation scenarios. She found that "the assessment abilities of nurses in both groups were significantly correlated to their critical thinking skills ($p < 0.05$); confidence in assessment abilities and confidence in critical thinking skills were significantly correlated for both groups ($p < 0.01$)" (Cimino, 2009, p. 75).

Mawhirter-Ambrosio (2010) investigated 182 senior baccalaureate-nursing students' preparation in pain management, cultural pain management, beliefs about pain management, nursing standards for pain management, and culturally competent pain management. For the purpose of this study, cultural competence, awareness of cultural considerations and cultural needs were included on a 6-point Likert scale survey.

Saarikoski and Leino-Kilpi (2003; 2008) Clinical Learning Environment Scale was used further to examine mentee willingness to remain in the nursing profession. According to Saarikoski and Leino-Kilpi (2003; 2008), the development, validation, and evaluation of the Clinical Learning Environment Scale (CLES) were performed in clinical practice areas in Europe.

Engin and Cam (2009) explored a methodological study for validity and reliability evaluation of the scale to measure job motivation of nurses in designated psychiatric clinics in Turkey's four largest cities. According to Engin and Cam (2009), the category of job motivation included both intrinsic and extrinsic motivation factors. Engin and Cam reported that the average total job motivation scale scores of the nurses working in Istanbul and Manis were significantly low. Nurses with the highest level of motivation were ward nurses.

Table 1 Renumbered Items: Renumbered Items, Ranges, and Alpha-Coefficient

Variables	Renumbered Items	Ranges	Items	Alpha Coefficient
Patient Assessment	1, 3, 4, 6, 11, 17, 19	7–42	7	0.794
Clinical Decision	2, 5, 7, 8, 9, 10, 12, 13, 14, 15, 16, 18	12–72	12	0.898
Cultural Competency	23, 24, 28, 33, 34, 39	6–36	6	0.650
Professional	20, 21, 25, 26, 29, 31, 35, 36, 37, 38, 40	11–66	11	0.766
Positive Feelings	32, 45, 46, 47, 50	5–30	5	0.870
Willingness to Remain	41, 42, 43, 44, 48, 49	6–36	6	0.905

5.5 Reliability

A Cronbach alpha analysis of the internal consistency for each subscale revealed that the Cronbach alpha coefficient ranged from .650 to .905 for each dimension.

6. Findings

Fifty medical surgical registered nurses completed both Part 1 and Part 2 of the survey; Part 2 contained 50 surveys items that used a 6-point Likert scale anchored by (1) strongly disagree and (6) strongly agree. One hundred percent of the pretest survey questions were completed and returned prior to the study. There was also a

100 percent completion and return rate for questions on the post-tests after the 8-week study. Tables 2, 3, and 4 present the age, gender and ethnicity of the participants in this study.

Table 2 Age of Respondents

Age Group (years)	Frequency	Percent
≤ 25	11	22.0
26 – 36	28	56.0
37 – 50	10	20.0
> 50	1	2.0
Total	50	100.0

Eleven or 22.0 percent of the participants reported their ages were 25 or less, 28 or 56.0 percent (the majority) reported their ages as 26–36, 10 or 20.0 percent reported their ages as 37–50, and 1 reported his/her age as older than 50.

Table 3 Gender of Respondents

Gender	Frequency	Percent
Male	10	20.0
Female	40	80.0
Total	50	100.0

As reported in Table 3, most of the study participants (80 percent) were females while only 20 percent were males.

Table 4 Ethnicity of Respondents without and with Mentorship

Without Mentorship		
Ethnicity	Frequency	Percent
African American/Black	8	32.00
Non-Hispanic/White	1	4.00
Latino/Hispanic	6	24.00
Asian	6	24.00
Other	4	16.00
Total	25	100.00
With Mentorship		
African American/Black	10	40.00
Non-Hispanic/White	1	4.00
Latino/Hispanic	3	12.00
Asian	7	28.00
Other	4	16.00
Total	25	100.00

Respondents' self-identified their ethnicity. In the non-mentored group 32.0 percent of the respondents self-identified as African Americans/Black, Non-Hispanic/White as 4.0 percent, 24.0 percent as Asian, 24.0 percent as Latinos/Hispanics, and 16.0 percent as other. For the mentored group, 40.0 percent of the respondents self-identified as African American/Black, 4.0 percent as Non-Hispanic/White, 12.0 percent as Latino/Hispanics, 28.0 percent as Asian and 16.0 percent as other. The patient population from 2011-2012 consisted of approximately 75 percent Latinos/Hispanics, 20 percent African American/Black, and five percent other ethnic groups (Personal Communication with the Admission Department May 4, 2012).

Respondents identified separately their cultural preference affiliations. Thirty-six percent of the respondents indicated their cultural preference affiliations as West Indian (e.g., Haiti, Jamaica, and Dominican Republic), 28.0 percent as Asian, 6.0 percent as South American, and 16.0 percent as other.

A paired sample *t*-test of related means was employed to determine if respondents differed significantly in their pre- and post-test scores for the Assessment of Patients, Clinical Decision-Making, Cultural Competency, Commitment to Professional Nursing Standards, Positive Feelings about Nursing at this Hospital, and Their Willingness to Remain in the Nursing Profession.

Table 5 presents the results from the paired sample *t*-test for nurses with and without mentoring pre- and post-tests.

Table 5 Paired Sample Test for Medical Surgical Nurses Mentoring Pre- and Post-Test

Status	Pair	Mean	Mean Difference	Std. Dev.	*T*	*df*	*P*
No Mentor	CD pre	65.44	0.71	4.832	0.718	23	0.480
	CD post	64.45					
	PA pre	39.04	0.16	2.718	0.294	24	0.771
	PA post	38.88					
	CC pre	31.68	0.52	2.485	1.046	24	0.306
	CC post	31.16					
	CS pre	58.64	0.84	5.161	0.814	24	0.424
	CS post	57.80					
	PF pre	25.12	0.52	3.776	0.689	24	0.498
	PF post	24.60					
	WR pre	33.00	0.76	3.756	1.012	24	0.322
	WR post	32.24					
With Mentor	CD pre	63.36	-2.92	5.016	-2.911	24	0.008
	CD post	66.28					
	PA pre	37.52	-1.16	3.236	-1.792	24	0.086
	PA post	38.68					
	CC pre	31.68	-0.84	2.495	-1.684	24	0.105
	CC post	32.52					
	CS pre	56.92	-2.64	4.872	-2.709	24	0.012
	CS post	59.56					
	PF pre	25.68	-1.68	2.795	-3.006	24	0.006
	PF post	27.36					
	WP pre	33.64	-0.80	1.708	-2.342	24	0.028
	WP post	34.44					

There were no significant differences on the pre- and post-tests for the no mentoring group. However, on the post-mentoring scores for nurses who received mentoring, significant differences were found for Clinical Decision Making, $t(24) = -2.920$, $p = 0.008$; Commitment to Professional Nursing Standards, $t(24) = -2.640$, $p = 0.012$; Positive Feelings about Nursing at this Hospital, $t(24) = -1.680$, $p = 0.006$; and Willingness to Remain in the Nursing Profession, $t(24) = -0.800$, $p = 0.028$. Nurses with mentors scored significantly higher on the post-test than they did on their pre-test, indicating that the mentor program positively influenced these scores.

To determine if any of the independent variables predicted the nurses' willingness to remain in the profession, hierarchical regression with a stepwise approach identified which set of variables among Patient Assessment, Clinical Decision-Making, Cultural Competency, Commitment to the Nursing Standards, Positive Feelings about Nursing at this Hospital were predictors of nurses' Willingness to Remain in the Nursing Profession. Table 6 presents the multiple regression analysis results for the group with and without mentoring.

Table 6 Multiple Regression Analysis

Mentor	Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
						R Square Change	F Change	df1	df2	Sig. F Change
no mentor		0.655[a]	0.428	0.402	3.17427	0.428	16.491	1	22	0.001
	2	0.850[b]	0.722	0.696	2.26477	0.294	22.218	1	21	0.000
with mentor		0.606[c]	0.367	0.340	1.93551	0.367	13.346	1	23	0.001
	2	0.760[d]	0.578	0.540	1.61558	0.211	11.011	1	22	0.003

Note: a. Predictors: (Constant), Cultural Competence post;
b. Predictors: (Constant), Cultural Competence post, Positive Feelings post;
c. Predictors: (Constant), Clinical Decision Making post;
d. Predictors: (Constant), Clinical Decision Making post, Positive Feelings post.

For the group without a mentor, Cultural Competency accounted for 42.8 percent of the variance in Willingness to Remain in the Nursing Profession and Positive Feelings about Nursing in this Hospital accounted for 29.4 percent of the variance in the nurses' Willingness to Remain in the Nursing Profession. Overall, Cultural Competency and Positive Feelings about Nursing at this Hospital accounted for 72.2 percent of nurses' Willingness to Remain in the Nursing Profession.

For nurses who had mentorship, post-treatment Clinical Decision-Making scores accounted for 36.7 percent of the variance in the nurses' Willingness to Remain in the Nursing Profession and Positive Feelings about Nursing at this Hospital accounted for 21.0 percent of variance to Remain in the Nursing Profession. Overall, Clinical Decision-Making and Positive Feelings about Nursing at this Hospital accounted for 57.8 percent of nurses' Willingness to Remain in the Nursing Profession.

Table 7 Coefficients[a]

Mentor	Model		Unstandardized Coefficients		Standardized Coefficients	*T*	Sig.
			B	Std. Error	Beta		
no mentor	1	(Constant)	4.290	6.875		0.624	0.539
		Cultural Competence post	0.894	0.220	0.655	4.061	0.001
	2	(Constant)	1.530	4.940		0.310	0.760
		Cultural Competence post	0.527	0.175	0.386	3.004	0.007
		Positive Feelings post	0.582	0.123	0.605	4.714	0.000
with mentor	1	(Constant)	17.083	4.767		3.584	0.002
		Clinical Decision Making post	0.262	0.072	0.606	3.653	0.001
	2	(Constant)	14.569	4.050		3.597	0.002
		Positive Feelings post	0.548	0.165	0.633	3.318	0.003
		Clinical Decision Making post	0.074	0.082	0.170	0.893	0.382

Note: a. Dependent Variable: Willingness to Remain in the Nursing Profession post.

Based on the two models tested in the regression analysis for the group with and without mentoring, model 2 was the best predictor for willingness to remain in the nursing profession. For the respondents without mentoring, Cultural Competency and Positive Feelings about Nursing at this Hospital predicted their Willingness to Remain in the Nursing Profession. For those nurses with mentors, Clinical Decision-Making and Positive Feelings about

Nursing at this Hospital predicted their Willingness to Remain in the Nursing Profession. Table 7 presents the coefficients for the groups with and without mentoring.

7. Conclusions

During a trial period of eight weeks, newly hired nurses who did not have mentors did not exhibit any change in their Patient Assessment, Clinical Decision-Making, Cultural Competency, and Commitment to the Nursing Standards, and Positive Feelings about Nursing at this Hospital or Willingness to Remain in the Nursing Profession.

After eight weeks of mentoring, newly hired nurses, who did have mentors, reported significant improvements in their Clinical Decision-Making, Commitment to Professional Nursing Standards, Positive Feelings about Nursing at this Hospital and their Willingness to Remain in the Nursing Profession.

For newly hired nurses who did not have mentors, their sense of Cultural Competence and Positive Feelings about Nursing at this Hospital predicted seventy-two percent of the variance in their Willingness to Remain in the Nursing Profession.

For newly hired nurses who did have mentors, their Positive Feelings about Nursing at this Hospital and their Clinical Decision-Making skills predicted fifty-eight percent of the variance in their Willingness to Remain in the Nursing Profession.

Nurse Mentors who are appropriately trained in the art and purpose of mentoring newly hired nurses offer significant benefits to hospitals because they increase the positive feelings that new nurses have about nursing at such a hospital. Also, the clinical decision-making skills of new nurses with mentors improve as a result of their interactions with their mentors.

Finally, hospital administrators should adopt a formal training program in the art and practice of mentoring for senior nurses. Senior nurses, who mentor newly hired nurses, should be compensated and encouraged to inculcate a high commitment to the professional nursing standards adopted by the American Association of Nurses and clinical decision-making skills.

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Appendix A

Survey Part I Demographics

Place a check mark or fill in the appropriate information that best represents you.

1. Age less than 25____ years; 26-36 _____years; 37-50 _____years; more than 50 ____years

2. Gender: Male ◯ Female ◯

3. Ethnicity: African American ◯ Non-Hispanic ◯ Latino/Hispanic ◯ Asian ◯
Pacific Islander/Hawaiian ◯ American Indian/Alaskan Native ◯
Other ◯ (Please specify) _____

4. Please describe your preferred cultural affiliation?
For example(Korean, Jamaican, Puerto-Rican)_____

5. Did you attend and graduate from a Baccalaureate Nursing College? Yes [ ] No [ ]

6. Do you have any nursing certification? Yes [ ] No [ ] If yes please specify_____

7. Years of experience as a Registered Nurse? _____

8. How many years of Medical/Surgical work related experience? _____

9. Total number of years working at the current hospital? _____

Part II Section One

Instructions:

For each question, circle the number that best describes how you feel about the following statements according to the scale:

1-Strongly disagree 2- Disagree 3- Somewhat disagree 4- Somewhat agree 5- Agree, 6. Strongly agree

1	When caring for patients, I ask what are their main concerns and reasons for hospitalization.	1	2	3	4	5	6
2	I recognize subtle patterns in patients and deviations from expected patterns in data and use these to guide my assessment.	1	2	3	4	5	6
3	I observe and monitor subjective and objective data when caring for a patient.	1	2	3	4	5	6
4	I collect subjective and objective data from the patient to effectively plan interventions.	1	2	3	4	5	6
5	I recognize signs and symptoms of a deteriorating patient.	1	2	3	4	5	6
6	I can independently complete an overview of a head to toe physical assessment of a patient.	1	2	3	4	5	6
7	I include patient and family members as an integral part of the assessment.	1	2	3	4	5	6
8	I evaluate goals towards patient care outcomes.	1	2	3	4	5	6
9	I communicate information about unique patient needs to the interdisciplinary team.	1	2	3	4	5	6
10	I synthesize general education knowledge to make informed clinical decisions.	1	2	3	4	5	6
11	I know how to activate the hospital's emergency and rapid response team.	1	2	3	4	5	6
12	I incorporate critical thinking skills to make informed clinical decisions.	1	2	3	4	5	6
13	I contribute to clinical decision-making with the interdisciplinary team.	1	2	3	4	5	6
14	I use all appropriate technology to decide effective patient care.	1	2	3	4	5	6
15	I use individualized care plans to promote health interventions.	1	2	3	4	5	6

16	I select appropriate evidenced based practice guidelines in the delivery of care.	1	2	3	4	5	6
17	When I am confronted with a problem, I can find several solutions.	1	2	3	4	5	6
18	I choose appropriate health education for my patients to facilitate their informed decision-making.	1	2	3	4	5	6
19	I am aware of language communication barriers and provide translation.	1	2	3	4	5	6
20	I am knowledgeable of the uniqueness of the individualized patient with preferences, values, and cultural needs when planning and implementing care.	1	2	3	4	5	6
21	I ask patients about their beliefs regarding pain medications.	1	2	3	4	5	6
22	I am not always able to meet the cultural needs of the patients.	1	2	3	4	5	6
23	A patient may think that his or her disease and suffering is necessary based on religious beliefs.	1	2	3	4	5	6
24	I am aware of my own culture and family values regarding disease process, safety, and comfort care.	1	2	3	4	5	6
25	When caring for patient from various cultures I take time to find out what the patient fears most about his or her illness.	1	2	3	4	5	6
26	I encourage my patient to express their feelings regarding their culture.	1	2	3	4	5	6
27	I experience some anxiety about caring for patients of cultures that differ from mine.	1	2	3	4	5	6
28	I try to be open to patients from different cultural groups.	1	2	3	4	5	6
29	I try to understand how my patient's beliefs differ from my beliefs.	1	2	3	4	5	6
30	I treat all people alike regardless of their cultural background.	1	2	3	4	5	6
31	I show respect for patient and family cultural values by listening carefully to how one describes his or her illness.	1	2	3	4	5	6
32	I feel supported in my role as a staff nurse.	1	2	3	4	5	6
33	I uphold nursing as a humanitarian and altruistic profession that fosters social justice through patient advocacy.	1	2	3	4	5	6
34	I apply ethical principles to all my nursing actions.	1	2	3	4	5	6
35	I participate in professional continued education offering.	1	2	3	4	5	6
36	I hold membership in nursing professional associations.	1	2	3	4	5	6
37	I am committed to making a contribution to nursing as a profession.	1	2	3	4	5	6
38	I think that the way I do this job brings extra benefits to my patients.	1	2	3	4	5	6
39	I am enthusiastic about doing my job well.	1	2	3	4	5	6
40	I feel a strong commitment to practice in accord with the standards of the Nurse Practice Act.	1	2	3	4	5	6
41	I would like to continue working in the profession of nursing.	1	2	3	4	5	6
42	I think I am very adept, competent and willing to remain in nursing.	1	2	3	4	5	6
43	I am making great effort for my job and want to stay in nursing.	1	2	3	4	5	6
44	My work as a nurse satisfies my goals for personal development and motivates me to stay in nursing.	1	2	3	4	5	6
45	My job provides me with meaningful work that motivates me to stay in nursing.	1	2	3	4	5	6
46	Because I feel comfortable discussing nursing issues with my colleagues, I am willing to remain in nursing.	1	2	3	4	5	6
47	Because I feel as though I am part of the health care team, I am willing to remain in nursing.	1	2	3	4	5	6
48	Because I feel fulfilled in my nursing practice, I will stay in nursing.	1	2	3	4	5	6
49	Because I value how I am developing professionally at my job, I will stay in nursing.	1	2	3	4	5	6
50	Because I feel valued to voice my concerns, I will remain in the nursing profession.	1	2	3	4	5	6