Mentoring and Motivation:

A STUDY OF
THE ONGOING PROFESSIONAL DEVELOPMENT OF
AUSTRALIAN DIABETES NURSE EDUCATORS

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Certificate of authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and in the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Ethics approval for this work is current and granted by the University of Technology (UTS HREC 2012-059).

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Abstract

Despite increasing research on the importance of healthcare organisations providing quality services, limited research is available on what motivates healthcare workers to engage in professional development activities throughout their working lives. This study investigates the relationship between mentoring, motivation and the ongoing professional development of Australian Diabetes Nurse Educators.

Using Victor Vroom's expectancy theory of motivation model, the study aimed to identify what motivates nurses to engage in formal mentoring and the impact if any of formal mentoring on the professional development of nurses who were not at the start of their nursing careers.

The study uses a mixed method research design of questionnaires and interviews to examine the experiences of a national cohort of Australian nurses who participated in a formal mentoring program from 2008 to 2012. Phase one consisted of an audit of nurses who completed the program. The questionnaires audited the attitudes, satisfaction and achievement of goals of the mentorship program participants. Phase two consisted of interviews conducted with five mentees and four mentors to examine what motivated these nurses to engage in formal mentoring.

Of the healthcare workers who completed the program (n=758), 617 identified as nurses, met the inclusion criteria and were recruited to phase 1 of the study, which consisted of 329 mentors and 288 mentees. A total of 94.4% of mentees indicated that they were motivated to participate in the formal mentoring program by the potential achievement of credentialling status, i.e. the attainment of 'the bit of paper' that made them eligible to apply to the

Australian Government for a Medicare provider billing number. On completion of the program, 64% of mentees applied to be credentialled. Mentors were motivated to mentor by the desire to belong and to contribute to the professional development of other nurses.

From the perspective of the nurses in this study, the experience of formal mentoring contributed to their ongoing professional development by improving their clinical expertise and competencies, increasing their confidence to provide diabetes education and management to their patients and developing their knowledge for facilitating practice development. The study concludes that motivation to participate in formal mentoring programs is linked to both outcomes and performance. In order to motivate more nurses to become involved in mentoring, the study recommends that program facilitators provide access to resources such as education and training on how to mentor, ensure the version control of electronically delivered mentoring program material and allocate mentors and mentees adequate time for their mentoring activities. ■

Chapter 1

Introduction: key issues in nursing professional development

1.1 Background to the research

As a nurse registered to practice nursing in Australia, I have observed that for nurses to be acknowledged as professionals by their peers they must be motivated to engage in professional development activities throughout their careers, not just in their early years of nursing. Previous research suggests that professional development or becoming a professional should not stop with the attainment of a tertiary qualification but should continue well on into a person's working life (Birden, 2012; Frenk et al., 2010a; Wood, 2006).

The nursing workforce is ageing, both nationally and internationally. The average age of Australian nurses is 47.6 years, while the average age of nurses globally is 47. Nurses need to continue to engage in professional development activities if they are to have the knowledge and capacity to be able to continue to deliver safe and effective health care throughout their working lives (Gould, Drey, & Berridge, 2007; Richards & Potgieter, 2010).

1.1.1 Nurses and professional development

To ensure the professional competency of nurses working in Australia, national competency standards were introduced in July 2010 by the Nursing and Midwifery Board of Australia for the ongoing professional development of all practicing nurses (Nursing and Midwifery Board of Australia, 2013). Australian nurses must now, as part of their scope of practice, at a minimum, participate in

at least twenty hours of continuing nursing professional development activities annually (Nursing and Midwifery Board of Australia., 2016).

The Nursing and Midwifery Board of Australia recommend nurses engage in activities that promote professional practice (Nursing and Midwifery Board of Australia., 2010, Domains1&2), critical thinking and analysis ((Nursing and Midwifery Board of Australia., 2010, Domains 3&4). The Board recommends that Australian nurses participate, where possible, in mentoring programs for their ongoing professional development, but this is not mandatory (Nursing and Midwifery Board of Australia., 2010, Domain 4.3).

Professional nursing associations not only have a duty to safeguard and protect the specialised knowledge of their field and to certify its attainment; they also have an obligation to their members and to the general public to keep abreast of developments and innovations (Henderson, Briggs, Schoonbeek, & Paterson, 2011, p. 13; Royal College of Nursing Australia, 2009-2012).

While accredited tertiary institutions prepare nurses for the workforce, participating in mentoring relationships has the potential to ensure their continuing professional development (Heartfield, Gibson, Chesterman, & Tagg, 2005; McCloughen, 2009; Poorman & Mastorovich, 2017).

1.1.2 Definition of mentoring

The definition of mentoring used in this research is that it is a personal development process whereby a more experienced or more knowledgeable person (the mentor), helps a less experienced or less knowledgeable person (the mentee) by providing support, guidance or information (Australian Diabetes Educators Association., 2008a, p. 6). However, for this study of formal mentoring the mentor/mentee relationship was encouraged to be a non-hierarchical, reciprocal relationship as defined by the facilitators of this formal mentoring program the Australian Diabetes Educators Association '*An effective mentoring partnership is seen as a two way street for sharing problems, information*

and higher work level through mentor/mentee direct interaction' (Australian Diabetes Educators Association., 2008a, p. 6; Kram, 1985; Morton-Cooper & Palmer, 1993, p. 56).

Both the mentors and the mentees in this study were encouraged to have learning goals and to work towards achieving specific professional and personal outcomes. Although the mentor was a senior nurse it was recommended that they should also take the opportunity to learn and develop with and from their mentee. (Australian Diabetes Educators Association., 2008a, p. 6; Kram, 1985; Morton-Cooper & Palmer, 1993, p. 56). General principles of mentoring suggest that mentors pass on life experiences and knowledge in order to motivate, support and enhance the personal career development of their mentees. Mentors should be approachable, reasonable and competent and be committed to lifelong learning (Ambrosetti & Dekkers, 2010, p. 52).

The mentor/mentee relationship in formal mentoring programs as opposed to informal mentoring programs usually follows a developmental pattern within a specified timeframe. Roles are defined, expectations are outlined and a purpose is (ideally) clearly delineated (Ambrosetti & Dekkers, 2010, p. 52). However, the reasons why nurses participate in mentoring relationships appears to be fragmented and insufficiently researched.

Evidence demonstrates that motivation is a factor that is known to influence strongly the quality and content of work-related outcomes in healthcare (De Simone, 2015a; Toode, Routasalo, & Suominen, 2011) and hence the study of motivational factors in mentoring relationships in nursing is an important one.

1.1.3 Nurses and mentoring

The benefits of engaging in mentoring are not in question (Eby, Allen, Evans, Ng, & DuBois, 2008; Kram, 1988; Ragins & Scandura, 1999). Individuals who have participated in mentoring relationships tend to express greater satisfaction with their careers, achieve more promotions and higher income, report greater

commitment to the organisation or profession and are more likely in turn to mentor others (Johnson, 2007, p. 4; Kram, 1985; McCloughen, 2009).

Evidence shows that mentoring can contribute to improved staff retention rates, professional development and job satisfaction. However, little research has been undertaken to examine what motivates individuals to participate in mentoring. Engaging in mentoring for nurses at all stages of their career trajectory has the potential to guarantee the professionalism of nurses practicing in the 21st century (Josephsen, 2014; Tompkins, 2001).

1.1.4 Diabetes nurse educators and mentoring

This study examined the experiences of a national cohort of Australian Diabetes Nurse Educators, a specialty subset of Australian Registered Generalist Nurses. The nurses in the study had participated as either mentors or mentees in the Australian Diabetes Educators Association's formal mentoring program for a minimum period of six months between 2008 and 2012. This study therefore focused on Australian nurses at various stages of their careers as opposed to nurses who were all at the start of their career and investigated what motivated them to engage in formal mentoring.

1.1.5 Definition of the term various stages of a career

The definition of the term 'various stages 'of a career or 'career phases' used in this research is reflective of Benner's theory of nursing expertise and closely follows the skill acquisition theory developed by Dreyfus and Dreyfus that proposes that the road from novice to expert nurse encompasses five stages (Kolb & Fry, 1975, pp. 13-14). These stages are novice, advanced beginner, competence, proficiency and expert (NSW Health., 2011).

Given that nursing is a complex interplay of skill acquisition, competence development and increasing capability throughout the individual nurses' professional life defining specific stages of a nursing career or career learning is

not straight forward (Kolb, 1976; Kolb & Fry, 1975) After initial registration as a nurse the practitioner continues to further enhance and develop their practice within the workplace; inevitably the 'starting point' for a new graduate registered nurse in terms of their capability and competence differs between graduates and so does the rate of ongoing development, illustrating the complexity of learning and application in nursing (Brown & Crookes, 2016; Craig & Smith, 2014).

However, various researchers have demonstrated that relations between work behaviours and attitudes are moderated by career stage (Kolb, 1984; Springer, Stanne, & Donovan, 1999) Although some researchers argue that career stage, like career commitment, has no single definition . Morrow and McElroy's review of past definitions of career stage, included one or more of four moderately intercorrelated criteria which are the following: chronological age, organisational tenure, positional tenure, and professional tenure (Morrow & McElroy, 1987).

Morrow and McElroy's review determined that, although specific cut offs for the criteria chronological age, organisational tenure, positional tenure, and professional tenure varied even within professions, definitions of career stage are all commonly based on some version of Super's theoretical model of career development (Super, 1957) . Super's model also suggests three to four loosely defined stages which are trial/exploration, establishment/stabilisation, maintenance, and disengagement.

Morrow and McElroy's review suggests that there are some cutoffs for each of the four possible career stage criteria. Using age as the criterion, for example, the first career stage lasts till age 30, the second stage then extends to age 45, when the third stage begins. Using tenure as a criterion, the first stage lasts until the 2nd year, the second stage extends to the 10th year, and the third stage

begins at the 10th year that the employee remains in the organisation, position, or profession.

Importantly, Reilly & Orsak's career stage analysis supported the proposition that continuance commitment is reported as significantly greater by nurses in the latter part of their careers, providing evidence for the discriminant validity of this commitment dimension. The career stage analysis also suggests that nurses' self-reported commitment to the nursing profession is high and consistent, regardless of career stage (Reilly & Orsak, 1991) .

However more recently conducted research on the influence of organisational tenure on nurses' perceptions of work process improvement initiatives demonstrated that a nurse's optimism or skepticism toward an organisation-mandated change initiative largely depends on their experience with similar change initiatives and their organisation's track record with previous change efforts (Edwardson, Gregory, & Gamm, 2016 July).

Wong et al. research findings suggest that the younger generations place greater importance on social values (Wong, Gardner, Lang, & Coulon, 2008), however, Twenge et al. research indicated that the older generations more strongly value social interaction at work (Twenge, Campbell, Hoffman, & Lance, 2010). Career stage literature provides some evidence that satisfaction with co-workers increases with career stage as measured by age but is curvilinear with respect to organisational tenure (Morrow & McElroy, 1987).

1.2 Aims and objectives of the study

The aim of this study was to investigate what motivates Australian nurses to engage in the ongoing professional development activity of formal mentoring at various stages of their careers. The study had three specific objectives:

1. To examine the tensions around the concept of ongoing professional development for nurses generally and the impact that this has on their ongoing professional education.
2. To consider how learning through mentoring was reconstituted as knowledge and how this potentially relates to the professional development of nurses.
3. To report on what motivates nurses to learn through mentoring, particularly in the Australian nursing profession, focusing on nurses who were not at the start of their nursing careers

1.2.3 Research questions

To achieve the study's objectives, I asked three research questions:

1. What motivates diabetes nurse educators to engage in formal mentoring relationships?
2. Does engagement in formal mentoring relationships contribute to nurses' professional development and if so, in what ways?
3. If mentoring does not contribute to nurse's professional development, why not?

1.2.4 Justification for the research

Investigation of the research problem is justified on several theoretical and practical grounds. Today, over half a million nurses working and practicing in Australia are over the age of 50, while the average age of registered nurses is 47 (Australian Institute of Health and Welfare, 2013). These statistics have potential implications for the profession.

While Australian health policies have placed nurses at the forefront of delivering clinical services to the Australian public, the assumption exists that nurses are adequately equipped with the necessary knowledge, attitude, beliefs

and skills to provide appropriate, safe effective clinical services (Thompson & Kenward, 2012, p. 206). However, a substantial number of the current registered nurses working in the Australian health industry may have participated in very few professional development initiatives since attaining their initial nursing certificate or nursing degree, completed up to 30 years ago.

To ensure the ongoing provision of appropriate quality contemporary health care it is considered a fundamental ethical obligation for all nurses to be able to demonstrate professional currency at every stage of the career path by engaging in professional development activities (Bertulis & Cheeseborough, 2008; Fleet et al., 2008; D. Schweitzer, J., & T. Krassa, J., 2010).

Subsequently, the Nursing and Midwifery Board of Australia introduced a mandatory Continuing Professional Development Registration Standard in 2010 (Nursing and Midwifery Board of Australia., 2010). This standard is applicable to all nurses and midwives practicing in Australia. It is not restricted only to nurses who work in the provision of direct clinical care. The Continuing Professional Development Registration Standard also applies to nurses using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession (Wenger, McDermott, & Snyder, 2002). All applicants for nursing and/or midwifery registration must meet a range of requirements to become eligible for registration. Registration standards define the requirements that applicants for registration or renewal of registration need to meet to be registered.

The aim of the introduction of continuing professional development standards was to enable nurses and midwives to maintain, improve, and broaden their professional knowledge, expertise and competence to meet their obligation to provide ethical, effective, safe and competent practice to the

Australian public (Rosenthal & Zimmerman., 1972). Continuing professional development is an important foundation of lifelong learning and helps nurses and midwives maintain their competence to practice (Wenger et al., 2002). Subsequently it is mandatory for all nurses to participate in a minimum of 20 hours professional development activities annually.

The Nursing and Midwifery Board of Australia recommend that nurses complete a range of continual professional development activities as this is more effective for learning than completing continuing professional development activities of only one type given that people learn in different ways. Accordingly, continuing professional development initiatives may include formal and informal learning activities. Nurses are encouraged to consider the combined use of multimedia and multiple instruction techniques, e.g. face-to-face, simulation, interactive e-learning, self-directed learning. Possible examples of activities include:

- Participating in mentoring
- postgraduate studies
- participating in journal clubs
- in-service education
- attending conferences, workshops and seminars
- authoring a book chapter, or
- having an article published in a peer-reviewed journal (Wenger & Wenger-Trayner, 2015)

The National Health Practitioner Regulation Law (section 128) stipulates that nurses practicing in Australia must participate in continuing professional development initiates throughout their careers (Australian Government., 2009). A registered health practitioner must undertake the continuing professional

development required by an approved registration standard for the health profession in which the practitioner is registered.

A contravention of this subsection of the National Health Practitioner Regulation Law by a registered health practitioner does not constitute an offence but may constitute behaviour for which action may be taken under this Part by the Australian Health Practitioner Regulation Agency (2014).

1.2.5 Philosophical framework

In this study I approached the research questions from the perspectives of interpretivism and phenomenology. The study was designed to build theory, and to investigate whether there is a relationship between mentoring, motivation and professional development. I use the definition of theory proposed by Argyris and Schon (Argyris & Schon, 1974), that is, that theory is a set of interconnected propositions that have the same referent—the subject of the theory. In this research the subjects are Australian diabetes nurse educators.

Theorising is also about discovering or manipulating abstract categories and explaining the process of relationships among those categories (LeCompte & Preissle, 1993). Given the complexity of cognitive behaviour (Weiner, 1974), understanding what motivates individuals or groups to behave in a particular way cannot be easily theorised, generalised or potentially predicted (Arkes & Garske, 1977; Bindra, 1959). For this reason, I draw on several theories as theoretical building blocks to provide an explanation for why the nurses in this study chose to participate in a formal mentoring program.

Epistemological and ontological assumptions provide the knowledge foundations that underpin this study. These assumptions entail, for example, ideas about what forms of knowledge can be obtained from the study participants, and how one can sort out what is to be regarded as true from what is to be regarded as false (Usher, 1998, p. 13).

In chapter three, I describe the ways in which the methodology influences the form and processes of the study, including the importance of my own experiences and understandings of the phenomena of being a nurse and the use of dialogue and reflection to understand aspects of mentoring, motivation and the ongoing professional development of nurses. I explore how the mentors and mentees acquired and shared their knowledge, from an epistemological interpretive paradigm, and discuss the social nature of reality for these mentors and mentees from an ontological stance (Cohen & Manion, 1994b, p. 6; Guba & Lincoln, 1994, p. 108).

1.2.6 Phenomenological research

Hermeneutic phenomenology, informed by the work of Martin Heidegger (1962), was chosen as the most appropriate methodology to guide the progress of the study because of its emphasis on establishing the meaning of phenomena as experienced by the individual. Phenomenology focuses on exactly how a phenomenon reveals itself to the experiencing person in all its specificity and concreteness (Brennan, 1986, p. 277; E. Husserl, 1980a, p. 27).

Heidegger provides a model for understanding educational experience based on hermeneutic underpinnings (Gallagher, 1992). Diabetes nurse educators participating in a mentorship program presumably will interpret the experience of mentoring from the tradition of other nurses. Hermeneutics theory claims that an individual's prior understanding is taken with them to any new situation to create their current understanding. The nurses' initial understanding is important because it sets the direction and scope for inquiry and action. How the nurses interpret their experience of mentoring and how they potentially learn from their experience of mentoring will be framed within Heidegger's hermeneutics theory because the theory has the capacity to link learning from experience and ways of making sense of that learning. That is, the theory argues that understanding through language is the fundamental mode of

our being-in-the-world (Heidegger, 1962). The social context of the environment in which nurses' work and interact plays a significant role in the development of nurses' professional identity and it is potentially through this interaction with each other in mentoring relationships that nurses have the capacity to create and self- categorise their identity as nurse professionals.

In chapter four, the experience of the motivation to mentor will be described and interpreted further using the expectancy theory of motivation model (Vroom, 1964). The journey of becoming a professional will be revealed and understood within the philosophical framework of Heiddegerian hermeneutics.

As I discuss further in chapter five, the expectancy theory of motivation as proposed by Victor Vroom (1964) proves useful as it offers a way of explaining the reasons given by the nurses in this study for participating in a formal mentoring program. Expectancy theory is based on four assumptions (Lunenburg, 2011; Vroom, 1964):

1. that people join organisations such as nursing organisations with expectations about their needs, motivations, and past experiences. These expectations will influence how individuals react to and or perform in the organisation.
2. that an individual's behaviour is a result of conscious choice: i.e. that individuals are free to choose those behaviours suggested by their own expectancy calculations.
3. that individuals want different things from an organisation: e.g. an increase in salary, an increase in professional status, or to be motivated by a challenge.
4. that individuals choose among alternatives in order to optimise outcomes for themselves personally.

These assumptions and their relevance to this study are explored further in chapters three and four.

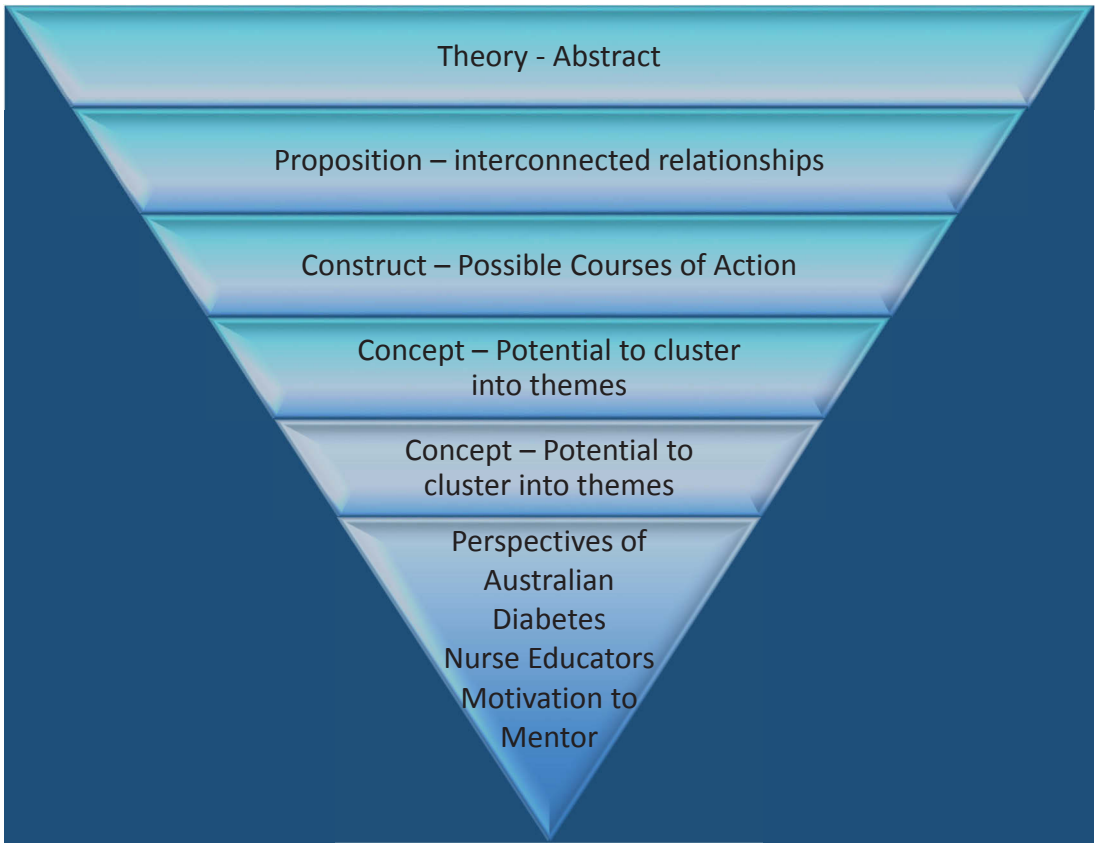

Figure 1.1: The building blocks of the Vroom's (1964) conceptual framework, applied to the perceptions of diabetes nurse educators' motivations to mentor

1.2.7 Research cohort

The study drew on a national pool of over 700 diabetes nurse educators who worked in a variety of health care settings in either a fulltime or part time capacity. The study participants worked in private and public health care, acute and ambulatory care, rural and remote health, and Medicare Locals.[1] They were working in isolation, in multidisciplinary teams, and in academia.

[1] Medicare refers to the national, government-funded scheme that subsidises the cost of personal medical services and that covers all Australians to help them afford medical

Participants in the study were all registered nurses (non-nurses were excluded), were financial members of the Australian Diabetes Educators Association and had participated as a mentor or mentee in the Australian Diabetes Educators Association formal mentoring program for a minimum period of six months between 2008 and 2012.

1.2.8 Research design

The study used quantitative and qualitative methods to explore and understand the perceptions, meanings and experiences of participating in formal mentoring relationships. As researcher, my role in this thesis is to try to present, as truthfully and accurately as possible, the thoughts and feelings of the study participants about what motivated them to act as mentors or mentees. The study design consisted of two phases.

In phase 1, I developed and distributed a questionnaire nationally to the 369 mentors and 389 mentees in the research cohort that is 758 diabetes educators completed the formal mentoring program. The study participants were asked to provide written feedback on their experience of participating in the program and to complete a questionnaire using a five-point Likert scale to measure the mentors' and mentees' satisfaction with the program and achievement of goals. Of the 758 questionnaires distributed 758 (100%) were completed and returned. 617 diabetes nurse educators were recruited to the study as they met the study

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care. Medicare Locals refers to the primary health care initiative introduced by the Australian Government in 2010 under the national health reforms which is a network of primary health care organisations. The role of Medicare Locals was to improve health outcomes for all Australians by working in partnership with the community to integrate primary health care in local health regions across Australia (Australian Government Department of Health., 2013).

inclusion criteria. Analysis of the 617 written responses led to the findings discussed in chapters four and five and six.

Phase 2 of the study was designed to support a phenomenological conceptual approach to explore in depth the study participants' thoughts and perceptions of what motivated them to participate in a mentoring relationship, and the extent to which that participation enhanced their professional development. Purposive sampling was used to recruit five mentors and five mentees to phase 2 of the study. Two semi-structured interviews were conducted to pilot the interview questions with a sample of mentors and mentees who had participated in the program. The pilot interviews were followed by semi-structured interviews with five mentors and four mentees.

The findings and discussion in this thesis are therefore based on 617 completed written responses to survey questions and nine in-depth interviews, five with mentors and four with mentees.

1.3 Limitations and key assumptions

While grounded in the disciplines of adult education, lifelong learning and professional development, the primary focus of this research was to investigate only one specific cohort of nurses: diabetes nurse educators. Although the study was conducted nationally, the study findings are the perceptions of the study participants about what motivated them to engage in formal mentoring. This cohort is a subset of Australian generalist registered nurses and the findings of the study may or may not apply to other practicing nurses. Whether mentoring contributed to their ongoing professional development is reflective of their mentoring experience and their definition of what constitutes a professional nurse. The findings therefore reflect the views of the study cohort only and

results cannot be generalised without careful consideration of contextual factors that may impact on the mentoring experiences of other nursing populations.

Although all nurses must be registered to practice nursing in Australia, it is not mandatory to be credentialled with the Australian Diabetes Educators Association. Nurses can work as Diabetes Nurse Educators but they cannot be credentialled with the Australian Diabetes Educators Association unless they have met the Association's mandatory criteria, one of which is to have completed their formal mentoring program. Although Diabetes Nurse Educators must provide ongoing evidence that they are engaging in activities that enhance their professional development in order to maintain crendiatialling status, it is optional whether they choose to continue to participate in the Association's formal mentoring program. In a future study it would be interesting to explore further what would motivate other generalist nurses to engage in formal mentoring.

Another limitation of this study was that the study participants' ethnicity was not captured during their registration to participate in this mentoring program hence the potential impact of the study participants' cultural identity on the mentoring program outcomes was unable to be measured.

Although neither the mentors nor the mentees identified money as a motivator to participate in mentoring previous research has often included wages as a determinant of effective performance i.e. an increase in wages is an almost universal inducement for individuals to perform work (Adams & Rosenbaum, 1962; Awases, Gbary, Nyoni, & Chatora, 2003; Feldman & Arnold, 1978; Met, Ali, & Ali, 2015, p. 192; Porter & Lawler III, 1968; Whitely, Dougherty, & Dreher, 1991; Zedeck, 1977). Future research on what motivates nurses to mentor could explore this concept further as there is an indirect correlation with being credentialled and the potential for promotion to Clinical Nurse

Consultant[2] status grade one, two or three, or entry into the domain of private practice.

1.4 Significance of the study

Commitment to ongoing professional development has been identified as an important preferred outcome of mentorship program participation (McCloughen, 2009). However, little evidence is available to explain what motivates individuals to participate in formal mentoring relationships and whether these mentoring relationships are judged successful by participants (McCarthy, 2015).

This research has the potential to contribute to the literature an understanding of what motivates nurses at various stages of their careers to participate in mentoring relationships to enhance their professional development. It impacts on what incentives may be used to engage nurses in professional development activities in order to enhance clinical practice and patient outcomes. It adds to the body of existing knowledge on what motives nurses to engage in professional development activities. The research has the capacity to inform nursing workforce planning by providing evidence about the cost effectiveness of types of inducements designed to encourage nurses to

[2] A Clinical Nurse Consultant provides expert clinical advice to patients, carers and other healthcare professionals within a defined specialty such as diabetes education and management. The role was established in 1992 in the state of New South Wales Australia and is seen as equivalent in function to other advanced clinical nursing positions common in some states of Australia as well as in the United Kingdom, United States of America and Canada. Since 1992, the CNC role in Australia has been delineated into the domains of clinical practice, consultancy, leadership, research; education and clinical service planning. These delineations are consistent for the three CNC grades used in salary determinations (Fair Work Commission Australia., 2017; New South Wales Government Ministry of Health Workplace Relations and Management Branch, 2011).

participate in mentoring for professional development. The study may also help clarify the perceived subjective nature of mentoring effectiveness.

1.5 Structure and outline of the study

In this chapter I have provided an overview of the study, identifying and contextualising the research problem. I have indicated the philosophical framework that supports the research design and outlined the overall structure of the study.

In chapter two, I review the research on formal mentoring, work motivation and the professional development of nurses and from the literature I position the study within the broader field of adult education. From the literature it would appear that engaging in formal mentoring programs has the capacity to enhance the professional development of nurses but the research on what motivates nurses to engage in mentoring is fragmented and scarce.

Chapter three describes the methodology used in this study. I present the rationale for the study design, arguing that a mixed mode research design was the most relevant framework within which to measure and to explore the meaning that the study participants attributed to their experience of participating in a formal mentoring relationship. The journey of becoming a professional nurse is revealed and understood within the philosophical framework of Heiddegerian hermeneutics because engaging in mentoring relationships for professional development is recognised as growing out of the past and present and being orientated toward the future, in particular, its generative impact is recognised. Phenomenology accepts that each individual nurse constructed their own meaning of being in the world and formal mentoring whilst at the same time they each created their world from previous understandings and experiences as individuals and as a nursing collective.

The meanings that evolved out of the interpretation of the experience of formal mentoring for the professional development of nurses are embedded in the philosophical framework of the study and reveal the phenomenon as a way of being in the world for these nurses. Meanings are discussed in terms of individual nurses, the contexts of nursing work, and the broader perspective of the Australian nursing profession. The key underlying assumptions of Husserlian phenomenology and Heideggerian hermeneutics are illustrated. The lived experience of motivation to mentor is described using expectancy theory of motivation model.

In chapter four I present the results from phase 1 of the study and in chapter five I present the results from phase 2 of the study. Credentialling is shown to be the catalyst, the motivational force for the mentees to engage in a mentoring relationship. The mentors' behaviour was motivated more by intrinsic motivational forces. Mentors demonstrated a strong desire to help the next generation of nurses to learn whilst also acknowledging that their mentees contributed to their own ongoing professional development.

The study findings demonstrated that mentoring contributed to the nurses' ongoing professional development. For example, mentoring improved their problem-solving skills, clinical competencies and enhanced their confidence in being able to provide education to their patients.

Chapter six provides a broader discussion of the key findings. The mentor and mentees level of self-efficacy, their perception of their nursing identity and the cultural climate of the Australian Diabetes Educators Association were all important factors that contributed to the mentors' and mentees' motivation to engage in mentoring. Encouraging nurses to engage in formal mentoring programs has the potential to improve their self-efficacy thereby potentially motivating them to participate in other continuing nursing education initiatives.

In chapter seven I discuss the contribution that this research makes to adult education and the body of knowledge on what motivates nurses to engage in mentoring for their ongoing professional development. By exploring the elements of valance, expectancy and instrumentality, the thesis offers a better understanding of what motivated these Australian nurses at various stages of their careers to engage in formal mentoring an outcome of which was their enhanced ongoing professional development. Expectancy theory of motivation provided a starting point for not only answering the research question, but it provided a framework for how learning organisations can systematically explain and potentially address shortfalls in their formal mentoring programs in order to enhance the ongoing professional development of their staff. Addressing all elements of the expectancy theory of motivation model is crucial if nurses are to be motivated to engaging in formal mentoring relationships.

1.6 Conclusion

In this chapter I have argued that this research has contributed to a better understanding on what motivates nurses to engage in formal mentoring relationships and how participation in formal mentoring programs has the capacity to enhance the professional development of nurses who are at various stages of the nursing career trajectory. Thefollowing chapter critically reviews existing research on mentoring, motivation and the ongoing professional development of nurses. ■

Chapter 2

Literature review: approaches to mentoring and motivation in professional education for nurses

2.1 Introduction

The aim of this study is to contribute to the existing body of knowledge on nursing professional development by asking what motivates nurses at various stages of their careers to engage in formal mentoring relationships and whether, and in what ways, formal mentoring contributes to their professional development.

In this chapter I critically review the relevant literature, providing a synopsis of what is currently known, based on research, on formal mentoring, work motivation and the professional development of nurses. The chapter positions the study within the fields of human resource development and adult education and examines the theoretical concept of work motivation, exploring how work motivation relates to nursing, formal mentoring and potentially to the professional development of Australian nurses.

2.2 Professionalism in nursing

The current literature defining what it is to be 'a professional' suggests that the concept of professionalism has evolved over time and is continuing to evolve for the nursing profession (American Nurses Association., 2015; Fealy et al., 2014; United Kingdom Nursing and Midwifery Council., 2015). Traditionally,

nursing has been portrayed as an occupation (rather than a career) mainly for women, something to do until one is married or as an excellent preparation for motherhood (Kalisch & Kalisch, 1987). Nurses have been described as 'ministering angels', 'Girls Friday', 'battle axes' and 'sex objects', but rarely as professionals or careerists (Harding, 2005, p. 93; Warner, Black, & Parent, 1995).

For well over one hundred years at 'pinning' ceremonies nurses have recited The Nightingale Pledge—a modified Hippocratic Oath. The pledge has been seen as the gold standard definition of what it is to be a nurse. Even today student nurses graduating from tertiary institutions declare:

> Before God and in the presence of this assembly to pass my life in purity and to practise my profession faithfully … May my life be devoted to service and to the high ideals of the nursing profession (Crathern, 1953; Nightingale, 1860; Reverby, 1987).

Pre-Middle Ages, only high ranking public officials, government leaders, physicians, lawyers and clergymen were acknowledged as professionals (Krause, 1996; Reader, 1966). From the Middle Ages through to the twentieth century, more occupational groups, such as engineers, accountants and bankers, have aspired to the status of a 'professional'. These new professions were, however, became known as 'occupational professions' rather than as status professions. Nursing was not included as either a status or a learned occupational professional group (Elliott, 1972).

2.2.1 Definition of a professional

It has been suggested that a profession has the following characteristics. It:

- confers status within society
- organises itself into some sort of professional body
- is learned—i.e., requires prolonged and specialised training and education

- is altruistic (orientated towards service rather than profit)
- offers autonomy within the job role
- is informed by an ethical code of some kind
- is non-commercial
- has collective influence within society
- is self-regulatory
- is collegial
- is client-focused (Warner et al., 1995, p. 20).

2.2.2 Motivation for the professional development of nurses

Nurses who aspire to be viewed as professionals, to have a professional identity, are expected to display the attributes listed above. The altruistic nature of the professional is often singled out as a defining feature. As Turner (Turner, 1993, p. 14) notes, 'The professional is motivated by service to the community rather than by the anticipation of an immediate material reward; altruistic values predominate over egoistic inclinations'. While nurses' personal values may be very different from this ideal of altruism, nursing as a profession is often defined as a culture of caring and compassion (Johnson, 2012; Snell, 2012).

2.2.3 Nursing identity

Individuals learn what it is to be a nurse by undergoing a subtle process of mental programming that culminates in the individual developing a nursing identity (Hofstede & Minkov, 2010). Nurses develop an understanding of ethical comportment and notions of good that are central to the nursing profession by being socialised into the nursing role, developing a professional identity that is constituted by the meanings, content, intents and practices of nursing (Benner, Sutphen, Leonard, & Day, 2010).

2.2.4 Nursing culture

The organisational culture or 'the way things are done around here' impacts on what nurses accept as the dominant beliefs and attitudes of nurses generally (Morgan, 1986; Schein, 2010; Seaton, 2010). Research demonstrates that there is a strong correlation between the willingness of nurses to learn and to engage in professional development activities when their organisational culture is both positive and supportive, demonstrating a common ethos, image and way of thinking (Bell, 2013; Ogiehor-Enoma, Taqueban, & Anosike, 2010).

In general nurses are reasonably satisfied with many aspects of their work environment, however, particular features of the work place, such as opportunities for professional interactions, interpersonal relationships between colleagues and managerial support have been demonstrated to be associated with an increased staff intention to turnover rate particularly for Generation X nurses (Christopher, Fethney, Chiarella, & Waters, 2017). Creating a culture where nurses value professional development means recognising that a 'one size fits all' approach to professional development is not going to provide activities that engage and meet the needs of all nurses (Henderson et al., 2011).

Some professional education theorists argue that effective professional development activities need to be self-motivating and potentially advantageous to both the individual and the organisation (Halcomb et al., 2014). Engaging nurses in professional development activities has been shown to have the potential to enhance a nurse's knowledge and to ensure that their clinical skills and ability remain current and relative (Anderson, 2011, p. 8; Cooper, 2009; Frenk et al., 2010b, p. 11).

Frenk and colleagues argue that instead of focusing on providing fragmented education to nurses through 'information transfer', the process of transferring information, not learning and understanding, nurses should be assisted to learn to learn through exposure to salient examples, in particular,

professional practice situations, and that the signature pedagogies of professional education should be to educate for clinical competence, integrity, and professional judgment (Frenk et al., 2010b, p. 10).

Beginner nurses learn through instruction, acquiring domain-specific facts, features, and actions and after experiencing a large amount of concrete experience move through to the expertise stage, not only having an understanding of the task, but also the decision of what to do next, is intuitive and fluid. Given their deep understanding of the situation, expert nurses act naturally without explicitly making decisions and solving problems.

However, assigning nurses to stages (number of years of experience and supervisors' judgements) may not be reliable and in fact have been shown not always to correlate with expertise (Kolb, 1984) as clinicians may be expert in one field but may perform less expertly in another sub-field of the same domain (Honey & Mumford, 1982; Springer, Stanne, & Donovan, 1999).

Thus, whilst Benner advocates that nursing practice can be learnt but cannot be taught for beginning students, nursing models and theories are necessary in order to compensate for a lack of experience (Craig & Smith, 2014). Education for practice therefore requires the student to learn in and from practice alongside more experienced practitioners. From this perspective, it would appear that the classroom teacher has little contribution to make to the education of practitioners once they have reached the level of competent.

However, educationalists such as Donald Schön maintain that the rift between the 'theoretical knowing' that is taught in universities and the 'practical knowing how' required by the professions can be bridged by academics and practitioners working together in order to create a reflective culture where knowledge is derived from a structured approach to thinking about practice (Schön, 1983). I propose that engaging in formal mentoring is a strategy that

may have the potential to bridge the theory to practice gap provided nurses are motivated to engage in mentoring relationships.

2.3 Professional development for nurses in the 21st century

Participating in professional development activities such as mentoring requires that nurses commit to engage in lifelong learning. As in other professions, the reality is that in nursing not every nurse is willing to take responsibility for their personal and professional development (Lannon, 2007; Twaddell & Johnson, 2007).

In the Australian health system everyone has the right to receive care that is of the highest quality, is safe and that is delivered by professional dedicated health care providers in order to ensure the best possible outcomes (Australian Commission on Safety and Quality in Health Care., January 1, 2009). As a result, national competency standards for registered nurses were introduced by the Australian Nursing and Midwifery Council in the early 1990s, hence nursing has seen a shift from the traditional model of front-end learning to an approach that insists on lifelong learning in order to ensure that nurses deliver safe and competent care. This change in practice, along with the requirement that nurses' compliance with the national competency standards is now assessed annually, focuses on ensuring the ongoing professional development of nurses for the duration of a nurse's working life, rather than focusing on the professional development of nurses only at the start of their nursing careers.

Key national and international nursing bodies now recognise that the ability of all nurses to perform at the expected level requires a process of lifelong learning (American Nurses Association., 2010, p. 21; Nursing and Midwifery Board of Australia., 2016).

One consequence of this 'lifelong learning' model is that professional development activities for nurses in the 21st century will increasingly need to be designed to meet the learning needs of nurses with diverse cultural backgrounds and different thinking, learning and communication styles (Siantz & Meleis, 2007; Terry, Carr, & Williams, 2013). The American Association of Colleges of Nursing, for example, recommends that to encourage nurses to engage in life-long behaviour changing learning, professional development activities need to incorporate synergistic, collaborative learner centred methods, infused with technology that promotes best practice in nursing education (Halcomb et al., 2014, p. 20; International Council of Nurses, 2013; Newhouse & Spring, 2010).

2.3.1 Motivators for the professionalism of Australian nurses

Nurses who cannot provide evidence of participation in professional development activities are not able to guarantee health services consumers of acceptable pre-defined standards of clinical care nor are they eligible to be registered to practice nursing with the Australian Health Practitioner Regulation Agency in partnership with the Nursing and Midwifery Board of Australia (Australian Nursing and Midwifery Council., 2012, pp. 4-5). Nurses cannot practice nursing in Australia unless they participate in a minimum of twenty hours of professional development activities annually. This is a mandatory compulsory requirement for all nurses.

There appears to be global consensus on the benefits of mentoring nurses (German Federal Ministry of Education and Research Deutschland Thüringen., 2016; United Kingdom Nursing and Midwifery Council., 2008). However, debate continues as to whether mentoring for post graduate nurses should be mandatory. In the United Kingdom and the Netherlands (Fealy et al., 2014; Royal College of Nursing Australia, 2009-2012), participation in mentoring for nurses is mandatory, whereas in the United States and Australia participation in

mentoring is recommended but not mandatory (American Nurses Association., 2011, p. 11; 2015).

However, some sub-specialisms within nursing do make mentoring mandatory as part of credentialling processes. For example, it is mandatory for Australian Diabetes Nurse Educators, the subjects in this study, to participate in the Australian Diabetes Educators Association formal mentoring program if they want to be credentialled. The association expects that diabetes nurse educators will work towards achieving the professional status of a credentialled diabetes educator and, once attained, will maintain this credential throughout their professional career by reapplying annually (Australian Diabetes Educators Association, 2016; Australian Diabetes Educators Association., 2008d).

2.3.2 Australian diabetes nurse educators

The role of the Diabetes Educator is to promote optimal health and well-being for individuals (or their carers), communities and populations at risk of, or affected by, diabetes using a range of specialised knowledge and skills. They integrate diabetes self-management education with clinical care as part of a therapeutic intervention to promote physical, social and psychological well-being. (Australian Diabetes Educators Association., 2007).

A wide range of healthcare providers provide some form of diabetes education. However, the term 'Credentialled Diabetes Educator' is used by the Australian Diabetes Educators Association to identify those health professionals who provide more comprehensive complex, interdisciplinary diabetes self-management education as described by ADEA and who meet the criteria of the ADEA Credentialling Program.

To achieve the nationally recognised status of a credentialled diabetes educator, health professionals must meet the following criteria:

1. Be a member of the Australian Diabetes Educators Association.

2. Hold a professional healthcare qualification and have completed a post-graduate certificate in Diabetes Education and Management from a tertiary institution that has been accredited by the Australian Diabetes Educators Association to provide this qualification.
3. Complete a set minimum of 1800 clinical practice hours in diabetes education.
4. Have a referee report addressing the criteria of the National Core Competencies for credentialled diabetes educators.
5. Participate in a mentoring partnership registered with the Australian Diabetes Educators Association's formal mentoring program for a minimum period of six months.

2.3.3 Benefits of credentialling

Diabetes Nurse Educators who are credentialled are eligible to apply to the Australian Government for the allocation of a Medicare Australia provider number from the Australian Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme. Nurses who have been allocated a Medicare Australia provider number are able to be financially reimbursed by the Australian Government for nursing services provided to their patients (Australian Government Department of Health, 2014). Credentialled diabetes nurse educators have the capacity and scope to work in private practice, as nurse practitioners or as clinical nurse consultants if they so choose, with potentially considerable increases in their earnings (Fair Work Commission Australia., 2017; Industrial Relations Commission of New South Wales., 2015). However, in order to become credentialled a nurse must have participated in a formal mentoring program.

2.4 Mentoring

The practice of mentoring can be traced back to ancient Greek mythology, when Odysseus entrusted his loyal friend Mentor to take charge of his infant son Telemachus when he left to go and make war on the Trojans (Carroll, 2004; Chenoweth & Lo, 2001). Mentor was responsible not only for the boy's education, but for the shaping of his character, the wisdom of his decisions, and the clarity and steadfastness of his purpose (Roberts, 1999; D. Schweitzer, J. & T. Krassa, J., 2010). Although understandings about the nature of mentoring and its practices have shifted over time and across cultures, mentoring is often defined by the characteristics that differentiate it from other learning relationships (Harris & Daley, 2006). A number of authors argue that mentoring is difficult to define because it is often confused with other support roles played by key persons (Huybrecht, Loeckx, Quaeyhaegens, De Tobel, & Mistiaen, 2011; Morton-Cooper & Palmer, 1993).

2.4.1 Ontology of mentoring

The definition of mentoring used in this research is that it is a personal development process whereby a more experienced or more knowledgeable person (the mentor) helps a less experienced or less knowledgeable person (the mentee) by providing support, guidance or information. While mentoring is conventionally thought of as a relationship that involves an altruistic service by the mentor to the benefit of the mentee, some recent definitions interpret mentoring as a two-way relationship, in which both mentor and mentee benefit from their interactions. For the Australian Diabetes Educators Association, 'an effective mentoring partnership is a two-way street for sharing problems, information and higher work level through direct interaction' (Australian Diabetes Educators Association., 2008c, p. 6). Rather than a hierarchical

relationship there is an emphasis on peer mentoring and mentoring that is not necessarily exclusively dyadic (Kram, 1985; Kram & Isabella, 1985).

2.4.2 Mentoring versus preceptoring

The nursing profession also uses 'preceptoring' to enhance student learning (Gendron, 2007, p. 5). Like mentoring, preceptoring is conducted as a one-to-one relationship. Unlike mentoring, the relationship lasts for only a short period of time. The goals of a preceptor tend to be specific and definite, and once the goals have been achieved, the preceptorship relationship ends (Ellinger, Hamlin, Beattie, Wang, & Mcvicar, 2011, p. 507). While the mentorship relationship may focus equally on the achievement of personal and professional goals, preceptoring tends to be a student–teacher relationship however this research does not look at preceptoring relationships (Krause, 1996).

2.4.3 Formal and informal mentoring

When examining a mentoring relationship, it is important to distinguish between whether the mentoring partnership is formal or informal, with the nurses who engaged in this study participating in a formal mentoring program.

The formality of the relationship may impact on the success and outcomes of the mentoring relationship (Allen, 2003; Usher, 1998). Informal mentoring relationships are often driven by the mentor and usually develop on the basis of mutual identification and the fulfillment of the developmental needs, such as the career needs, of the mentee (Ragins & Cotton, 1999). Mentors select mentees who are viewed as younger versions of themselves, and the relationship provides mentors with a sense of generativity, or contribution to future generations (Erikson, 1963). Mentors are usually in the mid-stages of their careers, a time that involve reassessment of life accomplishments (Erikson, 1963; Kram, 1985) and generativity helps mentors avoid stagnation and allows them to progress to the next life stage. Mentees select mentors who are viewed as role models. Mentees are in early stages of their careers, a time that involves

developing a sense of professional identity, and role modelling helps mentees advance through this stage. This mutual identification leads to the often-cited intensity of the informal relationship and the parallels drawn between mentoring and parent-child relationships (Ragins & Cotton, 1999, p. 530).

Informal mentoring relationships also develop on the basis of perceived competence and interpersonal comfort and tend to last for longer periods of time than formal mentoring (Devos, 2005; Kram, 1985; McCloughen, 2009). In contrast, formal mentoring relationships are characterised by the involvement of a third party who matches mentors with mentees. These relationships usually last for a shorter period of time, often 6 to 12 months (Dyson, 2015; Wanberg, Welsh, & Hezlett, 2003).

2.4.4 Mentoring as an educational practice in nursing in the 21st century

In nursing, mentoring has been used to improve nursing leadership (McCloughen, 2009; Wood, 2006), safety culture (Wynd, 2003) career development (Duchscher & Cowin, 2004; Medoff-Cooper, 2003), competence in conducting nursing research (Byrne & Keefe, 2002), socialisation of new members in nursing organisations (Clarke-Gallagher & Coleman, 2005) and to provide positive support for nursing students and new graduate nurses (Elcigil & Sari, 2008; Hefel, Williamson, & Hatlevig, 2006; Johnson, Cohen, & Hull, 1994; Kalnins, 2001; Robinson, 2013; Ryan & Brewer, 1997).

While many studies have focused on the impact of mentoring nurses at the start of their careers (Butterworth & Faugier, 1992), there have been few mentoring programs implemented to meet the needs of nurses further along in their careers. With many nurses leaving the profession for a variety of reasons, encouraging nurses to engage in mentoring relationships has been suggested as one way of retaining and strengthening the nursing workforce. Mentoring may provide a means of supporting future nursing leaders and sustaining nursing talent (Johnson, Billingsley, Crichlow, & Ferrell, 2011). Mentoring program

participation may be one strategy to help retain and capitalise on the intellectual capital of Australia's ageing nursing workforce (Gendron, 2007; Thomka, 2007).

Ageing and retired nurses possess the tacit and content specific deeper level learning that could be transferred through mentoring to younger nurse mentees (McDonald, Mohan, Jackson, Vickers, & Wilkes, 2010). This has the potential to enhance more junior nurses' professional networks and knowledge of strategic career development.

2.4.5 Willingness to mentor

However, not all individuals are suited to the role of mentor (Freeman, 2005; Hart, 2009), and not all are willing to mentor (Masters, 2003). A description of the characteristics of a good mentor often include terms such as 'a good listener', 'a guide', who is 'supportive', 'provides education', 'shares insights and experiences', 'create opportunities and open doors'.

Ideally, mentors want their mentee to become independent (Kappel, 2008; Richardson, 1999). Yet a limited amount of research has examined the dynamics of mentoring relationships (Wanberg et al., 2003), specifically how organisations can enhance factors that may lead to a willingness to mentor (Allen, 2003; Bear & Hwang, 2014; Hu, Thomas, & Lance, 2008).

For example, prior experience as a mentor or successful mentee (protégé) has been demonstrated to positively affect a willingness to mentor again (Ragins & Cotton, 1993; Ragins & Scandura, 1999). The desire to help the next generation has been found to become particularly acute as retirement approaches, with individuals reassessing their relationships with their employer and colleagues and reconsidering the meaning and focus of their work (Ekerdt & Deviney, 1993). Given that many Australian nurses are approaching retirement, the findings from Ekerdt and Deviney's study has implications for this study investigating what motivates nurses to engage in mentoring.

Research has demonstrated that men tend to be more willing to mentor than women (Bear & Hwang, 2014), and executives are more willing to mentor than manual workers (Clutterbuck & Megginson, 1999). More generally, the willingness to mentor has been shown to relate closely to personal characteristics (Allen, 2003; McCloughen, 2009). Evidence also suggests that willingness to mentor relates to perceived self-efficacy in mentoring: individuals who feel they could be effective mentors are more likely to volunteer (Kram, 1988; Penner, Craiger, Fritzsche, & Friefield, 1995).

The rapid changes in healthcare technologies and organisational structure mean that continuous workplace learning is essential. Because mentoring has been shown to enhance workplace learning, the last decade has seen an increased interest in identifying determinants of willingness to mentor in the workplace (Bear & Hwang, 2014; Hart, 2009). Research has demonstrated that individuals are more inclined to be willing to help others if they have high organisational based self-esteem and if they believe that the organisation they work for values their contribution and cares about their wellbeing (Jackson et al., 2015; Sambunjak, Straus, & Marusi, 2006).

However, although Sze's study that demonstrated that willingness to help tends to increase with age (Nick et al., 2012), a significant number of study respondents in Thurston and colleagues' study identified several barriers to mentoring relationships, including the shortage of qualified mentors and a lack of willing mentors (Thurston, D'Abate, & Eddy, 2012).

Whether a person has an informal professional mentor may depend on the person's personality (Shamir, 1991), motivational needs (Aryee, Chay, & Chew, 1994), locus of control (Hofstede, 1980), age (Hansford, Ehrich, & Tennent, 2004), sex (Baxley, Ibitayo, & Bond, 2013; Bolton, 1980; Burke & McKeen, 1990; Grindel & Hagerstrom, 2009); ethnicity (Thomas, 1990), professional status (Schön, 1983) and/or tenure with the organisation (Graf, 2006). In general, people with more

education are more likely to independently seek out an informal mentor for their career development (Kram, 1983, p. 608).

Rapid changes in the contemporary workplace, such as technological innovations, require nurses (who are typically older workers) to display skills in versatility and personal self-efficacy in order to manage effectively the changing demands of these new nursing roles. An individual's personal self-efficacy is their perception, their belief in their ability to influence events that affect their lives. This core belief is the foundation of human motivation, performance accomplishments, and emotional well-being (Bandura, 1997, 2006).

For people who have a low sense of personal self-efficacy, the demands of keeping up with new technologies can be intimidating (Bandura, 1997, p. 435). While popular literature portrays midlife as a period when personal growth has plateaued and people typically confront declining opportunities for career growth, the contemporary workplace delivers a different message: it suggests that education must be seen as a lifelong process rather than something that it is arrested at a midlife or that has an arbitrary beginning and end (Bandura, 1997, p. 197).

Learning can no longer be viewed as constituted of a place and time to acquire knowledge (school) and a place and time to apply that knowledge (the workplace) (Fischer, 2000). Instead, learning needs to be seen as something that takes place on an ongoing basis as a consequence of our daily interactions with others and with the world around us (Aspin & Chapman, 2007, pp. 19-38).

2.5 Epistemology of mentoring

For nurses or for other professionals, engaging in mentoring relationships appears to provide the opportunity for ongoing cognitive development of mentors and mentees (Eby et al., 2008; Ellinger et al., 2011). Experienced nurses

who act as mentors potentially have the opportunity to support and scaffold nurse mentees as they learn new things, thereby potentially enhancing the mentee's cognitive development (Vygotsky, 1978, pp. 130-131). The work of Lev Vygotsky (1978) has become the foundation of much research and theory in cognitive development over the past several decades, particularly through what has become known as social development theory. Through his key principles of the 'more knowledgeable other' and the 'zone of proximal development', Vygotsky's theories stress the fundamental role of social interaction in the development of cognition (Vygotsky, 1978).

2.5.1 Mentoring and the 'more knowledgeable other'

The concept of the 'more knowledgeable other' refers to someone who has a better understanding or a higher ability level than the learner with respect to a particular task or process (McLeod, 2010). Although the implication is that the more knowledgeable other is a teacher or an older adult, this is not necessarily the case. The key attribute of the more knowledgeable other is that they must have more knowledge about the topic being learned than the learner does (Covington Clarkson, 2014, p. 102; Makinde & Akinteye, 2014, p. 80).

2.5.2 Mentoring and the zone of proximal development

The concept of the more knowledgeable other is integrally related to the second important principle of Vygotsky's work, the zone of proximal development. The zone of proximal development is Vygotsky attempt to capture the difference between what an individual can achieve independently and what an individual can achieve with guidance and encouragement from a skilled partner (Vygotsky, 1978, p. 86).

Vygotsky (1978) viewed interaction with peers as an effective way of developing skills and strategies by providing the opportunity for collaborative learning. Collaborative learning is an approach to teaching and learning that requires learners to work together to deliberate, discuss, and create meaning

(Dillenbourgh, Baker, Blaye, & O'Malley, 1995, p. 602) the principles of which are based on the theories of John Dewey (Dewey, 2009), Lev Vygotsky (Vygotsky, 1980), and Benjamin Bloom (Bloom, 1956).

Theoretically, because individuals have different levels of ability, more advanced individuals or peers have the potential to help less advanced individuals or peers if they are given the opportunity to do so, as in mentoring (Turkich, Greive, & Cozens, 2014). Just as children can do more with the help and guidance of an adult or other more experienced knowledgeable person than they can do by themselves, engaging in a positive mentoring relationship has the potential to enhance a mentee's zone of proximal development. This may be achieved by enhancing skills and abilities that the mentee is still in the process of developing (Evans, 2008, p. 853).

While the nurse mentor may act to scaffold the mentee's learning, the mentor can also act as a motivator by providing positive feedback (Teatheredge, 2010). The more the mentee interacts with and takes advantage of the mentor's assistance, the more likely the mentee is to develop problem-solving skills and broaden their zone of proximal development (McCloughen, 2009), essential for maximum cognitive development to occur (Vygotsky, 1978, p. 86).

A zone of proximal development operates only when a person is interacting with other people in their environment and in cooperation with their peers (Vygotsky, 1978, p. 90). Consequently, an important mentoring characteristic to consider when matching mentors to mentees in formal mentoring programs is the compatibility of the beliefs and values of the mentors and mentees (Coombs-Ephraim, 2016; Hale, 2000, p. 232; McCloughen, 2009). Mentors and mentees must have the capacity to interact and cooperate with one another in order to engage in collaborative learning that requires the mutual engagement of both the mentor and the mentee.

2.5.3 Mentoring and collaborative learning

There are many positive results from collaborative learning, such as learners being able to learn more material by engaging with one another, retain more information from thoughtful discussion and have a more positive attitude about learning by working together. However, there are still many negative issues that may arise when using collaborative learning such as a lack of awareness of cultural norms and generation gaps and age differences that may impact on the learners' awareness of effective collaboration processes (Lee & Bonk, 2014). Not surprisingly, mentoring relationships have often been identified as problematic when mentors and mentees are paired up by a third party (Nursing Midwifery Council United Kingdom., 2008; Rosser, Rice, Campbell, & Jack, 2004).

In the UK, where participation in formal mentoring is a mandatory prerequisite to being authorised to practice as a registered nurse, cultural differences between formally matched non-white nurse mentors and white mentees have been used to justify different standards of clinical practice. Some white nurse mentees perceived that the standard of clinical practice demonstrated by their non-white nurse mentors to be inferior to the standard of clinical care and professional expertise provided by white nurse mentors (Scammell & Olumide, 2012). Nurses who have the potential to be registered to practice but who are not competent clinicians may compromise patient safety and patient outcomes (Mead, Hopkins, & Wilson, 2011).

As contemporary learning theorists have been stressing for some time, learning cannot be construed as an unproblematic process in which the learner absorbs the given, i.e. as a process of transmission and assimilation (Lave & Wenger, 2005, p. 151; Mezirow, 1991)). By exposing learners to authentic real-life situations where there may not be a right or a wrong answer per se, although one solution may be better or worse than others depending on the particular context, learners have the opportunity to develop understanding that

involves considerable reflective judgment, a valuable lifelong skill that goes well beyond the memorisation of content (Dede, Korte, Nelson, Valdez, & Ward, 2005).

Kolb and Fry argue that effective learning is a spiral process that entails the possession of four different abilities, concrete experience, reflective observation, abstract conceptualisation and active experimentation abilities (Kolb & Fry, 1975, pp. 35-36). As few of us can approach the ideal in our learning abilities, Kolb developed a learning style inventory (Kolb, 1976) which was designed to place people on a line between concrete experience and abstract conceptualisation; and active experimentation and reflective observation. Within Kolb's model learning is seen as a process, with for example learners using concrete, 'here-and-now' experience to test ideas; and feedback used to change practice (Kolb, 1984, pp. 21-22).

Engaging in a supportive mentoring relationship, facilitated in a teaching environment that provides real world experience (as opposed to hypothetical exercises), and group learning, working together coperatively or collaboratively without instruction (Springer et al., 1999), have been demonstrated to be effective strategies for ongoing learning and for developing capabilities in reflection (Birden, 2012, p. 68; Sugarman & Sokol, 2012), persistence and achievement-related outcomes.

2.5.4 Mentoring and learning styles

However, not all mentees and mentors have the same preferences for how they like to learn or learning styles. One approach to explaining learning styles is the model developed by Honey and Mumford which suggests four distinct learning styles: The Activist the Theorist the Pragmatist and the Reflector (Honey & Mumford, 1982). Activists are said to exhibit certain characteristics such as a preference to learn by doing, an open-minded approach and a tendency to engage fully with new experiences. The Theorist prefers to understand the

models and theory that apply to their learning. The Pragmatist likes to quickly put their new learning into practice in the real world, to experiment and try out new approaches and the Reflector prefers to learn through observation and to stand back from experiences and to view from different perspectives before coming to a conclusion.

For the mentor in nursing it may be difficult—if not impossible—to accommodate the learning style of all mentees, given that learning styles are dynamic and that mentees can change their learning style in response to new learning experiences (Craig & Smith, 2014, p. 67). Learning theories stress the significance of understanding the application and relevance on our motivation to learn and the importance of providing learning opportunities. Nurses are therefore more likely to learn if they can see how new learning can be used in future practice (Quinn & Hughes, 2007). However, to be an effective learner ideally one develops the ability to learn in other styles too (Honey & Mumford, 1982).

Another strategy used to stimulate meaningful learning is participation in directed learning activities (Mann, Gordon, & Macleod, 2009b, p. 602), such as the use of reflective practice. The importance of reflection and reflective practice are frequently noted in the literature; indeed, reflective capacity is regarded by many as an essential characteristic for professional competence (Mann et al., 2009b). Directed learning activities are exercises developed by a teacher, tutor or mentor that assist students or mentees to gain more practice on a concept or skill that may have originally been used in the classroom.

Such activities usually require a follow-up feedback session with a teacher, tutor or mentor. In nursing, directed learning activities have the capacity to increase professional effectiveness and enhance cognitive development by assisting to link theory to practice (Argyris & Schon, 1974). Nurses need to know about and use learning strategies such as reflective practice and problem-

solving as these strategies have been shown to enhance nursing taxonomies of knowledge (McLane & Turley, 2009).

2.5.5 Mentoring as a community of practice

A key concept in contemporary learning theory is that of the 'community of practice'. Lave and Wenger (1991) defined a community of practice as a group of people who share a craft or a profession however over time the definition has evolved (Lave & Wenger, 1991). A community of practice is a group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger, 1998). This very broad definition reflects the fundamentally social nature of human learning. In all communities of practice three key elements must be present. These elements are the learning domain where members are brought together by a learning need that they share (whether this shared learning need is explicit or not and whether learning is the motivation for their coming together or a by-product of it); the community, where their collective learning becomes a bond among them over time; and the practice, where the community's interactions produce resources that affect members' practice, whether they engage in actual practice together or separately (Wenger, McDermott, & Snyder, 2002; Wenger & Wenger-Trayner, 2015).

A community of practice can evolve naturally because of the members' common interest in a particular domain or area, or it can be created deliberately with the goal of gaining knowledge related to a specific field (Lave & Wenger, 1991). Connecting nurses to learn share knowledge and to achieve real world tasks—roles that characterise established communities of practice—has been demonstrated to be enhanced by mentoring. Mentoring stimulates learning by serving as a vehicle for communication in real (naturally occurring) contexts. It is through the process of sharing information and experiences within the group that members are able to learn from one another and have the opportunity to

develop personally and professionally as nurses (Andrew, Tolson, & Ferguson, 2007).

The concept of communities of practice is now viewed as a way to capture the tacit knowledge, or know-how, that characterises workplace groups but is not easily articulated (Hildreth & Kimble, 2004). For example, research conducted by a group of Scottish nurses working in the field of gerontological nursing found that a key outcome of participating in a community of practice was that it provided the opportunity to combine the expertise of nursing clinicians and nursing academics through the sharing of ideas and knowledge (Andrew & Ferguson, 2008).

When nurses perceive that they share a common identity and history of professional experiences, they appear to feel more bonded as a social group (Thrysoe, Hounsgaard, Bonderup Dohn, & Wagner, 2012). When nurses participate in mentoring relationships there is evidence that both patient care and organisational outcomes improve (Harper, Kurtz, Perron, Asselin, & MacArthur, 2012).

Research has shown that well-chosen mentors have the opportunity and capacity to guide the mentee to reflect on transient incidents and experiences, with the potential to turn these events into learning moments (Ragins & Cotton, 1993). Beyond this, some claim that the real power of mentoring is in the mentor and mentees' development of insights (Hale, 2000, p. 227). A mentoring relationship has the potential to provide an opportunity for peers (i.e. the mentor and mentee) to discuss different points of view, which acts as a facilitator for learning and development. Research demonstrates that peer interaction provides a powerful context for supporting change in logical and spatial reasoning (Glachan & Light, 1982, p. 239).

Cognitive conflict, discussions and or disagreements, created by social interaction, potentially between the mentor and the mentee, is the locus at

which the power driving intellectual development is generated (Perret-Clermont, 1980). Role modelling, active peer interaction (dialog and discussion) as opposed to observing peers and non-interaction progress reasoning and support change more than independent individual work alone and active peer interaction has been shown to enhance development and progress reasoning (Kuhn, 1974; McNamara, 1979; Rosenthal & Zimmerman, 1972).

Evidence shows that mentoring is most effective when the mentor and the mentee interact in real contexts in the workplace, where knowledge is delivered within the contextual realm in which it is used (Lindner, 1998; Ousey, 2009; Wolf & Morgan, 2011). However, evidence shows that merely being exposed to a particular experience does not necessarily lead to cognitive development (Kuhn, 1970). Exposing individuals to naturally occurring situations in which people are highly motivated to learn and to reflect on their experiences does appear to contribute to effective learning (Boud, Keogh, & Walker, 1985; Stendler Lavatelli, 1977, p. 127).

2.5.6 Mentoring and the stages of learning and development

Research on life-span development shows that chronological age per se is not the only predictor of learning ability (Wenger et al., 2002). Bastable for example proposes that at any given age, one finds a wide variation in the acquisition of abilities related to the three fundamental domains of development: physical (biological), cognitive, and psychosocial (emotional-social) maturation.

Age ranges correlating to developmental stages are intended to be used as merely approximate age-strata reference points or general guidelines; they do not imply that chronological ages necessarily correspond perfectly to the various stages of development (Wenger & Wenger-Trayner, 2015, p. 167).Thus the term developmental stage is the perspective used, based on the confirmation from research that human growth and development are sequential but not always specifically age related (Kuhn, 1970, 1974; McNamara, 1979).

As influential as age can be to learning readiness, it should never be examined in isolation. Growth and development interact with experiential background, physical and emotional health status, and personal motivation, as well as numerous environmental factors such as stress, the surrounding conditions, and the available support systems, to affect a person's ability and readiness to learn (Quinn & Hughes, 2007).

Based on Covey's three phases of learning: dependence, independence, and interdependence, often referred to as a continuum the adult's self-concept moves from one of being a dependent personality to being an independent, self-directed human being (Penner et al., 1995). He or she accumulates a growing reservoir of previous experience that serves as a rich resource for learning. Readiness to learn becomes increasingly oriented to the developmental tasks of social roles. The perspective of time changes from one of postponed application of knowledge to one of immediate application; there is a shift in orientation of learning to being problem centred rather than subject centred (Jones, 2001).

Although adulthood, like childhood, can be divided into various developmental phases, the focus for learning is quite different. Whereas a child's readiness to learn depends on physical, cognitive, and psychosocial development, adults have essentially reached the peak of their physical and cognitive capacities.

The emphasis for adult learning revolves around differentiation of life tasks and social roles with respect to employment, family, and other activities beyond the responsibilities of home and career (Noe, Hollenbeck, Gerhart, & Wright, 2015). The prime motivator to learn in adulthood is being able to apply knowledge and skills for the solution of immediate problems.

Unlike children, who enjoy learning for the sake of gaining an understanding of themselves and the world, adults must clearly perceive the relevancy of acquiring new behaviours or changing old ones for them to be

willing and eager to learn. In the beginning of any teaching-learning encounter, therefore, adults want to know how they will benefit from their efforts at learning (Australian Nursing and Midwifery Council, 2012).

In contrast to the child learner, who is dependent on authority figures for learning, the adult is much more self-directed and independent in seeking information. For adults, past experiences are internalised and form the basis for further learning. Adults already have a rich resource of stored information on which to build a further understanding of relationships between ideas and concepts (Illeris, 2017a).

One of the most significant qualities unique to adult learning as compared to that of children, teens, and traditional college students is life experience. That experience offers adult learners a meaningful advantage in the learning process particularly when the adult is viewed holistically (NSW Health., 2011). The sum of those experiences provides many reference points for exploration, new application, and new learning.

For many adults, the accumulation of life experiences and their proven record of accomplishments often allow them to come to the teaching-learning situation with confidence in their abilities as learners. However, if their past experiences with learning were minimal or not positive, their motivation likely will not be at a high enough level to easily facilitate learning.

Because adults already have established ideas, values, and attitudes, they also tend to be more resistant to change. In addition, adults must overcome obstacles to learning to a greater extent than children. For example, they have the burden of family, work, and social responsibilities, which can diminish their time, energy, and concentration for learning. Anxiety, too, may negatively affect their motivation and ability to learn (Tague, 2004).

2.5.7 Mentoring and the importance of engagement in learning

For adults to engage in learning and for learning to occur education theorists seem to agree there needs to be some form of mobilistion (Illeris, 2017b; Jarvis, 2012). However, we cannot consciously regulate this mobilisation, and therefore the kind and strength of the mobilisation is unconsciously regulated by the totality of the needs, interests, impulsions and aversions, etc. of the person. There may also be very conscious elements involved, a will, a hope or an insight into the importance of the learning and the consequences of not learning, sticks and carrots, but the mobilisation as such is unconscious.

Hence a prerequisite for learning is that there must be a mobilisation of energy, which is motivation to engage in learning or as defined by Illeris the incentive dimension of learning (Illeris, 2017b).

2.5.8 Barriers to nurses mentoring

Subsequently while nurses agree in theory that participation in professional development activities is important for ongoing learning and advantageous for their careers, research into what motivates nurses at various stages of their nursing careers to engage in formal mentoring relationships appears to be insufficient and fragmented.

Barriers identified to date to the participation of nurses in activities designed to enhance their ongoing professional development include the cost of education and a lack of appropriate childcare (Schweitzer & Krassa, 2010). Financial constraints and lack of time make it difficult for nurses to get time away from the patient's bedside in order to engage in education and other ongoing professional development activities (Aiken et al., 2014).

In the United Kingdom, where participation in formal mentoring is mandatory for nurses, nurses identified constraints such as competing time demands and lack of designated funding to backfill staff so that mentees could be allocated time to meet with their mentors (Robinson, 2013). The predominant

barrier to participating in mentoring was the lack of one hour a week as dedicated time for the nurse mentor and mentee to meet. Other barriers identified were the lack of support for mentors and a shortage of willing and qualified mentors to meet demand (Robinson et al., 2012b; Sweet, Fortier, Strachan, & Blanchard, 2012).

Even so, the UK government's response to an inquiry by the Mid Staffordshire National Health Service was that formal mentoring for nurses was to continue. The inquiry did, however, recommend that nurses needed to be appropriately trained in mentoring, motivated, and provided with enough time to both participate in mentoring and care for their patients (Hu et al., 2008; Kendall-Raynor, 2013).

Only nurses who have completed the formal mentoring program and have met the standards of the Nursing and Midwifery Council are authorised and registered to practice in the UK. All registered nurses practicing in the UK are likely to have to act as a mentor to a number of other nursing students – including newly qualified, internationally recruited and unqualified staff. For these reasons, a mentoring toolkit was developed to assist mentors in their role of working with pre-registration students (Nursing Midwifery Council United Kingdom, 2006).

However, only authorised 'sign-off' mentors can make the final assessment of practice and confirm to the Nursing and Midwifery Council that students have met the relevant standards of proficiency leading to registration thereby ensuring that nurses are able to provide quality clinical care that is both safe and of a high standard (Nursing Midwifery Council United Kingdom., 2008).The importance of the role of the mentor and the quality of the mentorship offered in practice cannot be over-emphasised (Poorman & Mastorovich, 2017; Stuart, 2013).

Figure 2.1 captures some of the barriers that constrain nurses from engaging in mentoring as discussed in the literature review.

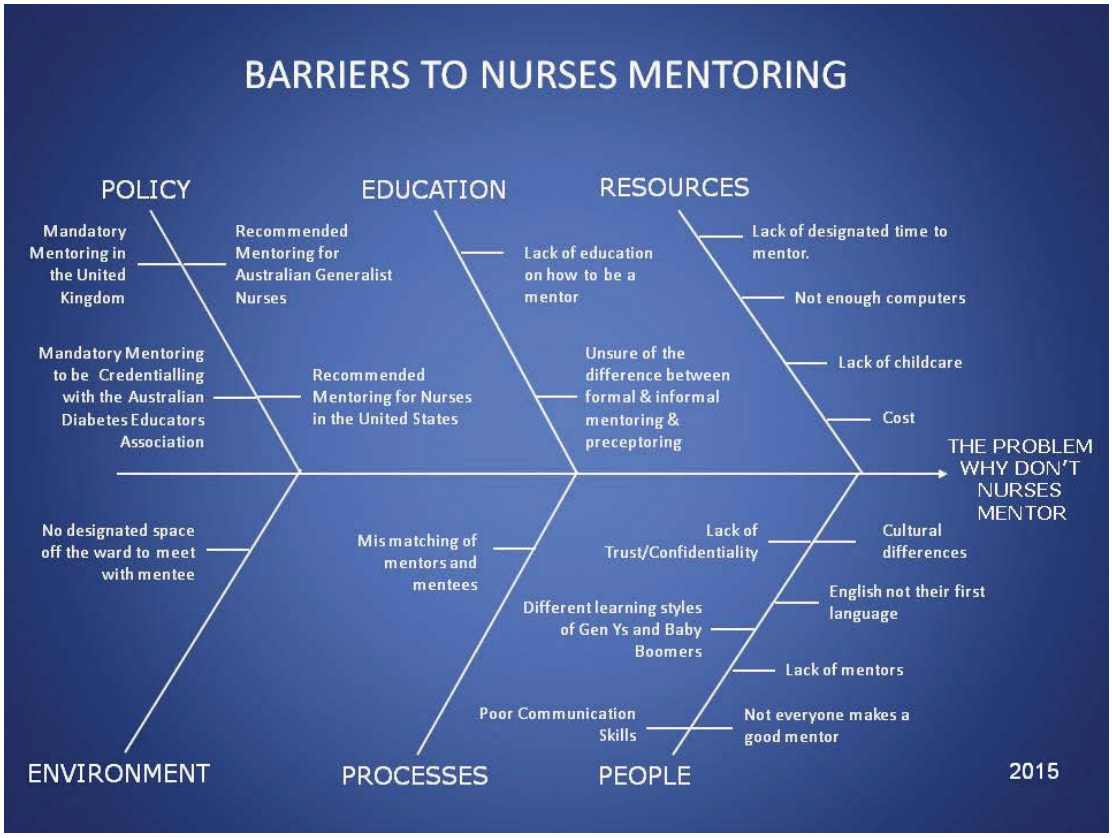

Figure 2.1: Barriers to nurses being motivated to engage in mentoring

The Ishikawa Fishbone Tool, developed in 1968 by Kaoru Ishikawa, has been used to demonstrate visually the findings generated from this literature review (Australian Nursing and Midwifery Council., 2012). The advantages of using the Fishbone Tool is that it provides a graphical display of the possible multiple causes or factors that contribute to a problem by organising and categorising

The researcher found it advantageous to use the Ishikawa Tool, also often referred to as a cause-and-effect diagram, because it has the capacity to identify not just the causes of a specific event which in this study was what were the barriers for nurses not engaging in formal mentoring to enhance their ongoing professional development but it also has the capacity as a quality tool to help reveal key relationships or correlations among the numerous variables, thereby providing additional insight into the process behaviour of the nurses being

studied (Ishikawa, 1990). Each cause or reason why nurses don't mentor is a source of variation. By using the Tool, causes may be grouped into categories to assist in not just identifying these sources of variation (barriers to mentoring) but with the potential of addressing (solving) the causes by category rather than by addressing (solving) individual variations. These categories are policy, education, resources, environment, processes and people (Tague, 2004).

Although participation in formal mentoring is not mandated globally, there is an expectation that nurses participate in formal mentoring for their ongoing professional development. Serving as a mentor is a volitional activity that goes above and beyond the mentors' formal job requirements (Allen, 2003). Given that providing effective mentoring to others requires a considerable time investment on the part of the mentor (Mullen, 1994; Ragins & Scandura, 1999) investigating what motivates individuals to mentor is an important issue.

2.6 Motivation

2.6.1 Introduction: defining motivation

The question of motivation—why people do what they do—has fascinated scholars for centuries. From the literature it appears evident that no one theory can explain all human behaviour or the complexity of factors that influence human behaviour. In effect most people act in what they perceive to be their best interests (Bolles, 1974). However, not everyone is rational or motivated to act virtuously. Rather, people are also influenced by nature and by the material environment, motivated by capitalism's financial incentives to maximise their own position and that of their families (Burke, 1969, p. 91).

While the study of human behaviour may originally have been the domain of philosophers who tried to provide an explanation for why some are motivated by virtue and others by pleasure and the avoidance of pain (Moore,

2013), at a very basic level, behaviour can be explained by the motivation to satisfy a need, a theory proposed by Freud in 1895 (Lothane, 1998).

2.6.2 Work motivation

For the purpose of this study, motivation is defined as the process that accounts for an individual's intensity, direction and persistence in governing voluntary choices and efforts towards attaining a goal (Robbins, Judge, Millett, & Boyle, 2014; Vroom, 1964, p. 7). Work motivation refers to the study of events and phenomena related to people in a work context (Pinder, 1998). This study of work motivation recognises the influence on work-related behaviour of environmental forces, extrinsic motivators (e.g., organisational reward systems, the nature of the work being performed) and forces inherent in the person (intrinsic motivators such as individual needs and motives) (Devadass, 2011, p. 566; Pinder, 1998; 2014, p. 11).

2.6.3 Expectancy theory of motivation

One of the most widely accepted theories to explain work motivation, although by no means the only theory, is Vroom's expectancy theory of motivation (McCormick & Ilgen, 1987, p. 287; Vroom, 1964). Vroom defines work motivation as a process governing choices among alternative forms of voluntary activities and this process is controlled by the individual (Vroom, 1995, p. 7).

What is unique about Vroom's expectancy theory is that it distinguishes between efforts arising from motivation as opposed to effort arising from performance driven by outcomes. This is in contrast to other work motivation theories (Lunenburg, 2011; Matsui, 1981; Quick, 1988; Van Eerde & Thierry, 1996; Vroom, 1995, p. 307).

In contrast to Vroom's theory, those proposed by Maslow (1943) and Herzberg (1959) focus on the relationship between an individual's internal

needs and the resulting effort expended to fulfil them (Herzberg, Mausner, & Snyderman, 1959; Maslow, 1943). According to Herzberg's two-factor theory, individuals are not content with the satisfaction of lower-order needs at work, such as needs associated with minimum salary levels or safe and pleasant working conditions. Rather, individuals look for the gratification of higher-level psychological needs having to do with achievement, recognition, responsibility, advancement and the nature of the work itself (Herzberg et al., 1959). This appears to parallel Maslow's theory of a need hierarchy (Maslow, 1954) which proposes that the most basic level of needs must be met, such as the need for food and shelter, before the individual will strongly focus their motivation on the secondary or higher level needs of, for example, love, self-esteem or self-respect.

Vroom, however, theorised that an employee's performance is based on individual factors such as personality, skills, knowledge, experience and abilities (Vroom, 1964, 1995). He stated that effort, performance and reward are linked in a person's motivation. He uses the variables expectancy, instrumentality and valence to account for this. Expectancy theory argues that people will be motivated because they believe that their actions will lead to their desired outcome (Redmond, 2009; Timm & Peterson, 1982, p. 26). This is in contrast to Herzberg's theory, which contains the relatively explicit assumption that happy and satisfied workers are more productive, even though this might not be the case. Herzberg's theory also fails to allow for individual differences such as particular personality traits, which would affect the individuals' unique responses to motivation. Maslow's hierarchy of needs theory has also been criticized for not having the capacity to make allowance for cultural differences between communities (Hofstede, 1984). Motivation may vary across cultures due to individual differences and the availability of resources in the region or geopolitical entity/country.

According to Vroom, expectancy refers to an individual's expectations and level of confidence about what they are capable of doing and their belief that increased effort will lead to the achievement of their desired outcome (Bandura, 1997, p. 125; Ellinger et al., 2011; Vroom, 1995, p. 20). If a person believes that they can achieve an outcome, they will be more motivated to try for it (Pinder, 1992a, p. 94). However, the concept of expectancy recognises that the choices an individual make are also dependant on events that may be beyond their control or ability (Weiner, 1994a). Expectancy theory proposes that work motivation is dependent on the perceived association between performance and outcomes, and that individuals modify their behaviour based on their calculation of the likelihood of achieving anticipated outcomes (Chen & Fang, 2008; Vroom, 1995, p. 26).

2.6.4 Valence, instrumentality and expectancy

Vroom incorporates three variables into the expectancy model: valence, instrumentality and expectancy. Vroom combines these variables in a formula that predicts the motivational force an individual requires in the work environment to achieve a preordained outcome. The model proposes that an individual's motivation is an outcome of how much the individual wants a reward (valence), the assessment that the likelihood that the effort will lead to expected performance (expectancy) and the belief that the performance will lead to a reward (instrumentality) (Vroom, 1995, p. 20).

In short, valence is the significance the individual attaches to an expected outcome. Valence measures the perception of satisfaction with the expected outcome—not the actual satisfaction—that an individual expects to receive after achieving their goals. Instrumentality is the belief that if you perform well, a valued outcome will result. In other words, it is the belief that if I do a good job there will be something in it for me. Expectancy is the faith that better efforts will result in better performance. Vroom argued that employees consciously

decide whether to perform or not at the job. In his view, this decision depends solely on the employee's motivation level, which in turn depends on the three factors of expectancy, valence and instrumentality (Vroom, 1964).

Expectancy theory is regarded as a cognitive process theory of motivation (Fudge & Schlacter, 1999). Process theories as opposed to content theories of motivation emphasise an individual's perception of the environment and subsequent interactions arising as a consequence of their personal expectations that is their perceived view of an outcome will determine their level of motivation. By contrast, content theories of motivation focus on the internal attributes of the person (Isaac, Zerbe, & Pitt, 2001). Expectancy theory allows the valence of outcomes for the nurses in this study to be correlated with their motives and to their conceptions of the instrumentality of participating in mentoring for the attainment of those outcomes (Vroom, 1995, p. 324).

The matrix in figure 2.2 captures the variables in Vroom's expectancy theory of motivation. The matrix provides a framework within which to explore the components of expectancy theory in order to answer the research's question driving this project: What motivated the nurses in the study sample to engage in formal mentoring? How did mentoring contribute (or not) to their ongoing professional development?

KEY CONSTRUCTS	VARIABLES
MOTIVATIONAL FORCE	Intrinsic motivators Extrinsic motivators
EXPECTANCY	Self-efficacy Perceived control Goal difficulty
INSTRUMENTALITY	Trust Job control
VALENCE	Valence of first degree outcomes Valence of second degree outcomes

Figure 2.2 Matrix of Vroom's (1995) expectancy theory of motivation process

Vroom proposes that the motivational force on a person to perform an act is equal to the product of the valence of outcomes and the strength of expectancies that these outcomes will follow the act. If this proposition is correct, it follows that attempts to predict or explain the amount of effort required by a task must consider both the valence of possible outcomes to that person and his/her expectancies regarding the consequences of different levels of effort to attain hem (Vroom, 1995, p. 225).

Using Vroom's terms, motivation is often expressed as a numerical score. That is, motivation is equal to valence multiplied by expectancy multiplied by instrumentality (Pinder, 1992b, p. 95; Vroom, 1964). However, in this descriptive study I use the study participants' feedback from questionnaires and interviews as data. The descriptions will be based on the participants' perceptions of the elements of valance, expectancy and instrumentality and will be applied to better understand what motivated Australian nurses at various stages of their careers to engage in formal mentoring and the extent to which they perceived there was a relationship between mentoring, motivation and their ongoing professional development.

2.6.5 Justification for using expectancy theory

Expectancy theory was adopted as an approach for this study as it offers the greatest scope for answering the research questions for the following reasons.

First, expectancy theory focuses on outcomes, not on needs, unlike the other motivational theories of Maslow and Herzberg (Thierry & Koopman-Iwema, 1984, p. 148). Vroom's theory states that the intensity of a tendency to perform in a particular manner is dependent on the intensity of an expectation that the performance will be followed by a definite outcome and on the appeal of the outcome to the individual. What differentiates Vroom's theory from other theories is that it focuses on the actual degree of satisfaction derived from achieving the goal, rather than only on the valence of the outcome (i.e. the expected degree of satisfaction).

Secondly, expectancy theory has the capacity to illustrate first and second level outcomes. According to expectancy theory, a first level outcome is the belief that if a person performs well they will receive the reward that they value. For example, if I participate in mentoring I will become credentialled with the Australian Diabetes Educators Association. A first level outcome can lead to the attainment of a second level outcome, which may be an increase in pay and a job promotion as a result of achieving credentialling status.

Vroom's theory has the potential to explain whether there is a gap between the nurses' anticipated satisfaction from participating in this mentoring program and their actual satisfaction from participation (Pinder, 1992a, p. 94; Vroom, 1995, pp. 18-19). From a management perspective, expectancy theory has important implications for motivating employees in healthcare settings as it has the potential to identify things that can be done to improve the motivation of nurses (De Simone, 2015b).

2.6.6 Limitations of expectancy theory

Expectancy theory has its critics, most of whom argue from a positivist paradigm that valence, instrumentality and role perceptions are significantly related to performance, while ability is not and hence there is debate over how these constructs should be measured (Behling & Starke, 1973; Heneman & Schwab, 1972; Korman, 1977). Behling and Starke (1973b) argue, for example, that what is needed is a shift to the testing of the basic interactive relationships between valence, instrumentality and expectancy in order to be able to predict motivation (p. 25). Other theorists have suggested that the model is too simplistic to measure or explain individual motivation (Porter & Lawler III, 1968). These critics argue that Vroom is operating under the questionable assumption that all employees are motivated by more power, money or prestige (Porter & Lawler III, 1968).

In choosing to apply Vroom's theory to this study, I argue that by using qualitative and qualitative methods, Vroom's expectancy theory has the capacity to capture both extrinsic and intrinsic motivators and is therefore a suitable theory for measuring what motivated theses nurses to engage in mentoring. Although expectancy theory has its critics, there is evidence to support the theory (Robbins et al., 2014). Chan (2012), Ramdianee (2013) and Lee (2007) argue that it is a convincing and useful model to apply when attempting to explore individuals' underlying incentives to engage in setting and achieving goals, especially when applied to the workplace.

2.7 Conclusion

The literature reviewed in this chapter suggests that participation in mentoring relationships for the purpose of ongoing professional development has the potential to provide nurses with the opportunity to reflect on and learn from

their nursing experience gained across their careers, which for the majority of Australian nurses will be lengthy and varied.

Participation for nurses (working longer, retiring later) and technological changes in healthcare and general IT mean nurses need to keep learning. The purpose of the ongoing professional development of nurses is to ensure that that they are able to continue to deliver a high standard of quality, safe nursing practice so that patients can achieve the best possible outcomes (Casey, Coen, Gleeson & Walsh, 2016).

The literature suggests that mentoring has the potential to offer nurses at the later stages of their careers the opportunity to feel valued. It may do this by giving older nurses opportunities to promote the nursing profession to their mentees and to serve as role models for ethical, scientific and professional behaviour (Ponti, 2009). However, current research does not clearly explain the factors that motivate nurses to engage in mentoring relationships. This limits the capacity of nursing organisations and government to improve the uptake and effectiveness of mentoring in nursing.

This chapter has also argued that the expectancy theory of motivation model has the capacity to identify what motivated these nurses to engage in formal mentoring. If nursing organisations have a clear understanding of what is valued by their nurses, they can design and build formal mentoring programs that nurses are motivated to participate in.

The following chapter provides an overview of the methodology used in this research and the rationale for the study design. ■

Chapter 3

Methodology

3.1 Introduction

This chapter provides an overview of the methodology that underpins the study. It presents the rationale for choosing a mixed mode study design. It argues that using quantitative and qualitative methods will provide scope for answering the research questions and divides the study into two distinct phases. As the chapter explains, phase 1 uses quantitative methods to measure the nurses' attitudes, satisfaction and achievement of goals. Phase 2 uses qualitative methods to explore the meaning of why and what motivates these nurses to engage in formal mentoring.

3.2 Philosophical framework

3.2.1 Research problem and hypothesis

The research aims to gain insight into what motivates diabetes nurse educators at various stages of their careers to engage in formal mentoring. The researcher's role in this study is to try to present as truthfully and accurately as possible the thoughts and feelings of these diabetes nurse educators on what motivated them to engage in mentoring. The methods used for data collection and analysis aimed to ensure that the nurses' voices were heard and that the research captured the nurses' experiences and perceptions on formal mentoring, not those of the researcher (Crotty, 1998, p. 88; Denzin & Lincoln, 1998, p. 221).

3.2.2 Research questions

The questions to be answered by this research study are the following:

1. What motivates diabetes nurse educators to engage in formal mentoring relationships?
2. Does engagement in formal mentoring relationships contribute to nurses' professional development and if so, in what way?
3. If mentoring does not contribute to nurse's professional development, why not?

3.2.3 Crotty's four element research model

In order to answer these questions, the study was framed within the research process proposed by Michael Crotty (1998). Crotty's four element model consists of epistemology, theoretical perspective, methodology and methods.

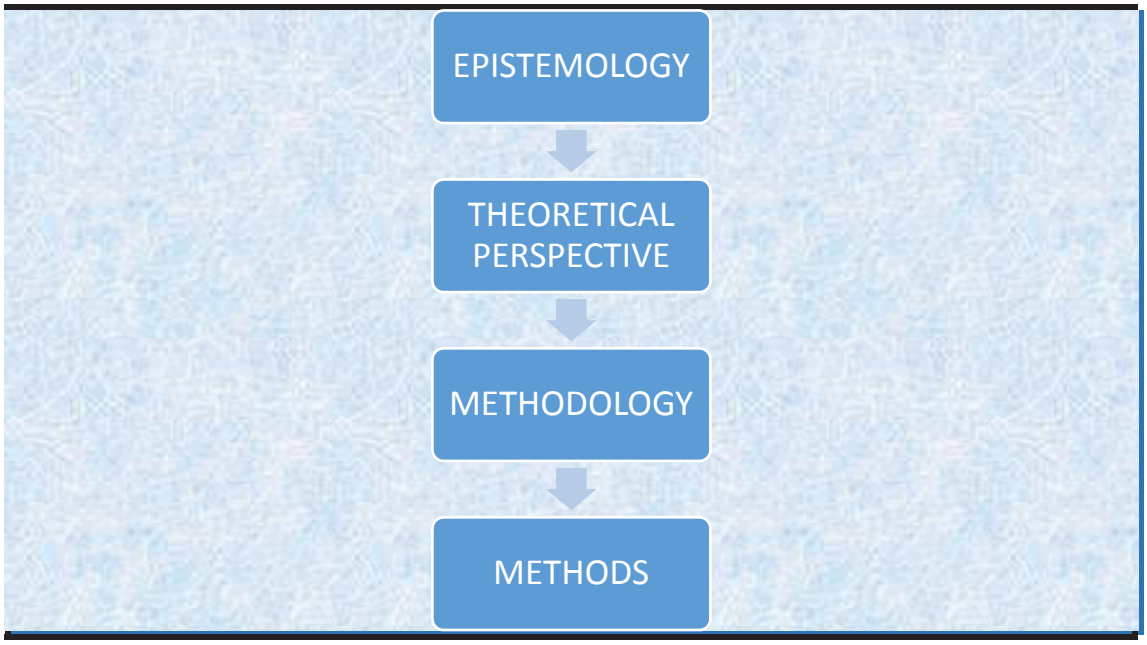

Figure 3.1: The Four elements of Research as proposed by Michael Crotty

Source: Crotty, 1998, p. 4

The rationale for choosing Crotty's model is that these elements provide a structure for understanding the research process (Crotty, 1998, p. 2). The elements also provide a ground from which to identify the assumptions about

the human world and social life within that world which are embedded within the methods used to undertake the study.

Crotty's model provides the capacity for this research to remain epistemologically consistent and objective whilst still providing the opportunity for the researcher to make distinctions from the study participants' everyday subjective meanings.

3.2.4 Epistemology

Epistemologically, this study will explore what was perceived as knowledge for these nurses. That is, the study asks: What is the nurses' understanding of the experience and reality of mentoring?

The epistemology of nurses and competencies required in health care today demand examination of how and where nurses' acquire clinical, conceptual and empirical knowledge (Hesook, 2010; Vinson, 2000). The epistemology of nursing, nursing's way of knowing, and patterns of knowing, has evolved as nurse scientists, in concert with nurse clinicians and educators, discover phenomena that help describe and explain relationships between health and illness behaviours, well-being, and nursing actions (Benner & Wrubel, 1989; Kasch, 1985). The significance of identifying patterns of knowing is to distinguish the discipline of nursing's unique structure from that of other disciplines by identifying nursing's patterns of knowing and the competencies required to practice the profession of nursing (Carper, 1978).

The epistemology of nursing and the resulting competencies required to practice nursing are reflected in how and where nurses acquire clinical, conceptual, and empirical knowledge, as knowledge in nursing is subject to change and revision allowing for the flexibility needed to discover additional patterns of knowing within nursing (White, 1995). Debate continues, however, about the ambiguity around knowledge possessed by individual practicing

nurses and that of the discipline of nursing as a whole (Cheraghi, Salsali, & Safari, 2010; Hesook, 2010).

Knowledge thus exists in the discipline of nursing as private knowledge and as public knowledge (Hesook, 2010, p. 10). Private, personal knowledge in nursing is assumed to be an art resulting from knowledge individually interpreted and developed. It is unique and differentiated from nurse to nurse (Benner, 1983). However, the development of personal knowledge in nursing also requires reflection (Boud et al., 1985) and opportunities for engagement as in mentoring (Leung & Kember, 2003) with the behaviour of mentors having an encouraging or inhibiting effect on reflection and reflective thinking (Mann, Gordon, & MacLeod, 2009a, p. 610).

Private personal knowledge has the potential to become public knowledge, however, when the knowledge is shared, as in mentoring (Queiró, 2014). The movement from practice to theory and back to practice is what Bishop and Scudder (1995), inspired by Gadamer, call the 'hermeneutical spiral' (Gadamer, 2004). It is in this hermeneutical spiral that the solutions to nursing problems are developed, drawing not only on empirical knowledge but being shaped by the specific context and in the light of personal experience and sagacity (Hesook, 2015; Queiró, 2014).

3.2.4.1 Epistemological and ontological assumptions

This study draws on underlying epistemological and ontological assumptions from interpretivism as the interpretivist paradigm recognises that different people construct meaning in different ways (Crotty, 1998, p. 9) and that truth is a consensus formed by co-constructors (Pring, 2000, p. 251). Therefore, the social world can only be understood from the standpoint of the individuals who are participating in it (Cohen, Manion, & Morrison, 2007).

Applied to this study, these assumptions mean that knowledge and reality are constructed in and out of interaction between the nurses and their world and will be developed and transmitted in the social context of nursing work (Crotty, 1998, p. 42). While the general aim for undertaking research is to create knowledge or generate theory for this research it is important to recognise that there are different types of knowledge (Vygotsky, 1980, p. 208). Diabetes nurse educators may be motivated to mentor in order to attain knowledge that is both propositional and or procedural.

Propositional or factual knowledge refers to facts and figures as opposed to procedural knowledge which refers to know how, the application of skills and competencies and or procedures (Australian Commission on Safety and Quality in Health Care., January 1, 2009, p. 154; E. Husserl, 1980). Nurses demonstrate propositional knowledge when knowing about a patient's illness or treatment i.e. the patient has diabetes. They demonstrate procedural knowledge when they provide treatment i.e. administer the insulin injection and they demonstrate personal knowledge by knowing what the right thing is to do at the right time in the patient's interest. Both propositional and procedural knowledge in nursing are strongly linked with the Aristotelian idea of phronesis, that is, wisdom in practice (Bloom, 1956; Dede et al., 2005). However, no one kind of knowledge is better than another and they are all integrated within a nurse's professional practice (Australian Diabetes Educators Association., 2008b, p. 25)

Subsequently, based on the historical and cultural context of nursing, the following statements capture key assumptions relevant to mentoring that underpin the formulation of this study's research questions:

- The level of motivation of nurses to engage in formal mentoring seems to fluctuate through time based on their experiences, career and life stage.

- Nurses aspire to be professionals acquiring clinical, conceptual, and empirical knowledge from varied sources.
- Nurses are socialised into the nursing role, developing a professional identity that is constituted by the meanings, content, intents and practice of nursing.
- A social world in social phenomena has different meanings for different nurses.

These epistemological assumptions are the background against which I have framed the research questions.

3.2.5 Theoretical perspective

This research aims to go beyond demonstrating a relationship between reflecting on the experiences of the nurses to demonstrate an understanding (Ricoeur, 1974b, p. 297) of the nurses' ways of thinking about mentoring, motivation and professional development. The study aims to understand what is 'real' and 'meaningful' for the nurses themselves, by gaining access to their experiences. The aim therefore goes beyond collecting and selecting from impressions (Ricoeur, 1974a, p. 4).

Hence the study investigates whether there is a connection between the interpretation of the experience of formal mentoring by these nurses and my understanding of their experiences as a researcher (Kearney, 1991, p. 277). At a personal level, understanding the relationship between the nurses' view of reality (ontology) and the meaning the nurses ascribes to knowledge and its creation (epistemology) is fundamental in order to be able to articulate the rationale for the research design and methodology (Darlaston-Jones, 2007)

3.2.5.1 Interpretivism

My objectives in this study were to establish a comprehensive, rational account of what motivated the nurses to engage in formal mentoring and to elucidate

whether and in what ways the formal mentoring contributed to their ongoing professional development (Cohen & Manion, 1994b, p. 37).

Viewed from an interpretive perspective, any learning that nurse mentors or mentees regard as having occurred will arise out of their interactions; it will be emergent (Cilliers, 2005; Goldstein, 2009). In studying learning that is emergent, theory does not precede the study but follows it (Argyris & Schon, 1974; Cohen & Manion, 1994b, p. 37; Williams, Karousou & Mackness 2011). Instead of applying my preconceived ideas of reality, the study investigates the ways in which learning occurs and is experienced from the nurses' perspective. The interpretive paradigm provides the framework for studying the different ways the nurses in the mentoring program made sense of the mentoring experience (Foley, 2000 p.p.19).

The interpretive view is differentiated from the positivist stance in that it argues that reality is socially constructed by and between the persons who experience it (Gergen, 1999). 'What mentoring means' is a consequence of the context in which the mentoring occurs and will be shaped by the cultural, historical, political, and social norms of the nurses that operate within that context and time. The interpretive paradigm accepts that reality is subjective and can be different for each of us, based on our unique understandings of the world and our experience of it (Berger & Luckman, 1966).

The aim of the methodology is to bring to light the experience under investigation through a process of interpretation and reinterpretation (Crotty, 1998, p. 82). This process entails researcher engagement in a circular movement between the part and the whole of the interview text, commencing with the identification of pre-understandings and as recommended by Charlton, asking the following three questions (Charlton, 1986, pp. 86-102):

1. What was the data telling me?
2. What did I want to know?
3. What was the relationship between the two findings?

3.2.5.2 Phenomenological approach

The research adopts a phenomenological perspective. This approach helps to provide the opportunity to give a voice to the nurse mentorship program participants in order to be able to interpret how they made sense of the experience of formal mentoring (Cohen & Manion, 1994b, p. 29). The methods used are qualitative description with a quantitative evaluation component. Qualitative description allows for the discovery and understanding of 'a phenomenon, a process, or the perspectives and worldviews of the people involved' (Merriam, 1998).

Phenomenological description is a method for interpreting meaning (Heidegger, 1962, pp. 61-62). The data will be presented so that the nurse participants' point of view can be made explicit and understood (Artinian, 1988). The philosophy of phenomenology, as defined by Edmund Husserl (Lindlof, 1995p.p.32), will help to explain how the diabetes nurse educators perceived the experience of being formally mentored.

Phenomenological analysis of the nurses lived experiences will be examined through the interpretation of narratives provided by the nurses during the interviewing phase of the study and through the analysis of free texts which some of the nurses provided during phase one of the study (Husserl, 1980 p.p.46). I will explore how these diabetes nurse educators experientially reconstituted the everyday taken for granted experience of being formally mentored (Crotty, 1998, p. 82).

Phenomenology concentrates on the study of phenomena as experienced by the individual, with the emphasis on exactly how a phenomenon reveals itself

to the experiencing person in all its specificity and concreteness (Brennan, 1986, p. 277; Husserl, 1980, p. 27). The aim is to uncover how the mentorship experience was perceived subjectively, and how it was produced and made meaningful by the participants themselves (Boud & Griffin, 1987; Brookfield, 1984; Gubrium & Holstein, 2003).

Heidegger suggested several possible ways of being: being influenced by our past, which is always with us; being influenced by our activities in the present, of which we are aware; being oriented towards who we will be in the future. He referred to these ways of being as 'being and time.' Heidegger believed that understanding, interpretation and meaning were inextricably linked and shaped by these being and time structures (Heidegger, 1962). Researchers therefore need to become aware of these structures.

In this study these being and time structures include the nurses' history, as their history is a part of who they are in the world, which will in turn influence the meanings they construct about themselves and their world (Jones, 2001). Heidegger was interested in how we live in the world as well as in temporal issues as they relate to authenticity, being in the world and life experience. Heidegger was critical of the way Husserl had constituted phenomenology with an emphasis on description rather than understanding [*verstehen*] and proposed the idea of hermeneutics as a method of interpreting and understanding. The notion of '*being*' became central to Heidegger's work and related to the fundamental question of the situated meaning of being a human in the world (Heidegger, 1962).

In summary, the main points of the philosophical framework for this study are based on concepts put forward by Husserl and Heidegger. In particular, (our) history has an unquestionable presence in (our) understanding; and language is the fundamental mode of our being-in-the-world and is closely tied to understanding (Blattner 2008; Gadamer 2004; Heidegger 1962).

3.2.5.3 Hermeneutic phenomenology

Husserlian terminology (Husserl, 1980) associates phenomenology with the goal of establishing the meaning associated with a particular phenomenon (such as being mentored) to reveal if there is a correlation between these nurses' experiences of mentoring, motivation and professional development and what has been presented previously in the literature (Wimpenny & Gass, 2000).

Diabetes nurse educators participating in a mentorship program are likely to interpret their experience from within the cultural tradition of the nursing profession (Crotty, 1998, p. 91). However, in order to make sense of Australian nursing culture, we need to examine it from not just the perspective of one layer but from the sedimentation of multiple layers of meaning, that is, we must collect different points of view of the lived experience of mentoring (Bourdieu, 1993; Ortega & Gasset, 1958, p. 100).

Phenomenology assumes that as humans we interpret and understand phenomena based on our own experience but that if we revisit these phenomena at another point in time there is the possibility that new meanings will emerge. In other words, intentionality has the potential to change (Crotty, 1998, p. 78). While the concept of intentionality is complex, for this research intentionality refers to the aboutness or directedness or reference of mind (or states of mind) to things, objects, states of affairs, events. That is, intentionality refers to what the nurses in this study were thinking about mentoring. The notion of intentionality lies at the heart of Husserlian phenomenology (Husserl, 1931, p. 245). Husserl, a student of Brentano (1874/1973) who had first defined intentionality in the phenomenological model, held that for a mental state to be conscious is for it to be an experience, a part of some 'stream of consciousness'.

Husserl argued that, distinct from any capacity for memory directed on an object in the past, in which you recall the experience you just had, there is a sort of 'retention' of what has just happened in your experience. This retained past

experience enables you to predict and anticipate future experiences (Husserl, 1991). For example, what each individual mentored nurse experienced enables them to perceive temporally and to predict and anticipate what their experience of mentoring might be in the future.

3.2.6 Justification for the choice of methodology

In contrast to positivists, phenomenologists believe that the researcher cannot be detached from his/her own presuppositions (Hammersley, 2000). Given that all researchers 'hold explicit beliefs' (Mouton & Marais, 1990, p. 12), according to Creswell (2009) and Quireó (2014) the researcher's epistemology should serve to decide how social phenomena should be studied.

In this study my epistemological position as a nurse had the potential to influence the perspectives of the nurses being studied. But at the same time, my experience as a nurse suggested how the phenomenon of mentoring could be studied. Thus, the phenomenological research approach appeared a suitable methodology to use to investigate what usually happens when diabetes nurse educators participate in a mentoring program (Cohen, Manion & Morrison, 2007).

The interpretive paradigm will then be used to attempt to explain the perceived subjective world of the nurses' experiences, to delve inside and understand their situations from within. The diabetes nurse educators' mentoring construction can only be judged adequate or inadequate utilising the particular paradigm from which it is derived that is it can only be judged within the framework that the nurses themselves judge to be meaningful (Denzin & Lincoln, 1998, p. 143).

In this research, inquiry followed a step-by-step dialectical process of query and response sequences, where the answers to my questions frequently opened up further questions (Rescher, 1982, p. 151). Whatever the motives or reasons are for doing or not doing something such as choosing to participate or not to

participate in a mentoring relationship, the logic of the situation is always open to debate about the choices made by the participants (O'Sullivan, 1977, p. 101).

Hence, by using a combination of research methods and by following a dialectical process of investigation, I set out to investigate what motivated these diabetes nurse educators to participate in formal mentoring and how the mentoring experience enhanced (or not) their professional development (Lindlof, 1995 p.p.72, 236-237; Silverman, 2010b, p. 180).

3.3 Methods

3.3.2 Study design

In order to answer the research questions, the study was designed using two distinctly different research approaches.

Phase 1 of the study uses a quantitative research methodology. As the aim of phase 1 was to measure the study participants' satisfaction with having engaged in a formal mentoring relationship the choice of research approach was guided by the objectives of the study. As positivism is an approach to social science that is based on the ontological assumption that traditional sciences can be tested and measured using quantitative methods is well suited for phase 1 of this study. However quantitative research methods have limitations in that it will not address the why - By using a mixed methods research design the researcher is not limited by using qualitative or qualitative approaches alone.

Mixed methods research provides the scope to explore what motivated these nurses to engage in mentoring by being able to use multiple world views and paradigms (Bandura, 1997, p. 10). Mixed methods allow the researcher to measure trends, prevalence's and outcomes whilst at the same time being able to examine meaning, context and processes (Frenk et al., 2010a, p. 27). Many researchers believe that mixed method strategies can result in enhanced

understanding of phenomena and better more rigorous methodology (Bandura, 1997, p. 175; Silverman, 2010a, p. 180).

Phase 2 of the study used the qualitative research methodology of interviews. Interviewing the study participants was consistent with the phenomenological conceptual approach. Interviews were designed to explore in depth the study participants' thoughts and perceptions of what motivated them to engage in a mentoring relationship and whether or not that participation enhanced their professional development.

3.3.3 Ethical considerations in human research

As indicated in chapter one, this study arose from my first-hand experiences. I am a nurse and a member of the Australian Diabetes Educators Association. In order to undertake this research, I sought and was granted permission by the Australian Diabetes Educators Association Board of Directors to recruit all members of the Australian Diabetes Educators Association who had participated in their formal mentoring program since its introduction in 2008 (see appendix A).

As the Australian Diabetes Educators Association was willing to provide access to a rich data source, it made good business sense for me to offer to give the association feedback on the results of my study, so that my analysis of the data could potentially inform further planning and organisational development (Hall & Hall, 1996, p. 17; Mertens, 2010, p. 250). However, Cohen and Manion make the point that when a researcher and a professional body come together to conduct research they will both have their own objectives and values and this can sometimes be problematic (Cohen & Manion, 1994c, p. 375; Finch, 1989).

Although both parties share the same interest in an educational problem, their orientations to it may differ (Cohen & Manion, 1994b, p. 195; Denzin & Lincoln, 1998, p. 165). For these reasons, the researcher worked closely and

communicated frequently with the executive of the Australian Diabetes Educators Association.

To ensure the safety and confidentiality of the study participants, the research was conducted in accordance with the principles of the Australian National Health and Medical Research Council Guidelines for the ethical conduct of human research (National Health and Medical Research Council., 2009).

In order to protect the participants' privacy and maintain confidentiality, fictitious names were used or numbers were substituted for participants' names (Kvale, 1996, p. 259). As the interviewees were known to the researcher, precautions were therefore taken during the interviews to maintain anonymity, ensure confidentiality and prevent risk of harm to the participants.

Ethical approval to conduct this research was received in 2012 from the University of Technology, Sydney, Human Research Ethics Committee (see appendix B). The clearance number for this research allocated from the University of Technology Human Research Ethics Committee was reference number 2012000059. Progress reports on the implementation of the study were provided annually to the ethics committee until the completion of the study (see appendix C).

3.3.4 Rigor during the design phase

To investigate what motivated these diabetes nurse educators to voluntarily engage in the Australian Diabetes Educators Association's formal mentoring program as mentors or mentees, inclusion and exclusion criteria were developed to guide phase 2 of the study. Phase 2 consisted of conducting two pilot interviews followed by eight illustrative interviews with the study participants (National Health and Medical Research Council, 2009 p.p.23-24).

Illustrative interviews are interviews undertaken with people whose experience or expertise is taken as representative of a broader group. For example, interviews were undertaken with a sample of diabetes nurse educators to ask them about their experiences of formal mentoring however the rigour of a qualitative study should not be judged on sample size alone.

However, the researcher in consultation with one of the interviewed mentors removed that mentor from the study because the researcher could not guarantee that the diabetes nurse educator could be adequately deidentified and they were possibly not representative of diabetes nurses educators as a group. This mentor worked in a very small specialled area of diabetes education and management and subsequently that mentor did not meet the inclusion/exclusion criteria of the study.

When sampling is appropriate, the objectives and theoretical basis of the research should determine the size of the sample and the sampling strategy. The rigour of qualitative research should be assessed primarily by criteria of quality and credibility of data collection and analysis and not by matters of validity and reliability as defined in research designs that employ quantitative methods alone.

Purposive sampling was used to recruit participants to phase 2 of the study. The interviewees were selected in order to provide a representation of nurse mentors and mentees, of different ages, working in a range of rural/remote and urban health care settings, working in the private and the public Australian health care industry. Most importantly, participants were at various stages of their nursing careers.

A purposive sample is a type of nonprobability sample also referred to as a judgemental or expert sample (Cohen, Manion, & Morrison, 2007). The main objective of a purposive sample is to produce a sample that can be logically assumed to be representative of the population. This is often accomplished by

applying expert knowledge of the population to select in a non-random manner a sample of elements that represents a cross-section of the population.

The diabetes nurse educators recruited to phase 2 of the study were included because they had lived the experience of mentoring that was the focus of this study and were willing and able to speak in detail about their experiences. During phase 1 of the study several of these nurse educators had provided written feedback which suggested that the opinions of these mentors and mentees warranted further investigation. A sample of these mentors and mentees were then contacted by the researcher and asked if they were willing to participate in this study.

3.3.5 Inclusion and exclusion criteria

When developing the inclusion and exclusion criteria I tried to limit the over-representation of any one group, male or female, old or young, working in a rural or urban health care environment (see appendix D). In selecting the study participants, the aim was to ensure that participants' backgrounds were reflective of their profession from different health care settings and environments and at different stages of their careers. The aim of broad representation was to give richness to the data obtained by controlling as much as was practical the bias of the responses by not limiting the data to only one geographical area or only one health care setting. All participants needed to be financial members of the Australian Diabetes Educators Association.

To comply with the National Health and Medical Research Council guidelines all study participants were over the age of eighteen years. Members of the Australian Diabetes Educators Association who were not nurses (e.g. podiatrists or dietitians) were excluded from the study as the study was investigating what motivated nurses specifically to engage in mentoring.

3.3.6 Validity and reliability in the research

The reason for systematically defining the inclusion and exclusion criteria for this research was to ensure that the research findings demonstrated scientific validity and reliability (Cohen & Manion, 1994a, p. 281). The rigour of a qualitative study should not be judged on sample size. When sampling is appropriate, the objectives and theoretical basis of the research should determine the size of the sample and the sampling strategy. The rigour of qualitative research should be assessed primarily by criteria of quality and credibility of data collection and analysis and not by matters of validity and reliability as defined in research designs that employ quantitative methods (National Health and Medical Research Council, 2009, p. 25).

3.4 Phase 1: Quantitative methods

3.4.1 Study design: questionnaire

Phase 1 of the study used quantitative methods to measure the diabetes nurse educators' satisfaction with, and achievement of the stated goals of, the Australian Diabetes Educators Association formal mentoring program.

3.4.2 Surveys

Survey questionnaires were designed by the Australian Diabetes Educators Association using a five-point Likert scale (Punch, 2003, p. 76). The questionnaires also provided capacity for the study participants to make individual comments and feedback.

3.4.3 Survey sample size

All members of the Australian Diabetes Educators Association who had participated as mentors or mentees since the program's introduction in 2008 until January 2013, for a minimum period of six months, were considered for inclusion in phase 1 of the study. A total of 369 mentors and 385 mentees completed the formal mentoring program within the specified timeframe. On

completion of the program the mentors and mentees completed a program evaluation questionnaire (see appendix E, *Mentor Notification of Completion of Mentoring Partnership* survey questionnaire; and appendix F, *Mentee Notification of Completion of Mentoring Partnership* survey questionnaire).

3.4.4 Consent for phase 1

For phase 1 of the study, group consent to use the information from the Australian Diabetes Educators Association members' survey questionnaires was obtained from the Australian Diabetes Educators Association Board of Directors. Australian Diabetes Educator Association members who participated in the mentorship program signed an agreement that the information in the surveys was intellectually owned by the Australian Diabetes Educators Association (ADEA). The information could only be used by the researcher if it conformed to strict privacy principles as defined in the *Australian Privacy Act 1988* (Australian Government Common Law., 1988) for maintaining the confidentially of the association's members and met any other terms as stipulated by the Australian Diabetes Educators Association Board of Directors.

The survey questionnaires were completed in hard copy by the mentors and mentees, sent to the Australian Diabetes Educators Association National Office in Canberra and viewed under supervision by the researcher at the national office.

3.4.5 Quantitative data analysis

The study participants were asked to self-report using a five-point Likert scale to indicate how much they agreed or disagreed with a certain statement. For example, 'Please indicate on a scale of 1–5 to what extent you believe the overall goals of your mentoring partnership were achieved (with 1 being the lowest and 5 being the highest)'.

The sum of the numbers for each statement in the questionnaire was tallied to provide a numerical score (McLeod, 2008). This score represented the mentors' and mentees' attitudes on the subject of mentoring, motivation and professional development. A Likert type scale assumes that the strength or intensity of experience for each of the study participants was linear, i.e. could be rated along a continuum from strongly agree to strongly disagree, the neutral point being neither agree nor disagree.

The advantage of using a Likert rating scale to measure the attitudes of the nurse mentors' and mentees' is that they are generally easy to read and complete and are likely to produce a highly reliable scale (Likert, 1932). However, while the Likert scale survey questions provided some evidence of whether the nurses achieved their personal or professional goals from participating in this formal mentoring program they did not produce evidence for what motivates nurses to engage in mentoring relationships.

3.4.6 Limitations of quantitative methods

Program evaluation as informed by survey methodology can assist the researcher in decision making regarding whether program A in practice is more appropriate than program B. Being able to validate the research findings may provide a platform for decision-makers to implement policy change (Ely, Anzul, Friedman, Garner, & McCormack Steinmetz, 1991; Isaac & Michael, 1995; Norris, 1990; Stufflebean et al., 1971); however, process evaluation alone will not answer the research question of why the study participants behaved in a particular way.

3.5 Phase 2: Qualitative methods

3.5.1 Study design: qualitative description/interviews

Phase 2 of the study used qualitative methods to shed further light on the findings from phase 1 of the study. Silverman argues that the qualitative researcher can face special difficulties in achieving credibility, particularly if the researcher is working in a field where quantitative research is the mainstream however qualitative and quantitative methods complement one another (Silverman, 2010a, p. 180).

3.5.2 Interviews

Interviews with the study participants were chosen as the most suitable qualitative method of collecting data on what motivated the nurses to engage in formal mentoring. Interviews offer the opportunity for study participants to provide clear in-depth information about how they perceived their experience of participating in a formal mentoring program.

Interview methodology provided scope for the study participants to talk about their experiences of mentoring and the impact mentoring had on their ongoing professional development. Kerlinger suggests that one reason for using interviews is that they help to validate other research methods by going more deeply into the motivations of the respondents and their reasons for responding as they did (Kerlinger, 1970).

As Silverman points out no method of research, quantitative or qualitative is intrinsically better than any other (Silverman, 2010b, p. 11). Choosing a research method should be based on what is the most appropriate method to use to answer your particular research problem. Interviewing individuals as a procedure for securing knowledge is relatively new historically as individuals

have not always been viewed as important sources of knowledge based on their own experience (Benney & Hughes, Sep 1956).

However, Riesman and Benney considered the introduction of the interview format to be the product of the changing world of relationships. One that developed rapidly following the post war years that was triggered by the growing trend to view individuals, no matter how insignificant they might seem in the everyday scheme of things, as important elements of populations that could be used to understand he social organisations of experience (Riesman & Benney, 1956).

As interviewing has become more pervasive in the mass media and in professional practice, using interviews has increasingly become a way of understanding survey research, public opinion polling and market research (Gubrium & Holstein, 2001, p. 5).

3.5.3 Consent for phase 2

Diabetes nurse educators participating in interviews in Phase 2 of this study were asked to provide their individual written consent (see appendix G). Potential study participants were provided with information both orally and in written format on both the rationale for the study and what their participation in the study would entail (see appendix H). The study participants were advised that their participation in the study was completely voluntary and that they would be able to withdraw from the study at any time without penalty.

3.5.4 Justification for using interview methods

Although there may be many reasons for conducting an interview, the conventional use of the term interview implies that the interviewer wants to find out something about the interviewee (Cohen & Manion, 1994b, p. 271). While interviews can be characterised as formal or informal, in this research

project the interview was defined as a 'conversation between two people' (Cannell & Kahn, 1968, p. 271; Kvale, 1996, p. 42).

As the interview was being conducted to ascertain information from the interviewee in order to answer the research question, it was based around a predetermined sequence of questions. However, the interview allowed for conversation between the interviewer and the interviewee. The interviewer had the discretion to change the wording of the interview questions to clarify meaning and in order to elicit further relevant information to answer the research question.

The advantage of using interviews rather than questionnaires alone is that interviews provide extensive opportunities for the interviewer to ask questions and to probe to find out, what were their attitudes and beliefs and what was their perception of the experience of mentoring and of their motivation (Ary, Jacobs, & Razavieh, 2002; Bell, 1999; Wellington, 2000). Using interviews as a method is also consistent with using a phenomenological approach.

3.5.5 Disadvantages of using interview methods

The disadvantage of using interview methodology is that the interviewer may be prone to subjectivity and bias (Cohen & Manion, 1994a, p. 281; Robinson & Karaminas, 2010). Previous studies have demonstrated that race; religion, social class and age can be sources of bias and can influence research outcomes (Briggs, 2001, pp. 911-923). As a researcher, I was aware that the less formal the interview and the more subordinate my role as interviewer became, the more I could provide opportunities and scope for the interviewee to give a wider repertoire of responses. Power relations such as gender, class or job status all have the potential to help or hinder the interview, irrespective of the interview type (Scott & Usher, 2011).

Unlike quantitative empirical analytical methodology, when using qualitative research methodology, it is not possible to control all variables

completely (Punch, 2003, p. 101). In this research, I endeavored to control all variables as much as possible. Declaring my biases will assist in this aim. Cohen and Manion suggest that the researcher/interviewer needs to examine their biases prior to conducting their research (Cohen & Manion, 1994a, p. 271). The attitudes, attributes and opinions of the interviewer may impact on how the interviewer interprets the responses provided by the interviewees. The role of the interviewer is to present as accurately as possible the thoughts and opinions expressed by the interviewees.

All the initial interviews were conducted face to face to enhance communication, with the option of using an electronic medium to follow up when clarification of data was required (Shuy, 2001, pp. 541-545). The research participants for the interview phase of the study were not randomly selected. The rationale for this was purely practical and based on travel and financial constraints on the researcher. However, the study participants were nurses from various stages of the career spectrum and as much as possible from different geographical regions and health care settings.

3.5.6 Setting

The study was conducted nationally with diabetes nurse educators who worked in a variety of health care settings. The study participants worked in private and public health care, acute care and ambulatory care, rural and remote health and Medicare Locals. As discussed previously, 'Medicare' refers to the national, government-funded scheme that subsidises the cost of personal medical services and that covers all Australians to help them afford medical care. Medicare Locals, established in 2010, were government-funded primary healthcare organisations, whose role was to integrate primary health care in local health regions across Australia. The participants were diabetes nurse educators working in isolation, in multidisciplinary teams and or in academia.

3.5.7 Interview sample size

The number of study participants chosen to be interviewed was based on research that suggests that meta themes potentially emerge after as few as six interviews. Research also indicates that the amount and type of data generated, in conjunction with reaching a point of data saturation, where little new knowledge is yielded, should ultimately determine the final number of study participants interviewed (Kvale, 1996).

The goal of phenomenological research is not to create results that can be generalised, but to understand the meaning of an experience of a phenomenon (Munhall, 2007). Therefore, the number of participants can be relatively small (Kleiman, 2004). The usual sampling strategy in phenomenology is the 'snowballing' purposeful method that means that the people being interviewed then refer the researcher to other people who have had a similar experience (Converse, 2012). For these reasons ten diabetes nurse educators were interviewed.

3.5.8 Interview questions verbal protocol

In order to elicit information and answer the research question the interviews followed a semi-structured interview protocol (see appendix I).

3.5.9 Interview pilot study

Two diabetes nurse educators were interviewed initially as part of a pilot study. The rationale for conducting the pilot interviews was for the researcher to practice her interviewing technique, test the interview questions (Cohen & Manion, 1994a, p. 284) and determine if the questions would help elicit data that could answer the research questions (Silverman, 2010b p.p.272). A logical way to test whether the researchers' interview questions and format produce relevant answers is to pre-test the questions before undertaking the main research interviewing phase (Lindlof, 1995, p. 280).

Cohen and Manion advise that researchers should avoid asking leading questions and giving excessive guidance, in order that the interviewee is able to speak with authority and account for their own actions (Cohen & Manion, 1994b, p. 206). Each interview was 60 to 90 minutes in duration, as were the follow-up interviews (when needed).

The interviews were recorded electronically and later transcribed (Silverman, 2010b, p. 272). The rationale for analysing individual conversation interview transcripts in social science is that by studying the recordings of each study participant's interview the researcher will be able to explore the meanings and experiences of participants on the topic under focus (Crotty, 1998, p. 96).

3.5.10 Conducting the interviews

Following the successful pilot interviews, another eight interviews were conducted with diabetes nurse educators and the researcher where the mentors and mentees spoke about their experience and motivation to participate in mentoring and the understandings and meanings they had developed regarding their motivation to engage in mentoring. The length of the interviews averaged 90 minutes, during which time the conversations were audio taped, with the consent of the interviewee. Following each interview, the researcher made notes of any observations, or any non-verbal information that was shared. These notations about the interview experience were added to the transcripts made of each recorded interview.

3.5.11 Data collection

The recorded interviews were transcribed. Using a phenomenological approach means capturing the 'rich descriptions of phenomena and their settings' and this would not be achievable by using quantitative methods alone. Given that qualitative data is rich data that is complex, multifaceted and vivid (Gubrium & Holstein, 1997, p. 132), the use of NVivo 10 software complemented the manual interpretation and analysis of the study participants' interviews.

3.5.12 Data coding

The transcripts were coded both manually and by using the computer assisted software visual analysis tool NVivo 10. The transcription of the interviews allows the researcher to focus on and capture 'how' the interviewees said what they said (Poland, 2001, p. 630) and to systematically empirically support the searching of the interview transcripts to try to identify key words, phrases or relationships between words (Bazeley & Richards, 2000, p. 1). Even when oral language is transcribed as accurately as possible, transcripts do not capture all that is really said during interviews (Laverty, 2003). Attention must also be paid to silence and the unsaid; as it is there that one may find what is taken for granted (Kvale, 1996).

3.5.13 Data analysis

The analysing of data obtained from this study was based on the principles of thematic analysis (Boyatzis, 1998). A thematic analytical process consists of searching for and then identifying themes in the data, which are patterns that describe, organise as well as interpret parts of a phenomenon (Boyatzis, 1998, pp. 29-35; Kvale, 1996, p. 257).

Thematic analysis was appropriate for this study because it focuses on identifying different phenomena and themes. For example, a search query was undertaken using specific words or phrases that had previously been identified during the manual review of the transcripts or from the phase 1 data findings and these were then coded to their source. The words or themes that occurred most often were coded in a node to indicate that these concepts warranted further investigation (Silverman, 2011, p. 68).

The data analysis process incorporated 'recognising the particular, isolating understandings, dialoguing with others about interpretation, making explicit the implicit, and, eventually finding language to describe language' (Moules, 2002, pp. 30-31). In quantitative studies, motivation is often expressed as a

numerical score. As this is a qualitative descriptive study, the interviews with the diabetes nurse educators are accepted as evidence for what motivated these nurses to engage in mentoring (Pinder, 1992a, p. 95; Vroom, 1964).

3.5.14 Data interpretation

A process of iterative comparison and the development of a combination of constructs, following the principles of hermeneutical phenomenology, led to the emergence of themes and sub-themes and the development of a hermeneutic circle (Crotty, 1998, pp. 97-98; Denzin & Lincoln, 1998, pp. 227-228). In the Husserlian phenomenological tradition I returned time and again to question the experiences of the study participants (Crotty, 1998, p. 85).

3.5.15 Ameliorating steps taken in the current research

One of the problems identified by previous researchers with the validity of findings from interview data has been that the interviewer had not considered in adequate detail whether the questions asked during the interview would answer the research questions and whether the interview responses have enough research depth to withstand scientific scrutiny and rigour.

While a well-conducted interview with a willing articulate interviewee can uncover details about motivation to participate in mentoring, from a phenomenological perspective there is no such thing as the researcher being irrefutably sure that what the interviewee says is representing 'the full story'. Phenomenology recognises that there are only people's experiences and perceptions of what happened.

For these reasons, various methods of triangulation were used during this study to ensure the reliability and validity of the study findings (Cohen & Manion, 1994b, p. 254; Kvale, 1996, p. 244; Lindlof, 1995, p. 166). These methods of triangulation included the examination of key documents, the administration

of survey questionnaires (phase 1) and the conduct of interviews with the study participants (phase 2).

3.6 Conclusion

This research set out to investigate what motivated diabetes nurse educators, represented by nurses at various stages of their careers, to engage in mentoring for their ongoing professional development, an area that has not been systematically investigated in Australia to date. This chapter has presented the philosophical framework that underpins the research. It has described in detail the epistemological and ontological assumptions that underpin the study.

This chapter has also described hermeneutic phenomenology, its foundations and key contributors, and has argued that it is a philosophical framework that can contribute to developing knowledge that is relevant for the nursing profession. The chapter has also explained the rationale for the choice of theoretical perspective, discussed the justification of methodology and the research methods used. Methods for collecting and managing the data have been described and the principles guiding analysis of the data have been highlighted. Attention to rigour and ethical considerations has been outlined. The following chapter presents the results from phases one and two of this study. ■

Chapter 4

Results from phase one

4.1 Introduction

This chapter presents the results from phase one of this study. Phase one results were obtained from the administration of a nationally distributed questionnaire to all participants of the research cohort who acted as nurse mentors or mentees in a formal mentoring program during the period January 2008 to December 2012. The process of making sense of the phenomenon of engaging in a formal mentoring partnership was explored further by the examination of opportunistic written feedback provided by these mentors and mentees. Phase 2 of the study consisted of interviews conducted with a sample of mentors and mentees to examine what motivated these nurses to engage in formal mentoring, with participants chosen to include nurses from every stage of the nursing career trajectory.

4.1.1 Participants

To be included in phase 1 of the research cohort the study participants had to be:

- a nurse currently registered to practice with the Nursing and Midwifery Board of Australia
- over 18 years of age
- a financial member of the Australian Diabetes Educators Association.

In addition, mentors must have participated in the Australian Diabetes Educators Association formal mentorship program as a mentor for a minimum

of six months between January 2008 and December 2012. Mentees must have participated in and completed the Australian Diabetes Educators Association formal mentorship program between January 2008 and December 2012.

4.1.2 Research cohort

A total of 369 mentors and 389 mentees participated in and registered their completion of this formal mentoring program. That is, 758 diabetes educators completed the program and completed the five-point Likert scale survey questionnaire at the end of their six-month mentoring contract. Of this research cohort, some of the study participants also chose to provide written feedback on their experience of participating in the program. Of the mentor cohort 89% (n = 329) of the participants met the study inclusion criteria. Of the mentee cohort 74% (n = 288) of the participants met the study inclusion criteria. Mentors or mentees were excluded from the study if they were not registered nurses, not financial members of the Australian Diabetes Educators Association or not over the age of eighteen years. This left 617 actual participants in phase 1 of this study.

4.1.3 Ethnicity of the study participants

As the study participants' ethnicity was not captured during their registration to participate in the mentoring program, the potential impact of cultural identity on the mentoring program outcomes could not be measured. While information was recorded on what language or languages were spoken at home by the study participants, this information alone does not guarantee the ethnicity of the participant nor was information available on whether the study participants identified as Aboriginal or Torres Strait Islander heritage or descent.

4.1.4 Professional identity of the study participants

The professional profile of the mentor study participants was captured by the Australian Diabetes Educators Association (ADEA) when the nurses registered to act as potential mentors to other members of the association (appendix A, page 188). The professional profile of the mentors was then verified by the researcher by correlating the information contained in the ADEA Mentoring Program Registration as Available Mentor form with the Australian Diabetes Educators Association membership program database. The professional profile of the mentees was obtained by the researcher by correlating the mentees ADEA membership identification number, captured on the Mentoring Agreement form with the ADEA member database (appendix B, page 189).

Members of the association who were registered as holding a doctorate but had not identified what health profession they belonged to were excluded from the study as there was no conclusive evidence that they were nurses or nurses registered to practice nursing in Australia.

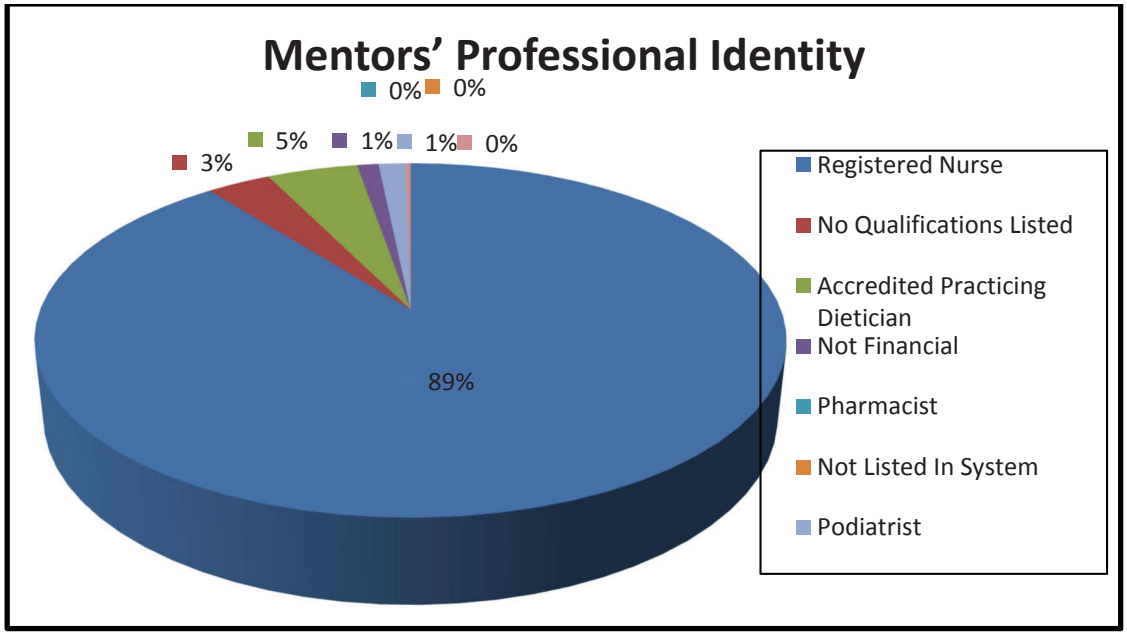

Figure 4.1 Mentors' professional identity

89% of the study participants who acted as mentors and completed the six-month formal mentoring program were registered nurses and therefore potentially eligible to be included in phase 1 and phase 2 of the study.

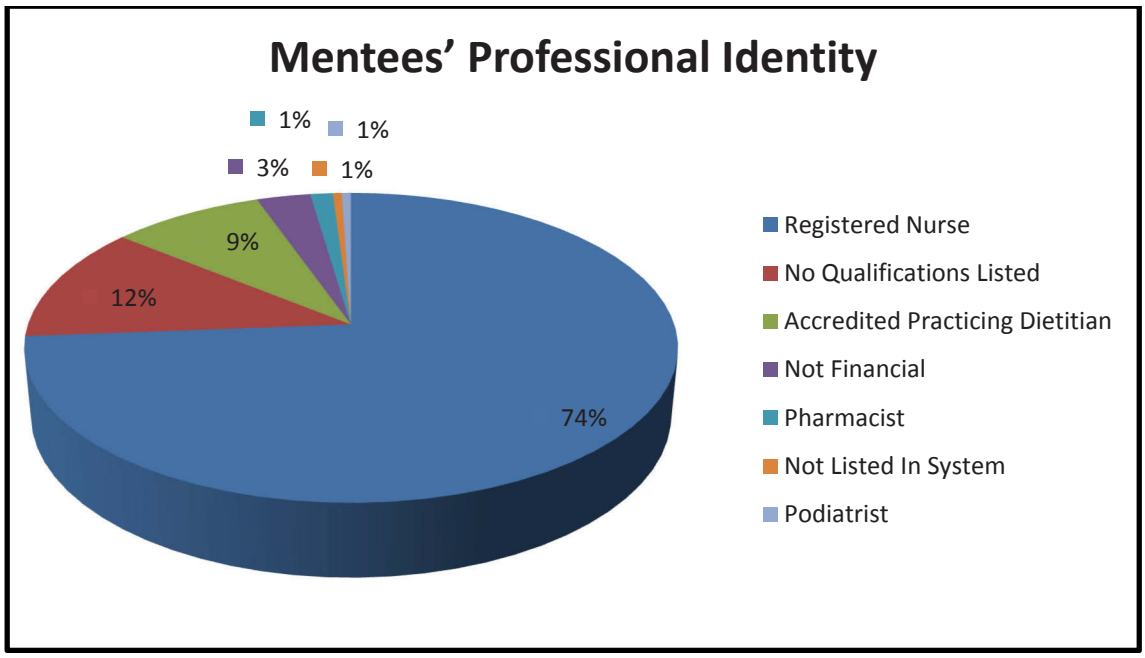

Figure 4.2 Mentees' professional identity

A total of 74% (287) of all the mentees who completed the six-month formal mentoring program were registered nurses and were therefore potentially eligible to be included in phases 1 and 2 of this study.

4.2 Process evaluation

4.2.1 Questionnaire administration

Survey questionnaires were completed by all mentors and mentees who had participated in the mentoring program for a minimum period of six months. The recruitment phase included all mentors and mentees who had completed the program since its introduction in January 2008 until December 2012. Templates of the evaluation survey questionnaires were included in the *Mentoring Program Manual* and distributed to all mentors and mentees at the

commencement of their mentoring partnership. The questionnaires were completed by the mentors and mentees at the completion of their six-month formal mentoring partnership, sent to the Australian Diabetes Educators Association national office in Canberra in hard copy and reviewed by the researcher under supervision at the research site.

4.2.2 Rationale for the questionnaire

The survey questionnaires served two main purposes. Firstly, the questionnaire captured quantitative data on the nurses' perceptions regarding their experiences of formal mentoring. Secondly, the survey questionnaires provided an opportunity for the study participants to provide individual feedback about their personal experience of formal mentoring.

While there were some limitations as to how the quantitative data could be collected or analysed given that it was the intellectual property of the Australian Diabetes Educators Association by using a combination of research methods the researcher was able to answer the research questions and gain an insight into what motivates diabetes nurse educators at various stages of their careers to engage in formal mentoring.

4.2.3 Results of the questionnaire

The evaluation survey questionnaire design allowed for the study participants to document their personal ratings about any aspect of their experience or perceptions on mentoring if they chose to do so. Overall, the study participants agreed strongly that from their perspective participation in this formal mentoring program was 'successful'. For example, 90% of mentors and 80% of mentees responded that they would be willing to act as a mentor in the future. The information obtained from the survey questionnaires and opportunistic written feedback provided a platform to inform phase 2 of the study, informing the design of a verbal protocol for the follow-up interviews.

4.2.4 Evaluation process

The Australian Diabetes Educators Association mentor and mentee responses were reviewed throughout 2012 and 2013. The responses from the mentors and mentees were aggregated. I plotted the survey response data from the study participants in column charts to illustrate the comparisons between the opinions of the mentors and mentors in response to each survey question. In figures 4.3, 4.6, 4.9 4.14 and 4.15 below the mentors' and mentees' opinions are demonstrated along the horizontal axis and the numerical values are demonstrated along the vertical axis for each question asked.

4.2.5 Achievement of overall goals

On entering the formal mentoring partnership, the nurse mentors and mentees were encouraged to establish learning objectives across areas in their nursing practice that they wanted to focus and improve upon. These learning objectives were then documented in the mentor's or mentee's professional development plan. The professional development plan provided a matrix of areas that the mentees and mentors could focus on to potentially improve their knowledge, skills or competencies. Some mentors and mentees also chose to maintain a reflective practice journal. It was suggested in the *Program Mentoring Manual* that mentors and mentees reflect on their current clinical practice, identify areas that they wished to focus on and to then use the journal as a prompt for measuring if they achieved their predefined goals as documented in their professional development plan.

As shown in figure 4.3, statistically the majority of the mentors and mentees responded that they had achieved their overall goals.

The overall goals achieved as assigned by the mentors and mentees on a response rate of one to five with five being the highest. One study participant made the following comment about goals:

Mentee feedback: 'Suggest including in the Australian Diabetes Educators Association *Mentoring Manual* a list of goals to choose from just as a starting point.'

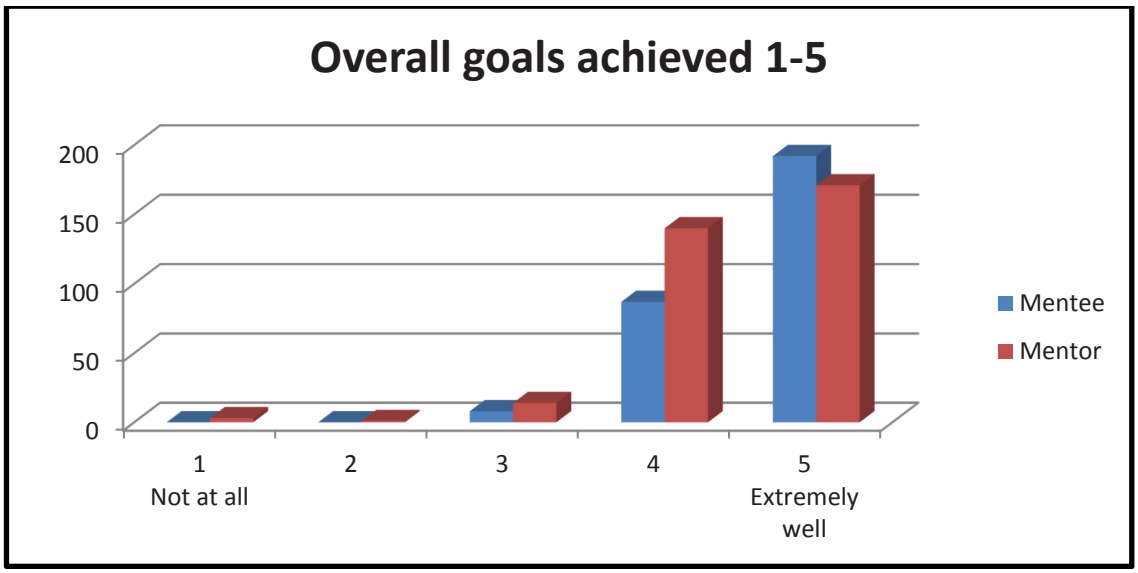

Figure 4.3 Overall goals achieved

4.2.5.1 Conflict resolution and early dissolution of the mentoring partnership

The next question asked respondents whether the mentoring partnership had been dissolved earlier than anticipated by either the mentor or the mentee. 96.5% of the mentees responded that—the partnership was not dissolved earlier than anticipated (refer to figures 4.4 and 4.5).

For those partnerships that were dissolved earlier than anticipated, the study participants were offered three options to explain why the partnership was dissolved early:

- Option 1. Goals were achieved earlier than anticipated
- Option 2. The mentor/mentee partnership was unsatisfactory
- Option 3. Other

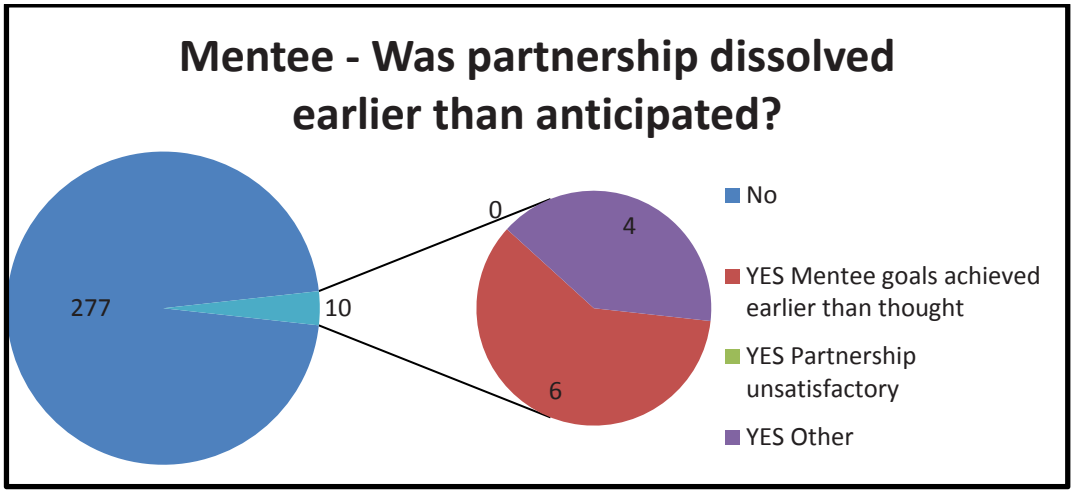

Figure 4.4 Mentee – Was the partnership dissolved earlier than anticipated?

For mentees who answered that the partnership was dissolved earlier than anticipated, figure 4.4 shows the reason why (response to question 3a).

The comments provided by some of the study participants were of interest because contrary to previous research findings (Jackson et al., 2015; Jakubik, 2007; Robinson et al., 2012b; Twenge, Baumeister, DeWall, Ciarocco, & Bartels, 2007) that demonstrated that mentee/mentor relationships are often dissolved early when matched up by a third party, in this formal mentoring program, when the nurses reported that their mentoring partnership was going well even though these nurses had perhaps not chosen their mentor, they queried why they should be forced to complete the program, stop their mentoring relationship once they were ready to apply to be credentialled:

> 'I realise I need to close a partnership for documentation reasons, but thought it unnecessary to cease just because mentee ready to apply for credentialling.'
>
> 'The mentorship program was good because it had a timeframe.'
>
> 'My mentor retired.'

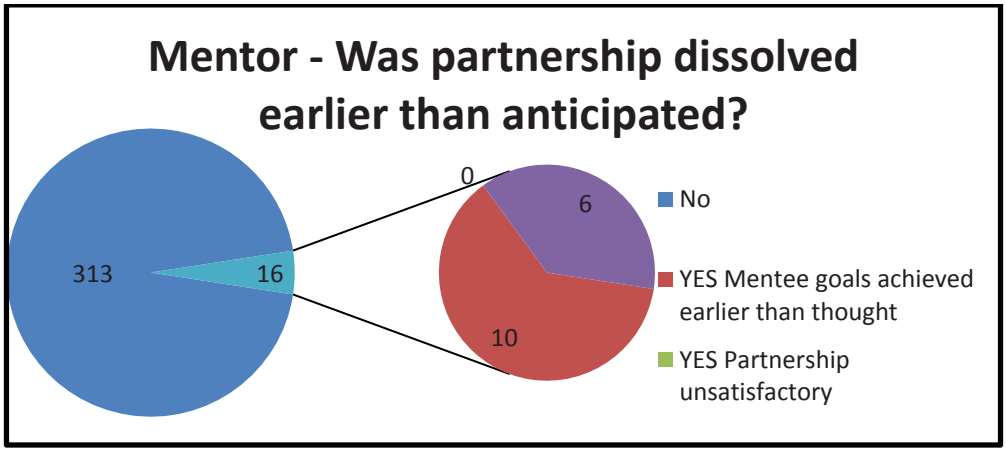

Figure 4.5 Mentor – Was partnership dissolved earlier than anticipated?

Figure 4.5 captures responses from mentors who answered that the partnership was dissolved earlier than expected (response to question 3b).

The fact that very few mentor–mentee relationships were dissolved earlier than anticipated strengthens the argument that high quality interpersonal relationships between mentees and mentors potentially contributed to their motivation, engagement and achievement of goals (Jakubik, 2007).

The next question asked the mentors and mentees to indicate on a Likert scale of 1 to 5 to what extent their personal goals for the mentoring partnership were achieved, with 1 being not at all (personal goals not achieved) and 5 being extremely well (personal goals were extremely well achieved).

62.3% of mentees responded that their personal goals were achieved extremely well while 42.2% of mentors responded that their overall goals were achieved extremely well.

4.3.6 Achievement of personal goals

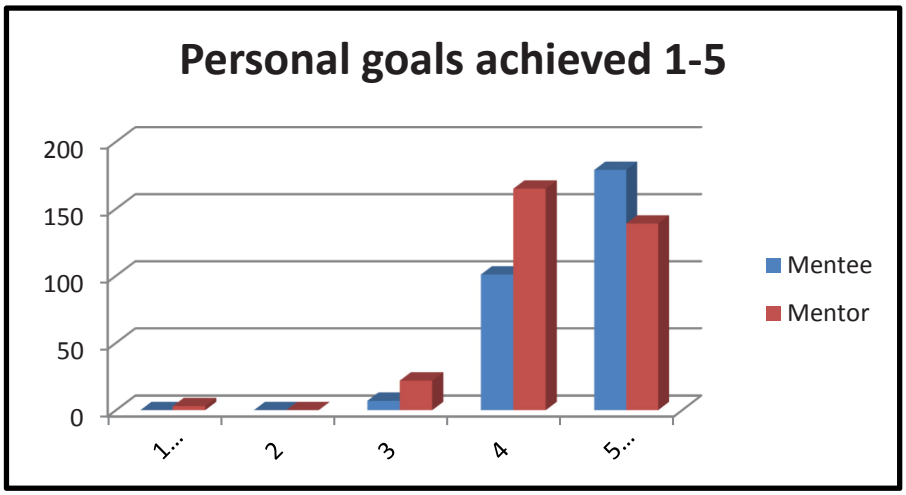

Figure 4.6 Personal goals achieved

The personal goals were achieved as assigned by the mentors and mentees (response to survey question 4).

Figure 4.7 below shows the number of mentees who contacted the Australian Diabetes Educators Association National Office and asked for support from the organisation while they were participating in the mentoring program. Only 27.9% of all mentees who participated in the program asked for support. The mentees who asked for support were then asked to rate their level of satisfaction with the support they received from the organisation on a Likert scale of 1 ('very poor support') to 5 ('support was excellent') (response to survey question 5).

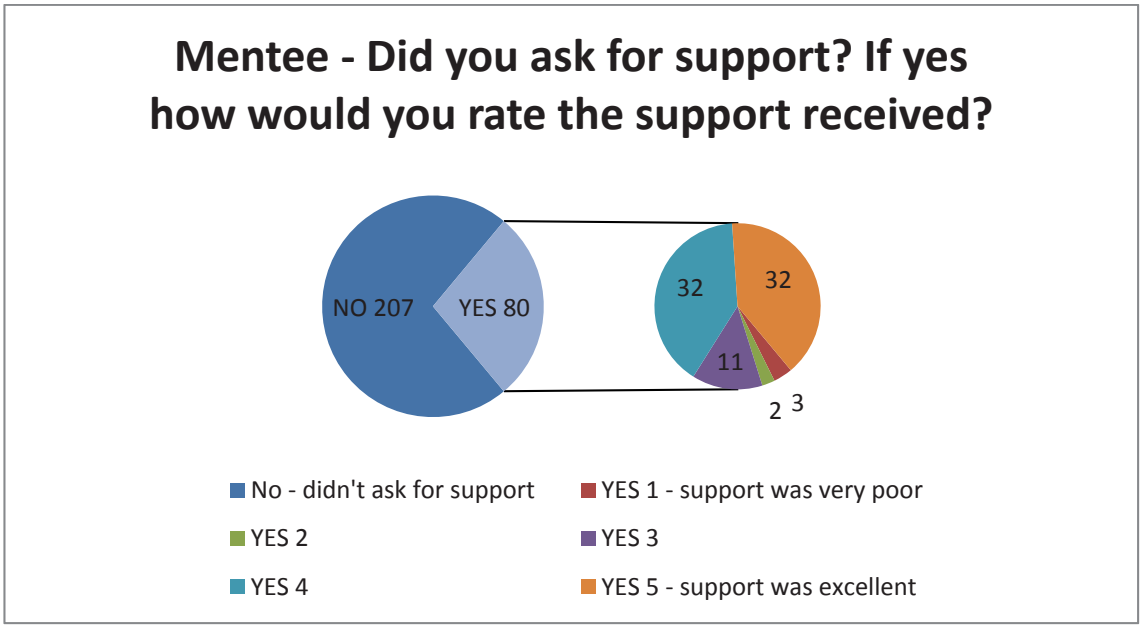

Figure 4.7 Number of mentees who asked for support from the ADEA National Office and their rating of the level of support provided

4.2.6.1 Evaluation of the level or type of support provided to the mentors and mentees

Forty per cent of the nurse mentees who asked for support responded that the report they received from the National Office was excellent. There were, however, some negative responses from the mentees such as the following:

> 'I would not have felt comfortable making any complaints if the mentorship was not working appropriately either to Australian Diabetes Educators Association or to my mentor.'

Figure 4.8 shows the number of mentors who contacted the Australian Diabetes Educators Association National Office and asked for support from the organisation while they were participating in the mentoring program. Only 17% of all mentors who participated in the program asked for support and only 2% responded that the support received was very poor on a Likert scale of 1 ('very poor support') to 5 ('support was excellent') (response to survey question 6).

Some of the mentors indicated that when the mentoring program was initially introduced by the Australian Diabetes Educators Association it was accompanied by an education program on mentoring including the role of the mentor. From the mentor feedback, it appeared that this education program was not repeated or ongoing. Some of the mentors newer to the program were unaware of or unable to attend the initial education day and subsequently were requesting that it be held again.

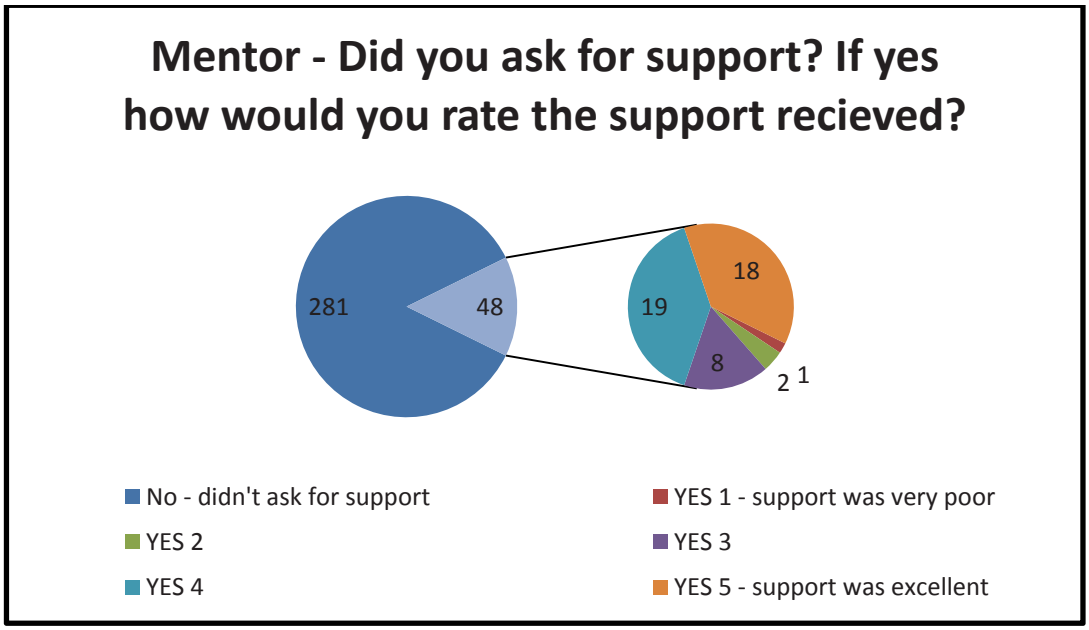

Figure 4.8 Mentor - Did you ask for support? If yes, how would you rate the support received?

Figure 4.8 shows the number of mentors who contacted the ADEA National Office and asked for support about the mentoring program at any time while participating in the program. Participants who did seek support were asked to rate the support they received on a scale of 1 ('very poor') to 5 ('excellent') (response to survey question 5).

Opportunistic feedback from the study participants about the support they received included the following:

> 'More support needed from the Australian Diabetes Educators Association to understand the process and what is required.'

'Mentor session at Roche Educator Day in 2009 was very useful. Are you repeating it?'

'ADEA needs to articulate the difference between clinical leadership, mentoring, preceptoring, coaching, buddying all different philosophies that need to be well articulated & defined. ADEA needs to articulate the goals of the program'

'The email reminders ADEA sent were great.'

'Some of the information on initial credentialling process was hard to follow'

4.2.6.2 Evaluation of the mentoring manual program material

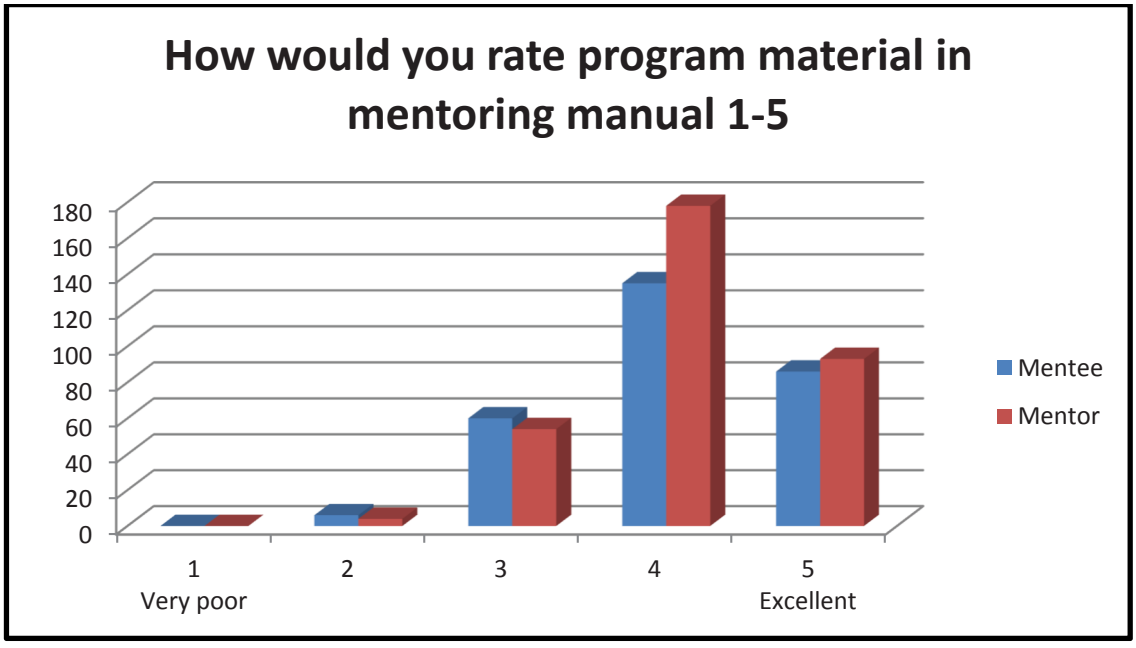

Figure 4.9 How would you rate program material in the mentoring manual?

Figure 4.9 shows how the mentees and mentors rated the program material in the *Mentoring Manual* on a scale of 1 (very poor) to 5 (excellent) (response to survey question 6).

A sample of feedback from the study participants about the program material in the *Mentoring Manual* included the following:

'Need to introduce document control.'

'All paperwork should be able to be lodged electronically.'

'The ADEA needs to provide a read receipt as acknowledgement that they receive the documentation.'

'Make the forms easier to find on the website.'

'Mentoring program material is a very useful tool -mentoring is not preceptoring.'

4.2.7 How did the mentees find their mentor?

The next question related to how the mentees found their mentor. In the present study, although mentees were offered the choice of being matched to a mentor by the organisation, most mentees found their mentor through their own network or personal contacts.

This may explain to some extent why so few of the mentoring partnerships were dissolved earlier than anticipated. Another explanation for this outcome could be attributed to the fact that mentees were provided with information in the mentoring manual on how to choose a mentor. These findings are explored further in phase 2 of the study.

Figure 4.10 shows how the mentees found their mentor. Options included through the ADEA website, through their ADEA state branch representative; from the mentees own network or contacts, and 'Other'.

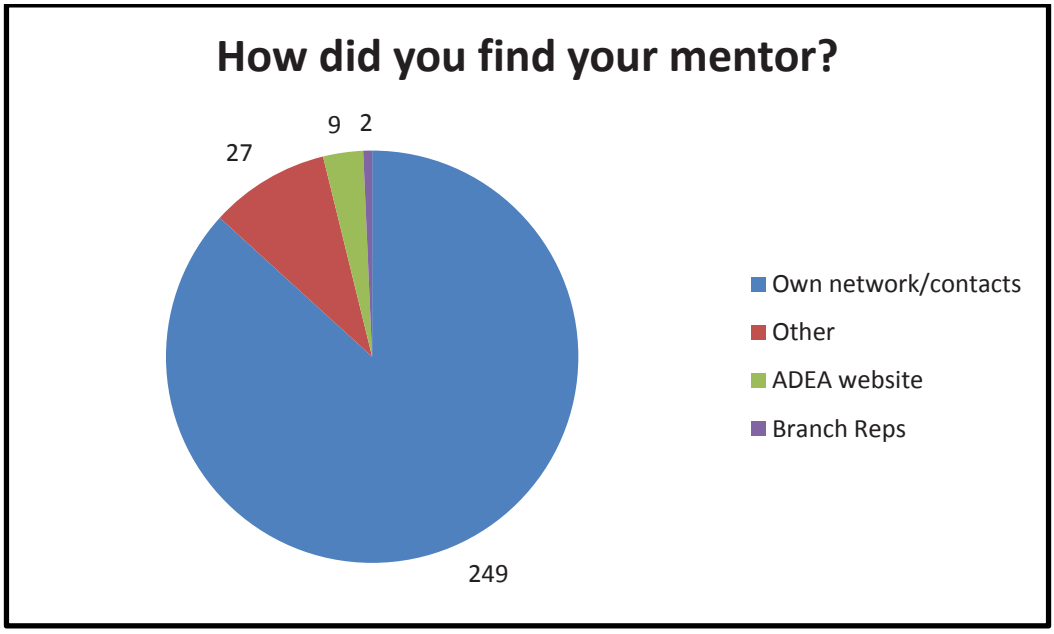

Figure 4.10 How did you find your mentor?

4.2.8 Were mentees motivated by credentialling to participate in mentoring?

The mentee respondents in phase 1 of the study stated strongly that they engaged in this mentoring program in order to become credentialled. The potential incentives were eligibility to apply for access to the Australian Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme (Australian Government Department of Health, 2014). Figure 4.11 shows that the vast majority of the mentees entered the mentoring partnership in order to become credentialed (response to survey question 8).

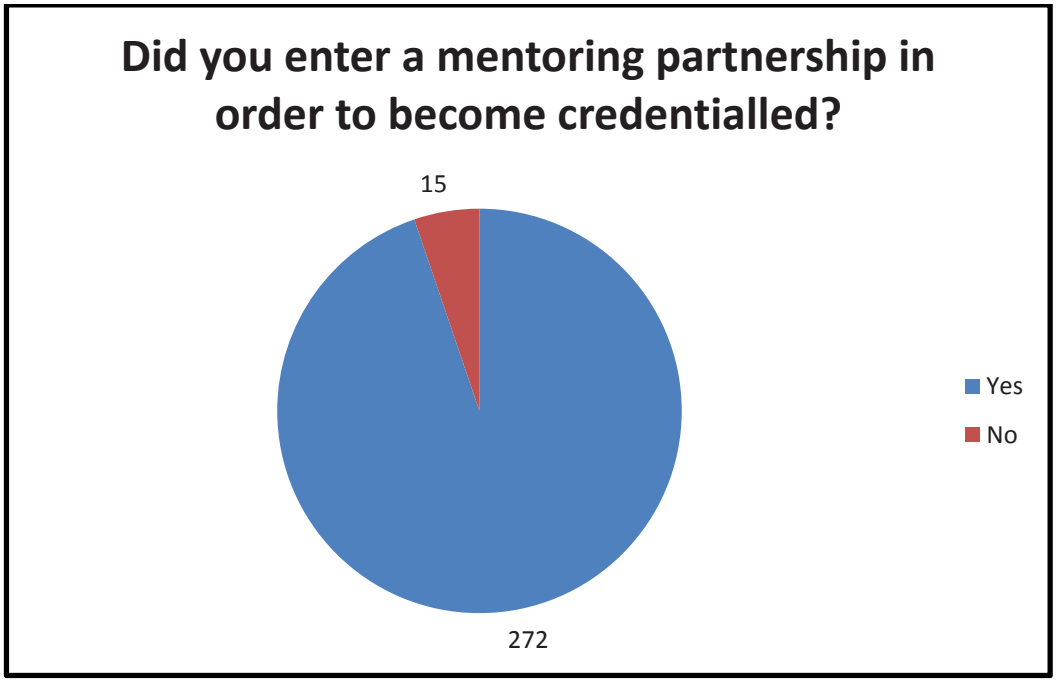

Figure 4.11: Did you enter a mentoring partnership in order to become credentialled?

Figure 4.12 shows that almost half of the mentees who entered the mentoring partnership in order to become credentialled had submitted their credentialling application form (response to survey question 8b).

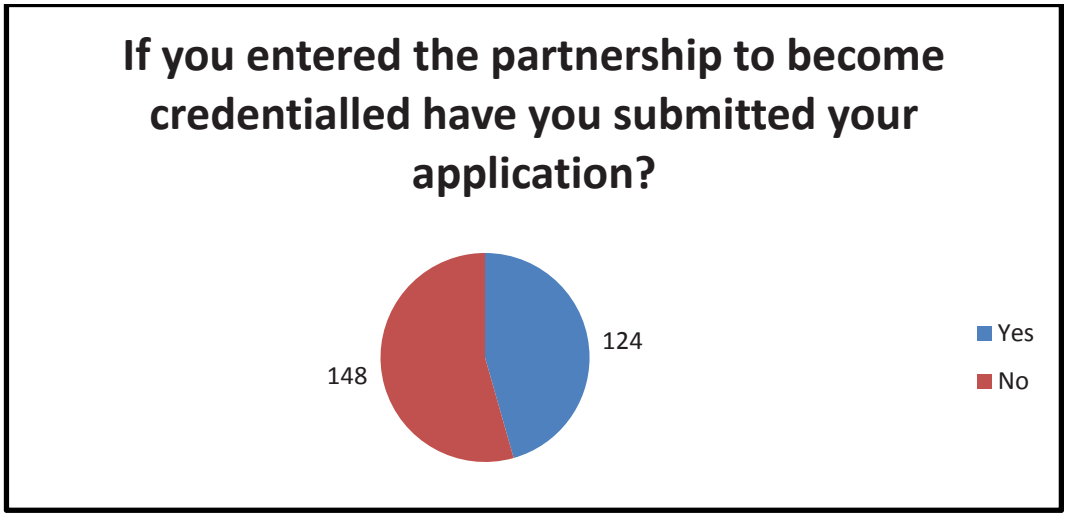

Figure 4.12 Have you submitted your application to become credentialled?

Figure 4.13 shows that the overwhelming majority of mentees who entered the mentoring partnership in order to become credentialled but had not submitted

a credentialling application form intended to submit an application in the future (response to survey question 8cb).

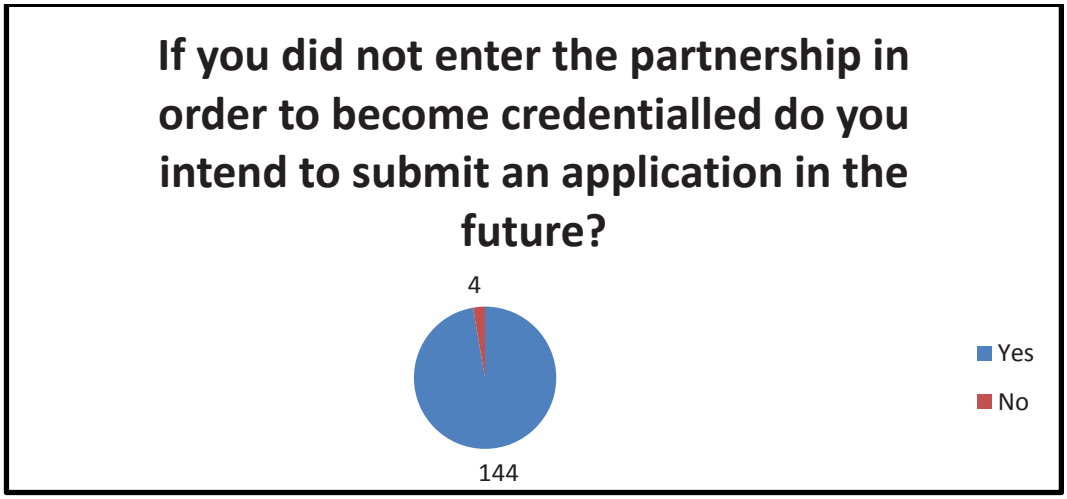

Figure 4.13 Do you intend to submit an application in the future?

Figure 4.14 shows that the majority of the study participants believed that overall, they were satisfied with the mentoring program.

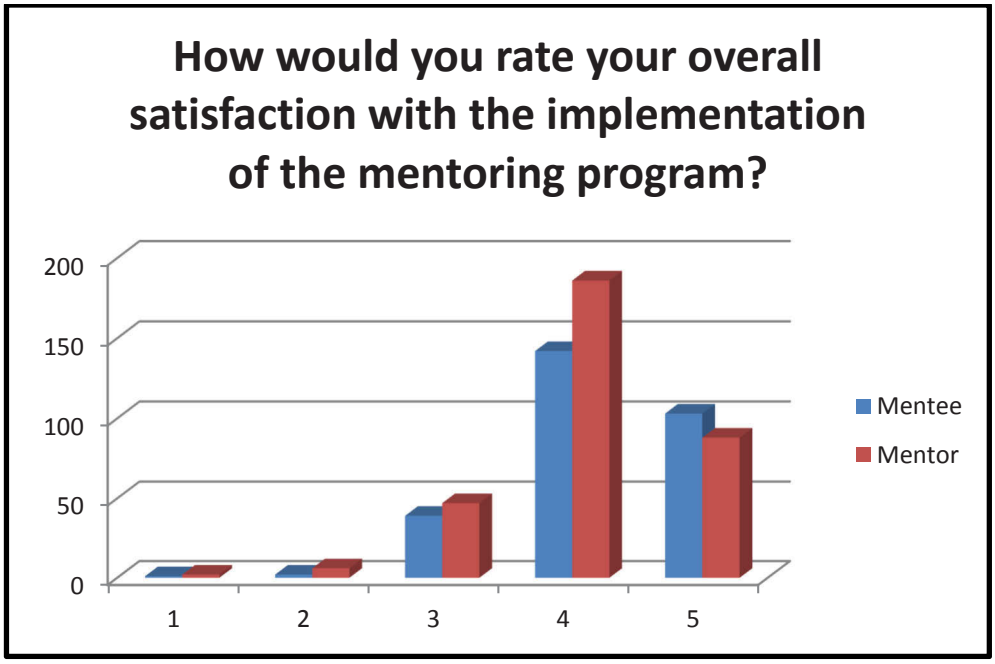

Figure 4.14 The mentors and mentees overall satisfaction with the mentoring program.

Figure 4.15 shows that the majority of respondents answered that they would be willing to acts as mentors in the future.

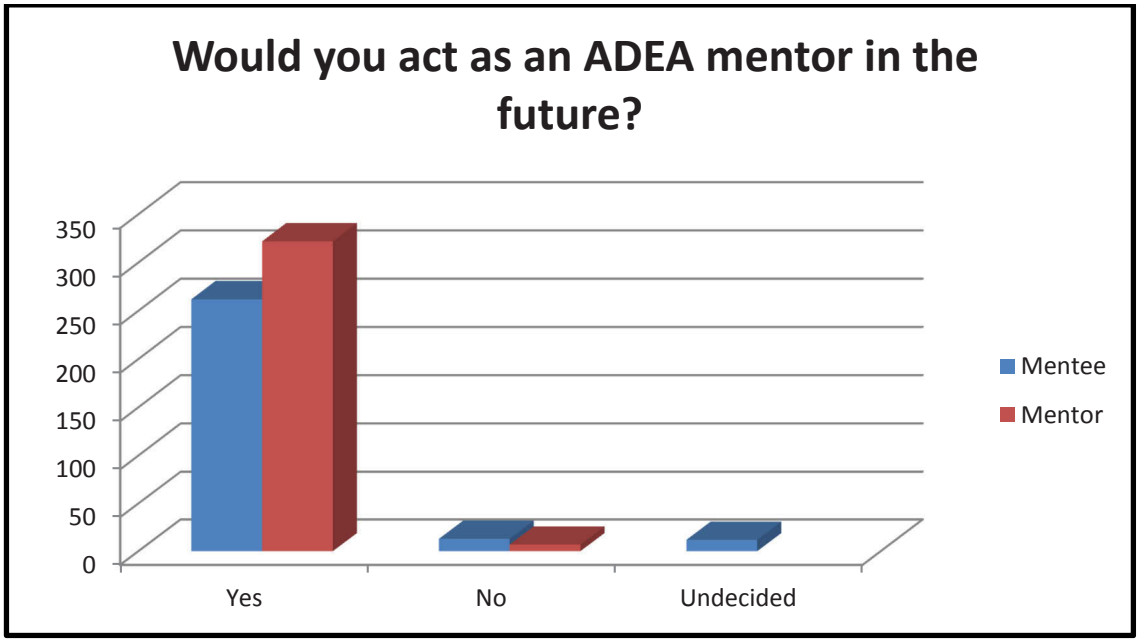

Figure 4.15 Would you act as an ADEA mentor in the future?

4.3 Opportunistic feedback

4.3.1 Introduction

The section below presents the analysis of the individual comments made by study participants during phase 1 of the study. Providing written feedback was optional and not all mentors or mentees chose to do so. From a phenomenological perspective these comments provide an insight into the experience of mentoring from the viewpoint of the nurse mentors and mentees. We cannot fully understand what motivated these nurses to engage in mentoring and whether and how related to their ongoing professional development without an in-depth analysis of the written feedback from mentors and mentees.

4.3.2 Thematic analysis

I followed a step-by-step analytical process, following the principles of formal logic defined in Schutz's theory of logical consistency (Taylor, Kermode, &

Roberts, 2006, pp. 43-44) to explore the meanings of the opportunistic feedback provided by the mentors and mentees.

4.3.3 Data coding

The mentor and mentee comments were coded both manually and by using the computer assisted software visual analysis tool NVivo 10. The aim of coding was to identify key words, phrases and relationships between words (Bazeley & Richards, 2000, p. 1).

4.3.4 Data analysis

The analysis of comments was based on the principles of thematic analysis (Boyatzis, 1998, pp. 29-35). The words or themes that occurred most often were coded in a node, i.e. they were grouped together as themes. These themes were thus identified as warranting further investigation in phase 2 of the study (Silverman, 2011, p. 68).

4.3.5 Mentee themes

Three themes were identified from the mentees' responses: 'more knowledgeable other'; 'cognitive development/professional development'; and 'improved confidence in diabetes education and management'. Key words included networking support, sharing ideas and experience, and being able to access advice. These themes were explored further in the subsequent follow-up interviews.

4.3.5.1 Mentee theme 1: More knowledgeable other

The dominant theme from mentees related to the sharing of ideas. Mentees identified achieving their goals through improved networking support, sharing ideas and experience, and being able to access advice and information as the number one benefit they received from participating in a mentoring relationship. They also mentioned improved problem solving skills, leadership, reflective practice, research skills and clinical expertise.

4.3.5.2 Mentee theme 2: Cognitive development/professional development

The second most frequently mentioned theme related to the mentees' knowledge and skills development, improved understanding of best practice protocols in diabetes management, increased learning and accelerated learning. Examples mentioned improved learning in Aboriginal health, use of insulin pumps, service management, motivational interviewing, gestational diabetes mellitus and the treatment of mental health issues.

4.3.5.3 Mentee theme 3: Improved confidence

The third most commonly reported theme was that the mentoring experience was both a rewarding and a valuable experience for improving the mentee's confidence to practice as a nurse in the clinical speciality of diabetes education.

4.3.6 Mentor themes

By far the most commonly identified outcome identified by the mentors related to their ongoing professional development. The other leading themes related to sharing ideas and the rewarding experience of valuing themselves as professionals. Key words included networking, support, sharing ideas and experience, improving confidence, enhanced reflective practice and problem-solving skills and being able to access advice. Mentor themes were explored further in the subsequent follow-up interviews.

4.3.6.1 Mentor theme 1: Professional development

Professional development through reflective practice (improved skills in clinical expertise, knowledge management, problem solving, practice development and change management) was identified time and again by the mentors. Mentors wrote comments such as this:

> 'The program was good for reflective practice, achieving goals, increasing their confidence in diabetes education, improving their clinical expertise, improving problem solving skills, knowledge & core

competencies facilitating practice development, increasing learning and change management– enhanced own professional development skills.'

4.3.6.2 Mentor theme 2: Sharing knowledge

Mentors mentioned that the program was helpful for the professional exchange of sharing ideas, information, communication, networking, support and experience.

4.3.6.3 Mentor theme 3: Rewarding experience valued as a professional

Mentors mentioned that the mentoring program was a valuable and rewarding experience and that many chose to extend their involvement in the mentoring program.

4.3.7 Relevance of the data to the research question

The aims of this study were (1) to investigate what motivated Australian nurses at various stages of their careers to participate in formal mentoring and (2) to examine whether and how mentoring contributed to nurses' professional development.

The findings from phase 1 indicated that both intrinsic and extrinsic motivational factors led to cognitive behavioural change and engagement with deeper level learning for these nurse mentors and mentees. Mentees tended to be motivated by extrinsic factors such as the achievement of credentialling, potential fiscal rewards associated with career advancement, eligibility to apply to the Australian Government for a Medicare Australia provider number through the legitimising of learning and the attainment of 'the bit of paper'. Mentors were motivated by intrinsic factors such as the desire help, to belong, and to contribute to the professional development of other members of the Australian Diabetes Educators' Association or simply because they wanted to be better at 'doing their job'.

The results from phase 1 of this study were in line with suggestions in the literature that engaging in mentoring relationships has positive consequences for the professional development of both mentees and mentors (Crathern, 1953; Eby et al., 2008).

4.4 Conclusion

In this chapter, I have presented the results from phase 1 of the study obtained from the administration of a nationally distributed questionnaire to diabetes nurse educators who participated in a formal mentoring program. The questionnaires used a Likert scale to measure the attitudes, satisfaction and achievement of goals of the mentorship program participants. The process of making sense of the phenomenon of engaging in a formal mentoring partnership was explored further by the examination of opportunistic written feedback provided by these nurse mentors and mentees.

In the next chapter, I present the results from phase 2 of the study which consisted of interviews conducted with five mentees and four mentors to examine from a hermeneutic phenomenological perspective what motivated these nurses to engage in formal mentoring. ■

Chapter 5

Results from phase two

5.1. Introduction

In phase 2 of the study I begin my analysis of the transcripts of the interviews conducted with the study participants, applying a hermeneutic phenomenological perspective to the data. While phase 1 of the study used primarily quantitative questionnaires to explore the meaning that the study participants attributed to their experience of participating in formal mentoring relationships, phase 2 the study used the qualitative method of interviews to examine what motivated these nurses to engage in formal mentoring. My aim was to study nurses at every stage of the nursing career trajectory.

Phase 2 of the study explored whether learning occurred through mentoring; and if so, how was it reconstituted as knowledge; and whether this related to the professional development of the study participants. The expectancy theory of motivation was used to describe and underpin the behavioural phenomena of motivation (Vroom, 1964).

Five major themes emerged from the interviews undertaken with both the mentors and the mentees. These themes substantiated the preliminary data obtained from the questionnaire analysis and opportunistic feedback from phase 1. These themes or clusters of thought developed around the concepts of professional development, professional identity, belonging, knowledge sharing and goal setting. These themes were examined further using Vroom's expectancy theory of motivation (Vroom, 1995, pp. 31-32).

5.1.1 Participants

Purposive sampling was used to recruit participants to phase 2 of the study. The interviewees were selected in order to provide a representation of nurse mentors and mentees, of different ages, working in a range of rural/remote and urban health care settings, working in the private and the public Australian health care industry. Most importantly, participants were at various stages of their nursing careers.

The diabetes nurse educators recruited to phase 2 of the study were included because they had lived the experience of mentoring that was the focus of this study and were willing and able to speak in detail about their experiences. During phase 1 of the study several of these educators had provided written feedback which suggested that the opinions of these mentors and mentees warranted further investigation.

All interviewed participants provided their written consent to participate and interviewees were de-identified to ensure confidentiality. Ethical approval to conduct this research was received in 2012 from the University of Technology, Sydney. The clearance number for this research allocated from the University of Technology Human Research Ethics Committee was reference number 2012000059. Progress reports on the implementation of the study were provided annually to the ethics committee until the completion of the study.

5.1.2 Profile of the participants

Participants in phase 2 of the study were all registered nurses who were financial members of the Australian Diabetes Educators Association and who had or were participating as a mentor or mentee in the Australian Diabetes Educators Association's formal mentoring program. Five of the participants were from New South Wales, two were from Victoria, one was from Tasmania and one was from Western Australia.

All of the participants were currently employed in a full-time capacity. Two of the mentees had previously worked in a part-time capacity and were therefore able to provide perceptions of the mentoring experience from both a full and a part-time perspective. The fact that all of the participants were female was not intentional but was attributable to the fact that only 11.4% of nurses across Australia are male (Nursing and Midwifery Board of Australia, 2015) and hence from a practical perspective it was easier to recruit female nurses as they were in greater supply. The matrix below reflects the profile of the study participants, i.e. whether they were credentialled with the diabetes nurse educator governing body, working in the private or public health sector, whether they held post graduate qualifications in diabetes education and whether they met the ADEA credentialling criteria of having completed a minimum of 1800 hours of continuous full-time practice in diabetes education.

Initially the researcher conducted two pilot interviews followed by eight illustrative interviews with the study participants (National Health and Medical Research Council, 2009 p.p.23-24). However, the researcher in consultation with one of the interviewed mentors removed that mentor from the study because the researcher could not guarantee that the diabetes nurse educator could be adequately deidentified, which was a requirement of the University of Technology Sydney Human Research Ethics Committee approval, given that this mentor worked in a very small specialled area of diabetes education (see appendix B). They were also not representative of diabetes nurse educators as a professional nursing group.

5.1.3 Conducting the interviews

The initial interviews were conducted face to face with each study participant. The interviews were undertaken at sites mutually agreed upon by the researcher and each of the interviewees. Two interviews were conducted in Queensland, three interviews in Western Australia, four in New South Wales

and one interview in the Australian Capital Territory. The interviews were undertaken at diabetes nurse educators' work sites, at conferences and in their own homes.

Follow-up interviews, phone calls and emails were undertaken with the study participants as required to make clear the phenomenon of mentoring in the context of nursing in Australia. After reflecting on their lived experience of mentoring, the nurses were able to provide examples to illustrate how mentoring was perceived at that time specifically for them.

Mentor or mentee	Professional status	Place of employment	Qualifications	Professional development
	Credentialled with the ADEA to practice in Australia as a Registered Diabetes Nurse Educator	Public, private; location	Holds tertiary qualifications in diabetes education	Completed > 1800 hours of continuous full-time practice in diabetes education
Mentor 1	Yes	Public & private sector	Yes	Yes
Mentor 2	Yes	Academia & public health sector	Yes	Yes
Mentor 3	Yes	Public health / rural & remote	Yes	Yes
Mentor 4	Yes	Public health sector	Yes	Yes
Mentor 5	Yes	Public health sector	Yes	Yes
Mentee 1	No	Public health / rural & remote	Yes	Yes
Mentee 2	No	Medicare Local	Yes	Yes
Mentee 3	No	Medicare Local	Yes	Yes
Mentee 4	No	Diabetes Australia	Yes	Yes
Mentee 5	Yes	Public health sector	Yes	Yes

Table 5.1 Profile of the phase 2 study participants

5.2 Applying the expectancy theory of motivation to the data

5.2.1 Introduction

The expectancy theory of motivation was used to explore what motivated these diabetes nurse educators to engage in mentoring (Vroom, 1964). The matrix in table 5.1 below reflects the basic categories of the expectancy theory of

motivation. The theory provides a framework within which to examine the components of valance, expectancy and instrumentality.

Vroom proposed that the motivational force on a person to perform an act is equal to the product of the valence of outcomes and the strength of expectancies that these outcomes will follow the act. If this proposition is correct, it follows that attempts to predict or explain the amount of task-related effort must consider both the valence of possible outcomes to that nurse and her expectancies regarding the consequences of different levels of effort for attaining them (Vroom, 1995, p. 225).

The diabetes nurse educators in this study chose to participate in a formal mentoring program but the results of the study demonstrate that for some of these nurses there was a discrepancy between their anticipated satisfaction from participating in the mentoring program and their actual satisfaction from participating (Vroom, 1995, pp. 18-19). While Vroom believed that increased effort leads to increased performance, the individual choices that a person makes are also dependent on events that are beyond their control such as the relationship between participating in mentoring and achieving the desired outcome of credentialling.

5.2.2 Motivational force

The themes below emerged from the mentors' and mentees' interview responses to the research question: 'What motivated you, a diabetes nurse educator, to participate in mentoring?' This question sought to understand the nurses' motivational force.

KEY CONSTRUCTS	VARIABLES
Motivational force	Intrinsic motivators Self-actualisation A desire to help Everyday work rewarded through the informal things Extrinsic motivators Eligibility for a Medicare Australia Provider Number Credentialling with the Australian Diabetes Educators Association
Expectancy	Self-efficacy Perceived control Goal difficulty
Instrumentality	How confident are the mentors and mentees that participating in a formal mentoring program will lead to their desired outcomes Trust Job control
Valence	Valence of first degree outcomes Belonging Professional identity Collegiality Technical currency Networking Professional development Confidence Valence of second degree outcomes Credentialling Clinical Nurse Consultant status Medicare swipe

Table 5.2: Matrix of Vroom's expectancy theory of motivation

The matrix of Vroom's expectancy theory of motivation in table 5.2 illustrates the correlation between participant feedback in interviews and the key theoretical constructs of expectancy, instrumentality and valence.

5.2.3 Intrinsic motivators

Some of the findings from the study cannot be easily explained in terms of the concept that these nurses performed effectively only to the degree to which their performance would lead to a reward. This phenomenon, as previously identified by McClelland and Vroom amongst others, is demonstrated

particularly by some of the mentors' responses about what intrinsically motivated them to engage in mentoring and this finding will be explored further in the following chapter (McClelland, Atkinson, Clark, & Lowell, 1953; Vroom, 1995, p. 308).

DeCharms, Deci and White defined intrinsically motivated behaviour as choice behaviour which is exhibited by individuals for no apparent external reward (deCharms, 1968; Deci, 1975; White, 1959). However, while this study helps to clarify the nature of intrinsic motivation for these nurses, it does not attempt to explain the human choice behaviour of these nurses solely as a function of intrinsic motivational forces and this concept is illustrated by the mentors' comment below:

> Mentor 5: 'It's working with that person to develop them. I think that to me the most interesting part of the process … is seeing them grow as professionals. Hopefully the mentoring has played a part in that development. Seeing how they sort of get back up to speed or start from early beginnings and flourish with time I think is a really nice process to watch. So I think it's being able to, help people develop.'

5.2.3.1 Self-actualisation

The mentors illustrated strongly that what motivated them to participate in formal mentoring relationships was a desire to be useful to the mentees by being able to help them develop professionally. However, another outcome was that they also found the mentoring experience useful for enhancing their own professional development. For Mentor 1 the experience of mentoring for professional development was reciprocated.

> Mentor 1: 'I think mentoring is a very useful tool to stimulate the mentor to "stay in the know" of knowledge, skills and research etc.

> And it allows the mentee a safe place to follow through on professional development goals.
>
> 'As a mentor I don't feel I have to know everything, but I can put a mentee in contact with someone who may be able to help. It's a mutually satisfying exercise. I am an enthusiastic supporter of this process—it's holistic, collegial and involves commitment and trust (I can do that!). Any process that supports nurses in as complex a work environment as nursing is has got to be very valuable and valued.'

5.2.3.2 A desire to help

Mentor 4 also talks about being 'helpful' and the impact this had on her self-esteem:

> Mentor 4: 'Well it was certainly lovely recognition of being someone that could be helpful with my experience in the chosen field of paediatrics. So, that was sort of you know lovely, for the self-esteem professionally. Look, I think it adds to your experience and your CV. In a way it was a privilege to be asked to be a mentor.'

5.2.3.3 Everyday work/rewarded through the informal things

One mentor mentioned the rewards of learning through everyday work:

> Mentor 1: 'Um, but you're meeting with like mind. You're sharing a topic that you might not know everything about but you're going to learn something from it.'

5.2.4 Extrinsic motivators

Unlike the intrinsic motivational forces described by the mentors, the motivational forces described by the mentees tended to be extrinsic in nature.

5.2.4.1 Eligibility for a Medicare Australia provider number

For those mentees working in the private health sector, only diabetes educators who are registered with Medicare Australia are eligible to claim a fiscal Medicare Australia rebate and only nurses credentialled with the Australian Diabetes Educators Association are eligible to apply for a Medicare Australia provider number (Australian Government Department of Health, 2014). This provides a powerful motivation for some participants:

> Mentee 3: 'So with a GP [General Practitioner] practice, there's a diabetes annual cycle of care—a yearly screening the patient does with a GP and the nurse—for care planning, and they get the Medicare rebate … the government says, "Diabetic patient, this is the deal". You have to look at their skills, their knowledge, and their psychological support and so on, and the government is fairly prescriptive as to what you have to do—there are mandatory elements.'

5.2.4.2 Credentialling with the Australian Diabetes Educators Association

Other interviewees participated in the mentoring program with some reluctance, frustrated by the credentialling demands of the ADEA:

> Mentee 2: 'Well I still love it (diabetes education). I love the job but I found the whole process of credentialling completely pedestrian and frustrating. But I knew it was like a game plan, I knew I had to do this because I had a three-year gap. My credentialling expired 2007 and I didn't start back till 2010. And because there was a three-year gap, I had to start from the beginning. There was no negotiating about that, no, absolutely none. I did try. I tried to negotiate before I left, to see if I could put it on hold but it really was frustrating because I've always been credentialled. So I had to do the ten, the whole study program and get a mentor and, do all the ins and outs and forms and... It's just

(sigh) I found it so [pause] labour intensive. And I didn't find it particularly educating but I wanted to be credentialled.'

5.2.5 Expectancy

According to Vroom, the concept of expectancy refers to an individual's expectations and levels of confidence about what they are capable of doing, and the belief that effort will lead to the achievement of a particular outcome (Bandura, 1997, p. 125; Vroom, 1995, p. 20). If a person believes that he can achieve an outcome, he will be more motivated to try for it, assuming that other things are equal (Pinder, 1992a, p. 94).

Of the various approaches available to measure expectancy, the approach used in this study relies on the verbal reports provided by the study participants about the probability that if they participate in a formal mentoring program they will achieve their desired outcome (Vroom, 1995, p. 29). Just as verbal reports may be taken as evidence for the valence of outcomes, they may also constitute the main form of evidence for expectancies. If a mentor or a mentee states that an outcome is certain to follow an act, I have assumed that this is true and meaningful as perceived by these nurses.

For example, the probability for Mentor 1 that she will be able to maintain her nursing registration with the Australian Health Practitioners Regulation Agency (AHPRA) and credentialling with the Australian Diabetes Educators Association is illustrated by the following:

Mentor 1: 'So whether people are going to start to jack up because you've got to more or less demonstrate for your nurse's registration that you've got credentialling … And then they think that mentoring's just an extra, added burden on to it. And, I don't know, I didn't feel it was. I really got a lot out of it.'

The concept of expectancy has been described as a belief that higher or increased effort will yield a better performance. In other words, if I work harder, I will achieve my desired outcome. However, internal and external conditions also impact on the nurse's expectancy perceptions. For example, the nurses' level of confidence in their skills to complete the mentoring program and the degree of help they expect to receive from their mentor were also relevant for the interviewees:

> Mentee 4: '[Mentee 4's mentor] understood what my needs were. She supported me, and she kept me accountable. We had, you know, really regular contact, you know, email.'

The quality of resources available including the amount of time they have to participate in mentoring meetings was also mentioned:

> Mentor 5: 'You don't have to be in the same town with people and... in fact I had an email from our, um, committee person up in the Northern Territory. And well you can imagine nobody's down the road there and she's mentoring somebody 500 k's [kilometers] away. They've set up... they now Skype once a month. So they actually can talk.'

All of these factors can influence the nurses' beliefs about being able to achieve their desired mentoring outcomes. Interviewee responses indicated that expectancy is likely to be enhanced if the nurses have the necessary resources available, the required mentoring skill set and the necessary support (Green, 1992, p. 5).

5.2.5.1 Self-efficacy

In the self-efficacy model proposed by Bandura (1997), an individual's expectations of personal efficacy are derived from four principal sources: performance accomplishments, vicarious experience, verbal persuasion, and

physiological states. The more dependable the experiential sources, the greater are the changes in the individual's level of self-efficacy. As demonstrated by Mentor 1, persistence and a belief in your own capabilities are paramount to the achievement of outcomes.

> Mentor 1: 'A lot of the, nurses in the hospital are in that older age group too and with the introduction of basic credentialling for all nurses, I know some have quit their hospitals because they don't want to—they can't figure out how they would ever possibly come up with 20 professional credit points a year. I mean that is so easy. However, [laughs] they just feel … they can't do it! But I also think maybe they could have like some kind of thing in place for them to develop the confidence to know that they can easily pick up 20 points a year. You know, it doesn't have to be just, "I went to this conference".'

Individuals who judge themselves as highly efficacious will expect favourable outcomes, whereas those who judge themselves as having low self-efficacy, who expect poor performances of themselves, will conjure up negative outcomes for themselves (1992, p. 3; Bandura, 1997, p. 24).

5.2.5.2 Perceived control

The amount of controllability individuals have also affects the extent to which efficacy beliefs shape outcome expectancies and this was illustrated by Mentee 4's comments:

> Mentee 4: 'I went from being yes, very negative and resentful about having to do it, to realising, this can make a big difference to my professional practice.'

However, from Mentee 4's perspective, choosing the right mentor and implementing controls to help her performance may have been instrumental in making her mentoring experience a positive one. She states:

> Mentee 4: 'Um, I knew [Mentor 5]—she was fantastic because, she, understood, what my needs were, she supported me and, she kept me, accountable. If I was going to, do mentoring I wanted to do it with someone who really knew their stuff. I guess I wanted to have, the best experience, you know, mentoring that I could have and I knew Mentor 5, would be able to provide that because of her work experience, her experience with ADEA you know, sort of the full package.'

All participants spoke about the importance of forming a relationship with their mentor or mentee and that this relationship was reciprocated, even extending to their relationship with their patients:

> Mentor 3: 'But then I go into every contact with the idea that I'm going to learn something. You know, even with the patients. It's building people's concept of the relationship, how they actually access the information they need.'

The comments made by Mentee 3 demonstrate her belief in how she uses the concept of the mentoring relationship in her role as not only a mentee but also as a mentor:

> Mentee 3: 'So it was always mentoring with the purpose of moving the person [the patient] forward to the best of their ability in the area they wanted to be in.'

5.2.5.3 Goal difficulty

Goal setting theorists assert that by setting clear specific goals, by specifying the time frame for achieving the goals and the process for measuring whether they have been met, and by allowing the mentors and mentees latitude in how to achieve their goals individuals can maximise their motivation (Deci, 1992, p. 17). Several of the mentors referred to the problem of the mentees having too

many goals and raised the issue of the mentees documenting goals that lacked specificity and direction, concepts generally agreed upon as not being advantageous for goal achievement and motivation (Timm & Peterson, 1982, p. 170). As mentor 5 put it:

> Mentor 5: 'So he came and he showed me his learning goals. And I've said, "I can't, for the life of me see how in 40 hours of clinical placement you're going to fulfil those goals. Can we try and break them down?" So yeah, I think one of the biggest problems people have is setting goals that they can achieve and again I think it's an experience thing.'

Goal commitment has been shown to have a strong positive effect on performance across several research studies and expectancy and attractiveness of goal attainment, the antecedents thought to me most proximal have been demonstrated to be strongly and positively related to goal commitment (Klein, Wesson, Hollenbeck, & Alge, 2003, p. 212). Mentor 5 illustrated her grasp of the importance of this concept through her persistence in guiding her mentees to define and commit to achieving their goals through their documentation of their goals in their mentoring plan. She also discusses communication strategies for how the processes will occur and negotiates timeframes for achieving the goals with her mentees:

> Mentor 5: 'We set our goals for the next two weeks, or whatever it is, what are you going to achieve in that time. If you can't or it's looking like it's a problem, let me know... I think it doesn't matter how it gets done as long as... I don't think you necessarily always have to be in the same room with a person. As long as you've set it up at the beginning and have an understanding of how you're going to, communicate.'

Mentee 3's comments below illustrate that she subconsciously worked towards a cognitive behaviour change, not only in herself but also in her patients, by

instilling in them the belief that their ability and effort will empower them to achieve whatever it is they want to achieve (Weiner, 1994b). Mentee 3 sees the attainment of goals for herself and her patients as something that is achievable if appropriate internal and external controls are put in place:

> Mentee 3: 'Ah, to be, to have someone to be accountable to for setting a plan, for clarifying. Mentoring for me helped me take time out of just the business of the work day, where you get to work and, you just go, go, go. Mentoring gave me the time to sit and reflect on, "Where are my gaps?" and "I'm going to commit to doing that because I've told my mentor and that's going to keep me you know on that path." And I think that's why I found the mentoring six-months experience, so productive and worthwhile.'

From the perspective of motivation and control, it might be expected that the nurses who attribute the control of events to themselves, who have an internal locus of control, would display greater work motivation than the nurse mentors or mentees who attribute the control of events to their external environment, i.e. who have an external locus of control (Spector, 1992, p. 110). However, not all individuals who are motivated by external controls are less oriented towards valued rewards or attaining personal goals. Rather, individuals who are motivated by internal controls tend to exert greater efforts towards achieving goals because they are more likely to believe that their efforts will be successful (Spector, 1982). This concept is illustrated by the comment made by Mentee 3:

> Mentee 3: 'I always believe that people want to maximise their capacity and reach their potential and I don't believe that people don't have potential or that people's capacity is poor. I always feel that people's capacity is whatever level they can get to, at the time that they're approaching the problem. Ad if they've got the motivation to

> get there, we're going to get there and I have the desire for them to succeed and be successful.'

5.2.3 Instrumentality

Theoretically the concept of instrumentality proposes that if an individual performs well, then they will be rewarded by the outcome that they value. However, obtaining the valued outcome is dependent on the individual having trust and respect for the people who make the decisions about who gets what reward, and seeing transparency in the process reward giving (Vroom, 1995, p. 307).

5.2.3.1 Trust

The measure of instrumentality in this study was reflected in the descriptions provided by the mentors and mentees as to how confident were they that participating in this formal mentoring program would lead to the achievement of their desired outcomes e.g. credentialling? For mentee 1, her level of trust that the Australian Diabetes Educators Association would grant her the reward of credentialling even if she completed the required process was in doubt and hence her motivation to complete the program was compromised.

> Mentee 1: 'I did the official mentoring program, having someone mentor me, in order to get my credentialling. When I actually did the mentee program it was more like going through the steps. I hadn't pursued credentialling before because it seemed so onerous and I just—I didn't need it for the position I was in at the time.'

5.2.3.2 Job control

The descriptive measures of instrumentality provided by some of the mentees highlighted a lack of control and ambiguity about whether their performance as mentees would be rewarded by the organisation. That is, interviewees were not sure that their participation in the mentoring program would be rewarded by

the Australian Diabetes Educators Association even if these nurses met the requirements of credentialling. From Vroom's perspective, performance is deemed positively valent if an individual believes that it will lead to other outcomes (Pinder, 1992a, p. 92).

Mentee 2's experience of being mentored illustrates that, although she believes she has ticked all the right boxes to meet the organisation's requirements for credentialing, she still considers that she has little control over achieving this outcome:

> Mentee 2: 'But I tell you what, this process is enough to just put you right off. It really is. It's just... and the girl from... a woman really not a girl. A woman from [ ], she wasn't going to bother. We had to talk her into keep on going. But she's brilliant. So there are a lot of very, very clever people out there, very good educators, who've said, "it's all too hard, I can't be bothered to be a credentialled educator!"'

5.2.4 Valence

The valence of an outcome to these nurse mentors and mentees is described (rather than numerically scored) as the sum of the product of the valences of all other outcomes and their conceptions of its instrumentality for the attainment of other outcomes (Vroom, 1995, p. 324). That is, effective performance may constitute a reward as well as lead to a reward (Vroom, 1995, p. 230).

5.2.4.1 Valence of first degree outcomes

I measured the valence of the first degree rewards identified by the mentors and the mentees in the verbal reports they provided through their interviews (Vroom, 1995, p. 24). These first degree valences were the initial rewards identified by the study participants and were grouped together as conceptual clusters that I refer to as themes. These themes were: belonging, professional identity, technical currency, sharing knowledge, networking, professional

development and reflective practice. These themes are discussed in more detail below.

5.2.4.2 Belonging

While previous research has demonstrated that there is a correlation between the self-descriptions of student nurses and the self-description of registered nurses (Morrison, 1962), the findings from this study appear to imply that there is a relationship between the valence of an occupation to a person and the extent to which she perceives similarity between her own attributes and those of other members of the occupation (Vroom, 1995, pp. 85-86). However, as Arthur (1992) points out, if we are serious about the issue of the professional self-concept of nurses, we need to develop and refine instruments that will validly measure the self-concept of nurses (Arthur, 1992).

The mentee diabetes educators interviewed in this study appeared to be influenced by the motives and values of the mentor diabetes educators, in that mentees were willing to go to considerable lengths in order to be professionally recognised by their professional peers (Vroom, 1995, p. 102). Mentor 1 for instance gives the example of the impact that the introduction of compulsory continuing professional development points for all Australian nurses had on some of her colleagues. She explains:

> Mentor 1: 'People initially just, took the negative of it, on board. "Now I have to bloody, um, prove myself again." It's not about that. It's actually for yourself, it's for yourself to see, yeah, I'm getting the opportunity to do whatever, I only have to make 20 points annually and I can do them in all of these different areas and, gosh I never even thought of, going for points in such and such an area. You know, like we got a journal club started up at the hospital—it's because of the credentialling. But guess what? People are loving it and they're

> meeting with people who are of like mind too—and that's what mentoring is like to me.'

Mentee 1 expressed a similar view about the importance of developing a cultural shift to value the ongoing professional development of all nurses:

> Mentee 1: 'I think we should be mentoring our nurses, no matter what the background or the profession. You know, we should be mentoring them and guiding them and, and developing a culture where they know that it's OK to ask. It is OK to actually say "I'm not sure here, can I just run this by you or is there a better way to do this?" That it's not a fault or a failure.'

Previous research suggests that the valence of an occupation (e.g. of diabetes nurse educator) is directly related to the extent to which a person believes herself to have not only the attributes necessary for success in it (Vroom, 1995, p. 88). In addition, if a person has invested considerable time, money and post-graduate study in their chosen field, they are less likely to revoke that career choice even if the credentialling process is arduous (Vroom, 1995, p. 104). The experiences of Mentee 2 and Mentee 4 both support this perception:

> Mentee 2: 'Initial credentialing is just a nightmare! I mean I've been a diabetes educator now for 29 years and I've had to apply for initial credentialing because of, because of the Medicare thing.'

> Mentee 4: 'The 10 years' experience I'd had and most of it as a Clinical Nurse Consultant in diabetes education was completely disregarded when it came to re-entering the field after being at home with kids for seven years. And then, you know, to discover all the processes involved in credentialling. So I found it a, you know, I guess an irritation that the experiences I've had in the past weren't recognised.'

5.2.4.3 Professional identity

Professional identity in nursing is complicated, and nurses historically have struggled to define their work in parallel to other professions. However, it has been suggested that the identity of nurses is related to the social context of their nursing work (Willetts & Clarke, 2014). Social identity theory, for instance, argues that an individual's sense of self-worth is reflected in their evaluation of the groups to which they belong, and that the individual's level of respect within the group, rather than evaluation of the group as a whole, has an effect on the individual's self-esteem (Porter, Lawler III, & Hackman, 1991). Although I acknowledge that the professional identity of the self, self-esteem and self-efficacy are distinct concepts, there does appear to be an interconnectedness in the context of work groups (Bandura, 1997, p. 11; Lave & Wenger, 2005, pp. 152-153).

Studies using the Professional Self-concept of Nurses Instrument (PSCNI), developed by Arthur (Arthur, 1992) for the express purpose of exploring how nurses viewed themselves as professionals, suggest that although the majority of nurses start their nursing careers with 'normal' levels of self-esteem and a positive professional self-concept, they tend to leave nursing with below average self-esteem (Arthur & Randle, 2007; Randle, 2001). The descriptions some of the mentees gave of the process of becoming credentialled illustrated an undermining of their previously established and professionally acknowledged self-concept. These nurse mentees perceived the existence of a hierarchy of organisational social control:

> Mentee 3: 'So I just had to bite the bullet. You just have to do whatever the organisation [ADEA] requires and you just try and make the best of it. I wanted to be credentialled. I had no financial assistance from my employer [Medicare Local] to pay for the course [Graduate Certificate in Diabetes Education and Management or the Mentoring

> Program]. I paid it all myself and there was no time off but two study days and time for me to go and do mentoring with my two mentors.'

Research by the American psychologists Twenge and Baumeister (2005) suggests that individuals with inflated views of self and a strong motivation to garner the admiration of others exhibit strong negative reactions to social exclusion (Twenge & Baumeister, 2005). Such people are particularly prone to exhibit aggression in the wake of being rejected and are known to have hostile tendencies, which social rejection tends to bring out (Twenge & Baumeister, 2005, p. 41). These findings confirm the view that human beings are not only highly social creatures with a strong need to belong but that their cognitive performance is enhanced when they are provided with a rich and supportive social network (Twenge & Baumeister, 2005, p. 37; Twenge et al., 2007). This point is demonstrated by Mentee 4:

> Mentee 4: 'You know, probably early on in the credentialling program or re-credentialling really for me because I'd been out of the workforce. So, when I came back into the field I had to begin from scratch, achieving credentialling again. It took me three years because I was only working part time, 15 hours a week initially, to accrue the 1800 hours I needed. And, I was really reasonably um, resentful um to put it mildly when I discovered I had to also do the six-month mentoring program.'

However, with the support of her mentor, Mentee 4's perception of mentoring changed. Originally extrinsically motivated to participate in the mentoring in program, she then became intrinsically motivated:

> Mentee 4: 'You know once I shifted my attitude and realised, you know, how beneficial mentoring would be if I approached it the right way, you know I very much appreciated having to do the mentoring.

5.2.4.4 Technical currency

The nurse mentees in this study, who were typically in their midlife, initially were not enthusiastic to engage in mentoring relationships. However, as their relationship with their mentor developed it became evident that so did their proficiency in mastering technological change. An outcome of engaging in mentoring for these nurses appears to have been enrichment in their working lives:

> Mentee 4: 'You know insulin pumps weren't even around when I originally started back in the field in 2006. When I came back into diabetes education after seven years out, the pumps, that was the main thing I needed to get my head around, and I'd go and learn about pumps. But because I wasn't directly working with them it didn't matter how much education or sessions I went to, or information I read, I would still forget it because I wasn't applying that information at all. So, the best thing for me has been going to camps with diabetic kids. I went to our teenagers' camp on the Gold Coast with 40 teenagers with Type 1 diabetes. And that's been just fantastic for me, really, feeling, competent, and confident … dealing with pumps and pump adjustments and insulin you know, and working everything out. I didn't deal with that sort of knowledge. It was more the practical experience, really, through the mentoring.'

Improving their technical currency was not just an outcome for the mentees. Mentors spoke about learning as well, as illustrated by Mentor 1:

> Mentor 1: 'I really lifted my game as she [my mentee] had background experience in ICU [Intensive Care] and she was actually working in ICU part time at the same time she was working as a diabetes educator. So, I learnt a lot from her … Wow, that really lifted that part off for me too. So, it's a really mutual learning experience for me. [My

current mentee] works in the renal unit, so up goes my game in understanding a lot about renal nursing care.'

Another example of technical currency from Mentor 1 was the following:

Mentor 1: 'Like, when I went to the ADEA conference, I almost fell over at the number [laughs] of new meters that have come out just this year and how technical—the technology that's, out there right now. But it also makes me go, "Oh yeah, you don't put the plug in there, you put it over there!" [laughs] And you know I just ask my mentee "Do you mind if I ask you how to use them?"'

5.2.4.5 Knowledge sharing

Recent learning theorists suggest that conventional theories of how people learn were based on generic fundamental assumptions about the person, their world and their relations within that world. However, the concept of legitimate peripheral participation provides a framework for explaining the process of learning based on the concept that learning is an integral and inseparable aspect of social practice (Lave & Wenger, 1991, p. 31). Lave and Wenger argue that the theory of knowledge production in which the learner internalises knowledge—whether that knowledge is discovered, transmitted from others or experienced in interaction with others—is just one explanation for how people learn (Lave & Wenger, 2005, p. 150). Building on Vygotsky's concept of the zone of proximal development, Lave and Wenger propose that a learner's problem-solving abilities, and their learning, thinking and knowing are related to activity in, with and arising from their socially and culturally structured world (Lave & Wenger, 2005, p. 152).

Participating in this formal mentoring program provided these nurses with the opportunity to learn through their social interactions with one another as part of a nursing community of practice. Communities of practice as defined by

Lave and Wenger (1991) are groups of people who share a profession, have a passion for what they do and they learn how to do it better when they interact regularly (Lave & Wenger, 1991; Wenger, 1998). Communities of practice can be particularly useful in helping individuals become aware of the knowledge and skills of peers who perform the same or similar tasks within an organisation (Lesser & Fontaine, 2004, p. 17; Noe et al., 2015, p. 306). By creating a single place (either physical or virtual) where individuals can meet and interact with others, individuals can be exposed to likeminded practitioners (Lesser & Storck, 2001). As Mentor 3 explains:

> Mentor 3: 'It kinda depended on what it was that I felt I needed um which person I would actually go to. And whether they really knew it or not, they were all mentors. So I could have four or five at any given time, you know. So if it was a paediatric issue I would ring um kid's hospital. If it was an issue around management I would have somebody who I thought was good at managing who could help or advise me. I think because of the informal nature of how we actually ah connect with people I think [sigh] to get what we want.'
>
> Mentee 1: 'We did it as a group in actual fact because there was another two people that we all knew were doing [the mentoring program] at the same time and had all asked the same person. So we did it in almost a little group fashion. I caught up with her individually at times, but other times we actually had like little workshops where we all brought along something and had a coffee and a bikkie and a chat and so it was worthwhile. I did get stuff out of it.'

Lave and Wenger argue that through legitimate peripheral participation, the process of learning has the potential to be dynamic and ongoing (Lave & Wenger, 1991, p. 37). The peripherality that is enabled through the development

of mentoring relationships provides the mentors and the mentees with access to sources for ongoing understanding and involvement with the diabetes educator nursing community, as illustrated by Mentor 1:

> Mentor 1: 'So we do case studies from the hospital, from the community, from the aboriginal community, so Indigenous case studies. So it's different kinds with each session and then we also do journal club. So we also look at opportunities that are coming up, like professional development opportunities. So I would look at a case and I'd let the other person talk about the case and I'd say, "So what happened here for you? What did you think you could do better?" So looking at obstacles, gaps in learning experiences. And we always put a practice point at the end of the case study to say what we learned today.'

Practice theorists argue that in any community of practice, there is usually a process of community reproduction over time (Lave & Wenger, 1991, p. 56). In this study some of the mentees were initially seen as the learners but gradually these mentees took on the role and identity of their mentors, as illustrated by Mentee 1:

> Mentee 1: 'I hadn't worked within that health network before. And so [my mentor] helped me even with some of the logistics and the paperwork and the funding structures because I'd come from a different area and so they were all very new to me. She helped me with things like the choice of resources I used. And gradually over time that almost became a reciprocal relationship really. As I gained more confidence and more experience, and especially because I moved into the area of working with refugees and the homeless and the aboriginal community, she has said to me that she felt like I was

> mentoring her just because as your experience grows, your confidence grows.'

5.2.4.6 Networking

During the interviews some of the participants talked about their relationship with their mentor or mentee and how this enabled them to develop professional networks. This seemed to be an important outcome of the mentoring relationship as it promoted the development of professional networks that had the potential to provide ongoing support for not just the mentees but also for the mentors:

> Mentor 5: 'Now I think that it is quite an important element in the [mentoring] process because it does set up networks for people. Particularly new people coming into the area. I think it's a very important time for them to get those sort of people they can bounce ideas off. Particularly if they don't work in a team like we do here.'

Some of the mentees also talked about the importance of building professional relationships outside their formal mentoring dyad.

> Mentee 3: 'I not only had Mentor 1 as my mentor. Mentor 1 only offered me a certain amount so, I had to look at my mentor and say, "What are you offering me that I am getting that's useful? And what else am I missing? And then I went out, and got further mentoring by others.'

Research conducted by Higgins and Kram (Higgins & Kram, 2001) and Higgins, Dobrow and Roloff (Higgins, Dobrow, & Roloff, 2010) has demonstrated that the development of both informal and formal diverse mentoring networks is linked to shaping career outcomes. In this study evidence of the mentors or the mentees having diverse mentoring networks, and being aware of the importance such diversity, was identified by both

mentors and mentees. This was illustrated by an earlier quotation from Mentor 3 who said she 'could have four or five' mentors at any given, drawing on different mentors with different skill sets.

Mentor 3 and Mentee 2 also identified professional isolation as a problem they had experienced when they were working in a city or as part of a team. As demonstrated by their comments below, they developed other mentoring relationships so that they had a network of health professionals that they could consult for advice or guidance on a range of topics:

> Mentee 2: 'I absolutely miss being in bigger [diabetes] centres because I find I am professionally isolated. I find not having a team around me pretty difficult oh not difficult, I just miss it.'
>
> Mentor 3: 'You can imagine in a state like [Western Australia], which is geographically a third the size of Australia, and I was sitting there one day and I thought, well isolation is only the distance between my hand and the telephone.'

5.2.4.7 Professional development

The nurses in both phases 1 and 2 of the study made reference to how the relationship with their mentor or mentee related to the process of their professional development. Time and again the nurses commented, saying for example that the program was good for their reflective practice, helped them achieve their professional goals, increased their confidence in being able to provide education to their patients, improved their clinical expertise, improved their problem-solving skills, developed knowledge and clinical competencies, facilitated practice development, and increased learning and change management. It would seem from the perspective of these nurses that their own professional development skills were enhanced by their participation in mentoring relationships and that their learning and professional development

could not be separated from the social context in which the collaboration between the mentors and the mentees occurred. Mentor 3 interpreted the role of the mentor as a way to develop her professional self:

> Mentor 3: 'I think well professional development is really just about continuous learning and applying best practice principles, isn't it? That's my opinion and I think that having mentors, formal or informal, is what we should all have access to.'

5.2.4.8 Reflective practice

Engaging in mentoring made Mentor 4 more aware of the role reflective practice had in enhancing not just her professional practice but also her professional development:

> Mentee 4: 'So I guess that's how I used the mentoring, to really reflect on what I was ignoring because the work day just seemed too busy to take time to sit back and reflect on "what or where are my gaps?" and "what I need to be doing and how am I going to go about doing it?" And I think that's why I found the mentoring six-months experience so productive and worthwhile, because it really gave me time out to sit and look at what I was doing, how I was doing it where my gaps were and what I needed to do to fill those gaps.'

The mentoring experience was also perceived to be reflective of leadership:

> Mentee 1: 'I think mentoring, it's actually part of leadership. It's part of being a leader in nursing. To grow and develop other people and yourself in the process.'

> Mentor 3: 'So you know as a mentor you've got to think about not your circumstances but their circumstances where they're trying to develop their practice. It's interesting.'

Mentors observed that professional development and goal setting were not just the domain of mentees. Mentor 1 talked about her experience and what she thought of having to set goals for herself, rather than that she was there just for the mentee:

> Mentor 1: 'Mentoring is a reciprocated arrangement. When I had to fill in the documentation about it to say "these are my goals" and I realised this is what the other person's goals are. So it made me start to think about "what do I want to get out of this?" Where previously I would *never* have thought "what do I want to get out of this?"'

In the interviews for my study, the mentees and mentors talked about the importance of goal setting and the process of goal setting. However, in contrast to the outcomes of other studies, the mentors' and mentees' goals all appeared to be psychosocial in nature rather than career focused. This finding will be discussed further in the next chapter.

5.2.4.9 Valence of second degree outcomes

Using the expectancy model of motivation, I hypothesised that the choices made by the mentors and mentees among alternative courses of action would depend on the relative strength of their motivational forces. The nurse mentors indicated that the motivational forces that induced them to engage in formal mentoring were generally intrinsic in nature, such as a desire to see the mentees grow as professionals.

5.2.4.10 Professional growth

> Mentor 3: 'You go into mentoring to learn. You don't go to, to do anything but that. And then maybe what you can do is tweak things a little so that people have, you know, a bit of a broader view or, you know, some ideas around how to access what they need or do things slightly differently. And I think that that's what mentoring is, it's

> giving people a bit broader view or some ideas about how to access, what they need or do things slightly differently. It's really the novice to expert stuff, isn't it? You know, so as a novice we have a theory, but then applying it isn't that easy.'

Mentors were motivated because they felt the need to achieve, particularly when they felt the task was difficult and challenging. For example, the mentors expressed the view that mentoring was time consuming but they still did it:

> Mentor 5: 'It certainly is time consuming, there's no doubt about that. But I don't think there's any easy way out of that either. I think it's an important process. I still think it is. It's just the time factor. But you know you learn to structure it so that you both can fit that in, and if it's important to [the mentees], sometimes it's after hours, just when the phones stop ringing, you can actually sit and talk about something.'

They also stepped up to the challenge, performed at a higher level, when they believed that mentoring required abilities that they valued or believed themselves to possess:

> Mentor 4: 'So I was asked to be a mentor for three different people. One a colleague that, um, sort of works, in the [Clinical Nurse Consultant Grade 1] role who works in a different institute. And then ah, another CNC1 who also works in another institute, and then another one that's only needing to be re-credentialled because she'd gone out of the workforce to have a baby. And I think it went quite well because we managed to complete it in the timeframe and I managed to get those two, the initial two mentees I'd done first, up and running and credentialled and was successful on that. So that's good.'

Mentor 1 found the mentoring experience so rewarding and beneficial for her own professional development that she chose to continue mentoring after her mentee completed the program and moved on:

> Mentor 1: 'When my initial mentee left, I was working alone for a couple of months. Then Sally [not her real name] came on board and I thought, she's a new grad, here is a perfect opportunity to carry forward mentorship. Not knowing whether she was going to go for credentialling or not didn't come into it. So, I just kept it going!'

Engaging in a mentoring partnership is argued to offer the opportunity for mentees and mentors to provide positive role models in a reciprocated relationship (Hudson, 2013). However, mentors do not always have all the answers, as explained by Mentor 5:

> Mentor 5: 'I've had people contact me for instance who want to do stuff around insulin pumps and I've thought, ugh don't ask me cause I can't—I haven't got that sort of expertise. But I can give you people's names who would be far better qualified than me to do that with you. So, I think that it's important to know your own limitations as a mentor as well.'

5.2.4.11 Credentialling, clinical nurse consultant status, Medicare swipe

For the mentees, the motivational forces that induced them to engage in mentoring were to enhance their professional development through the achievement of credentialling, clinical nurse consultant status (either grade one, two or three) and eligibility for the allocation of a Medicare Australia Provider Number. The valence or achievement of the first degree outcomes was necessary in order for the mentees to achieve the valence of the second degree outcomes.

5.3 Conclusion

In this chapter, I have presented the results from phase 2 of the study. The chapter has provided an overview of the processes undertaken to complete the study within a hermeneutic phenomenological framework. The expectancy theory of motivation has been used to better understand what motivated these Australian nurses at various stages of their careers to engage in formal mentoring and to find out whether they perceived there was a relationship between mentoring, motivation and their ongoing professional development.

The outcomes from participating in this formal mentoring program identified by the study participants were the following:

- Professional Development: Both the mentors and the mentees responded that participating in formal mentoring enhanced their professional development. Outcomes from mentoring were improved reflective practice, achievement of professional goals, increased confidence in being able to provide education to patients, improved clinical expertise, improved problem-solving skills, development of knowledge and clinical competencies, facilitated practice development, and increased learning and change management.
- Professional identity: The findings from the study supported the theory that the professional identity of these nurse mentors and mentees was related to the social context of their nursing work and was reflected in their motivation to participate in mentoring.
- Belonging: The study demonstrated that there was a correlation between the diabetes nurse educator mentees' perception of their attributes, motives and values and the attributes, motives and values of their mentors. In order to belong the mentees were willing to go to considerable lengths to be recognised by their professional peers.

- Knowledge Sharing: Participating in formal mentoring provided these nurses with the opportunity to learn through their social interactions as part of a community of practice. While the mentees were initially seen as the learners they gradually took on the role and identity of their mentors in that they became the teachers. The sharing of knowledge between the mentees and mentors was reciprocated.
- Goal setting: Setting clear, specific, measurable, achievable, time framed goals was seen as an important element in the success of this formal mentoring program. Developing an understanding of how to set clear goals and also being given the latitude on how to achieve their goals enhanced the mentees motivation to participate in mentoring. Goal commitment was also demonstrated to enhance goal attainment.

In the next chapter, I discuss the results in light of the study's research questions, literature review, and conceptual framework. Overall, this chapter offers the reader an opportunity to reflect thoroughly on the study's findings, and the practical and theoretical implications thereof. ■

Chapter 6

Discussion

6.1 Introduction

This research was designed to answer three questions, reviewed in chapter two:

1. What motivated diabetes nurse educators to engage in formal mentoring relationships?
2. Does engagement in formal mentoring relationships contribute to nurses' professional development and if so in what ways?
3. If mentoring does not contribute to nurses professional development, why not?

This chapter discusses the key findings in response to these questions, based on the analyses of data from the research questionnaire and follow-up interviews. In the discussion I bring together the themes that emerged in the nurses' expressions of their motivation to engage in mentoring and my interpretation of the essential aspects of Australian nurses' mentoring experiences.

In addressing the research questions, I draw on Vroom's (1964) expectancy theory of motivation to describe the lived experience of motivation to mentor. I argue that a way of being in the world for these diabetes educators. I draw on the philosophical framework of Heiddegerian hermeneutics (Gallagher, 1992) to reveal and understand the research participants' journey of becoming professional nurses. I also discuss the meaning and interpretation of the language these Australian nurses used to express the emerging themes and I

position each theme in light of the literature to further elucidate meanings and understandings.

From the thematic analysis I show that credentialling was the principal catalyst, an extrinsic motivational force, for the nurse mentees to engage in a mentoring relationship. For the nurse mentors', I argue that their behaviour was motivated by intrinsic motivational forces. Their decision to engage in a mentoring relationship as mentors was an outcome of a career journey that included a myriad of life experiences that contributed to them wanting to help the next generation of nurses.

6.2 Interpreting the results in light of the expectancy theory of motivation

6.2.1 Introduction

Vroom theorised that the source of motivation is a multiplicative function of valence, instrumentality and expectancy. He argued that if the components of expectancy, instrumentality, or valence are not present, then individuals will not be motivated (Pinder, 1992a; Porter & Lawler III, 1968; Rynes & Gerhart, 2000; Stecher & Rosse, 2007; Vroom, 1964). Figure 6.1 summarises Vroom's model.

Applying Vroom's model, we would anticipate that, for mentoring programs to effectively motivate nurses to participate in formal mentoring programs, those programs would need to demonstrate equally all of the components of the model (Forsyth & McMillan, 1991; Malouff & Sims, 1996).

It would appear from the literature reviewed in chapter two that previous descriptive research studies conducted using the expectancy theory of motivation model placed a strong focus on the perceived relationship between expectancy and valence, with little emphasis on the measure or contribution of

instrumentality (Carmichael & McCole, 2014). The findings from this study, however, have identified a gap in the relationship process between performance output (instrumentality) and performance outcome (motivation), as I explain in the following sections.

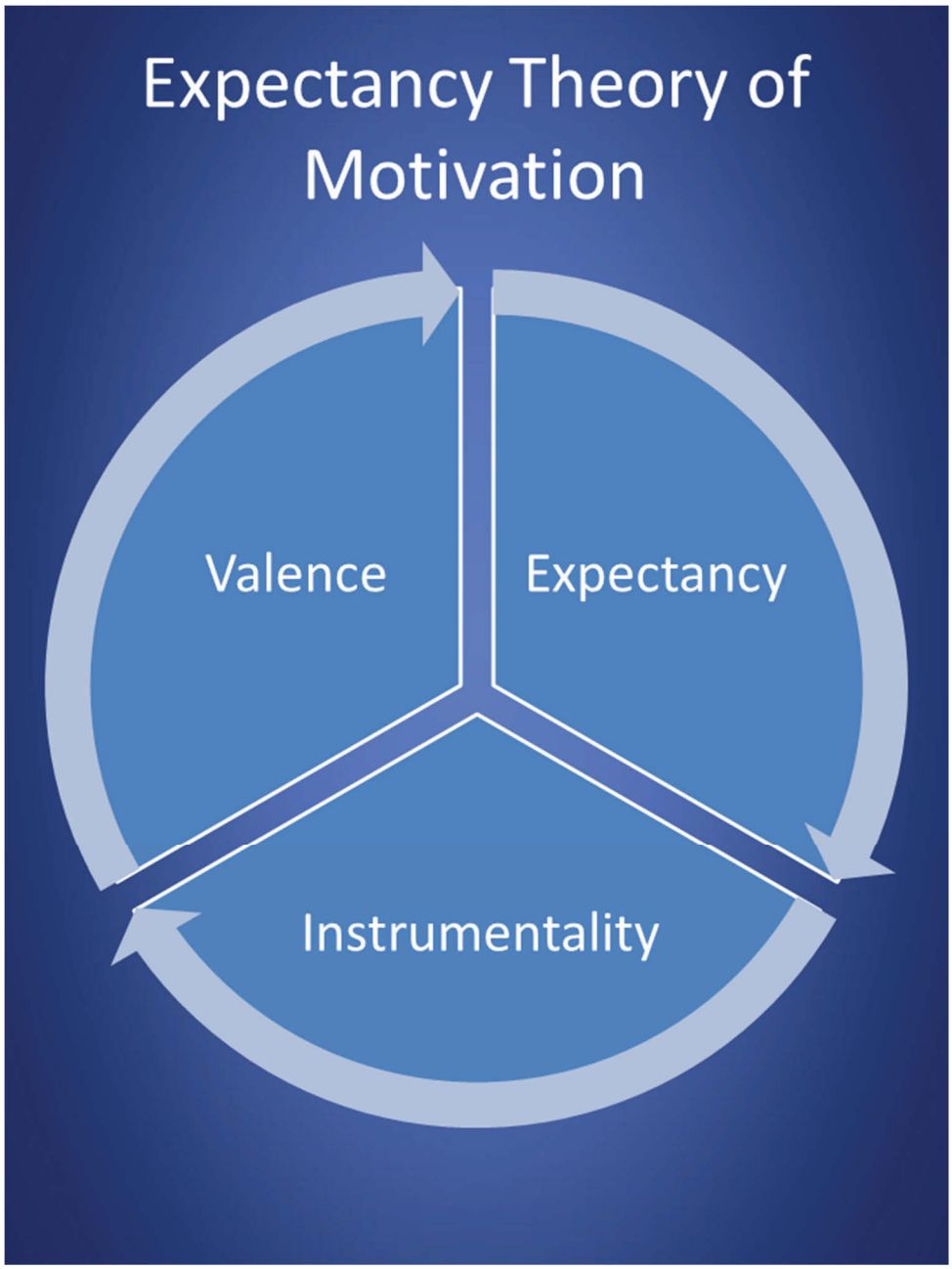

Figure 6.1: Components of Vroom's expectancy theory of motivation (Vroom, 1964)

6.2.2 Instrumentality

For instrumentality to be a motivating factor, mentors and mentees need first to believe that if they participate in mentoring they will receive the perceived reward, in this case achievement of credentialling status. However, they also need to be provided with environmental supports such as education and training in how to mentor, access to electronic paperwork with version control and allocation of time to mentor (Jackson et al., 2015; Kendall-Raynor, 2013; Robinson et al., 2012a). The findings from this study showed a perceived lack of support for nurses to become credentialled

> Mentee 2: 'The paperwork is ridiculous and it's so... my whole experience of trying to become credentialled again, it's like they don't want people to be credentialled.'

The motivational force of credentialling lacked consistent expectancy because the nurses did not believe that participating in the mentoring program would result in credentialling. Individuals tend to be motivated when they can see that their actions will result in the achievement of their desired outcome (Holdford & Lovelace-Elmore, 2001).

6.2.3 Expectancy

As discussed in chapter five, expectancy for these nurses was their belief that their effort would result in the attainment of their pre-defined goals. The study demonstrated that mentees were motivated by the potential to achieve professional credentialling status. They were motivated to legitimise their learning and attain 'the bit of paper' that made them eligible to apply to the Australian Government for the allocation of a Medicare Australia provider number.

Healthcare providers who have been allocated a Medicare Australia provider number are able to be financially reimbursed by the Australian

Government for services provided to their patients (Australian Government Department of Health, 2014). From an economic perspective this means that these nurses have the option and the professional capacity to work in the Australian public health care sector or in private practice as Diabetes Nurse Educators.

The motivational forces that inspired the mentors to engage in mentoring tended to be intrinsic in origin. Mentors were motivated by the desire to belong, to be helpful and to contribute to the professional development of other members of the nursing profession.

> Mentor 4: 'Well it was certainly, um, lovely recognition of being someone that, that could be helpful … In a way it was a privilege to be asked to be a mentor.'
>
> Mentor 5: 'For me, is seeing them grow as professionals … I think it's being able to help people develop.'

However, at the core of the expectancy theory of motivation model is the cognitive process of processing or aligning different motivational elements. For the nurses in this study this process was influenced by their perceived level of self-efficacy, their belief about the difficulty of achieving their goals and their general perception of how much control they had over achieving their desired outcomes.

6.2.4 Valence

The valence of outcomes for these nurses can be correlated with their motives and their conceptions of the instrumentality of participating in this mentoring program to attain the desired outcomes. The mentors' performance was motivated by intrinsic values rather than the extrinsic values which motivated the mentees. Hence, with a demographically diverse workforce such as nursing,

it is misleading to believe that all employees will be motivated by the same rewards (Lunenburg, 2011).

Although neither the mentors nor the mentees identified money as a motivator for participating in mentoring, there is an indirect correlation between being credentialled and the potential for promotion to the role of Clinical Nurse Consultant at grades one, two or three, or entry into the domain of private practice or academia. Previous research has often indicated wages as a determinant of effective performance, i.e. an increase in wages is an almost universal inducement for individuals to perform work (Adams & Rosenbaum, 1962; Awases et al., 2003; Feldman & Arnold, 1978; Met et al., 2015, p. 192; Whitely et al., 1991; Zedeck, 1977). However, money as a motivating factor was not mentioned by the diabetes nurse educators in this study.

Although fiscal incentives alone are not enough to motivate health workers, it is clear that recognition is highly influential in health worker motivation (Franco, Bennett, & Kanfer, 2002) and that adequate resources and appropriate infrastructure can improve morale significantly (Willis-Shattuck et al., 2008). It may therefore be advantageous for the Australian Diabetes Educators Association to highlight to its members that being credentialled has the potential to enhance career progression, with the strong possibility of also increasing monetary rewards. Future studies could also explore further the relationship between fiscal rewards and motivation to mentor.

6.3 Motivation to mentor

6.3.1 Introduction

The following section discusses the role that nursing identity and nursing culture had on the ongoing professional development for the nurses in this study and how it influenced their motivation to engage in formal mentoring.

Participating in mentoring as mentors and or mentees was a transformative process for these nurses, influenced by their nursing culture, their wanting to help other nurses' and this was reflected in their responses as to what motivated them to engage in mentoring.

6.3.2 Being a nurse

Although there are many definitions of what it is to be a nurse (International Council of Nurses, 2014; Nursing and Midwifery Board of Australia., 2010), my role as the researcher in this study was to interpret the participants' perceptions of what it was to be a nurse, the mode of being a nurse. The following motivators reflect the meanings and characteristics these nurses ascribed to their nursing identity.

6.3.3 Nursing career identity

For the mentors and mentees in this study, their nursing identity was a powerful motivator for participating in mentoring. For example, the majority of the nurses commented that they would be willing to act as mentors again. They and frequently described their motivation for mentoring in terms of 'being helpful', 'wanting to help' or to 'help nurses develop as professionals'.

Career identity has been found to be one of the top three factors in why individuals are motivated to channel their energy, behaviour and performance toward a specific set of career objectives (London, 1983, 1993). Research suggests that organisations can contribute to career identity by providing opportunities for self-development, advancement, and mentoring (Quigley & Tymon, 2006).

6.3.4 Nursing organisational culture

A nurse not only has an identity and relationship with herself but she also develops a relationship with the people around her and also with her environment. As Heidegger puts it: 'Being-in-the-world, the world is always the one that I share with others' (Heidegger, 1962, pp. 154-155).

The world of these diabetes nurse educators is their nursing environment, the everyday world that they are closest to and familiar with. The term 'world' refers to a 'meaningful set of relationships, practices, and language that we have by virtue of being born into a culture' (Leonard, 1989). Another way to capture this idea is to say that what I do is determined largely by 'what one does', and 'what one does' is something that I absorb in various ways from my culture (Dreyfus, 1990).

Culture may be defined as 'the way we do things around here' (Adams, 2015, p. 8; Gray, 1998). However, Meyerson and Martin (1987) argue that no organisation has a single, monolithic, dominant culture (Meyerson & Martin, 1987). Instead, a culture is composed of a collection of values and manifestations, some of which may be contradictory. For example, espoused values may be inconsistent with actual practices (Hofstede, 1993). Complex organisations reflect broader societal cultures and contain elements of occupational, class, racial, ethnic, and gender-based identifications. These sources of diversity often create overlapping, nested subcultures inconsistent with each other. Individuals may share some viewpoints, disagree about some, and are ignorant of or indifferent to others (Sackmann, 1991). As illustrated in figure 6.2 being a nurse is influenced by the individual's beliefs and values, their social identity, their nursing identity and their cultural identity all of which contribute to what it is to be a nurse.

One of the most important factors influencing the nurses' motivation to engage in mentoring was their perception of nursing culture: their belief that other members of the nursing community shared their assumptions (Cleland, 1994). These assumptions consisted of beliefs about their world and how it works and the ideals that they thought were worth striving for (Rokeach, 1968).

The cultural climate of an organisation arises from the perceptions of the people who work in the organisation (Timm & Peterson, 1982, p. 101). The cultural orientation of any organisation will have implications for the people working in it (Hofstede, 1993; Noe et al., 2015, p. 684). The mentors' and mentees' comments illustrated a conflict in how they viewed the organisation's culture:

> Mentee comment: 'I would not have felt comfortable making any complaints if the mentorship was not working appropriately either to the Australian Diabetes Educators Association or to my mentor'.
>
> Mentor comment: 'Suggest the Australian Diabetes Educators Association Board look at developing an accreditation program for Mentors. Not all credentialled Diabetes Educators make good mentors'.

6.3.5 Nursing cultural changes over time

The concept of nursing culture is closely interwoven with the values espoused by the nursing community and these can change over time (Suominen, Kovasin, & Ketola, 1997). Older members of the nursing profession were likely to have been initiated into a nursing culture that was developed based on the military model. These nurses would have tended to act as part of a nursing collective that reflected aspects of Hofstede's cultural dimensions model (Hofstede & Minkov, 2010). The military model, which essentially transferred into the 'command' workplace model, is about hierarchies and taking and giving orders, and was often associated with nuns and nurses (Cox, 1996, p. 149).

However not all nurses today accept that the military model, being told what to do, motivators all nurses to engage in mentoring. This point of view is illustrated by the following comment:

> Mentee 2: 'Mentoring should be a reciprocated sort of arrangement but having to do it; it's almost like a slap in the face as I couldn't see the purpose.'

However not all mentees shared this point of view. The following nurse mentee perceived nursing culture as one where it is acceptable to not have all the answers:

> Mentee 1: 'I think we should be mentoring our nurses and guiding them and developing a culture where they know that it is OK to ask. It is OK to actually say I'm not sure here or can I just run this by you. It's not a fault or a failure.'

From a cultural perspective younger nurses are more likely to be abused by more senior nurses (Rowe & Sherlock, 2005), and mentees who had previously held leadership positions with the Australian Diabetes Educators Association perceived that they were not supported by the current women executives in the organisation in their pursuit of credentialling.

While cultural stereotypes are rarely entirely reliable for recognising potential problems of cultural misunderstanding, an awareness that in some cultures individuals are unwilling to spend personal time on work may be advantageous when trying to motivate individuals to participate in future mentoring programs:

> Mentee comment: 'I had no financial assistance from my employer (Australian Government Medicare Local) to pay for the course (Graduate Certificate in Diabetes Education and Management or the Mentoring Program). I paid it all myself. There was no time off but two study days.'

Comments like this one appear to suggest a conflict over whose responsibility it is to provide opportunities for education and training, that of the collective or the individual (Hofstede, 2011).

6.3.6 Building a positive nursing culture

The best clue to how to motivate individuals from different cultures along the nursing spectrum may be to first identify what rewards have high valence for them (DuBrin, 2014, p. 466). Providing meaningful work, the feeling of doing work that matters or makes a difference, particularly work that has an impact on society, is a key motivator of worker engagement (Chaudhary, Rangnekar, & Barua, 2012; Cranston & Keller, 2013; Thomas, 2009).

Transforming nurses into individuals who have a secure sense of their identity, meaning, and reality through participating in practices such as mentoring has the potential to be empowering (Clark, 2008). Empowering individuals to use their personal initiative can instil in them a belief in themselves, making them feel more highly valued and passionate about their work, with the potential to be able to derive a more rewarding experience from their work (Cilliers, 2005; Rogers, Meehan, & Tanner, 2006).

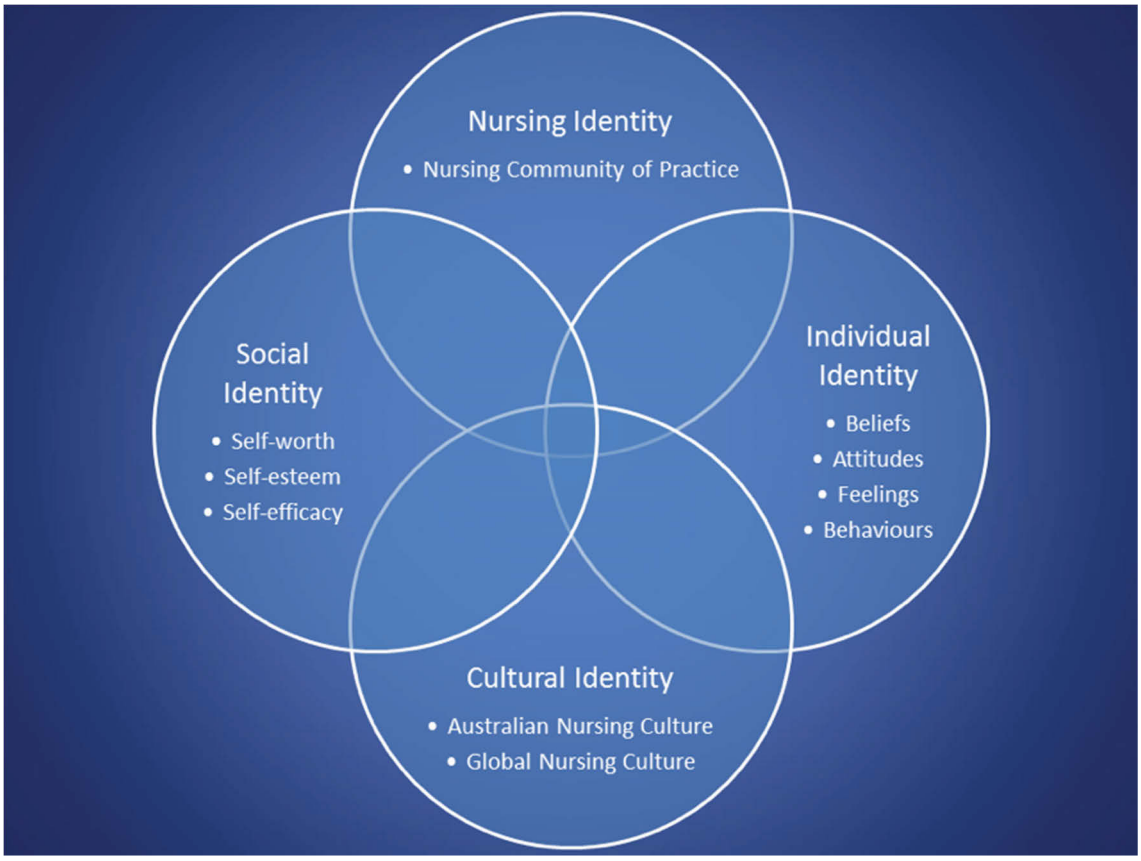

Figure 6.2 Contributors to being a nurse

6.4 Being a professional

6.4.1 Introduction

The following section discusses some of the tensions around the ongoing professional development of nurses. These include for example the ageing nursing workforce and the challenges associated with continuing to learn as nurses age. I then discuss the concept of self-efficacy and the potential impact a positive self-efficacy has on improving nurses' motivation to continue to engage in professional development activities throughout their careers.

Nurses who aspire to be professionals, to have a professional identity, develop the attributes of a professional within the social context of their daily nursing work environments (Chenoweth & Lo, 2001, p. 10). By promoting the principles of lifelong learning through engaging in activities such as critical

thinking and reflective practice, diabetes nurse educators have the potential to enhance their professional development (Wolf & Morgan, 2011). In nursing practice, reflection has been recognised as a means to help nurses develop professionally by reflecting on and learning from past experiences (Bagay, 2012).

6.4.2 Nurses and reflective practice

Using reflective practice, for example by listening to nurse mentees lower down in the organisation, makes good business sense as these more junior nurses may provide ideas for new ways of doing 'things' (Noe et al., 2015, p. 99). The mentoring process has the potential to facilitate communication throughout the Australian Diabetes Educators Association, and it is this communication that allows for ideas from the mentees, effective emergent strategies, to make their way up to the Australian Diabetes Educators Association executive. The following comment suggests both the role and challenges of reflecting on practice:

> Mentee comment: 'The mentoring program is incredible in supporting the development of Professional Standards within the field of Diabetes Education, however we probably need to consider a more interactive process e.g. PPT with audio or webinar (videoconference and recorded).'

Feedback from the nurses at the grass roots of the organisation can be a source of competitive advantage by developing a pool of human capital that gives the Australian Diabetes Educators Association the unique ability to adapt to the ever-changing health care environment. As more organisations become knowledge based, it is important that they promote a continuous learning philosophy at the employee, team and company levels. This philosophy needs to focus on performance that supports the goals of the organisation (Noe et al., 2015, p. 289).

6.4.3 Nurses and lifelong learning

A learning organisation embraces a culture of lifelong learning, enabling all employees to continually acquire and share knowledge (E. Husserl, 1980b; Noe et al., 2015, p. 23). Improvements in service quality do not stop when formal training is completed (Senge, 1991). Encouraging nurses to engage in mentoring relationships that are 'professional friendships' can assist in their professional growth (Lee, 1988, p. 102), and this is applicable to nurses at all stages of the nursing career spectrum (Lee, 1988, p. 67).

Providing opportunities for nurses to continue their ongoing education has been demonstrated to be advantageous to healthcare organisations (Mutale, Ayles, Bond, Mwanamwenge, & Balabanova, 2013). One of the major benefits of studying as a mature-age student is that the positive outcomes are often greater than those gained from studying at an earlier stage. Mature adult learners have been found to be proactive, highly motivated and committed (Swain & Hammond, 2011).

Although individuals participate in ongoing education and training for different social and cultural reasons, the value of participating in education is often strongest when associated with collective identities. Awareness of this may be potentially advantageous for nurses who identify as being a part of a nursing community (Fevre, Rees, & Gorard, 1999; Swain & Hammond, 2011). Similarly, nurses undertaking post-registration study not only 'keep up' professionally; they are also receive more respect at work (Cooley, 2008). This benefit could be promoted as a motivator to encourage more diabetes nurse educators to participate in workplace mentoring.

6.4.4 The ageing nursing workforce

Ageing Australian nurses, whether Diabetes Nurse Educators or Generalist Registered Nurses, who cannot demonstrate participation in current

professional development activities, are not able to guarantee Australian health consumers that they can provide an acceptable standard of clinical care (Australian Nursing and Midwifery Council, 2012, pp. 4-5; Henderson, Schoonbeek, & Auditore, 2013).

Although population ageing in Australia is largely a positive outcome reflecting improved life expectancy, the ageing of the Australian workforce is an issue of vital importance. Population growth and ageing will affect labour supply, including of the nursing workforce, economic output, infrastructure requirements and government budgets (Harris et al., 2013). Globally, already one in four workers is over the age of 50 (Naegele & Walker, 2011, p. 253). However, it is not the age of Australian workers that is the strongest predictor of worker ability. Rather, it is the culture of an organisation coupled with worker satisfaction mediating this relationship (Palermo, Fuller-Tyszkiewicz, Walker, & Appannah, 2013).

As a result, it makes good business sense to promote a nursing culture where older nurses feel valued (Fitzgerald, 2007; Stanley, 2010, p. 850). This could be achieved by providing opportunities for these ageing nurses to act as mentors. Mentoring has been shown to reignite older workers' sense of purpose (Smith-Jentsch, Fullick, & Bencaz, 2012, p. 58).

Nurse mentors who are in the latter years of their own professional careers have previously stated that mentoring is a strategy that provided them with the opportunity to nurture and support others (Jackson et al., 2015, p. 6). Older nurses who have reached a career plateau may find acting as a career role model to mentees to be intrinsically satisfying. Although, in one sense, intrinsic motivation exists within individuals, in another sense intrinsic motivation exists in the relation between individuals and activities (Ryan & Deci, 2000, p. 56).

6.4.5 Ageing and resistance to learning

In the early days of these ageing nurses' careers, the organisations they worked for would have been responsible for their career development (Hopkins Kaoanagh, 2012, p. 59). However, this trend has changed, putting the onus for career development and progression on the individual (Hall & Moss, 1998). However, when a person's attitude toward their career reflects a sense of calling in their work, such as demonstrated by some of the nurse mentors in this study, these workers tend to be motivated to mentor because mentoring provides them with a sense of purpose that gives a deep meaning to their work and to their careers (Hall & Chandler, 2004)

Careers these days tend more than in the past to reflect the individual's personal values, and this is associated with an expectation that employees make the choice to engage in self-directed learning (Briscoe & Hall, 2002). According to this view, Quigley and Tymon argue that the benefits to the individual are that they will be intrinsically motivated to manage their own career (Quigley & Tymon, 2006).

While this may be true, changes in occupational activities are occurring so rapidly these days that individuals, including the ageing nursing workforce, will require a high sense of personal efficacy and versatility to meet these vocational changes (Bandura, 1997, p. 447). Access to and competence in using internet based technologies has been demonstrated to enhance the status and confidence of older persons (McConatha, 2008). Participating in a reciprocated mentoring relationship may provide the opportunity for older nurses to develop these skills.

For most people, however, learning new things is associated with anxiety (Converse, 2012). Anxiety comes from being afraid to try something new for fear that it will be too difficult, that we will look stupid in the attempt, or that we will have to part from old habits that have worked for us in the past. Learning

something new can cast us as the deviant in the groups we belong to. It can threaten our self-esteem and, in extreme cases, even our identity. Research suggests that you can't talk people out of their learning anxieties; they're the basis for resistance to change. Motivating people to 'unlearn' what they know and learn something new is challenging (Schein, 2010, p. 301). However, a high sense of efficacy and efficacious adaptability has the capacity to foster innovativeness (Goldstein, 2009).

Providing positive verbal reinforcements to the mentors and the mentees during the mentoring process, rather than only at completion of the program, has the potential to increase their intrinsic motivation (Allen, 2003; Deci, 1992; Deci & Casio, 1972).

If nurses are to develop motivation to change, they need to be provided with an element of psychological safety. That is, they need to be able to see a possibility of solving the problem and learning something new without loss of identity or integrity. The higher a nurse's age or years of practice, the less likely she is to intend to return to 'school', citing as reasons that it would be intimidating and the cost would be prohibitive (Romp et al., 2014). In Australia, motivation to undertake tertiary education has been shown to be very much related to individual choices driven by social, educational and labour market factors (Fredman, 2014).

6.4.6 Ageing and self-efficacy

While studies conducted on young people have demonstrated that their beliefs about their abilities and their expectancies for success change over time, research into whether this is applicable to individuals as they age is more limited (Meece, Wigfield, & Eccles, 1990; Wigfield & Eccles, 2000). It is generally argued that a declining sense of self-efficacy, stemming more from disuse and undermining cultural practices than from biological ageing, can set in motion a

negative spiral of self-debilitating appraisals that result in diminishing cognitive and behavioural functioning (Bandura, 1997, p. 211), as illustrated by the mentors' comment below:

> Mentor 1: 'A lot of the nurses in the hospital in that older age group too with the introduction of credentialing for general registered nurses, I know some have quit their hospitals because they don't want to—they can't figure out how they would ever possibly come up with 20 professional credit points a year. I mean that is so easy. However, they just feel that they can't do it! But I also think maybe they [the organisation] could have like, maybe not mentoring but some kind of thing, in place for them to develop the confidence to know that they can easily pick up 20 points a year.'

However, individuals create and develop their self-efficacy beliefs from varied sources (Pajares, 1997) and providing positive feedback has been demonstrated to not only improve a person's self-efficacy but also to enhance their problem-solving skills (Bouffard-Bouchard, 1990). Engaging in mentoring relationships has the capacity to support the transition of individual mentees from one developmental stage of their careers to the next (Chandler & Kram, 2005).

6.5 Being Motivated

6.5.1 Motivation and self-efficacy

The importance of having high expectations for motivation meshes well with the contribution of self-efficacy (Bandura, 1991; Ormrod, 2006). If individuals have a high self-efficacy about a task, their motivation will be high (DuBrin, 2014, p. 317). For example, diabetes nurse educators need to feel confident of their ability to carry out the specific tasks asked of them.

The impact of a positive self-efficacy has been demonstrated to be advantageous for improving the motivation and work-related performance of individuals (Bandura, 1997, p. 24; Cherian & Jolly, 2013). For example, doctors with a high sense of self-efficacy were found to be much more likely to be motivated to participate in continuing medical education than those with low self-efficacy (Williams, Kessler, & Williams, 2014). Hence, encouraging diabetes nurse educators to engage in mentoring has the potential to improve their self-efficacy, thereby potentially motivating them to participate in other continuing nursing education initiatives.

An individual's commitment to their career has also been found to be associated with their ability to link their motivation to their performance levels. An antecedent to this motivation is self-efficacy (Morrow, 1993). This is important as a career is not only a source of income for the individual but also activity that presents a great deal of occupational meaning, continuity as well as ensuring employment security (Aryee et al., 1994). This was illustrated by these diabetes educator nurse mentors and mentees.

6.5.2 Motivation and mentoring

In general, people with a high self-efficacy are more likely to make an effort to complete a task, and to persist longer in those efforts, than those with low self-efficacy (Bandura, 1993; Schunk, 1990). To successfully achieve the desired outcome, individuals must possess the necessary skills as well as a buoyant self-belief that they are capable of controlling the specific situational factors (Bandura, 1989). When feedback shows that they are not reaching their goals, people with high self-efficacy are more likely to respond with renewed effort (expectancy) by developing more successful strategies (Smith-Jentsch et al., 2012).

When individuals participate in mentoring programs, their self-efficacy and intrinsic motivation has been found to be enhanced (Bear & Hwang, 2015; Jordaan, 2014) if they choose the right mentor:

> Mentee 4: 'And so, when I approached her to be my mentor there were different levels that drew me to her. Her standing with the ADEA was certainly high on my list because I just knew she would be very professional, she would do everything, the right way and therefore, I would have a mentoring experience that was, you know, as good as you could get.'

Choosing the right mentor, a mentor who brings a range of personal and interpersonal skills, who is willing to be involved in the process of mentoring over whatever period of time it takes, is advantageous (Dyson, 2015, p. 91). A good mentor displays acceptance for the person they are working with and, most importantly, shows empathy for the other as they help their mentee find solutions and continue in an ongoing transformative learning process (Mezirow, 1991).

Individuals who are willing to take on the role of mentors have been shown to demonstrate a range of desirable behaviours, such as being more cooperative with others, and a willingness to go above and beyond typical work demands to help others in the workplace (Finkelstein, 2006; Thurston et al., 2012). Other behaviours include the roles of modelling, communication of expectations, task assignment, skill development, reward contingencies, goal setting and feedback to mentees, all central to motivation and achievement-related theories (Bandura, 1986; West & Thorn, 2001). Bandura's self-efficacy theory has the potential to contribute to answering this study's research questions: What motivated diabetes nurse educators to engage in formal mentoring? And whether and how this contributed to their professional development? Figure 6.3 applies Bandura's model to interpret the results from this study.

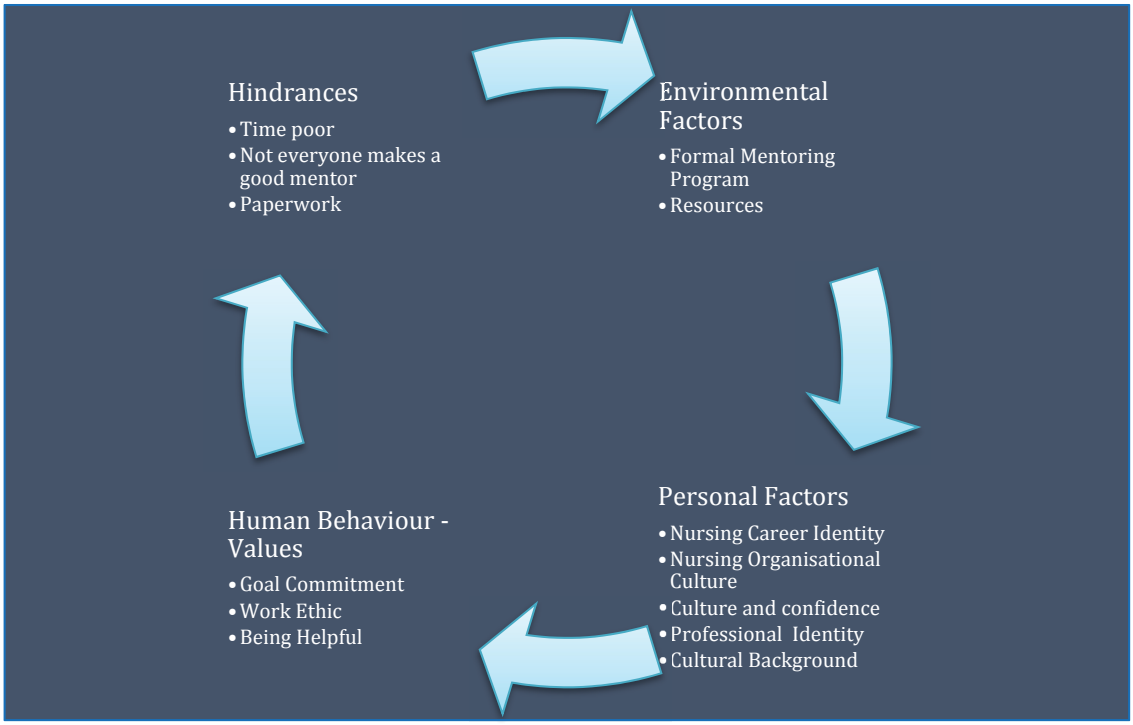

Figure 6.3 Application of self-efficacy and social cognitive theory to nurses' motivation to mentor for their professional development
Source: modified from triadic reciprocal determinism (Wood & Bandura, 1989)

6.6 Conclusion

In this chapter I have discussed the results in light of the study's research questions, literature review, and conceptual framework. I have argued that mentees tended to be motivated by the extrinsic factor of credentialling, while mentors were intrinsically motivated, demonstrating a strong desire to help the next generation of nurses to learn whilst also acknowledging that their mentees contributed to their own ongoing professional development.

Applying the expectancy theory of motivation to the data led me to argue that addressing the gap in instrumentality may enhance Australian diabetes nurse educators' motivation to mentor.

In chapter seven I consider the implications of the answers to the research questions in light of Vroom's expectancy theory of motivation model and the

current practice of formal mentoring. Chapter six also presents conclusions and makes a series of recommendations designed to apply the findings to improve mentoring programs. Chapter seven ends with suggested directions for further research in this field. ■

Chapter 7

Conclusion

7.1 Introduction

This concluding chapter is intended to demonstrate how this research makes a contribution to better understanding the motivation to engage in formal mentoring for the ongoing professional development of nurses. The chapter presents answers to the research questions introduced in chapter one. In this chapter I consider the implications of these answers within the framework of Vroom's expectancy theory of motivation. I also present conclusions and recommendations dealing with how the study findings might be applied in practice and suggesting how further research could contribute to our understanding of the principles of lifelong learning.

The research literature presented in chapter two suggested that a commitment to ongoing professional development is as an important preferred outcome of formal mentorship program participation (Clutterbuck & Megginson, 1999; Coombs-Ephraim, 2016; Freidson, 1994; Kram, 1988). However little evidence was available to explain what motivated nurses at various stages of their careers to engage in formal mentoring relationships and what impact—if any—participation had on their ongoing professional development.

Research indicates that there have been many positive outcomes as a result of mentorship. Mentoring has contributed to higher career satisfaction (Hart, 2009), augmented professional identity and increased self-confidence (Kram, 1985), enhanced professional development (Sambunjak et al., 2006) and

supported the development of new leaders among Australian nurses (McCloughen, 2009). Hence, although there is little debate about the effectiveness of participation in mentoring relationships in general, questions still existed around what incentives can be used to motivate individuals to engage in mentoring. The key to motivating individuals is to know what motivates them and then to design a program based on those motivational needs (Lindner, 1998). Consequently, the aim of this study was to explore what motivated nurses at various stages of their careers to engage in formal mentoring in order to be able to design future mentoring programs that can meet the needs of nurses who are at various stages of the career spectrum. Given that nursing is a complex interplay of skill acquisition, competence development and increasing capability throughout the individual nurses' professional life, understanding if and how formal mentoring contributes to the ongoing professional development of nurses is important.

By applying the principles of Vroom's expectancy theory of motivation it was predicted that the study participants' expectations would have a significant effect on their motivation to engage in formal mentoring.

7.2 Answers to the research questions

The synopsis of the literature in chapter two identified a knowledge gap between the theoretical concept of work motivation and evidence of how work motivation related to nurses' motivation to engage in formal mentoring and the potential contribution of mentoring to nurses' ongoing professional development. I formulated two questions to guide my exploration of what motivated nurses at various stages of their careers to participate in formal mentoring relationships. Interpretation of the research results from the

perspectives of the nurse participants identified the following answers to those questions.

7.2.1 Q1. What motivates diabetes nurse educators to engage in formal mentoring relationships?

For the mentees, it appears reasonable to conclude that their motivation to engage in formal mentoring was closely affected by the potential rewards of credentialling, Medicare Australia provider eligibility and potential achievement of Clinical Nurse Consultant status. While the mentees tended initially to be extrinsically motivated, their perceptions of the value of mentorship changed by the time they had completed the program and they then became intrinsically motivated to mentor others.

The majority of the nurses indicated that they believed the goals that led them to participate in a mentoring partnership were achieved. In addition, mentees indicated that they would be willing to act as mentors in the future. This finding supports the work of previous researchers (Ragins & Cotton, 1993; Ragins & Scandura, 1999).

Mentors were motivated by intrinsic factors such as the desire to help, to belong, and to contribute to the professional development of other members of the Australian Diabetes Educators' Association or simply because they wanted to be better at 'doing their job'. A desire to help the next generation has been found to become particularly acute as retirement approaches, with individuals reassessing their relationships with their employer and their colleagues, and reconsidering the meaning and focus of their work (Ekerdt & Deviney, 1993).

The desire to assist less experienced nurse colleagues was the primary motivator for all of the mentors. These mentoring participants recognised that they had experiences and knowledge gained over the years of their nursing careers that could be used to enhance the careers of less experienced diabetes

nurse educators. Almost none of the mentors had had the benefit of formal mentoring themselves. They wanted to ensure that newer diabetes nurse educators were better equipped for their careers.

These findings expand our understanding of workplace motivation, indicating that not all individuals are motivated only by the degree to which their performance leads to rewards in the form of more power, money or prestige (Porter & Lawler III, 1968). Mentors were particularly motivated to mentor because they felt they needed to achieve something worthwhile, even when mentoring others was difficult and challenging. Mentors were time poor and mentoring was time consuming but they still were motivated to mentor. In-depth interviews helped to clarify the nature of the intrinsically motivated behavioural choices made by these nurses.

Interestingly the study outcomes supported previous research findings that demonstrated that commitment and work behaviours have been reported as significantly greater by nurses in the latter part of their careers (Kolb, 1984; Springer et al., 1999). The results from this study supported this finding in that the nurses in the latter part of their careers agreed to act as mentors. However the nurses who acted as mentees who were in the early stages of Benner's Novice to Expert Model on completion of the mentoring program agreed to act as mentors in the future, thus providing evidence that the progression through Benner's career stages of nursing model is not necessarily linear (NSW Health., 2011). Nurses can transition in and out of the Novice to Expert Career Stages Model. The career stage analysis also suggests that the diabetes nurse educators' self-reported commitment to the nursing profession is high and consistent, regardless of career stage.

Expectancy theory of motivation provided a convincing and beneficial model to use to explore the underlying incentives that motivated the nurses to

engage in a formal mentoring program. The valence of outcomes for these nurses can be correlated to their motives and their perceptions of instrumentality. The nurses judged that by participating in mentoring they could attain multiple outcomes (Van Eerde & Thierry, 1996, p. 577; Vroom, 1995, p. 324). Mentees believed that a high level of performance was instrumental in achieving the desired outcomes of credentialling, Medicare Australia provider eligibility and Clinical Nurse Consultant status. Mentees also expected that achieving these outcomes would be gratifying.

Hence, both mentors and mentees indicated that participating in formal mentoring would be instrumental in achieving desired outcomes. The mentees would be able to become credentialled and the mentors could maintain their credentialled status. Mentees identified a chain of potential outcomes. Mentees considered that becoming credentialled would be instrumental in their potential attainment of Clinical Nurse Consultant status, which in turn had the potential to lead to a promotion accompanied by an increase in salary and in professional prestige.

7.2.2 Q2. Does engagement in formal mentoring relationships contribute to professional development and if so, in what way does it contribute?

The second research question explored the relationship between formal mentoring and professional development. The majority of the nurses in this research reported a positive pedagogic outcome from participating in the formal mentoring program. Engaging in formal mentoring contributed to the professional development of both the mentors and the mentees. The nurses reported that participating in mentoring created new learning, which can be seen as a positively valent outcome in Vroom's terms (Vroom, 1995, p. 26). For the nurses in this study learning was associated with the rewards of belonging, professional identity, collegiality, knowledge sharing, enhanced technical

currency, networking and increased confidence in being able to provide education to other nurses and to their patients.

On entering these formal mentoring partnerships, mentees and mentors reflected on their clinical practice and identified areas that they wanted to focus on in order to improve their knowledge, skills or competencies (Schön, 1983). The mentors and the mentees then used their reflective practice journals and professional development plans as prompts to measure if their learning goals and objectives correlated with their learning outcomes. Hence the findings from phases 1 and 2 of the study were in line with suggestions in the literature that engaging in mentoring relationships has positive consequences for the professional development of both mentees and mentors (Crathern, 1953; Eby et al., 2008; Jackson et al., 2015).

By engaging in continuing professional development initiatives members of the nursing profession have the potential to maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (Australian Nursing and Midwifery Board Authority, 2009). Since the introduction in 2010 of compulsory participation in 20 hours annually of continuing professional development initiatives for all practicing nurses, engaging in a formal mentoring program has the added advantage of being recognised as meeting the criteria of the Australian Nursing and Midwifery Board to maintain recency to practice as a nurse in Australia. The Australian Nursing and Midwifery Board stipulates that continuing professional development activities must be relevant to the nurse's area of professional practice, and have clear aims and objectives as in formal mentoring initiatives. The Board also recommends that for ongoing professional development nurses should consider engaging in activities that use multimedia and multiple instruction techniques such as face-to-face, simulation, interactive e-learning and or self-directed learning all of

which have the scope to be used in mentoring (Wenger & Wenger-Trayner, 2015).

7.2.3 Q3. If mentoring does not contribute to nurses professional development, why not?

The third research question was designed to explore if mentoring does not contribute to nurses' professional development then why not but as mentoring did contribute to their professional development the researcher will not address this question.

7.2.4 Conclusions about the research problem

The findings from the study indicated that both intrinsic and extrinsic motivational factors led to cognitive behaviour change and engagement with deeper learning for these nurses. The study demonstrated that the elements of expectancy and valance were consistently strong but not the element of instrumentality. According to the expectancy theoretical position, motivation is a multiplicative function of valence, instrumentality and expectancy (Vroom, 1964). All elements of the process must therefore be present in order for individuals to be motivated (Hoffman, 2015). However, this study revealed inconsistencies in the mentees' confidence in the mentoring process, and in their belief that if they participated in this formal mentoring program they would achieve their desired outcome of credentialling.

The mentors and mentees commented on a lack of access to resources (such as education and training about how to mentor) and a lack of allocation of time to mentor. Another issue identified by the mentors and mentees was that the mentoring program manual and correlating mentoring program forms and templates were not available in electronic format, only in hard copy with little or no document version control and no receipt of mentor or mentee

documentation acknowledgement by the Australian Diabetes Educators Association.

The outcome of these shortcomings was that the program participants expressed difficulty in knowing what was the right or current form to use. They also experienced problems submitting their hard copy completion of mentoring documentation in the mail as it was sometimes lost or misdirected.

All of these factors contributed to the nurses' beliefs about whether they would or would not be able to achieve their desired mentoring outcomes (Halcomb et al., 2014). Research suggests that levels of expectancy may be enhanced if nurses have access to the necessary resources and if they are given support to develop the required mentoring skill set (Green, 1992, p. 5).

To encourage mentee buy-in, potential mentees need to be provided with information on not just why participating in ongoing professional development activities is important but how mentoring can benefit them (Parkin, 1995; Romp et al., 2014) and they also need to be provided with access to the appropriate resources (Diefendorff & Chandler, 2011). Focusing on improving the component of instrumentality is one strategy that has the potential to improve diabetes nurse educator's motivation to participate in future formal mentoring programs.

7.2.4.1 Nurses are motivated by intrinsic and extrinsic motivational forces to engage in mentoring.

Identifying the incentives that can be used to motivate nurses to mentor should in turn lead to a better overall understanding of mentoring relationships and should also help inform organisations about how to develop more effective strategies for their facilitation.

The nurses in the study overwhelmingly demonstrated a collective identity that supported a culture of caring and compassion. Promoting mentoring as a

professional development initiative that will enhance these characteristics may encourage nurse 'buy in'. As identified in the literature reviewed in chapter two, nurses achieve more when their organisational learning culture is supported by a common ethos, image and way of thinking (Bell, 2013; Coutu, 2002; Ogiehor-Enoma et al., 2010). This can be achieved by promoting a culture where nurses value their ongoing professional development and recognise that mentoring their colleagues is not only advantageous to mentees but also to mentors.

There were clear benefits for nurses to mentor. For example, mentoring enhanced the mentees' understanding of the impact of diabetes in indigenous health and the challenges faced by clinicians and patients with diabetes working and living in rural and remote Australia. Mentoring has the potential to be self-motivating for the mentor as well as enhancing the mentee's and the mentor nurse's knowledge by ensuring that their clinical skills and ability remain current and relative (Anderson, 2011, p. 8; Cooper, 2009; Frenk et al., 2010b, p. 11).

7.2.4.2 Nurses' expectations have a significant effect on their motivation to mentor.
In order for mentors and mentees to maintain a positive attitude and enthusiasm for mentoring they must be provided with organisational support. This may be provided by either the Australian Diabetes Educators Association or the Nursing and Midwifery Board of Australia. The value of mentoring is not in question; however, the process of mentoring requires that mentors and mentees be supported in order to have the opportunity to engage in mentoring. This process is more; likely to occur when mentors and mentees have protected time to mentor (Huybrecht et al., 2011).

Healthcare organisations that facilitate mentoring programs with designated time to mentor send a positive message to their nurses that they value their engagement in mentoring. Mentoring is seen as important for

enhancing the professional development, clinical competency and technical currency of their nursing staff. Having the time to mentor has the potential to enhance the value and the quality of the mentoring (Jackson et al., 2015; McCloughen, 2009; Rosser et al., 2004).

7.2.4.3 Engaging in formal mentoring is a strong predictor of professional development

Evidence from this study indicates that formal mentoring leads to deeper levels of learning for nurses who are at various stages of their careers. Participants indicated that establishing a positive relationship with their mentor or mentee was instrumental in enhancing the ongoing professional development process. The experience of mentoring for these nurses was overwhelmingly positive and the benefits of mentoring from the mentees' and the mentors' perspectives augmented their professional development. Mentors and mentees credited formal mentoring with helping them to strengthen their skills in reflective practice, in achieve their learning goals, increase their confidence in being able to provide education to others, improve their clinical expertise and problem-solving skills, develop knowledge and clinical competencies, and facilitate practice development, increase learning and confidence in managing the change management process.

The perspective of the nurses in this study was that their professional development skills were enhanced by their participation in mentoring relationships and that their learning and professional development could not be separated from the social context in which the collaboration between the nurse mentors and the mentees occurred.

7.2.4.4 Summary of conclusions

These findings expand our understanding of what motivates nurses at various stages of their careers to engage in mentoring for their professional development. The conclusions are summarised in three points:

1. Intrinsic and extrinsic motivational forces act as incentives to motivate nurses to engage in mentoring.
2. Nurses' expectations have a significant effect on their motivation to engage in mentoring.
3. Engaging in formal mentoring is a strong predictor of enhanced professional development that leads to deeper levels of learning for individuals at various stages of their careers.

These conclusions are captured in figure 7.1 below, which interprets the findings within the theoretical context of Vroom's expectancy theory of motivation. Later in this chapter I offer recommendations for stakeholders and outline the opportunities for further research that arise from these conclusions.

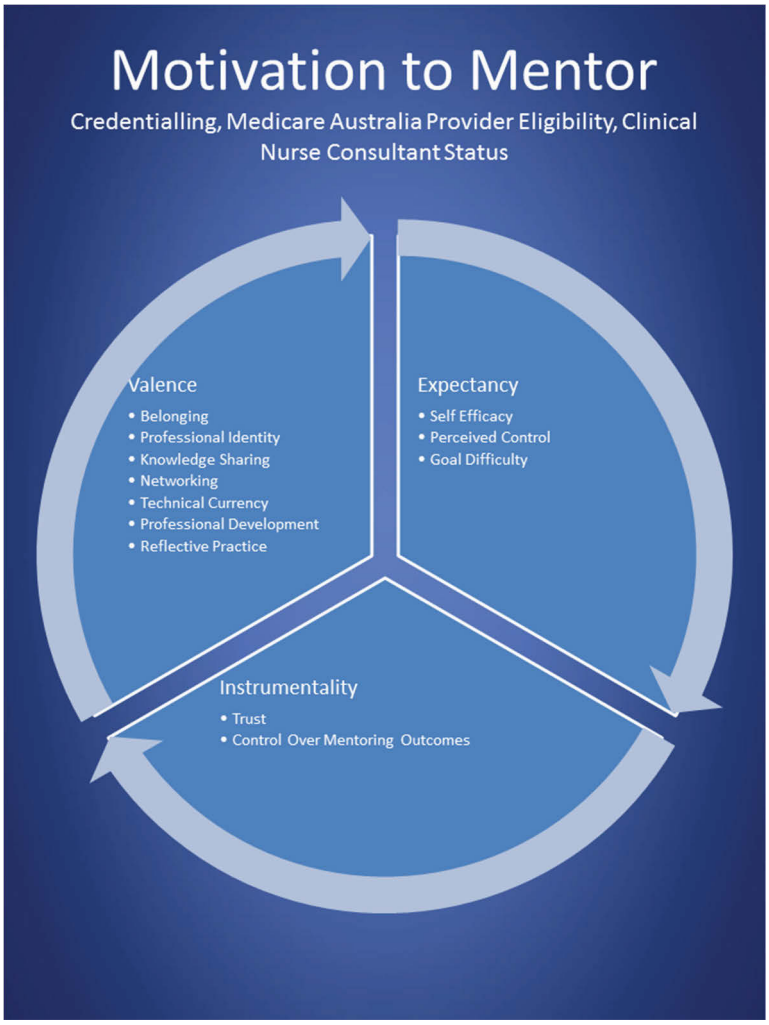

Figure 7.1 Summary of the study's conclusions interpreted within the constructs of Vroom's expectancy theory of motivation

7.3 Implications arising from the research conclusions

The following section discusses the implications of the research conclusions as they affect theory and practice within the domain of adult education.

7.3.1 Contributions to theory

The research findings culminated in demonstrating that nurses' expectations have a significant effect on their motivation to engage in formal mentoring relationships. Exploring the elements of valance, expectancy and instrumentality enabled a better understanding of what motivated these

Australian nurses at various stages of their careers to engage in formal mentoring. One outcome of their mentoring involvement was their enhanced ongoing professional development. The expectancy theory of motivation provided a starting point for investigating the nurses' motivation as well as a framework that suggests how learning organisations can systematically explain and potentially address shortfalls in their formal mentoring programs in order to enhance the ongoing professional development of their staff. Responses from nurses in this study suggest that addressing all the elements of the expectancy theory of motivation model is crucial if nurses are to be motivated to engaging in formal mentoring relationships.

It would appear that motivating others proceeds best when individuals have a clear understanding of what needs to be accomplished. At the same time, mentoring program facilitators should make sure that the desired levels of performance are possible (Murray, 2015; Nadler & Lawler III, 1983 pp. 67-78; Stoner & Freeman, 1989, p. 448). As discussed earlier, the expectancy theory of motivation is based on the premise that the amount of effort people expend depends on how much reward they expect to get in return, as in any given situation, people want to maximise gain and minimise loss (DuBrin, 2014, p. 315). However, it was the collective cultural identity of these nurses that was perhaps the strongest motivator for these nurses to choose to engage in mentoring. This confirms the claim that motivation is linked to self-image. People are motivated to express the values they see as appropriate to their concept of self (Katz & Kahn, 1966, p. 346).

The nurses in this study were motivated to maintain and enhance their self-esteem and self-worth through their participation in mentoring. Previous research has demonstrated that a great deal of our behaviour is motivated and regulated by internal standards and self-evaluative reactions to our own actions (Bandura, 1986, p. 20; Shamir, 1991). This study's findings suggest that the

nursing workforce places a high value on their continuing professional development. The implication is that organisations should place the nurses' motivation to learn and to continue to enhance their ongoing professional development—rather than the organisation's needs (Schein, 1978)—as the foundation of their educational theory. The learners'/nurses' motivational needs can provide a strong force to drive the necessary (re-)education of an ageing workforce. This research thus offers researchers and educators a foundation for further understandings about the principles and practice of adult education.

Diagrammatically, the outcome of this research and its relationship to the broad field of study is shown in figure 7.2. This diagram reinterprets a figure first presented in chapter two, adding in the findings from the survey and interview data. The research outcomes thus point the way to further consideration of the benefits of formal mentoring for the ongoing professional development of adult learners.

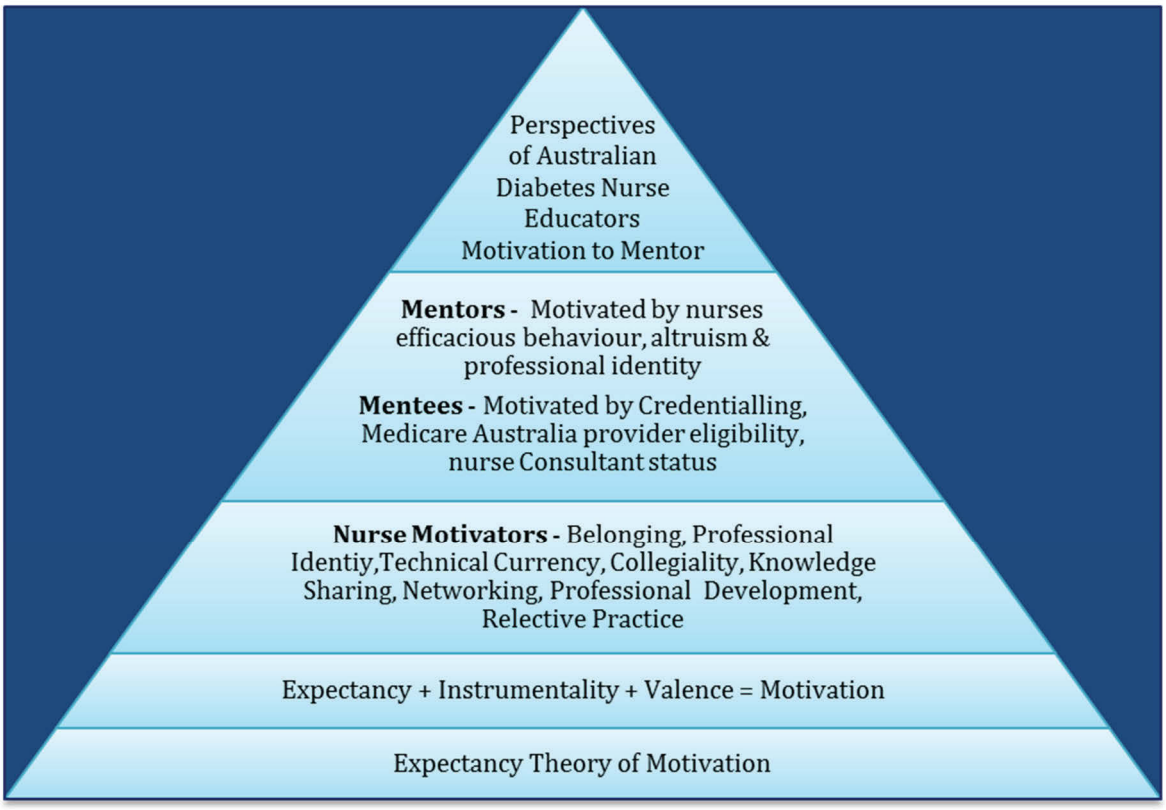

Figure 7.2: The building blocks of a conceptual framework illustrating the perceptions of diabetes nurse educators' motivation to mentor

7.3.2 Contributions to practice

Motivational research has many implications for nurses, particularly for nurses trying to motivate or mentor others (Lee, 1988). Good management practice in general is enhanced when learning organisations (in this instance the Australian Diabetes Educators Association) make explicit the link between the reward and the learner's performance (DuBrin, 2014, p. 317; Gyurko, 2011; Weinstein, 2013). Nurse mentees should be reassured that if they meet the Australian Diabetes Educators Association criteria, then they will be rewarded with credentialling, Medicare Australia provider eligibility and the potential achievement of Clinical Nurse Consultant status.

Formal mentoring programs should be planned, structured and coordinated interventions. It therefore makes sense for those responsible for implementing

such programs to endeavour to ensure that the goals of the program are clear and known to the key parties, that mentors and mentees are well-matched (Coombs-Ephraim, 2016), and that organisational support and commitment are evident (Hansford et al., 2004). Since organisations invest considerable resources into mentoring programs, it is incumbent on the planners, such as nursing organisational administrators, to minimise potential problems that could arise (Robinson et al., 2012b).

Formal mentoring programs are only successful if they are part of the organisation's culture (Colonghi, 2009), receive leadership support with designated individuals to staff and maintain the program, and are subject to formal program evaluation processes (Grindel & Hagerstrom, 2009; Smith Mascellim, 2016). Research and review on continuing professional development shows that by engaging others in continuing professional development planning, this results in positive learning outcomes and evidence-based changes to practice (Rosenthal & Zimmerman., 1972).

7.4 Recommendations for practice

As the National Health Practitioner Regulation Law (section 128) stipulates, nurses practicing in Australia must participate in continuing professional development initiates throughout their careers (Australian Government., 2009), and given that participation in mentoring is strongly recommended by the Nursing and Midwifery Board of Australia engaging in formal mentoring initiatives that have been specifically designed to meet the needs of nurses working in the Australian health industry makes good business sense. Mentoring should be regarded as an essential part of career progression and personal growth.

By engaging in continuing professional development initiatives members of the nursing profession have the potential to maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (Australian Nursing and Midwifery Board Authority, 2009). Continuing professional development is an important foundation of lifelong learning and helps nurses and midwives maintain their competence to practise (Wenger et al., 2002).

To ensure the ongoing provision of appropriate quality contemporary health care it is considered a fundamental ethical obligation for all nurses to be able to demonstrate professional currency at every stage of the career path by engaging in professional development activities (Bertulis & Cheeseborough, 2008; Fleet et al., 2008; D. Schweitzer, J., & T. Krassa, J., 2010)

The recommendations resulting from this research project are listed below.

7.4.1 Mentoring policy

The decision to participate or not in formal mentoring is influenced by personal, professional and organisational factors. As a result, organisations need to promote a variety of potential rewards for participating in mentoring programs. These may include but should not be limited to just credentialling. Other rewards that motivated the nurse mentors included professional acceptance, recognition by peers from other health disciplines, career satisfaction, job promotion ability and salary progression. Hence there is scope for motivating other Australian diabetes nurse educators to participate in this formal mentoring program by marketing rewards beyond credentialling, including acceptance by peers, networking, enhanced reflective practice, professional development, career progression and advancement of clinical competencies.

In the absence of an Australian nursing mandate that stipulates mandatory mentoring participation, policy changes are needed to promote formal mentoring and to overcome persistent barriers to participation. Organisations could enhance participation by linking mentoring program participation to nursing industrial awards and monetary rewards, and by making willingness to participate in mentoring programs a criterion in nursing position descriptions.

Inclusion of formal mentoring into position descriptions indicates the expectation that all nurses will participate in mentoring activities. This sends a strong message that supporting colleagues in their ongoing professional development is standard institutional nursing practice (American Nurses Association., 2015; Eby et al., 2008; Jackson et al., 2015; Kram, 1985). Although the administrative responsibility for coordinating an educational mentoring program may lie with human resources personnel, the initial starting point is the introduction of policy mandates by nursing organisations.

Establishing the need for mentoring and making sure the financial resources and personnel are available implicates the development of an overall plan (Goldrick, 2016; United Kingdom Nursing and Midwifery Council., 2015). If organisations perceive mentoring as a role requirement, experienced managers should be required to mentor subordinates and this should be documented in the organisation's formal reward system (Aryee, Chay, & Chew, 1996; Kram, 1985).

7.4.1.1 Recommendations for nursing healthcare organisations

- The role of mentoring to be documented in nursing workforce plans.
- Develop and provide succinct flowcharts and diagrams to define the mentoring partnership process and structure.

- Consider employing designated nurse educators, particularly for health facilities such as hospitals that employ large numbers of nurses, to facilitate and coordinate their formal mentoring programs.
- Establish explicit mentor selection criteria, including evidence of nursing excellence and an ability to serve effectively as a mentor.
- Provide or require foundational mentor training prior to assignment and on-going mentor professional development.
- Ensure that mentors receive sufficient foundational training and on-going professional development in clinical observation, formative assessment of nursing practice, providing actionable feedback, and engaging in collaborative coaching conversations.

7.4.2 Administrative support and resource development

Another critical strategy that would enhance mentee buy-in would be for nursing organisations or administrators to allocate resources to insure administrative support is available to mentors and mentees (Baxley et al., 2013). The results of this study demonstrated inadequate instrumental resources such as a lack of access to education and training on how to mentor, inadequate provision of electronic mentoring program material and insufficient time to mentor. Administrative support and commitment has been found to be a core prerequisite for an effective formal mentoring program (Aryee et al., 1996). Without authentic support from nursing administration, mentoring programs are likely to struggle.

In this study, the lack of administrative support was a barrier. It caused stress for the mentees, because support and guidance were not provided. If nurse mentoring is a priority, then resources must be allocated to it. The level of importance should be manifest in the level of priority assigned (Saffle, 2016).

Developing strong nurse leaders necessitates an investment in mentoring (McCloughen, 2009).

7.4.2.1 Recommendations for nursing healthcare organisations

- Ensure all mentoring program material is available online and that all mentoring manuals and forms are document version controlled.
- Provide the ability to complete all forms / paperwork online.
- Ensure online platforms for mentoring are easy for nurses to find and access.
- Ensure that the ratio of nurse mentors and mentees to computers is adequate.
- Ensure that nurse mentors and mentees have access to the internet - this may need to be authorised by the nurse's employer and for nurses working in rural and remote Australia access to the internet may also be dependent on whether the National Broadband Network has been implemented or not.
- Improve the quality of online resources to better support the mentoring experience e.g. investigate the introduction of a mentoring program mobile phone application (app).
- Introduce an online system for mentorship program nurse mentor and mentee registration.
- Have a drop down list of potential goals and recommended outcomes of mentoring program participation that are able to be individualised by mentors and or mentees.
- Revise existing mentoring resources and/or develop new resources that are inspiring and motivating for nurse mentors and or mentees.

- Ensure all mentoring program manuals and guidelines reflect and align with the Australian Plain English Guidelines (Australian Goverment Office of Parliamentary Counsel., 2013).

7.4.3. Providing release time

Best practice requires some financial expense in the form of release time for mentor and mentee participants (Kendall-Raynor, 2013). While release time pays for intangible activity at the beginning of the mentoring relationships, release time as the mentoring relationship progresses has been shown to be directly associated with other benefits such as increased innovation (Shamir, 1991). Mentoring program administrators should not be deterred over this last resource, since previous research has demonstrated that investing in mentoring offers a long-term return on investment (Nick et al., 2012).

7.4.3.1 Recommendations for nursing healthcare organisations

- Employ/fund full-time and or part time designated nurse mentors.
- Provide regular designated release time from clinical duties for nurse mentees and nurse mentors.

7.4.3.1 Recommendations for nurse unit managers of hospital wards, community health facilities or Australian Medicare Local General Practices

- Provide regular designated release time from nursing clinical duties for nurse mentees and nurse mentors.

7.4.4 Offering mentor training programs

Because not all would-be mentors have effective mentorship skills, another strategy is to provide training to nurses in how to mentor (Jackson et al., 2015). Effective mentorship extends beyond simply sharing one's knowledge or expertise; mentors can also be taught how to be effective mentors. Best practice includes having mentor training workshops to increase the number of mentors available and the quality of the mentoring (Robinson et al., 2012b). Allen and

Poteet (1999) suggested training for mentors to counter deficiencies in skills or knowledge when individuals possess other key characteristics that would make them a good mentor (Hofstede, 1980). Depending on the experience level of mentors and mentees, training and education in active listening, conflict resolution, cultural diversity, team dynamics, or problem solving may be beneficial (Coombs-Ephraim, 2016; Dyson, 2015; Hansford et al., 2004).

7.4.4.1 Recommendations for nursing health care organisations

- Consider employing designated nurse educators to provide education on how to mentor.
- Provide training for mentors and mentees that promotes open and trusting communication and develop skills in how to provide constructive criticism so that both parties feel comfortable and confident when they communicate.
- Develop and implement guidelines that can be individualised for each partnership that set out recommended contact requirements so that participants can plan their time commitments.
- Provide education on distance mentoring and how to build rapport when using e-technology.
- As Expectancy Theory predicted that the nurses expectations have a significant effect on their motivation to engage in mentoring, mentors need to communicate what they expect of their nurse mentees throughout the mentoring program and they need to reinforce those messages continually.

7.4.5 Matching mentees to mentors

Not everyone in the workplace is suited to participating in a mentoring relationship (Kram, 1988). Both parties must have a high degree of motivation

and commitment to the profession, the organisation, and to their own professional growth (Green & Jackson, 2014; Jakubik, 2007). Therefore, it is important to encourage nurses to make informed choices about entering into a mentoring relationship, most importantly in the choice of mentor or mentee. It is also important to establish ground rules in the mentoring relationship around time commitment, expectations, confidentiality, and location of meetings and so on (Robinson et al., 2012b).

Negative mentoring experiences have been associated with reduced learning, less career and psychological support, a higher incidence of depressed mood at work and lower job satisfaction, leading to higher levels of job withdrawal and increased turnover intentions (Burk & Eby, 2010). Unsuccessful mentoring relationships can also generate anger, isolation and frustration (Barker, 2006). This study's finding that some mentees were dissatisfied with their experience of mentoring is not new but rather highlights the importance of acknowledging at the start of the mentoring relationship the potential for problems. Because not all mentoring relationships are positive, systems and processes need to be in place at an organisational level to deal with difficulties should they occur.

Mentors who provide their mentees with genuine, direct and realistic assessments and feedback promote in their mentees a positive belief in their ability to pursue and attain goals (Coombs-Ephraim, 2016). Hence mentors must clearly encourage mentees, to give them the confidence to participate in activities that will contribute to their ongoing professional development.

7.4.5.1 Recommendations for nursing healthcare organisations

- Develop an online register of suitably qualified potential nurse mentors.

- For mentees who are looking for mentors using nursing websites, provide adequate information so an informed choice can be made about the suitability of potential mentors.

7.5 Study limitations

Chapter one outlined the assumptions and limitations of this research. Chapter three further discussed the assumptions that underpinned the methodology and framework used to interpret the results. This section discusses other limitations that became apparent during the progress of the research. The comments in this section are intended to serve as a prelude to the subsequent section which offers suggestions for further research.

Firstly, the research and its findings are positioned within explicit boundaries. The research was grounded in the discipline of adult education, lifelong learning and professional development, specifically investigating the practice of formal mentoring and the ongoing professional development of nurses in Australia. The primary focus of the research was one discrete cohort of Australian Diabetes Nurse Educators registered to practice nursing in Australia and who participated in a formal mentoring program facilitated nationally.

The conclusions about the research findings are therefore principally relevant to this cohort of Australian Registered Nurses. They are also relevant to the context of nurses registered to practice as Diabetes Nurse Educators. For greater generalisability of the research conclusions, this formal mentoring program with the evaluation component could at a later date be trialled with nurses in other countries, nurses of different nationalities and nurses registered to practice nursing but not nursing in the specific domain of diabetes education.

A further limitation of this study is that it did not specifically incorporate questions about the ethnicity of the participants (Hoffman, 2015, p. 92), their age

or the role of money as a specific incentive to mentor. Previous research has demonstrated that many of the differences in employee motivation, management styles and organisational structures of companies throughout the world can be traced to cultural differences, which this study was not able to test (Hofstede, 1980).

Other studies have found that a lack of financial assistance is a barrier to nurses engaging in ongoing educational activities. The lack of additional fiscal compensation for completing ongoing educational activities is also a barrier to participation (Romp et al., 2014). The Australian Nursing Award does not provide any financial loading for nurses who participate in or complete formal mentoring programs. However, the literature indicates that nurses with post-graduate tertiary qualifications do, on the whole, make more money across their careers than nurses without such qualifications (Graf, 2006).

A further limitation is that this study did not explore in depth the mentors' prior knowledge of mentoring, although their views may have been formed based on previous experience in their own mentee/mentor relationships (Jackson et al., 2015; Kram, 1985; Schuck, 2003). While an initial development workshop for mentors was held when the mentoring program was introduced, not all mentors were able to participate so it is likely that mentors entered their mentoring relationships with differing levels of expertise. This may have influenced their views. Despite several attempts it was not possible to facilitate a meeting or follow-up educational session to provide an opportunity to discuss the mentoring program or support of the mentoring participants.

7.6 Recommendations for further research

The findings from the study indicate that the motivation to participate in mentoring was more important than volition and was linked to outcomes.

Recommendations for future formal mentoring programs must consider what factors will motivate mentees and mentors to participate. Organisations must also consider the level of support and commitment they are willing to provide to mentorship program participants to ensure that they can achieve the goals of the program.

As this study only examined the experiences of a cohort of Australian Nurses, that is Diabetes Nurse Educators, it would be beneficial for a future researcher to consider undertaking a more comprehensive study into the area of mentoring with Registered Generalist Nurses. The advantages of studying generalist nurses is that it would provide a large comparison group with the potential to reduce the possibility of subject bias. Another advantage of undertaking a prospective study with generalist nurses would be that the researcher could design the study and the survey tools used to measure the data thereby ensuring the quality of the data.

Limited systematic research has been conducted to examine the propensity to mentor others, and even less research has focused on what motives underlie mentoring behaviour. There therefore needs to be further research to delineate the variables that influence and motivate nurses to participate in the challenging task of mentoring. Identifying the incentives that can be used to motivate nurses' relationships. This should help mentoring program planners to develop more effective strategies for program facilitation.

Further research that explores the role of self-efficacy and its links with the element of expectancy may further increase the predictive power of a model of nurse's motivation to mentor. If the researcher's goals are to understand individual behaviour, as well as to be able to predict individual behaviour, then there must be an emphasis on measuring important mediating variables that capture the essence of motivation.

Research integrating the expectancy theory of motivation (Vroom, 1964) and self-efficacy theory (Bandura, 1997) may provide an opportunity to understand how nurses form expectancy judgments. Integrating these two theories in future studies may enhance our understanding of both motivation and outcome variables such as performance, choice of behaviour and persistence in pursuing the choice—i.e. persistence in the decision to participate or not in mentoring.

As indicated earlier, self-efficacy can be a factor in both willingness to mentor and resistance to mentoring (Katz & Kahn, 1966). Consequently, a more thorough investigation of the potential link between previous mentoring experience and perceived self-efficacy as a mentor may be advantageous. Empowering nurses to feel that they have the skills and competence needed to assume the role of mentor may encourage them to mentor others. Formal mentoring programs may help increase willingness to mentor as they provide experience and opportunities for people to increase their self-efficacy in mentoring roles. It is clear from the mentees' responses in this study that nurses appreciated the support they received from their mentors and recognised the importance of their own actions in enhancing their mentoring experience and increasing their confidence to potentially mentor others.

7.7 Reflections of the nurse researcher on the research process

This research study was undertaken because the researcher was motivated by a need to know more about the ongoing professional development of nurses working in Australia. The concepts of adult education and engaging in lifelong learning practices throughout a nurses' career was relatively new in the Australian nursing industry. The introduction of participation in mandatory ongoing professional development standards for all nurses wanting to practice

nursing in Australia was greeted with anxiety, fear and scepticism by some nursing colleagues.

While the researcher had had some previous experience and held post graduate qualifications in undertaking research the concept that colleagues found the idea of engaging in mandatory ongoing professional development initiatives as a reason to leave nursing was horrifying.

Undertaking this research experience enhanced this nurse researcher's skills and confidence to conduct research. While the researcher was curious to know more about what motivates nurses to engage in professional development initiatives it was her motivation to engage in research, her persistence to learn, not cleverness or giftedness, and the support she received from others which assisted her to complete this research project.

The researcher's experience of conducting research fits well with the Expectancy Theory of Motivation model. All three components of the model expectancy, instrumentality and volition were present during the research journey. To undertake a research inquiry, nurses must be motivated by a curiosity or need, however, to complete a research inquiry nurses need to be educated and nurtured in and on the research process.

7.8 Conclusion

As learning organisations look for activities that meet organisational objectives in the most efficient way, the results of this study indicate that nurses were motivated to mentor by the expectation of credentiallng and because they wanted to make a contribution to the professional development of other members of the nursing profession. Thus, instrumentality and the valence of these needs, that is the value that these nurses placed on wanting to become credentialled were significant predictors of their willingness to mentor.

Vroom's expectancy theory of motivation is not about self-interest in rewards but about the associations people make between expected outcomes and the contribution they feel they can make towards those outcomes. Crucially, Vroom's expectancy theory works on perceptions, so even if an organisation thinks they have provided everything appropriate for motivation, and even if this works with most people in that organisation, it doesn't mean that someone won't perceive that it doesn't work for them. The person's perception is what will deter them from participation, so organisations must address their workforce's perceptions if they wish to achieve change.

This study has addressed gaps in the current literature on what motivates nurses at various stages of their careers to engage in formal mentoring. The findings have demonstrated that formal mentoring contributed to the ongoing professional development of these nurses. Based on the findings, I have put forward recommendations for motivating individuals to participate in formal mentoring relationships. These recommendations may be applicable to other organisations that are considering introducing formal mentoring to improve the ongoing professional development of their staff. ■

Appendices

Appendix A: Authorisation to evaluate the Australian Diabetes Educators Association formal mentoring program

From: HEATHER HART [HHART@BarwonHealth.org.au]
Sent: Wednesday, 28 July 2010 8:34 PM
To: Maureen KingstonRay
Subject: RE: Introduction and Opportunity Sought from ADEA Regarding Possible Evaluation of Mentorship Model

Dear Maureen,

The ADEA Board discussed your application of 23rd June 2010, applying for authorisation to evaluate the ADEA Mentoring Program, at the recent Board meeting held on the 24th July 2010.

Approval is granted, subject to you:
1.providing more detailed information about your research, including current Ethics approval
2.providing the final report to ADEA for review prior to publication
3.advising where it is intended to be published
4.presenting your research at a future ADS/ADEA Annual Scientific Meeting

Best wishes for every success of your research.

Regards
Heather
President
ADEA

Heather Hart
RN CDE
Diabetes Referral Centre
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-----Original Message-----
From: Maureen KingstonRay
[mailto:Maureen.KingstonRay@SESIAHS.HEALTH.NSW.GOV.AU]
Sent: Wednesday, 21 July 2010 1:44 PM
To: Maureen KingstonRay; HEATHER HART
Subject: RE: Introduction and Opportunity Sought from ADEA Regarding Possible Evaluation of Mentorship Model

Hi Heather

Can you please confirm that you received my application to evaluate the ADEA Mentorship Program?

I sent the documents in hard copy several weeks back in preparation for the next ADEA board meeting.

Looking forward to meeting you at the national conference

Thanks for all your help

Kindest regards

Maureen

UNIVERSITY OF TECHNOLOGY SYDNEY

Appendix B: Application for authorisation to evaluate the Australian Diabetes Educators Association's mentoring program

Outline of intended research

This paper is a discussion of a proposed study to be conducted collaboratively with the Australian Diabetes Educators Association and the University of Technology, Sydney. The study will be an investigation of the impact of the implementation of a mentoring model implemented within the Australian Diabetes Educators Association to promote knowledge sharing amongst those in the profession to empower them to continue to provide best practice diabetes education and care to the community ("ADEA Mentoring", 2008).

The study will lay the groundwork for another proposed research activity to investigate the implementation of a staff retention model within a public health facility to promote nursing as a desirable career choice, an area that has not been systematically investigated in Australia to date. This study will provide an evaluated model of how introducing a mentoring program for nurse professional's impacts on staff retention. The learning's make an important contribution to the development of nursing staff retention approaches by integrating mentoring programs for nurse professionals into public health services.

Background

The literature reviewed so far has not established that the introduction of a mentoring program will automatically solve the nursing workforce crisis. In the Unites States, research has demonstrated that the cost to develop the knowledge and skills of existing staff nurses is estimated to be only one third that of hiring a new graduate nurse. The turnover cost for one staff nurse is estimated to be ten thousand dollars U.S.

Research conducted by MacGregor (2000) noted that there is a particularly high staff turnover in the 25-35 year age group, or Generation X. These younger employees have demonstrated links to a change in values and a need to be continually learning and growing. A study of two Australian business organisations, who introduced mentoring models to target staff retention from generation X, demonstrated that by providing mentees with personal/professional support, guidance and an introduction to new contacts and networks the mentees felt more valued and appreciated and ultimately, they performed better.

Jakubik (2007) found that the quality of the mentoring provided has been the single best predictor of the benefits of implementing a mentoring model in the nursing profession. While research conducted by Delahaye (2005) demonstrated that the overarching principle for all mentoring and e-learning is the belief system that an organisation values learning. While there will always be competing priorities in the workplace – production demands, time constraints, attitude of trainees and guides, assisting staff to learn needs to be a priority (Billet 2002).

It has also been acknowledged by the Australian Nurses Federation that a lack of an adequate nursing workforce will make it difficult for nurses to deliver clinical services that meet National Standards. The problem of high nursing staff turnover is a major cost on the health system. Doiron and Jones (2006) found that the annual nurse attrition rates in New South Wales have been suggested to be around twenty percent.

The Australian government is committed to a combination of recruitment, retention, education and training strategies to improve workforce flexibility and strengthen career pathways in order for nurses to continue to provide high quality health care to the Australian public (NSW Health 2007). Whilst Australian nursing education is recognised with an excellent international reputation recent funding shortfalls have limited the ability of nursing education providers to offer quality education to a sufficient number of nursing students to meet workforce demand ("Impact of Higher

Education", 2003). An ageing population and an aging workforce have placed an increasing demand on the nursing profession.

Evidence shows that the introduction of a mentoring program can contribute to improved staff retention rates and job satisfaction in other professions however little work has been reported on:

- The impact of the introduction of a mentoring model on a national diabetes education association.
- The impact of the introduction of a mentoring model in a public health facility.
- The impact of a mentoring program targeting nursing staff at various stages of their career not necessarily new graduates (Sweeney, 2002).

Improved understanding of the contributing factors behind nursing staff resignations will inform the health system to introduce mentoring as a key component to providing quality professional development for the benefit of nurses. If nursing staff retention rates in the public health system are improved, the unnecessary cost burden on the health system and a major source of clinical frustration are removed.

Research question

Can the introduction of a mentoring program solve the nursing workforce crisis?

Aims

- Promote knowledge sharing amongst Diabetes Educators.
- Encourage the utilisation of evidence based best practice principles in providing services to people with diabetes or at risk of developing diabetes and their families and carers.
- Reduce nursing staff turnover in public health facilities.

- Promote mentoring as an activity that can form part of the ongoing cycle of professional development.

Proposed research program

Protection of the Rights of Human Subjects Ethics application will be sought from the University of Technology Ethics Committee prior to any research being conducted. Privacy and confidentiality of all participants will be maintained through the de-identification of all research subjects. This research project will be undertaken as part of my doctor of philosophy thesis. This study will be supervised by Dr. Shirley Saunders, Dr.Tony Holland, Associate Professor Sandra Schuck and Dr.Katharine Collier.

METHODOLOGY

Phase 1 – evaluation of the ADEA mentoring program

Will comprise of meeting with the Australian Diabetes Educators Association (ADEA) Mentoring Advisory Group to negotiate my proposed plan for evaluating the ADEA mentoring program. There needs to be consultation with all stakeholders involved in the ADEA mentoring project to reach agreement about the broad parameters of the evaluation so that all parties are clear as to how it will proceed and are aware of what the evaluation might realistically be expected to achieve.

I will be utilising the Interactive Model of Program Planning and Evaluation for Adult Learners developed by Caffarella (2002). This model meets the learning objectives of the ADEA Mentoring Program because it is grounded on the assumption that education and training programs should focus on what the participants actually learn and how this learning results in changes to the participants (educators) the clients and the ADEA organisation itself.

I propose that the methodology for this descriptive correlational study will include data collection and analysis procedures. The statistical analysis will include descriptive

statistics, non-parametric summary statistics, and measures of dispersion and shapes of distribution.

Phase 2 – implementation of a mentoring model in a public health facility

A public health facility mentoring advisory group will be convened to include representation from management, nursing staff (from a variety of clinical areas and at various stages of their careers) and a nurse educator. The role of the advisory group will be to hold discussions focused on gaining input and guidance on how to successfully implement a mentoring program in an acute public health care facility (Clutterbuck 1993).

- The mentorship advisory group will
- Target nurses to participate in mentorship workshops
- Ensure a high attendance rate at the workshops
- Content of mentorship workshops
- Timing of workshops
- Evaluating the workshops
- Recruiting nurse "Mentorship Champions"

Measuring success

This study will address the growing problem of nursing staff resignations, one of the national accreditation workforce reporting criteria for public hospitals specified by the Australian Council on Health Care Standards.

The following performance indicators will monitor the success of the research project

- Number of staff resignations in a regional public health facility after the implementation of a mentoring program.

- Number of registered mentoring partnerships.
- Percentage of registered partnerships that are completed to the satisfaction of the mentor and the mentee.
- Number of registered partnerships that are voluntarily dissolved.
- Goal attainment within mentoring partnership.
- Participant satisfaction with mentoring program.

Significance

Relevance and importance of this research project to the Australian Diabetes Educators Association and to the University of Technology Sydney Centre for Research In Learning And Change

This project relates to the vision of the Australian Diabetes Educators Association to support educators to provide optimal health and well-being for all people affected by, and at risk of diabetes.

The study also relates to two research areas identified by the University of Technology Sydney Centre for Research in Learning and Change. One is organisational and workplace learning and the other is health communication. While there are no absolute answers as to what constitutes research in education, activity deemed as research is generally thought legitimate when it conforms to the practices, ideals and values shared by a community of researchers (Usher, R & Bryant, I.1989). Communication in health offers the concept of paradigm to understand research and inquiry into a specific field of practice– the health organisation. Researching the promotion of mentoring as an activity that can form part of the ongoing cycle of professional development to reduce workforce shortages can be of benefit to diabetes educators, nurses and other health organisations. Reducing nursing workforce shortages by improving staff retention has been identified as a Commonwealth and State Health priority. Monitoring staff perceptions on what our organisation does well and what

areas of human resource management can be enhanced with a view to proactively improving staff satisfaction may make employment in the nursing profession a desirable career choice.

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Appendix B: Human Research Ethics Committee approval letter

Research & Innovation

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www.uts.edu.au UTS CRICOS PROVIDER CODE 00099F
10 May 2012
Dr Tony Holland
Learning Cultures & Practices Group
Faculty of Arts and Social Sciences
CB10.05.291
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Tony,

UTS HREC 2012000059 – Dr Tony HOLLAND, Ms Katharine COLLIER (for Ms Maureen KINGSTON-RAY, PhD student) –

"Mentoring and Professional Development of Diabetes Nurse Educators"

Thank you for your response to the Committee's comments for your project titled, "Mentoring and Professional Development of Diabetes Nurse Educators". Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics approval is now granted.

Your clearance number is UTS HREC REF NO. 2012000059
Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.
If you have any queries about your ethics clearance or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9772.

Yours sincerely,
Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee

Appendix C: Annual progress report to the UTS Human Research Ethics Committee

UNIVERSITY OF TECHNOLOGY SYDNEY

ANNUAL PROGRESS REPORT TO THE UTS HUMAN RESEARCH ETHICS COMMITTEE

This report is to be completed every twelve months following the date of ethics approval, and at the completion of your research project. To cross the check boxes, double click on the check box and tick checked (under default value). Type your responses into the box which expand to accommodate your answers.

Project Title: Mentoring and Professional Development of Diabetes Nurse Educators.

Approval Number: UTS HREC 2012-059

Current status of project: (Double click on box and mark 'checked')	
☐ Not yet commenced	Estimated commencement date:
☒ In Progress	Estimated completion date: 1st January 2015
☐ Completed	Approximate completion date:
☐ Terminated	Approximate termination date:

Position	**Name** (include title)	**Contact number**	**Email**	**Period of involvement**
Chief Investigator/ Supervisor	Dr. Tony Holland	9514 3824	Tony.Holland@uts.edu.au	01/04/2012
Co-investigator	Dr. Kate Collier	9514 3461	Katharine.Collier@uts.edu.au	01/04/2012
(Student)	Maureen Kingston-Ray	0434078595	maureen.kingstonray@uts.edu.au	01/04/2012

(Note: copy this section as required to accommodate the number of investigators)

1. **Have there been any changes to your research project since ethics approval was granted or since your last progress report?** *Please tick Yes or No to the options below. If yes, please outline and explain the reasons for any changes that have occurred in any of the following areas in the boxes provided:*

   (Note: major changes may require an amendment application form. Please contact the Ethics Secretariat on 02 9514 9772 if you are unsure)

   (a) Participating investigators Yes ☐ No☒

   (b) Procedures or methodology Yes ☐ No☒

   (c) Data collection instruments (surveys /questionnaires/interview questions)

   Yes ☐ No☒

   (d) Has an amendment application been submitted for any of these changes? *Note: changes to personnel do not require an amendment application.*

   Yes ☐ No☒

2. **Did any of the following events occur?** *Please tick Yes or No. If yes, please give details of the event, and how it was resolved or addressed.*

   (a) Unforeseen ethical or other difficulties during your research Yes ☐ No☒

   (b) Adverse effects for your subjects /participants Yes ☐ No☒

   (c) Complaints received from participants or other persons involved in the research

   Yes ☐ No☒

3. **How and where have you stored the data you have collected?** *Please give details (e.g. coded on computer, files, etc.)*

   The survey/questionnaires used for this research are stored at the Australian Diabetes Educators Association National Office, Canberra and can only be accessed at this secured site.
   Interviews conducted with the study participants are de identified by coding, stored electronically and computer password protected.

4. **What steps have you taken to ensure the confidentiality of your participants?**

   Please give details (e.g. de-identified data, password protected, locked filing cabinet, limited access to data, etc.)
   Confidentiality of the participants is ensured by not including any identifying information such as the participant's name, age or where there live in any of the study reports.

5. **Are you planning to publish or have you published the results of your research?**

Please tick Yes or No. If yes, please provide the reference and attach a copy of any articles or abstracts.

Yes ☒ No☐

Please find attached a copy of the abstract submitted to the Australian Diabetes Educators Association & the Australian Diabetes Society Annual Scientific Meeting 2013.

6. **Additional Comments?** *Please add any further information you feel may be relevant.*

Nil

DECLARATION

I declare that the information I have given above is true and that my research has contravened neither the *National Statement on Ethical Conduct in Research Involving Humans;* the *Joint NHMRC/AV-CC Statement and Guidelines on Research Practice;* the Commonwealth Privacy Act (1998); nor the UTS policy and guidelines relating to the ethical conduct of research.

I also declare that I have respected the personality, rights, wishes, beliefs, consent and freedom of the individual subject in the conduct of my research and that I have notified the UTS Human Research Ethics Committee of any ethically relevant variation in this research.

_____ Date: __15__/__6__/__13__

Chief Investigator/Supervisor

_____

Name & Title

Maureen Kingston-Ray Date: 05/06/2013

Student (if applicable)

M. Kingston

Appendix D: Inclusion and exclusion criteria

INCLUSION CRITERIA

- Must be a nurse currently registered with the Nursing and Midwifery Board of Australia
- Must be over 18 years of age
- Must be a financial member of the ADEA
- Must have participated in the Australian Diabetes Educators Association mentorship program as a mentor or mentee between the period 2008 to 2012

EXCLUSION CRITERIA

- Non-nurses
- Anyone not working in diabetes education
- People under the age of 18 years
- Anyone not working in diabetes education as defined by the Australian Diabetes Educators Association

Appendix E: Mentor notification of completion of mentoring partnership questionnaire (ADEA)

Established 1981

MENTOR NOTIFICATION OF COMPLETION OF MENTORING PARTNERSHIP

TO BE COMPLETED BY MENTOR

I *(name of mentor)* .....

(ADEA Membership Number) .....

Am advising ADEA that the mentoring partnership with *(name of mentee)*

.....

was completed by mutual agreement on ..... .

I have maintained copies of relevant documentation to substantiate my role as a mentor including a record of contacts between me and my mentee.

Signature: ..... Date: ..... / ..... / .....

EVALUATION

Your answers to the following questions will be used to evaluate and improve the ADEA Mentoring Program. They will not be used as a means of assessing either your role as a mentor or your mentee's achievements within the partnership.

Please complete the following pages and forward them to the ADEA National Office together with this page.

EVALUATION

1. Please indicate your role in the partnership

☐ Mentor ☐ Mentee

2. Please indicate on a scale of 1 – 5 to what extent you believe the overall goals of your mentoring partnership were achieved.

1 2 3 4 5

Not at all Extremely well

Comments:

.....

.....

.....

.....

3. Was this partnership dissolved earlier than originally anticipated?

☐ Yes ☐ No

***If yes,* what was the reason?**

☐ Mentee goals were achieved earlier than anticipated

☐ Partnership was unsatisfactory and dissolved by mutual agreement

☐ Other: please specify:

.....

.....

.....

4. Please indicate on a scale of 1 – 5 to what extent your Personal goals for the mentoring partnership were achieved.

1 2 3 4 5

Not at all Extremely well

Comments:

.....

.....

.....

.....

5. Did you contact the ADEA National Office for support regarding the mentoring program at any time?

☐ Yes ☐ No

***If yes*, please indicate on a scale of 1 – 5 how you would rate the support you received from the ADEA National Office**

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

6. How would you rate the mentoring program material in the ADEA Mentoring Program Members Manual?

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

7. Please indicate on a scale of 1 – 5 how you would rate your overall satisfaction with the implementation of the ADEA Mentoring Program?

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

8. Would you act as an ADEA mentor again?

☐ Yes ☐ No

Comments:

.....

.....

9. Please write any other comments or suggestions regarding the ADEA Mentoring Program?

.....

.....

.....

Thank you for being an ADEA Mentor and for your support for the ADEA Mentoring Program

This Notification of Completion and Evaluation must be submitted to the ADEA National Office within two (2) weeks of completing the mentoring partnership.

Appendix F: Mentee notification of completion of mentoring partnership questionnaire (ADEA)

Established 1981

MENTEE NOTIFICATION OF COMPLETION OF MENTORING PARTNERSHIP

TO BE TO BE COMPLETED BY MENTEE

I *(name of mentee)* . . . .

(ADEA Membership Number) . . . .

am advising ADEA that the mentoring partnership with *(name of mentor)*

.....

was completed by mutual agreement on . . . / ...../ ..... .

I have maintained copies of relevant documentation to substantiate my involvement in the mentoring partnership including a record of contacts between me and my mentor.

Signature: ..... Date: .../...../..

EVALUATION

Your answers to the following questions will be used to evaluate and improve the ADEA Mentoring Program. They will not be used as a means of assessing either your achievements within the partnership or your mentor's role the partnership.

Please complete the following pages and forward them to the ADEA National Office together with this page.

EVALUATION

1. Please indicate your role in the partnership

☐ Mentor ☐ Mentee

2. Please indicate on a scale of 1 – 5 to what extent you believe the overall goals of your mentoring partnership were achieved.

1 2 3 4 5

Not at all Extremely well

Comments:

.....

.....

.....

.....

3. Was this partnership dissolved earlier than originally anticipated?

☐ Yes ☐ No

***If yes,* what was the reason?**

☐ Mentee goals were achieved earlier than anticipated

☐ Partnership was unsatisfactory and dissolved by mutual agreement

☐ Other: please specify:

.....

.....

.....

4. Please indicate on a scale of 1 – 5 to what extent your Personal goals for the mentoring partnership were achieved.

1 2 3 4 5

Not at all Extremely well

Comments:

.....

.....

.....

.....

5. Did you contact the ADEA National Office for support regarding the mentoring program at any time?

☐ Yes ☐ No

***If yes*, please indicate on a scale of 1 – 5 how you would rate the support you received from the ADEA National Office**

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

.....

.....

6. How would you rate the mentoring program material in the ADEA Mentoring Program Members Manual?

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

.....

.....

7. How did you find your mentor?

☐ ADEA Website

☐ Branch representatives

☐ Own network and contacts

☐ Other (*Please specify)*: .....

Comments:

.....

.....

.....

.....

8. Did you enter a mentoring partnership in order to become credentialed?

☐ Yes ☐ No

***If yes*, have you submitted a credentialing application?**

☐ Yes ☐ No

***If no*, do you intend to submit a credentialing application?**

☐ Yes ☐ No

Comments:

.....

.....

9. Please indicate on a scale of 1 – 5 how you would rate your overall satisfaction with the implementation of the ADEA Mentoring Program?

1 2 3 4 5

Very poor Excellent

Comments:

.....

.....

10. Would you act as an ADEA mentor in the future?

☐ Yes ☐ No

Comments:

.....

.....

11. Please write any other comments or suggestions regarding the ADEA Mentoring Program?

.....

Thank you

Appendix G: Participant consent form

UNIVERSITY OF TECHNOLOGY SYDNEY

Project: Mentorship and professional development of diabetes nurse educators

Researchers
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I have read the participation information sheet and have had the opportunity to ask the researcher any further questions I may have had. I understand that my participation in this research is voluntary and that I may withdraw at any time from the study without question or penalty.

I understand that the risks to me are minimal. I understand that I will be interviewed by the researcher and that the interview will be electronically recorded. My name will not be used to identify my comments or work in the study at any stage.

I understand that this study will be conducted according to the National Health and Medical Research Council Guidelines. If I have any concerns or complaints regarding the way the research is or has been conducted I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Technology, Sydney on 02 9514 9772.

By signing below, I am consenting to:

- Being interviewed and asked questions in regard to my experience of mentoring or being mentored.
- The interview being digitally recorded.
- The interview should take no more than ninety minutes.

I understand that the information provided by me will be used for a PhD thesis and, possibly, other published studies. I consent for my information to be used in this manner.

On this basis, I give my consent to participate in this research study.

Please insert your name: _____

Date: _____

Signature:

_____

Appendix H: Participant information sheet

Introduction

You are invited to take part in a research study to determine if participation in a formal mentorship program contributes to the professional development of diabetes nurse educators. This Participant Information Form tells you about the research project. It explains what is involved to help you decide if you want to take part. Participation in the research is voluntary. If you do not wish to take part, you do not have to.

Purpose of the study

The purpose of this study is to identify some of the gaps in the literature on the professional development of diabetes nurse educators and whether participation in formal mentoring programs is advantageous for diabetes nurse educators.

Evidence shows that the introduction of mentoring programs can contribute to improved staff retention rates, professional development and job satisfaction in other professions however little work has been reported on the impact of mentoring for the professional development of nurses, targeting nurses at various stages of their career. Professional development or becoming a professional does not stop with the attainment of a tertiary qualification but it should continue well on into a person's working life.

As nurses numerically comprise the largest occupational grouping in the Australian health industry and with the average age of nurses being 46.7years, an understanding of how mentorship can contribute to their professional development invites a more rigorous investigation of the work undertaken by nurses. Will there be enough skilled, professional nurses to meet the health demands of an aging population in the 21st

century. My research builds on the theory that the professional development of nurses can be enhanced by their participation in formal mentorship programs.

The national registration of nurses and midwives and the implementation of professional development standards for the nursing profession illustrate a vision for a better health system through a comprehensive approach for continuing professional development. To be most effective, nurses at every stage of their careers must continue learning about advances in research and treatment in their fields in order to obtain and maintain up-to-date knowledge and skills in caring for their patients.

This research will add to the growing body of knowledge related to nursing staff, specifically diabetes nurse educators and their professional development, and would contribute to the debate on whether investing financial resources for the ongoing professional development of nurses is worthwhile.

Appendix I: Interview questions

Project title: Mentoring and professional development of diabetes nurse educators: What do nurses explicitly learn from participating in a mentoring program and how does that impact on their professional development?

INTERVIEW QUESTIONS – Verbal Protocol

My first aim is to establish what were the Diabetes Nurse Educators experience/opinions of participating in the Australian Diabetes Educators Association (ADEA) Formal Mentorship Program as either a mentor or a mentee.
My second aim is to ascertain what did the Diabetes Nurse Educators explicitly learn by participating in the ADEA formal mentoring program.
My third aim is to establish did the experience of being a mentor or mentee in the ADEA Mentorship Program have any impact on the development of those Diabetes Nurse Educators.

Mentorship and learning

1. Did you act as a mentor in the ADEA formal mentoring program?
2. Were you provided with any training or education for this role?
3. Did this help? Yes or no?
4. Did you act as a mentee in the ADEA formal mentoring program?
5. Were you provided with any training or education for this role?
6. Did this help? Yes or no?
7. Have you been involved in an informal mentoring program before?
8. From your experience was there any difference between participating in the ADEA formal mentoring program compared to participating in an informal mentoring relationship?
9. What was the difference?

10. What did you learn by participating in the ADEA formal mentoring program?
11. What were your set goals as to what you wanted to achieve by participating in the mentorship program?
12. How well were those learning goals met?
13. To achieve the same results do you think there is a viable alternative to participating in a formal mentorship program?

Professional development policy/legislative compliance

1. Has the new national nursing guidelines for professional development impacted on what training or educational activities you have undertaken in the last 12 months?
2. Do you think mentorship could help with the professional development of nurses?
3. Why?
4. How?
5. Do you think all nurses should participate in a formal mentoring program?
6. Why?
7. Has being part of mentorship program helped /or not with your professional development?
8. Do you think mentoring could work for nurses working in hospitals?
9. Why?
10. Do you think implementing a mentoring program for Diabetes Nurse Educators in the ADEA has helped them achieve professional recognition?

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