FINDING MEANING IN MENTORING:

LIVED EXPERIENCES OF BEDSIDE NURSES IN THE ACUTE CARE SETTING

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Abstract

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The literature and available studies have long attributed mentoring to the empowerment of nurses and their professional identity. When mentoring becomes part of an organization's culture, professional identity development can improve nurse retention and patient care outcomes. Mentoring takes different forms, including formal and informal connections with experienced peers or leaders. However, variations in definitions and applications provide a meaningful opportunity to wonder about what mentoring truly is like for bedside nurses in the acute care setting.

This qualitative study used a hermeneutic phenomenological method to give insight into bedside nurses' experiences of being mentored in clinical practice. Eleven nurse leaders were interviewed about their experiences of being mentored as bedside nurses with the aim of bringing the phenomenon's essence to light. Findings were analyzed, and the five essential themes revealed from those shared experiences were: (a) Evolving Mentor Role, (b) Creating a Safe Space for Change, (c) Pearls in Clinical Practice, (d) Transitioning from the Nest to Flight, and (e) Honoring the Transformative Experience. The findings from this study will contribute to the body of knowledge about the experience of being mentored within the context of the nursing profession and organizational leadership.

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Dedication

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Our inward power, when it obeys nature, reacts to events by accommodating itself to what it faces—to what is possible. It needs no specific material. It pursues its own aims as circumstances allow; it turns obstacles into fuel.

Marcus Aurelius, Emperor of Rome (121-180)
Meditations (2002), p. 37

Chapter 1: INTRODUCTION

Those having torches will pass them on to others.

Plato, *The Republic* (2007)

The moment had come when she joined in the recitation of the Florence Nightingale pledge, "I will do all in my power to maintain and elevate the standard of my profession." It transpired during the pinning ceremony—that special rite of passage unique to only nurses. She reflected on the support she had received from her peers and professors and anticipated the professional adventure that lay ahead.

Upon passing her National Council Licensure Examination (NLCEX), she became a Registered Professional Nurse. Professors had guided her preparation for the NCLEX, and the staff nurses whom she shadowed during the clinical rotations shared real-life experiences that made the exam questions come to life. The nursing license, along with glowing letters of recommendation, afforded her an opportunity to choose the job of her dreams.

As a new employee in her healthcare organization, she was welcomed with a formal orientation and nurse residency program to introduce her to her chosen specialty. Again, she was supported by her peers, managers, educators, and the rest of the leadership team. She grew more confident and capable as role models shared their resources and time with her. As her competence developed, she continued her education to acquire knowledge that would mold her into a leader. She had received so much inspiration from her mentors; it was time for her to mentor others. And so, she did.

Imagine if this vignette mirrored an everyday experience for all nurses. With all levels of the nursing profession welcoming nurse graduates into their new roles and providing a network of professionals, this scenario could be the norm. Suppose mentoring can provide an opportunity

to create a positive change in individuals and transform professional nursing culture and practice. In that case, it may be worth wondering what it is like to be mentored.

The term *mentor* originated from Greek mythology and Homer's writings in his epic 7th-century BC poem, *The Odyssey* (Homer & Fitzgerald, 1990). Odysseus entrusted his son, Telemachus, to his faithful advisor, Mentes (or Mentor), when he left for the Trojan War. Athena, the goddess of wisdom, took the form of Mentes and served as a guide, teacher, tutor, and father figure to Odysseus's son (Homer, 2018; Ragins & Kram, 2007; Sawatzky & Enns, 2009). In this role, Mentor inspired Telemachus to complete the challenges presented in his life and has since grown in relevance within modern society (Ambrosetti & Davis, 2016; Yoder, 1990). In keeping with the description in the myth, the *Oxford English Dictionary* (Fowler et al., 1992) defined a mentor as an "experienced person who advises you over a period of time" (p. 556).

In nursing, the description of a mentor is similar to that of Homer's Mentor. Vance and Olsen (1998), in their seminal article on mentoring, asserted that the mentor relationship has the "capacity to transform the path of our human journey" (p. 3). It is an individualized relationship that has the potential to have a profound impact on self and career development. Mentoring or being mentored is focused on the relationship or dyad that develops between a mentor and mentee (Burgess et al., 2018). For this study, the mentor is an experienced nurse professional who supports a less experienced nurse in their professional development and clinical advancement in nursing practice.

Aim of Study

With this study, I aimed to increase the understanding of the experience of nurse leaders who were mentored while in the role of bedside nurse using Max van Manen's (1990, 2002)

approach to phenomenological research. While mentoring in nursing continues to be widely researched, no study has looked for the true essence of the phenomenon. Phenomenology aims to gain a deeper understanding of the nature or raw descriptions of our everyday experiences (van Manen, 1990). This method allows the researcher to appreciate aspects of human phenomena that have yet to be unearthed.

Definition of Terms

The following definitions were adopted to clarify the use of certain key terms in this study that could otherwise be unclear.

Acute Care Setting: A healthcare environment where patients with severe medical conditions receive immediate and intensive treatment for a short duration. It often requires specialized medical equipment and rapid assessment for diagnosis and treatment planning (Groher & Puntil-Sheltman, 2016).

Bedside Nurse: Registered Professional Nurses working at the bedside and providing direct patient care. Guidance and structure in delivering person-centered care at the bedside are needed, as well as utilizing nurses' competence and knowledge in achieving such care (Muntlin et al., 2003).

Mentoring: This term has been defined in many ways and is discussed in great detail in Chapter 2. This study aimed to understand more about the phenomenon of being mentored, in which case it may be helpful to appreciate the mentor role. Mentors are advisors, people with career experience willing to share their knowledge; supporters, people who give emotional and moral encouragement; tutors, people who give specific feedback on one's performance; masters, in the sense of employers to whom one is apprenticed; sponsors, sources of information about

and aid in obtaining opportunities; and models of identity, the kind of person one should be to be a nurse (Gogio, 2020).

Nurse Leader: An individual defined by their actions and not always by a position of authority. Leaders in nursing inspire and influence others to achieve their maximum potential (ANA, 2023).

"Nurses Eating Their Young": A provocative image coined by Meissner (1986) used as a call to action for the nursing profession. The behaviors described could be any toxic interaction between nurses, which the literature described as negative behaviors that may include bullying, lateral violence, verbal abuse, horizontal violence, harassment, disruptive behavior, and incivility (Sauer, 2012).

Preceptor: A nurse who guides students in integrating theory into practice, teaching clinical skills, assessing clinical competencies, and enhancing problem-solving and critical thinking skills over a finite period of time (Wu et al., 2020).

Phenomenon of Interest

The phenomenon of this study is mentoring. When integrated into nursing practice and career development, mentoring allows for the creation of short- and long-term relationships between experienced and novice nurses in the clinical setting to develop and facilitate knowledge transfer. Weng et al. (2010) found that through trust and respect for the mentors, mentees aim to emulate the mentor's behavior, as experienced in their dyadic relationship, as well as improve their practice. A decline in conflicts experienced by the mentee is also significantly related to the mentoring experience and the development of relationships between mentor and mentee (p. 5). Vance (1977), a foremost scholar in mentorship, leadership development, and nursing education, suggested that 93% of those mentored were likely to mentor. Based on her study, if all leaders

choose to mentor, then opportunities for mentorship might be more commonly available. Yet, do we truly understand the meaning of mentorship in nursing?

The value and existence of mentors have been well-documented for decades. The concept of mentorship has proven readily transferable to various professions, like business, medicine, education, and the arts, or any colleague system, to provide a gateway toward the ladder of success (Ambrosetti & Davis, 2016; Roth, 2015; Vance & Olsen,1998).

However, in nursing, the knowledge or use of mentors is not as formalized or consistent. The term *preceptor*, a teacher or instructor who assists a novice nurse with skills development over a finite period of time, is a more familiar role for nurses. It is important to note that the concepts of mentor and preceptor are commonly used interchangeably and may confuse the functionality and expectations of the respective roles.

The Context for the Phenomenon

The context for this phenomenon was the nurse leader who began their career as a nurse practicing at the bedside in an acute care setting. According to Benner (1982, 1984, 2000), the clinical competence of a new nurse graduate or a nurse working in a new specialty develops along a continuum from novice to expert. The nurse bridges the gap between theoretical and practical knowledge during the transition from novice or advanced beginner to expert. The new nurse graduate is assigned to a preceptor who is responsible for socializing and orienting them to the chosen department or specialty area while evaluating their clinical practice and professionalism (Roth, 2015). Within a predetermined number of weeks, depending on the institution of hire, this new nurse graduate or nurse new to a department or specialty is expected to provide competent care.

The Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* in 2010, outlined recommendations to transform nursing practice and education by supporting nursing along the continuum. The report found that mentoring strengthens individuals in the nursing workforce and improves the quality of care and patient outcomes (Committee on the Robert Wood Johnson Foundation, 2011). Schmitt and Schiffman (2019) described the transition experience of the new graduate nurse and the experienced nurse at the bedside. During the first year of their transition, nurses characterized their mentors as a resource and *go-to* person. Mentors were regarded as support persons with a more formal role and were perceived as a resource to "help you find your way" (p. 5).

This study highlighted nurses mentored in the clinical setting because it is a role where nurses often struggle as they transition through their practice development (Schmitt & Schiffman, 2019, p. 8). Through this phenomenological research, I sought to understand the lived experiences of nurse leaders who were supported by mentors while in the role of bedside nurse.

Justification for Study

Recent nursing studies (Hale & Phillips, 2019; Mazzoccoli & Wolf, 2016; Raines, 2019) have showcased the benefit of mentorship and posited that a fulfilled dyadic mentoring relationship enriches individuals personally and professionally. However, the nursing culture has not always been so forward-thinking and supportive. The least favorable attribute of the nursing profession is related to a question posed by Meissner (1986), "Do nurses eat their young?" (p. 2). Meissner questioned and exposed the negative manner in which nurse educators and administrators addressed nursing students and new nurse graduates. By blaming the profession for creating an unwelcoming environment for new nurses to thrive in, nursing was

challenged to reflect on its possible failure to create a nurturing environment for new learners or practicing nurses.

Colleague aggression, professional terrorism, and lateral violence are terms in the literature used to describe a lack of respect or support for colleagues experienced by novice nurses or those transitioning to a new environment (Gillespie et al., 2024; Hubbard et al., 2010; Latham et al., 2008, Stanley et al., 2007). More recently, Fang et al. (2020) found that nearly two-thirds of nurses experienced bullying behaviors, and these behaviors can cause harm and create isolation from the group. These types of experiences have long been barriers to professional development and retention in nursing practice. Studies (Chu & Evans, 2016; Kumar & Blake-Beard, 2012) have addressed the hostile reception experienced by nurses new to the practice or a specialty; however, fewer studies have addressed the experience of being mentored as a newly transitioned nurse. With research tracing back nearly 150 years ago to the correspondence between Florence Nightingale and her protégées about the presence of a negative nursing culture (Lorentzon & Brown, 2003), we should be emboldened to contemplate and bring to light experiences where nurses are supported throughout their career trajectory.

In 1997, Lucille Joel, a past president of both the American Nurses Association (ANA) and the International Council on Nursing (ICN), recognized the need for mentoring in an *American Journal of Nursing* editorial. At the time, the nursing community was acutely aware of its declining commitment to mentoring. However, loosely defined in other terms, Joel described mentoring as a "patron relationship" (p. 7). She addressed how the culture had changed and questioned the cause for lowered participation levels, possibly resulting from a lack of compensation or difficulty in standardizing nursing responsibilities and competencies.

To this point, Kumar and Blake-Beard (2012) asked, "What good is bad mentorship?" Since prior studies had discussed the benefits of mentorship, Kumar and Blake-Beard sought to explore the negative mentoring experiences of mentees or protégés. The purpose of investigating the negative experiences in mentoring involved gaining greater insight into the effects on the mentor-mentee relationship and the possibility of mitigating any negative consequences to the individuals in the relationship. Findings in a recent study (Gillespie et al., 2024) showed that when negative experiences occur, both productivity and patient care are negatively impacted. Recommendations from these studies revealing negative outcomes call for research studying mentor-mentee relationships with positive experiences and encouraging leaders in healthcare organizations to consider the nature of these relationships.

Significance of Mentoring

Mentorship has been shown to empower nurses to form a professional identity while transitioning into their newly chosen roles and careers (Posluszny, 2014). Professional identity development, or *professionalization*, can also improve nurse retention and patient care outcomes, especially as mentoring becomes part of the hospital culture (Latham et al., 2011; Posluszny, 2014). Programs that have used mentorship demonstrated higher new graduate nurse retention and satisfaction rates (Block et al., 2005; Cottingham et al., 2011; Greene & Puetzer, 2002). According to an IOM (2011) report, early mentorship, which emphasizes the early career nurses' role, significantly influences their professional identity and goals.

The outcomes of mentoring provide a significant benefit in understanding how nurses learn, adapt, transition, and succeed in their new roles on all levels. From student to nurse graduate to nurse leader in specialties that include education, administration, and clinical practice, there is value in learning how to complement their professional journey (Grossman,

2012; Joel, 1997; Mazzoccoli & Wolf, 2016; McBride et al., 2019). I hope this study builds on the wealth of current information by highlighting mentoring and gaining insight into the possible value of mentoring as a standard of practice in nursing professional development.

Relevance of Mentoring in Nursing

Nurse turnover in the first year of practice ranges between 35% and 60%, with the highest turnover among new nurses (Weng et al., 2010). Turnovers are costly both to the organization and to the individual. New nurses often bear heavy work pressure due to limited clinical skills, experience, and full responsibility for patient care. This pressure impacts their job satisfaction as well as organizational commitment. Weng et al. (2010) posited that mentoring can promote the transfer of knowledge and values that support a hospital's mission. Therefore, a mentoring program is a valuable approach to improving the retention of new nurses.

Organizational commitment is a statistically significant predictor of nurse absenteeism, turnover, and intent to resign (Latham et al., 2011). Educational opportunities and career development are two influencing factors that affect the retention of new nurses. Mentors are essential in creating opportunities for new nurses to facilitate socialization within the organization.

Nurse Solutions Inc. (NSI, 2022) underscored the effects of the COVID-19 (coronavirus disease of 2019) pandemic on nurse staffing. The "Great Resignation" described the mass exodus of nurses (and other healthcare professionals) since the onset of COVID-19 from healthcare and hospitals in the last 4 years due to competition for labor, employee burnout, and retirement. Contributors of burnout included, but were not limited to, an increase in nurse-to-patient ratios and adverse patient outcomes, higher acuity, and emotional and physical exhaustion. In 2023 (NSI, 2024), 23.8% of nurses with less than 1 year of experience left their

hospital positions, with first-year turnover accounting for 34% of all RN departures. Over the past 5 years, nurses working in specialties most affected by the pandemic (step-down, emergency services, behavioral health, and telemetry) had turnover rates ranging from 112.1% to 119%. Hospitals are now compelled to invest in human capital and recapture revenue. Operational considerations now address employment decisions, including opportunities that build relationships, commitment, and confidence early in the employment cycle.

From its inception, the nursing profession has made great strides in arming itself with knowledge about mentoring. However, the benefits of incorporating mentoring into bedside clinical practice still need to be examined. With the appropriate dose of wonder and the right questions, the answers are all within reach. The narratives of those who have experienced this phenomenon can reveal significant insights into nursing. Hopefully, valuable lessons will also emerge from these stories.

Assumptions and Biases

Van Manen (2016) suggested that "the problem with phenomenological inquiry is not that we know too little, but that we know too much" (p. 46). Our common sense, pre-understandings, assumptions, and existing knowledge lead us to interpret the nature of the phenomenon before we even establish the significance of the phenomenological question. Although it is impossible to truly forget what is known, an opportunity to keep them at bay is created by making our assumptions and biases explicit (p. 47).

My assumptions related to this study included that mentees would view mentoring as a positive experience. Mentoring is encouraged in many healthcare and professional organizations to assist in career development and allow for meaningful connections to flourish. I also assumed that nurses would be honest about their experiences, whether positive or negative. Furthermore, I

assumed that nurses in leadership roles have greater access to opportunities for formal mentoring in their institutions or professional organizations and may, therefore, be able to identify whether they were mentored as bedside nurses to describe what that was like.

My bias as an educator and mentor was that mentorship is valuable in a nurse's professional development. Yet, I was not confident in my understanding of the true essence of mentorship. Mentors and mentees are often challenged by knowing how to develop their relationship and recognize a successful relationship. Identifying relationships or dyads that are not mutually beneficial is part of my role; however, I favor promoting mentoring opportunities for nurses.

Summary

Chapter 1 introduced the aim and significance of the study. Through this study, I aimed to understand the lived experience of nurse leaders mentored as staff nurses while working at the bedside. The next chapter describes the evolution of mentoring in nursing, including historical and experiential contexts.

Chapter 2: EVOLUTION OF STUDY

As iron sharpens iron, so one man sharpens another.

Proverbs 27:17, *New American Standard Bible* (2022)

This chapter reviews the literature on nursing education and practice from a historical context. The focus is on the development of nursing practice and the evolution of mentoring in nursing practice. The chapter closes with an experiential context describing my experiences as a nurse with mentoring.

Nursing Practice

The American Nurses Association (ANA, 2022) has described the nursing practice as the "protection, promotion, and optimization of health and abilities: prevention of illness and injury; facilitation of healing; alleviation of suffering through the diagnosis and treatment of human response; and advocacy in the care of individuals, families, groups, communities, and populations." This practice is carried out by the registered professional nurse, licensed to care for patients "whenever there is a need for nursing knowledge, compassion, and expertise" (ANA, 2022). The acquisition, development, and transference of knowledge and expertise are instrumental in developing the nursing practice.

Historical Context

Evolution of Nursing Practice

Modern nursing education has traditionally recognized the contributions of Florence Nightingale in elevating the nurse's role into the profession it is today. Nightingale received a divine calling on February 7, 1837, at age 16, leading her on a selfless journey, apart from her upper-middle-class comforts, to train and serve as a nurse (Snodgrass, 1999). Her eventual administrative roles in hospitals developed her abilities to innovate, create solutions, and

modernize the operations of British hospitals. When Nightingale resolved to execute her vision of nursing, she began with a training program on June 24, 1860, through the Nightingale School of Nursing at St. Thomas's Hospital. Nursing was a vocation steeped in charity and humanity and viewed "as a primary Christian virtue" (Bradshaw, 2001, p. 1). Nursing students, or *probationers* as they were called, signed a year's contract for their service and training in the hospital (Dossey, 2000). The Nightingale tradition of nursing applied the apprenticeship model as the educational program of that period.

Apprenticeship Model (1860-1977). Training for nursing practice occurred in hospital-owned or hospital-based nursing schools for the first 100 years. The probationers in the original nursing schools set up by pioneers like Nightingale received board and lodging, classroom learning from an appointed lecturer, and clinical training from ward "Sisters" charged with instructing the new students (Dossey, 2000). In the apprenticeship model, probationers gained confidence and competence through clinical experience and didactic lectures from physicians and nurse supervisors. The model relied on motivated, experienced nurses to share their knowledge of skills and experience with their students (Glenn, 2008).

Nightingale described the foundational principles of nursing as the correct balance of theory and practice. "The aims and objective of their teachings were fourfold: to develop moral character, to teach technical knowledge and skill, to perpetuate the method of apprenticeship learning by the example and tuition of the ward sister, and to encourage the professional etiquette of right relationships" (Bradshaw, 2001, p. vii). In apprenticeship, students were introduced to the tradition of nursing practice, an organized community, of which ward Sisters were the guardians, and that involved the crucial formation of character as its essence (Bradshaw, 2001). A writer in a 1912 issue of *Nursing Times* asked, "Can a nurse be trained to be kind if she is

naturally thoughtless and inconsiderate? Under certain circumstances, she cannot by any course of instruction but under the power of example. Character is caught rather than taught" (p. 43).

The arrangement of having nurse apprentice training in the hospital was beneficial for both the students and the institution hosting the program. The nurse probationers signed a 4-year contract and were admitted free of charge. The room and board were free as well as their tea and sugar, and they earned a wage of £10 (Dossey, 2000). Service to the hospital included 12-hour shifts for 6-7 days per week, following instructions given by physicians for the benefit of physicians. Despite the meager salary and laborious clinical teaching, the hospital assured the nurse had a secure job in a prestigious profession upon completion of the program (Kelly & Watson, 2013). The agreement also ended in a favorable financial return for the hospital, where the nurse graduate would often return a year of service for the privilege of participating in the apprenticeship. This arrangement was an inexpensive way of maintaining staffing from a pool of experienced, homegrown nurses.

In 1949, Agnes Gelinas, the National League of Nursing Education president, voiced her disdain for the established apprenticeship model. Gelinas was part of the nursing leadership who advocated for educational opportunities at the university level (Lewenson, 2013). For leaders in nursing education and individuals called to the profession, an opportunity presented itself at this time. A window of opportunity arose as there was a nursing shortage, an increase in hospital construction, and a federal G. I. Bill (Servicemen's Readjustment Act of 1944) for nurses who served in the war and sought to further their education in practice and leadership. This faction of nurse leaders moved to transition nursing education out of the hospital's control and into the university.

College and University Education Model (1948-1960). In 1948, Mildred Montag advocated for 2-year programs in her doctoral dissertation, *The Education of Nursing Technicians* at Teachers College, Columbia University, to prepare technical nurses to work alongside the Bachelor of Science Nursing degree (BSN)-prepared registered nurse (Klainberg, 2010). Today, most diploma nursing schools have been replaced by 2- and 4-year nursing programs in community colleges, comprehensive colleges, and universities. Tuition has now replaced labor, and education in university has replaced the hospital-based apprenticeship to prepare for the National Council of Licensure Examination (NCLEX®) as part of the requirement to practice as a Registered Professional Nurse.

The redesigning of education and practice models did not escape some conflict. The advancement of theoretical knowledge in the college classroom led to differing relationships in the clinical setting. Christman (1979) addressed the need to mend the nursing role in the 1970s because it was partially fractured by the separation of hospital and school. The professors were "non-doing" (p.11) nurses and nursing students were left at the mercy of clinical nurses or "doing" nurses (p. 11) who were not informed of or included in the class curriculum. Christman was a proponent of the BSN programs; however, he acknowledged how the clinically experienced instructor might positively affect the students' advancement (Christman, 1998). He proposed a Practitioner-Teacher Model to close the knowledge gap between didactic and clinical while improving the clinical experience of the new nurse.

It may be hypothesized that despite the concerns expressed regarding the apprenticeship model, the original support of "sisterhood" or one-to-one sharing of expertise between nurses provided guidance when transitioning to the university education model. The absence of that support may have created a need for the same instructor to observe clinical practice at the

bedside. Mentoring may have allowed for closing a gap in nursing practice and professional development.

Mentoring

Mentoring Defined

From mythology to contemporary times, there are multiple permutations of the term and concept of mentoring. The *New Oxford American Dictionary* (McKean, 2015) provided a current definition of a mentor as an experienced and trusted advisor or an experienced person in a company, college, or school who trains and counsels new employees or students. Mentoring involves advising or teaching someone, especially a younger colleague. There are references to mentoring in scriptures in the Bible, such as the Book of Proverbs (Proverbs 27:17, *New American Standard Bible*, 2022).

> There is a mutual benefit in rubbing two iron blades together; the edges become sharper, making the knives more efficient in their task to cut and slice. There is an even greater benefit when individuals sharpen one another to empower the other.

Daniel Levinson (1978), psychologist and researcher of adult development, shared a unique definition of mentoring when he stated:

> A mentor is a person who shares a dream—not necessarily a consciously formulated career goal but a cherished perception of self. The mentor encourages the young person's development by believing in him, sharing his youthful dream, and giving it [his] blessing, helping [him] to define the newly emerging self in its newly discovered world, and giving the young adult the autonomy to work out a reasonably satisfactory life structure that contains the dream. (p. 48)

Stewart and Krueger (1996) provided a theoretical definition of mentoring in nursing:

> Mentoring in nursing is a teaching-learning process acquired through personal experience within a one-to-one, reciprocal, career development relationship between two individuals diverse in age, personality, life cycle, professional status, and/or credentials. The nurse dyad relies on the relationship in large measure for several years for professional outcomes, such as research and scholarship: an expanded knowledge and practice base, affirmative action, and/or career progression. Mentoring nurses tend to repeat the process with the other nurses for the socialization of scholars and scientists

> into the professional community and the proliferation of a body of nursing knowledge. (p. 315)

This theoretical definition of mentoring is more closely related to how nursing uses this term than the standard dictionary definition, which more accurately defines the mentor's role for other professions.

Ng et al. (2020) suggested that mentoring shapes professional identity and personal development and enhances mentors' and mentees' careers, progress, and satisfaction. The benefits gained by mentees who begin their career with a mentor are as follows: a feeling of empowerment, greater job satisfaction, accelerated learning curve, better opportunities for promotion and salary increase, reduced stress, an affirmation of self-worth, and better socialization. For the mentor, the beneficial outcomes include leaving a legacy with a new generation of nursing, productive use of knowledge, gratification from peer recognition, gains of support, and opportunities on the organizational ladder (Kumar & Blake-Beard, 2012).

Eby et al. (2010) described the prevalence and use of mentoring in our lives in the vernacular as a mixed blessing. A favorable outcome of its popularity includes the interest that mentoring has generated in education, student-faculty, and the workplace. The challenge, however, exists in the definitional and conceptual confusion about what mentoring is or means.

Kram (1983, 1985), a foremost classic mentoring expert, was a student of Levinson (1978) who described mentoring of males in early childhood. Kram's research involved the informal cultivation of mentoring dyads in one organization. When Chandler (2011) asked how she saw the field of mentoring evolving over the next decade, Kram put forward suggestions for the study of cultural context and how organizational practices affect what kind of relationships. In addition, it is important to understand the inner makings of high-quality relationships within

organizations and the impact these relationships have on the careers of people and the learning curves they face. These relationships are important not just to individuals, but to organizations.

Mentorship and Nursing

In an interview with Nickitas (2014), Vance was asked to discuss her interest in mentorship in nursing. Vance's (1977) dissertation study investigated factors contributing to leadership development, and the word "mentor" resurfaced throughout her literature search. The term *mentor* appeared in the literature for established professions, like medicine, law, business, and corporate institutions, yet was absent from the nursing lexicon.

Vance (1977) researched the top 'nurse influentials' and posited a strong need for nursing mentors. Included in her recommendations were: (a) raising the mentor concept to a high level of awareness through research and presentations; (b) holding workshops for nurses about how to be a mentor and how to get a mentor as well as the personal and professional benefits of mentoring; and (c) continuing to research the mentoring concept and mentor activity in various areas and levels of nursing levels (p. 202).

Evolution of Mentoring in Nursing Practice

Unlike other professions, nursing does not have a consistent history of mentorship. The apprentice education model focused on skills development and assistance to the physician. Nursing was a practice in service to the community, and there was little time for anything else. When Levinson (1978) performed his research, it was done on a cohort of men. Vance (1977) and Kram (1985) created a theoretical foundation for how these relationships developed among leaders and in the workplace, including men and women. As the years pass, the relationship that defines mentoring varies. For example, Eby et al. (2010) described mentoring as a "broad and complicated" construct applied to many areas of study.

In nursing practice, a more commonly recognized term is *precepting.* The concept of precepting is derived from the Latin *praeceptum,* meaning to rule or guide for conduct (Fowler, 1992). The word has been part of the English vocabulary since the mid-15th century, with the basic meaning of instructor or tutor. For this reason, the American Academy of Preceptor Advancement (Roth, 2015) defined nurse preceptors as "specialists in their fields, disciplines, and areas of service, clinical practice, and work performance who facilitate successful orientations, transitions into practice and role competency of students, new graduates, and staff members through formal preceptorships" (p. 3). Precepting in nursing takes the form of an experienced person providing information, instruction, and feedback in a formalized manner to a novice (Carroll, 2004, p. 318). Preceptorship occurs over a finite period with set goals for a specific specialty. Historically, nurses invoked the terms *preceptor*, *role model*, *coach*, and *sponsor* to describe developmental relationships and activities (Vance, 2022). Although an individual may serve as a mentor as well as a preceptor, it is essential to note the distinction when researching the mentoring phenomenon.

Kramer (1974, 1975) researched the impact of the schism between school-bred values and work-world values on baccalaureate graduate nurses. In *Reality Shock: Why Nurses Leave Nursing,* Kramer (1974) used the term *reality shock* to describe the phenomenon and the specific shock-like reactions of newly graduated nurses who spend years studying to prepare for their new work situation and find themselves suddenly unprepared. The research highlighted the implications related to the transitioning experience of the novice nurse. Considerations for leaders, such as clinical educators, included acknowledging their role as socializing agents of the work environment. This role included the responsibility of introducing the bureaucracy of the organization.

Around the same time when Kram (1985) disseminated her research about mentoring at work, Meissner (1986) published an editorial titled “Nurses: Are We Eating Our Young?” In the article, she opined that nurse educators were the first offenders of creating an authoritarian environment while behaving like drill sergeants with their nursing students. She continued by describing the nurse administrators and preceptors in a similar light. The phrase “eating our young” was graphic, yet it highlighted a seemingly irredeemable quality within nursing practice. For nearly 40 years, the phrase describing an antiquated hazing process has resurfaced to inspire the profession to do better, support each other, and find lasting innovative solutions.

In the article “Wherefore Art Thou, Mentor?” Vance (2022) harkened back to nursing’s better angels in recognizing the need for the human connection that mentoring provides. As a proponent and content expert in mentorship and nursing, Vance emphasized an expansive view that focused attention on creating a dynamic mentoring paradigm that is more diverse, inclusive, and equitable. This is related to our changing nursing population and individual nurses’ needs. Raso (2022) underscored this sentiment by stating that “meaningful mentoring relationships have more purpose than defined career achievements” (p. 5).

Mentoring today appears in different forms. The formal one-to-one mentor-mentee or protégé still exists, in addition to the informal presentations of the mentor as an experienced leader or peer. Varied definitions and applications provide a meaningful opportunity to give insight into what mentoring is like for nurses working at the bedside.

Experiential Background

I entered nursing practice filled with hope and good intentions. Like many new nurse graduates, I aimed to provide holistic care for my patients in a culturally sensitive way. As a

second-degree nurse with a background in science and music, I applied my scientific knowledge toward healing and transitions to wellness while developing a new sense of the art of nursing.

Upon graduation, I was afforded an opportunity by the Dean of the Nursing Program in my college to apply for a graduate nurse externship as a Hillman Foundation nursing scholar. This opportunity to work in critical care as a new graduate nurse allowed me to "interview" for 8 weeks in my desired specialty and receive a job offer pending receipt of my license.

From that point forward, advice or guidance related to my profession was generally lacking and inconsistent at best. There were a few leaders I could count on one hand who extended themselves to offer advice and provide support. However, nurse managers in my department rarely remained in their positions long enough to recognize potential in my colleagues or me.

Inspiration to seek professional or scholarly opportunities came to me when I started to precept. Precepting newly hired nurses and students allowed me to provide a positive learning experience for novice practitioners while developing my skills and confidence in the process. Their gratitude and satisfaction from our precepting experience shaped the trajectory of my professional journey; it led me to pursue a career in nursing education. The acknowledgment of meaningful work mattered; however, a mentor who could guide the steps in my journey evaded me.

As an educator, I regularly recognize and seek potential and abilities in other nurses. I consider the experiences I would have grown from and how, despite my own story, I could contribute to improving someone else's professional career. Yet, I still wonder what it would have been like to have that kind of relationship with another colleague or leader who provided support and shared their knowledge.

My curiosity about mentoring developed as I witnessed nurses still "eating their young" or behaving less than collegially. I wondered if change agents who prioritized the mentorship of nurses could also contribute to retention within the profession and the collective advancement of nursing careers. I could not know for sure because I had not yet encountered those mentors in my career. I remained uncertain about how to proceed in my budding professional journey.

As a leader who has had the opportunity to facilitate a formal nurse mentoring program, I appreciate the challenges integral to the coordination of supporting the creation of a relationship between novice and experienced nurses. There are challenges related to defining mentoring and the expectations of building that connection in a structured way, as well as the dedication to being present and offering one's time while creating a space to allow the mentee to thrive and grow professionally.

Throughout my nursing practice and leadership years, opportunities for change and improvement in the profession abound. I feel honored to be a nurse and more honored for the opportunity to assume a role, like Athena did for Telemachus, in guiding, educating, and creating meaningful moments to develop our future nurses and the nursing profession.

Summary

This chapter traced the evolution of mentoring in literature from historical, conceptual, and experiential contexts. The next chapter describes the phenomenological research method chosen for this study.

Chapter 3: METHODOLOGY

> Phenomenology does not offer a fine theory but, rather,
> gives a plausible insight.
>
> Jan H. van den Berg (1972), p. 4

Phenomenology

The purpose of this chapter is to describe the philosophical foundation of phenomenology, the origins of the phenomenological method, and van Manen's approach to using the phenomenological method in research. A discussion of phenomenology as the rationale for the method of inquiry to explore the lived experience of nurse leaders when they were mentored as bedside nurses is also included.

Introduction to Qualitative Research

Research is conducted in a paradigm or worldview, which leads to questions that spark curiosity. In nursing research, quantitative and qualitative methods are commonly used. These alternative paradigms allow for different ways of developing evidence and outcomes (Polit & Beck, 2012). Quantitative research is most closely aligned with the positivist paradigm that assumes a reality can be studied and known. This paradigm involves deductive reasoning, which develops predictions from general principles (Polit & Beck, 2012). Qualitative research utilizes inductive reasoning, which is a process that starts with the details of the experience and creates a general picture of the phenomenon of interest (Speziale & Carpenter, 2011). Munhall (2012) opined that in nursing research, "thinking qualitatively is thinking of holistic beings that cannot be understood by reducing them to parts; each has a distinct situated context that will influence the individual's subjective world, perspective and use of language" (p. 7).

Nursing is a human science that investigates objects from the inside to the outside, with its most important concern being meaning (Munhall, 1989, p. 23; Munhall, 2012). The human

sciences seek understanding and interpretation; qualitative research methodologies allow meaning to be revealed in human subjectivity.

Introduction to the Phenomenological Approach

Phenomenology was the methodology used for this qualitative research study to allow for an understanding and appreciation of the lived experience. It is a philosophy, method, and qualitative research approach to human science (Earle, 2010; Munhall, 1989; Speziale & Carpenter, 2011). Polit and Beck (2017) defined phenomenology as focused on the lived experiences of humans, and it provides a way to learn what life experiences are like and what they mean. It is a unique approach to studying people and people's understanding, beliefs, and interpretations of the world (Ellis, 2016). Phenomenologists focus on describing what all participants have in common as they experience a phenomenon (Creswell, 2012, p. 58). In the context of this study, the methodology emphasizes the descriptive nature of the phenomenon of being mentored as a bedside nurse.

The philosophical movement known as phenomenology originated in the works of German philosopher and mathematician Edmund Husserl (Ellis, 2016). Husserl (1859-1938) believed philosophy should be viewed as a rigorous science that would restore contact with deeper human concerns (Speziale & Carpenter, 2011, p. 75). The phenomenological approach he pioneered was descriptive phenomenology. This approach emphasized the descriptions of human experiences, a description of "things" as people experience them. These "things" include hearing, seeing, believing, feeling, remembering, deciding, evaluating, and acting (Polit & Beck, 2017).

Husserl is credited with the insight that objects always appear to human consciousness as endowed with meaning (Zimmermann, 2015, p. 33). Phenomenology is a science of

consciousness rather than empirical things. What appears in consciousness is the phenomenon. The word *phenomenon* comes from the Greek *phainomenon*, meaning "thing appearing into view," and *phaenesthai*, to flare up, to show itself, to appear (Moustakas, 1994). Husserl also introduced the concept of *life-world* (*Lebenswelt*) or lived experiences (Cohen et al., 2000). The world of the *natural attitude* of everyday life or the way we see the world Husserl described as the original, pre-reflective, pre-theoretical attitude (Racher & Robinson, 2003; van Manen, 1997). The *life-world* is composed of what is taken for granted without resorting to interpretations and, therefore, not easily accessible; it forms the ontological and epistemological foundation for understanding the lived experience (Sundler et al., 2019). Husserl wanted to illuminate the essential structures of consciousness or *essences* and critically evaluate their role in determining the sense of it all. The central insight of Husserl's descriptive transcendental phenomenology was that consciousness was the condition of all human experience (Wojnar & Swanson, 2007, p. 173). Husserlian phenomenologists will always ask about the meaning of the human experience and the reality of the lifeworld (Koch, 1995; Polit & Beck, 2017).

Phenomenology seeks the nature of a phenomenon, for that which makes a "thing" what it *is*—without which it could not be what it is (Husserl, 2012; van Manen, 1997). *Essences* are elements related to the true meaning of something, the common concepts that provide an understanding of the phenomenon being researched (Speziale & Carpenter, 2011). Van Manen (1997) described phenomenology as "the systematic attempt to uncover and describe the structures" in pursuit of the *essences* of the lived experience (p. 10).

To designate *essences*, Husserl introduced the phenomenological or *eidetic reduction*, often referred to as *bracketing* (Cohen et al., 2000). He sought to explain how to overcome biases to experience pure consciousness, where the researcher may successfully abandon their

personal lived reality and describe the phenomenon. *Bracketing* describes how one must take hold of a phenomenon and then place it outside of one's knowledge (van Manen, 1997, p. 47). The term *reduction* refers to the researcher reducing the world as it is in the natural attitude to that of the pure phenomena. Husserl challenged individuals to go "back to the things themselves" to recover the original awareness, as free as possible from conceptual presuppositions (Spiegelberg, 1975, p. 10).

Phenomenologists who succeeded Husserl (2012) questioned the ability to "bracket" everything known about an experience. Bracketing must be continuous in order to provide descriptions of the phenomena in their pure form. His critics believed that it was not possible to fully detach from their own views and biases and considered methods to present their knowledge of the phenomenon to be kept at bay. Martin Heidegger (2008), one of Husserl's students, agreed with the declaration of "to the things themselves" yet disagreed with the view of the importance of description rather than interpretation.

Martin Heidegger (1889-1976) transitioned from the epistemological emphasis of Husserl to an emphasis on the ontological foundations of understanding reached through "being in the world" (Racher & Robinson, 2003, p. 472). Heidegger used "hermeneutics," the theory and practice of interpretation, in pursuit of a fundamental ontology. Hermeneutic phenomenology assumes the findings are not a pure description but rather the interpretation of the researcher (van Manen, 1990).

In the phenomenology of Husserl, Heidegger missed the conceptual tools and methods to discover the processes of being in human existence in such a way that being may come into view (Palmer, 1969). The phenomenological realm of the preconceptual attainment of phenomena saw this as a vital medium to the nature of being (p. 124). *Being* is the universal concept in

Heidegger's (2008, original published in 1962) hermeneutic phenomenology; the *Being* of something is the nature or meaning of the phenomenon. The Heideggerian concept, *Dasein*, the human way of being in the world, emphasizes that individuals cannot abstract themselves from the context that influences their choices and gives meaning to the lived experience (Wojnar & Swanson, 2007). In 1927, Heidegger's *Sein und Zeit* (Being and Time) pushed beyond Husserl in that it replaced the intentional structures of consciousness with the fundamental study of the relation between *Dasein* and *Being* itself.

Heidegger strongly insisted that questioning carries certain presumptions which govern the query and may even predetermine what can be discovered. In this way, one may disclose the answer in light of what they already know (Moran, 2000, p. 237). This questioning is described as an interpretive process that is circular and moves back and forth through which the parts and the whole are understood. Our questioning, then, is a kind of light that casts a certain pattern on the phenomenon while also filling in our expectations in a way that allows us to formulate further questions and thus advance our understanding (Moran, 2000; Wojnar & Swanson, 2007). Spiegelberg (1975) identified hermeneutics as a process and method for bringing out and making manifest what is normally hidden in the human experience and human relations.

For Maurice Merleau-Ponty (1908-1961), French existential phenomenologist and successor of Husserl, the focus was on the perception of an individual's situatedness in the world through experience. He elaborated on the assumptions of Husserl and Heidegger and suggested that the objective of phenomenology is to describe the barest elements of the human experience: the "things themselves" (Racher & Robinson, 2003). Merleau-Ponty (Merleau-Ponty & Landes, 2012) believed that meaning and understanding of life experiences occur through perception.

In the *Phenomenology of Perception,* Merleau-Ponty (1962) considered the definition of phenomenology and posited that it is still in the process of being defined. He was focused on the facticity of the body, the medium that we are, that puts us in the world and allows for our understanding of human existence (Gallagher, 2010, p. 183). *Consciousness* is a sensory awareness of the environment, and it is the existence in the world through the body (Munhall, 2012, p. 127). *Embodiment*, the relation of the mind and body, allows for a means through which we are aware of and experience the world. *Perception*, then, is essentially bodily; "it is sensory and motor, neither merely subjective nor objective, neither inner nor outer, spiritual nor mechanical" (Merleau-Ponty & Landes, 2012, p. xv).

The lifeworlds of human existence may also be studied in fundamental thematic structures. Merleau-Ponty is credited for offering four categories of fundamental lifeworld structures or *essentials*, which include: *lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality or communality). These essentials may be utilized in research to assist in the process of questioning, writing, and reflecting (Dowling, 2007; Merleau-Ponty & Landes, 2012; van Manen, 1997).

The phenomenology of Husserl, Heidegger, and Merleau-Ponty was theoretical in nature; they were purely focused on philosophy. Their original foundational writings offer fundamental insights that appear inexhaustible in their philosophical significance (van Manen & van Manen, 2021, p. 1070). However, the collective writings did not develop rules or procedures for conducting human science research (Earle, 2010). Van Manen (1990, 1997) incorporated the philosophy of his predecessors and offered an approach to conducting human science research while viewing phenomenology as both a philosophy and a practice.

Two prominent schools of thought that incorporated phenomenology into human science research were the Utrecht School in the Netherlands and Duquesne University in Pittsburgh, Pennsylvania. The Utrecht School consisted of phenomenologically oriented psychologists, sociologists, educators, pediatricians, psychiatrists, jurists, and medical doctors who were primarily interested in phenomenology as a practice and reflective method, not as a professional philosophy (van Manen, 2007). During the 1960s, Max van Manen, a Canadian social scientist born in the Netherlands, was influenced by the Dutch or Utrecht School phenomenological pedagogy and the German tradition of human science pedagogy (van Manen, 1990). Their interest was in *doing* phenomenology in service of their professions and for the purpose of understanding the practices of everyday life (van Manen, 2007, p. 23).

Interpretive phenomenology was learned through reflective studies about the pedagogic life-world written by phenomenologists like Langeveld (1905-1989); however, guidance or a method for participating in such scholarly research needed to be explained. One of van Manen's contributions has been to identify and discuss questions of phenomenological research methodology and how to partake in scholarship (O'Donoghue & Punch, 2003, p. 55). He described phenomenology as the quest for meaningfulness and originary meaning of human existence and lived or living experience; it is a way of profoundly understanding human phenomena. Van Manen (1990, 1997) introduced specific guidelines to inform the way we conduct human science research.

The methodology of this hermeneutic phenomenological research design was based on van Manen's (1990) themes of human science research. Van Manen offered the following six methodological research activities as a guide:

1. turning to a phenomenon that seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole. (pp. 30-31)

Rationale for the Phenomenological Method of Inquiry

Phenomenology provides an opportunity to look at a feeling (van Manen, 1990). The interviewing process allowed for the personal life story to emerge. For nurse scholars, phenomenology offers an approach to inquiry that aligns with the philosophy and art of nursing by understanding unique individuals and the meaning of their interactions with others and their environment (Lopez & Willis, 2004). While mentoring has been researched in the last four decades, it fails to be a consistent term in the nursing lexicon or a standard practice (Joel, 1997; Raines, 2019). Other research methods, such as quantitative and mixed methods, have illuminated the benefits of and barriers to mentoring; however, there remains a gap in the research and a need to reflect on what it is like to be mentored as a bedside nurse. When little is known about a particular topic, qualitative research is often more fruitful than quantitative (Munhall, 2012). In phenomenological research, we try to evoke understanding through language that in a curious way appears to be non-cognitive. In professions like nursing and education that require specific training skills and specialized bodies of knowledge, they also benefit from having discretionary and intuitive capabilities (van Manen, 1997). This hermeneutic phenomenological study has the opportunity to contribute to the epistemology of professional nursing practice. Mentoring has yet to be approached as a retrospective study where one may

gain insight from nurse leaders who were mentored as bedside nurses before their role advancement and shared their meaning of that phenomenon.

Summary

This chapter discussed the origins of phenomenology and offered descriptions and definitions by historical philosopher phenomenologists Husserl and Heidegger. The contribution of Merleau-Ponty's perception of the lived experience and van Manen's approach to conducting human science research were also presented. The rationale for using this phenomenological methodology for this study was explained. Chapter 4 next presents van Manen's phenomenological method applied to this study.

Chapter 4: METHOD APPLIED

This chapter discusses the application of the method that was used to conduct this phenomenological human science research. Van Manen's (1997) six research activities are discussed. In addition, the study's aim, sample criteria, setting, protection of human subjects, data collection and management, confidentiality, and data analysis are presented.

Application of van Manen's Method of Phenomenology

Van Manen's (1997, 2014) approach to the phenomenological method for human science research was applied to this study of the phenomenon of nurse leaders who were mentored as bedside nurses. Van Manen drew from the works of influential phenomenological philosophers such as Husserl, Heidegger, Merleau-Ponty, and others to offer methodological guidance for researchers conducting a phenomenological inquiry (Errasti-Ibarrando et al., 2019).

Van Manen (2007), like the Dutch scholars of the Utrecht School, provided insight for those interested in *doing* phenomenology for the benefit of their professional disciplines as well as understanding the practices of everyday life. This study utilized van Manen's (1990, 1997) six methodological themes to increase the understanding of the experience lived by nurse leaders mentored as bedside nurses.

When embarking on a phenomenological inquiry, a quest for the meaningfulness of a lived experience, van Manen (2016) explained that the lived experience or pre-reflective is found in the moment of the "Now." Although our focus was to capture the moment of "Now," it can be rather elusive. We are always in the Now, yet it remains absent from our grasp. In van Manen's opinion, this is what makes phenomenological inquiry so wondrous.

To provide guidance in doing hermeneutic phenomenological human science research, van Manen (1990, 1997) introduced a methodological structure to be "seen as a dynamic

interplay" among six research activities. These six research activities are as follows: turning to a phenomenon that seriously interests, investigating experience as we live it, reflecting on the essential themes characterizing the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strongly oriented relation to the phenomenon, and balancing the research context by considering parts and whole. Although the numbered steps imply that there is a specific order to apply the methodological themes, the research process may work intermittently or simultaneously (1997, p. 34).

Van Manen (1997) introduced the methodological themes with the first activity of turning to a phenomenon that truly interests us and to which we are committed. Through this commitment, one can allow for a deep questioning of the chosen phenomenological inquiry (p. 31). The phenomenological inquiry I wonder about and was committed to researching in this study was the lived experience of nurse leaders who were mentored while in the role of the bedside nurse. Mentoring is a phenomenon that I think deeply about, yet I am uncertain about what makes mentoring its own phenomenon. My aim was to better define mentoring in order to contribute a richer, deeper meaning to this uniquely human experience.

The second research activity of van Manen (1997) discusses investigating the experience as is it lived rather than as it is conceptualized. The aim of phenomenological research is to reconnect with the original experience. In becoming full of the lived experience, one gains wisdom in the practice of having lived a life deeply (p. 32). Thus, researchers can stand in the fullness of that life lived in the world. This activity involves searching for experiential descriptions in each participant's interviews. The interview questions guided each participant in describing what it is really like and helping the researcher to understand the lived experience "from the inside" (p. 8).

In the third activity, van Manen (1997) asserted that a true reflection on the lived experience provides an understanding of the phenomenon. In the reflective grasping of what is, the researcher discerns between the appearance and essence of the phenomenon. This activity involves "bringing a nearness to that which is obscure" (p. 32). I employed a thoughtful gaze to grasp the essential themes of the lived experience of being mentored as a bedside nurse. This involved an immersion into the transcribed interviews to conduct a thematic analysis and search for essential meanings.

The art of writing and rewriting to describe the phenomenon leads to the fourth research activity. Van Manen (1997) stated that "to *do* research in a phenomenological sense is already and immediately and always a *bringing to speech* of something" (p. 32). In this sense, phenomenology is the "application of *logos* (language and thoughtfulness) to a phenomenon (an aspect of lived experience), to what shows itself precisely as it shows itself" (p. 33). For this activity, I wrote and rewrote a clear description of the participants' experiences, followed by a thoughtful and discerning interpretation of the meaning of mentoring for the bedside nurse. To be human is to be concerned with meaning, to desire meaning. Desire is a state of being that refers to an attentiveness and deep interest in a particular aspect of life (p. 79). I used this desire to return to the phenomenon to seek its meaning.

The fifth activity implores the phenomenological researcher to maintain a strong and oriented relation to the phenomenon. To establish a strong connection with a particular phenomenon, van Manen (1997) suggested that the practitioner must remain oriented to the wonder of the study and fully embrace it. To honor this process, I aimed to ward off the temptation to become distracted by any speculations or settle for preconceived notions (p. 33).

In the sixth and final research activity, van Manen (1997) instructed researchers to balance the research context by considering the parts and the whole. As I sought to reveal the "phenomenon in its whatness" (p. 33), I remained mindful of not getting buried in the writing where I could lose my direction. It was important to take a step back and look at how the parts of the text contributed toward the whole of the phenomenon of mentoring.

Participant Selection

The participants selected for this research study were nurse leaders who were mentored as bedside nurses in the acute care hospital setting. Participants had a minimum of a baccalaureate degree from an accredited nursing college. This study was limited to nurse leaders mentored as bedside nurses in the acute care setting because this area has a minor focus on mentoring (Nickitas, 2014).

Recruitment of participants for the study began with snowball sampling. Polit and Beck (2017) defined snowball or *chain* sampling as selecting participants through referrals from earlier participants. Using snowball sampling assisted in recruiting participants with the unique experience of being mentored as a bedside nurse and establishing a referral from a previous participant with whom trust had already been established (Heckathorn, 2011). The sampling began with a convenience sample of a few volunteers who met the study criteria for inclusion. These initial participants served as "seeds" who recommended additional participants for the study, providing the final sample like a snowball rolling down a hill (Heckathorn, 2011, p. 365). The initial participants received recruitment flyers that included my contact information about the research study, inclusion criteria requesting nurse leaders mentored as bedside nurses to participate in the study, and a QR (quick response) code to access a participant eligibility survey.

In qualitative research, there are no fixed rules for sample size; the size is based on informational needs. In phenomenological studies, in-depth interviews with the researcher and participants are the primary source of data in a sample size of typically 10 or less (Polit & Beck, 2017, p. 471). A guiding principle used to establish an appropriate sample size is data saturation or redundancy. Saturation is obtained when the researcher determines that no new information is provided, and redundancy is achieved. The data were collected "to the point where a sense of closure was attained" (p. 521). When new data yielded redundant information and saturation was reached, the data collection was completed. At that time, I conducted an additional interview to ensure saturation was reached.

An electronic and paper recruitment flyer was created that included all relevant information for participation in the study with my contact information, including name, Institutional Review Board (IRB) approval number, email, phone number, and information regarding study recruitment as well as the study (Appendix D). A unique email address and phone number were created solely for the study to ensure privacy for the participants who needed to contact me with inquiries regarding participation, follow-up questions, or feedback. Participants were contacted after completing the initial survey through a QR code with a link to a form that provided a description of the study and the inclusion criteria to establish their eligibility for the study. All applicants were contacted to confirm eligibility for the study based on the information entered in the survey. A link to a demographic questionnaire and informed consent form was then emailed to each participant who met the criteria to be reviewed before the interview and served as an introduction.

The demographic questionnaire inquired about the potential nurse leader participants' gender identity, age, race/ethnicity, years of nursing practice, years as a nurse leader, type of

nursing degree earned, current position held, name of their current employer or hospital, what specialty unit they worked in while in the role of bedside nurse, which shifts(s) they worked on, and whether nursing was their first career or profession.

Setting

Once the participant consented to participate in an audio-recorded interview, a mutually agreed-upon meeting date and time was established for the virtual meeting on the Zoom video conferencing platform. The location was safe, private, comfortable, and convenient for the participant. For those participants who agreed to participate in the study who did not live locally, the interviews took place at a time convenient for them via the Zoom application. Face-to-face meetings allowed for observing body language, facial expressions, and other nonverbal communication relevant to storytelling. The Zoom application had audio and video recording as well as transcription capabilities.

Protection of Human Subjects

Institutional Review Board (IRB) approval from Teachers College, Columbia University was obtained to protect the participants. I completed the Collaborative Institutional Training Initiative (CITI) program as a requirement to conduct research and followed the policies as instructed. Participation in this study was voluntary, and participants were informed that they may choose to withdraw at any time without penalty. Participants who agreed to be interviewed in this study provided written consent before the interview. Before starting the interview, participants were also provided with a verbal explanation of the nature of the study, the procedure, risks, anticipated benefits, and the means of keeping their confidentiality and anonymity secure. All participants were given the necessary time to ask questions or express concerns before starting the interview. Participants were informed of compensation for

completing all tasks in this study on the informed consent form and the research recruitment flyer. A $25 USD Amazon electronic gift card was emailed to each participant when the tasks were completed. No compensation was provided to participants who did not complete all the tasks required for the study.

Data Collection Procedure

Informed consent and demographic data were collected before the start of each interview. The demographic data that were collected included their age, gender identity, race/ethnicity, type of nursing degree earned, years of nursing practice, current position held, years in their current leadership role, work location, area of specialty as bedside nurse (e.g., medical/surgical, critical care, telemetry, peri-operative), shift type while working at the bedside, and whether nursing was their first career or profession. All interviewees were given a choice to consent to audio alone or both audio and video on the Zoom application.

After introductions, the participant was given time to review the consent and ask any additional questions. Upon providing consent, the interview commenced. The purpose of this qualitative study was to describe the lived experience of nurse leaders mentored as bedside registered nurses. Each nurse leader was asked, “Tell me about a time when you were mentored as a bedside nurse?” This open-ended question may have been followed by a clarifying question like, “What comes to mind when you hear the word *mentoring*?” As the participant continued to share, additional questions such as “Can you tell me more about that?” or “And what was that like?” were asked to guide the participant back to the moment of that experience and gain insight into the meaning of mentoring. The interview specifically explored and gathered experiential narratives, stories, or anecdotes that gave a more profound sense of the lived experience of the

phenomenon of being mentored as a bedside nurse. The participants' experiences unfolded in their verbal or nonverbal stories, both of which were compelling.

Confidentiality and Data Storage

To maintain confidentiality and protect the privacy of the research participants, I stored all data collected for this study on a password-protected, fingerprint-coded computer and an encrypted flash drive that was placed in a locked file cabinet in my home. The data included informed consent, demographic information, audio recordings, transcripts, and written field notes that were placed in the locked file drawer and a password-protected computer.

Each participant file/transcript was assigned a pseudonym and corresponding number. After 3 years, all digital and hardcopy files, including participant information, will be destroyed.

Data Analysis

The goal of analysis in hermeneutic phenomenological research is an interpretation that accurately captures and communicates the meaning of the experience lived by the participants being studied (Cohen et al., 2000). The audio recordings were transcribed using Otter.ai, an online service that ensures privacy and security for the encrypted data transcribed. The transcript was created in real-time and encrypted for confidentiality for interviews done through an audio-video format, like Zoom. I reviewed each transcript to ensure its accuracy. To begin the analysis, I listened to the audio and video recordings, read the transcripts for accuracy, and then gleaned an understanding of their general experience of being mentored.

Data analysis necessitates the researcher to dwell with or become one with the data (Speziale & Carpenter, 2011). To become one with the data, I read and re-read the verbatim transcripts in their entirety as well as written notes in the margins and analytic memos to extract any significant statements. Every significant statement was initially given an equal value;

overlapping or repeated statements were then filtered. Then, I clustered and categorized the statements into themes or meaning units (Moustakas, 1994). Patterns of the meaning unit were categorized, color-coded, and compared to lay bare themes and essential themes. This process was utilized for each transcript. To validate the themes and essential themes, I provided 10% of my transcripts, categories, and essential themes for review by an experienced researcher of phenomenology. I also shared the transcripts and essential themes with the participants to ensure they agreed with the interpretation of their mentoring experience.

I employed phenomenological reflection to capture the essential meaning of each participant's mentoring experiences. The insight into the essence of a phenomenon involved a process of reflecting appropriately to clarify and make explicit the structure of meaning of the lived experience (van Manen, 1997, p. 77).

Summary

This chapter presented the applied phenomenological method according to van Manen's six activities that was used to conduct this human science research. Participant selection, setting, and plan for protecting human subjects were discussed. The procedure and process of data collection and analyses were also presented.

Chapter 5: FINDINGS OF THE STUDY

> Words mean more than what is set down on paper. It takes
> the human voice to infuse them with shades of deeper meaning.
>
> Maya Angelou (2015), p. 98

In this chapter, I delve into the findings of this phenomenological study, presenting an analysis of experiences shared and the insights gleaned from them. This study explored, described, and revealed the phenomenon of being mentored as a bedside nurse as perceived by the nurse leader participants. Eleven nurse leader participants were interviewed about their experiences of being mentored as a bedside nurse using van Manen's (1990) approach to research with the hermeneutic phenomenological method. This research methodology allowed for description, analysis, and interpretation of the phenomenon that uncovered themes and offered insights into the lived meaning of being mentored as experienced by the participants in this study.

Participants' Demographics

Participants shared their backgrounds before each interview. Each nurse leader portrayed their nursing experience and professional accomplishments as a context of their unique journey. The participants in this study were nurses currently in leadership positions who shared experiences of being mentored as a bedside nurse in the acute care hospital setting in various specialties. The nursing specialties represented by the participants were as follows: Neurology (two), Critical Care: Medical and Cardiothoracic Intensive Care Units (five), Medical and Surgical Unit (three), Liver Transplant (one), Renal Transplant (one), Orthopedics (two), Telemetry (one), and Emergency Medicine (one).

A few participants shared experiences that occurred while working in more than one specialty unit. The orientation experience for these participants was diverse; most had a formal

orientation period that included a preceptor, and a few had a less formal introduction to nursing practice with different preceptors assessing their competence or there was an absence of an orientation.

The participants' ages ranged from 33 to 73 years old (see Table 1 for the participants' demographic information). Three nurse leader participants had previous careers in fields outside of nursing: administrative assistant, emergency services, and marketing. The current roles of the nurse leader participants included the following titles: Adjunct Professor, Assistant Clinical Professor, Professor, Clinical Director, Stroke Coordinator, Magnet Program Director, Nurse Educator, Manager, and Senior Clinical Program Manager. Study participants were given pseudonyms; no actual names were used in this study.

Individual Participants' Experiences

Hanna

Hanna heard about this study from a former professor who assisted me in recruiting participants and initiating the snowball sampling. Hanna has been a nurse for 51 years and has 49 years of experience in nursing leadership and academia. She currently holds a position as a professor at a large university in the northeastern region of the United States.

We arranged a virtual face-to-face video interview via Zoom while she was at home, and I was in a private room in the college library. It was winter, and she was wearing a cozy pink top. She met me with a welcoming smile that put me at ease, and we broke the ice by reviewing her demographic information for accuracy. The interview began with my initial question: "Tell me about a time you were mentored as a bedside nurse." Hanna paused for a moment and then shared:

Table 1

Demographic Information

	Name	Gender Identity	Age	Race/ Ethnicity	Highest Degree Earned	Total Years in Nursing	Years in a Leadership Role	Shifts Worked
1	Hanna	Female	73	White	EdD	51	49	Day, Evening
2	Sophie	Female	41	White	EdD	13	6	Day, Night, Flex shift
3	Jacqueline	Female	44	White	DNP	19	8	Day
4	Harold	Male	33	White	BSN	8.5	2.5	Day
5	Barbara	Female	34	Black/ African American	BSN	9	6	Day, Night
6	Evelyn	Female	63	Black/ African American	DNP	40	4	Night
7	Franklin	Male	38	Asian	DNP	17	3	Day, Night
8	Rachel	Female	66	White	MSN	22	8	Day
9	Katie	Female	67	Black/ African American	MSN	28	17	Day
10	Elisabeth	Female	46	White	MSN	20	6	Day
11	Amy	Female	36	Asian	MSN	16	10	Evening

> I think you really have a very important study because I was thinking back on my experiences after I read your little blurb (on the flyer) and thinking, you know, that (mentoring) was really what gave me the confidence to get my start in and be in a leadership role. I first started out in neurology, and the person who was the head nurse was a wonderful mentor.... What she did with me was definitely mentoring. You know, I learned about how to be a head nurse at that time, which was, you know, my first major leadership position. And what she did was put me in charge when she wasn't going to be there.... I was a little bit competitive at the time...and I remember feeling very honored.

Sophie

Sophie responded to the survey and used the QR code on the recruitment flyer to contact me. She holds a doctoral degree in education and is also a nurse practitioner. Her extensive career began in critical care and led her to various leadership roles in the acute care setting and academia. In the academic setting, Sophie has served as an adjunct professor at several universities in the northeastern region.

Sophie and I arranged our virtual interview through Zoom on a winter evening after work. She settled into a comfortable room with her laptop and presented a calm demeanor. She realized she had a story to share when she saw the subject on the research flyer.

> So, I had the one experience that I always hold dear to my heart...she was my technically my preceptor, by title,...when I got hired...but clearly it was a lot more than that. She did things outside of what was required of her, basically she would offer a lot of advice for me, not just professionally, but also on a personal level. And I don't know if that's because maybe she saw a little bit of me in her, and that's why she was that way, but it definitely felt more personal than just a very professional transaction, you know, "I'm going to teach you this," and then "you're going to learn this," [instead] she definitely gave more than that. So, she was not a formal mentor, but that is how I saw her to be. And she had that role [while] I finished my orientation...and I was there for six years working at the bedside. She was always cheering me along and really giving me that extra little push that I needed to do more and learn more. That's how I remember it to be. I can't say it's just one moment, but it feels like [she] was always present.

Jacqueline

I met Jacqueline through a former colleague who had shared my recruitment flyer with her. Jacqueline's energy beamed through the camera as she sat in her office at her hospital. I

could hear an overhead public announcement call in the distance and checked with her if this was still an excellent time to speak. She assured me that it was. We broke the ice by discussing her experience as a bedside nurse and nurse leader, and she shared that she had recently received her Doctor of Nursing Practice (DNP) degree. Jacqueline is a second-degree nurse (with her first bachelor's degree in biology) who serves as a program director focused on nursing excellence.

Jacqueline began her nursing career in a metropolitan university hospital system in a northeastern state and shared that her work environment was sometimes supportive. However, as we began our interview, Jacqueline recalled one particular person she credits as a mentor. She credited this mentor for preventing her from leaving the nursing profession 19 years ago and helping her develop into the critical thinking leader she is today.

> So, for ten years, really, as a clinical nurse, my one mentor that always speaks out to my mind, that calls out, is a lady by the name of [Kathy]...she was a mentor-preceptor... and during my time there...she was just one that always would listen to me if I had any questions.... I don't think I understood what mentoring was at that time. So, I can't really put a pinpoint on [a specific time]. I can only reflect upon that now, going back through my journey and my nursing career.

Harold

Harold received my research flyer from a former nurse leader colleague of his. Harold's personality shone clearly through his email before I met him, and his spirited presence was just as bright. Before our interview, he shared the story of his blossoming nursing career that began 9 years ago. He started his nursing practice in a medical center in a neighboring northeastern state.

We arranged a meeting during his workday in the hospital. Harold sat comfortably in a chair wearing a lab coat in a room where we remained undisturbed for the entirety of the interview. His speech was fast and overflowing with details as he shared his personal experience of being mentored:

> I can talk a great deal about...one individual in particular who mentored me more than anybody else. And then, even when I got into a leadership role, I continued that mentorship and, you know, to this day, is somebody I called as early or recently as the last couple of weeks to discuss career advancement.

Barbara

Barbara was referred to me through a recruitment flyer given to her by one of her colleagues. She completed her survey and provided her contact information. We texted a few times to coordinate an interview time. She was bubbly and enthusiastic about my study and its subject matter. She found the idea of a phenomenological approach to the study of mentoring exciting and was looking forward to sharing her story about her mentor with me.

Barbara shared that she has been a nurse for 11 years and a leader for 6 of those years. She noted that her experience with the person she identified as her mentor was instrumental in transitioning to a new organization, in the way she considered opportunities in advancing her career and how she learned to take her place in the nursing profession. She sometimes showed her emotion (happy tears, she called them) during the interview simply in response to her gratitude for her mentoring experience.

> I remember specifically when I started at [my hospital] in the ICU. [She] was my assistant nurse manager overnight...she definitely took an interest in me. I would ask questions, and she would encourage me to, you know, look things up. She was the first person who let it be known to me that it was an option to do a project based on something that I saw or had found.... And there was an instance when it didn't happen to me; it was something that happened to another nurse, and she would pull me aside and say, "Okay, what would you have done differently? How do you think this could have been prevented?" And I think she was very much trying to angle me in the direction of leadership. She said, "You seem more interested in what happens next than most other people." And I appreciated that because I was interested. I always wanted to know, "What do we do now?"... She very much wanted me to see something that I wouldn't have otherwise seen if she didn't bring me there.

Evelyn

A nurse educator, Evelyn, received my recruitment information from a former colleague. Initially, I could not reach Evelyn by phone or email. We eventually connected and spoke over the phone to make an initial introduction and discuss the steps leading up to the interview. On a quiet Sunday afternoon, I met with Evelyn on Zoom for the interview.

We started the interview by reviewing her demographic information. Evelyn's training and education began in the West Indies and continued in the United States. She explained that in the 1990s, there was an influx of registered nurses from abroad, so there were more opportunities to choose one's desired specialty since the staff was needed. The moment was ripe for transitioning to the intensive care unit in this circumstance. Evelyn shared that her enthusiasm was not met with the same energy from her assigned preceptor, but her experience would eventually shift to a more positive and memorable one.

> There was one nurse there who was [the] same ethnicity [I was]. And she was subjected to the same thing [nurses not being kind or willing to teach] I had been…. She was like a forerunner, you know, she was there before. If I were mentored by her, there was so much that we learned because she was more open. She was open to sharing information. And she made the environment more relaxed. She laughed a lot, many times, you know, silly laughter...but she knew her work. She wasn't afraid to share information with you and was like that across the board. You know what I mean? And part of what helped to shape her whole persona was because of what [negativity] she encountered before, you know, her own personal experience. She just wanted to make it better for other people. She didn't want other people to [experience that], and she knew we were going through that.

Franklin

Franklin is a doctorally prepared nurse practitioner who was referred by another participant. I emailed Franklin, and we found a time separate from his work, teaching, or family obligations. He expressed his delight in contributing his story to nursing research and acknowledged how important the subject of mentoring was to him.

We began the interview by reviewing his demographic information, and I listened to his experiences leading to his current position in Quality and Research. Franklin took me back to the time when he was a newly graduated nurse in the intensive care unit and shared the following about his mentoring experience 17 years ago:

> It was a great experience, to say the least. There was a lot of scientific knowledge, [it was] knowledge-based skill-based, but the most important things were, you know, the day-to-day how-to, really, and, how to be more. Back then, it wasn't used, but the whole spectrum of being emotionally intelligent...communication skills.... How do you deal with a difficult conversation with a fellow [physician], an attending [physician], or an intensivist, as well as a fellow nurse? And most topics that I would appreciate were things like assignments, you know, as a new nurse, I remember there will be times where you feel that the assignment is too challenging in terms of acuity, you know, how do you mitigate that and just really having the tools to, to get through to do what you have to do as a nurse.

Rachel

Rachel shared her interest in participating after receiving the information from a mutual colleague. We texted and spoke by phone to establish a mutually convenient time before the interview. We settled on a chilly Sunday evening to meet, and she shared her triumphant journey to completing her initial nursing degree and the 22 years that followed.

Rachel entered nursing with extensive experience in private pediatric practice as a medical assistant and emergency medicine as a paramedic. As a mature adult, she knew and had witnessed effective communication, what it was like to be encouraged and supported by family and employers, and how to be responsible and work hard. In the final semester of nursing school, she identified a professor as her mentor, who supported and believed in her during her novice nurse beginnings.

> And I remember the day graduation came; I handed her...I remember like it was this morning, I handed her a little fern, and I said, I hope my career grows like I hope this fern grows for you. And she remembers that still. And she said, "Stay in touch." And I did. And we did. And we knew a lot of mutual people...which is what kept our friendship really strong. And like I said, I called it a friendship. *Hey, can I run something by you?*

> *Hey, what do you think of this?* I knew it was mentorship, but...I didn't ever start a conversation with "I'm sorry to bother you. I know we haven't spoken or I'm sorry to bother you. I'm sure you're busy." It was like, *Hey, how are you? I want to run something by you. You're busy? I'll call you back.* So, I was very comfortable with our relationship. I was very comfortable with my skills because I knew she had been a part of that. And I was comfortable that she would never say, *Why are you calling me?*, you know, or anything along those lines.

When Rachel described her mentor as a friend, I asked her which qualities she would use to describe a friend, and she shared the following:

> Honesty, upfront, integrity...honesty is what it takes to be a friend. That's what I have, and I hold that very dear. And if I can trust you, it doesn't necessarily mean I won't be friendly towards you...but a true friend...it's all about integrity. And she's got that.

Katie

I was introduced to Katie through a former coworker who shared my recruitment information with her. Katie is a nurse manager with 28 years of nursing practice. Her experience spans acute care to long-term care in private and government facilities. The joy in her voice was contagious when she harkened back on the start of her career and her experience of being mentored. She began by sharing her story of her first orientation.

> She was the one who worked with me after the six weeks [of orientation]. Actually, she was so fast that I had to catch up, but she was excellent...she was young, very young, but she had more experience than me...she knew her job! She knew the ins and outs of nursing and how to [manage] any technical difficulty or any technical skill you need, and she was able to show you.

Elisabeth

Elisabeth is an Assistant Clinical Professor from the southwestern region of the United States who learned about my study from a former coworker. We communicated by email and texts to establish a suitable time to meet within the 3-hour time difference.

When I met Elisabeth for our interview on Zoom, she was in an office with a beautiful quilt in the background. Her cheery nature created a favorable start to the discussion, and she

was eager to begin and share her experience. She drew me back to the start of her practice 20 years ago in an environment that needed to be more welcoming. She described working in the neonatal ICU as a high-pressure environment with great responsibility and minimal support from her colleagues, who were responsible for orienting her to the unit. We spoke for a considerable time about an unkind, disrespectful milieu and a challenging space to learn as a new nurse.

> So, twenty years ago, it was do or die; you learn on the fly. I started in the neonatal ICU. Then, I quickly moved into the pediatrics and pediatric ICU. I was assigned a preceptor, and it would be like, *watch one, do one*. We would have two babies...one would be really sick; one would be not as sick...she [the preceptor] would have the sicker one. [There were no goals set]. Because it was such an *eat your young* mentality, and it was very, oh, what's the word? "Cliquish." Yeah, the senior nurses would always get those [critical] cases. So, they weren't open to having new nurses learn. So, you have to be willing to speak up, and you have to be willing to fight for what you want to do. So, if you could stand by, I would not have been able to grow as much as I did. So, when they would say, "Who wants to float to peds?", I would be like, I'll do it, you know, I want to learn, I want to grow. And that would be kind of how your mentorship was; you did it yourself.

After sharing her initial experiences of the lack of guidance she received, Elisabeth compared her initial experience to now being mentored by the chair of her DNP program. I asked her if she could tell me about another time that she could identify as being mentored when she was still practicing as a nurse at the bedside, and she shared a story about her director:

> When I was working on my master's [degree], I rounded with my director for my clinical hours. I always thought she was so hard-nosed... She was more of a transactional leader and, in some cases, dictator-leader, but I learned so much from her. So much that I didn't realize in the time that she taught me. This was when I was in the ICU bedside.... So, I got to see a lot of different sides of her, and I realized she really was a mentor to all of the nurses. And maybe in the moment, [there wasn't] a warm, fuzzy feeling that you wanted, but she really cared about her nurses. Like when there was a holiday, and we had three [nurses] call out, she came in with scrubs and took patients. So, she mentored [me] by working alongside us, you know, and so she would probably be one that would come to mind the most when I look back.... She really did mentor me.

Amy

I was referred to Amy by one of the participants who shared the recruitment flyer with her. We communicated through email a few times to connect our schedules until we settled on an early spring morning before her workday started. We met on Zoom while she was in her office.

Amy shared the experience of her nursing journey with me, starting from Southeast Asia, where she received her nursing education. After completing her Bachelor of Nursing degree, she worked in Europe for a few years before coming to the United States. Although Amy moved to the United States with a few years of experience, the culture and practice differed. She described the nurse's role as feeling more subordinate to the physician as a student than while practicing in Europe or the United States. Despite the excellent education and knowledge she received, Amy was amazed by how independent nurses were and how much the nursing profession was promoted. She started working at the bedside in a hospital in a metropolitan setting on a medical-surgical unit and shared with me her story of being mentored:

> Okay, so I was only a bedside nurse for one year, exactly one year. And after that, I moved up. But in that one year, my first preceptor was also my mentor. That is how I should really put it because I have only had one area where I worked [and] one person who precepted me. And that one person is somebody I would remember for the rest of my life. That person mentored me. Initially, like every preceptor, she would teach me...then she became like a friend, and then a mentor...she was there, trying to tell me, okay, do this or expect and watch for this.... She would go above and beyond, like arguing with the doctors, getting things done from the lab, or not waiting. *Come on, let's go, let's go*. And she wouldn't wait for the PCA [patient care associate] to transfer the patient. *Let's go*. *Let's do it.* I wouldn't be waiting for somebody to do [the] job...if that is also a part of my job responsibility. And then there's that transition, I would say, from watching what I am doing to feeling confident. She [eventually] let me do everything on my own.

Thematic Analysis

The fourth activity of van Manen's (1997) phenomenological method encapsulated the thematic analysis for this study. This activity describes the art of writing and rewriting. As discussed in Chapter 4, prior to embarking on the analysis, I remained committed to the chosen phenomenon of inquiry and wondered about the lived experience of nurse leaders who were mentored as bedside nurses. In the second activity, I aimed to conduct an interview with the participant that would allow me to connect with the original experience of being mentored. The third research activity involved seeking a true reflection of the lived experience to understand the phenomenon by immersing myself in the transcribed interviews. I implemented the steps in this activity by dwelling on and connecting with the participants' individual stories. The process of the fourth activity required deep reflection while listening to the audio-recorded interviews multiple times, reading the transcripts several times, reviewing my notes, writing and rewriting, and, finally, identifying the themes that emerged from the interpreted meanings.

The analysis process took several months to complete. After each interview on Zoom, an audio recording was securely transferred to Otter.ai, where the transcript was generated. Then, I listened to each audio recording while reviewing the written transcript for accuracy. I repeated this process for each participant's interview until the transcript matched the audio recording. This re-listening of the interviews, re-reading the transcripts, and dwelling on their experiences allowed the preliminary themes to emerge. I highlighted phrases in the text on each transcript and noted tentative theme names. These themes were then color-coded according to common ideas to indicate where they appeared throughout the interview. I also developed a document that consisted of participant quotes and phrases representing the meaning units. The extracted phrases with similar ideas were then placed into clusters of similar categories. These meaning units were

examined to identify and name each group's themes. This immersive process allowed for a deeper significance or meaning structure of the lived experience to be revealed. Fourteen preliminary themes were identified.

Further analysis and synthesis resulted in five essential themes. Each of the essential themes included subthemes. Specific participant quotes were identified and included during the writing process to support each theme and essential theme. This process aimed to verify the essential themes and elucidate the essence from the essential themes of being mentored as a bedside nurse.

Van Manen (1997) encouraged utilizing collaborative discussion on the themes and their descriptors. The meaning units, essences, and themes were discussed and reviewed with my advisor. The 14 themes were synthesized into five essential themes and 10 subthemes and were identified as the most consistent among the nurse leaders' experiences. The 14 themes that emerged were:

1. Safe Space
2. Relationship
3. Available
4. Guidepost
5. Knowledge Sharing
6. Offering Self
7. Role Model
8. Spark Recognition
9. Encouragement
10. Transformation

11. Personal Connection

12. Cheerleader

13. Support

14. Admiration

Table 2 presents the emerging essential themes and subthemes. I emailed the study participants with the final essential themes and subthemes to request any feedback, comments, concerns, or questions they might have about the themes. This process provided validation of the themes, subthemes, and essential themes. The responses indicated concurrence with the themes with specific comments such as “Looks good” and “I think you nailed it.” One participant thoughtfully described how each theme reflected their lived experience of being mentored.

Table 2

Essential Themes and Subthemes

Themes	Subthemes
Theme 1: Evolution of the Mentor Role	I Transition from Preceptor/Leader a Formal - Assigned or Unassigned b Informal - Organic or Planned Transition II Evolving Relationship Complexity of Personal and Professional Connections
Theme 2: Creating a Safe Space Change	I Offering Self II Providing Nonjudgmental Guidance
Theme 3: Pearls in Clinical Practice	I Bonding in Caring Practice II Bridging into Leadership
Theme 4: Transitioning From the Nest to Flight	I Taken Under a Wing II Given Flight into Greatness: Introduction to Opportunities
Theme 5: Honoring the Transformative Experience	I On Becoming II Creating a Legacy

All Themes

Establishing Rigor

Establishing rigor or trustworthiness is an essential part of the qualitative research process. The fifth step of van Manen's (1997) approach to the phenomenological method is maintaining a strong, pedagogically oriented relation to the phenomenological question. I was careful to maintain a phenomenological attitude toward what it was like to be mentored as a bedside nurse by suspending assumptions and judgment. While doing research, the phenomenological point of view was always to question how we experience and know the world in which we live as human beings (van Manen, 1997).

Human science research expects that the texts produced are oriented, strong, rich, and deep so that they have powerful and credible validity. This structure invites dialogue with those who interact with it (van Manen, 1997). To orient myself to the *lived world* of those who were mentored, I developed a conversational relationship with each research participant. During the interview, I concentrated on each participant's original language (descriptions in their own words) to ascertain their exact meaning. I maintained a strong orientation to the object of the study in a unique and personal way by preventing my unreflected preconceptions from developing any biases or assumptions. To protect the research from personal bias, I noted the possible areas of bias shared in Chapter 1 and used my journal to make them explicit as they arose. The rich and thick meanings of the lived sense of the phenomenon were captured through the lens of the nurse leaders via their reflected stories and anecdotes. These detailed descriptions that explored the meaning structures beyond what was immediately experienced allowed me to gain dimension of depth (van Manen, 1997). I developed a strong personal connection by dwelling on the participants' shared experiences, listening to the audio recordings, and re-reading

the transcripts to orient myself to their world. This immersion process enabled deeper and richer meanings to emerge from their reflected descriptions. The four conditions of strong, oriented, rich, and deep texts described as methodological requirements were utilized as evaluative criteria for this phenomenological human science study.

Essential Themes

Identifying a theme is a form of capturing the phenomenon one is trying to understand or "wonder" about. A theme describes a unique aspect of the lived experience; it gets to the meaning of the experience, provides shape to the shapeless, and touches the core of the notion we wish to grasp (van Manen, 1997). To determine the essential quality of a theme, van Manen stated that our "concern is to discover which aspects or qualities make a phenomenon what it is and without which the phenomenon could not be what it is" (p. 107). It is with openness to the notion embedded within the lived experience and insightful discovery that I arrived at the following essential themes and subthemes to illuminate the lived meaning of being mentored as a bedside nurse, as shared by the nurse leader participants.

Essential Theme 1: Evolution of the Mentor Role

All of the participants were consistent in describing their introduction into clinical practice. The evolution of the mentor role originated from various leaders with other titles. All participants, except for Hanna who started to work without a formal orientation, shared the experience of having an orientation as a newly graduated nurse or when starting to work in a new department or specialty.

The participants' stories began with an introduction to their work environment and the staff, who would eventually be their colleagues. Nursing orientation often included the presence of a preceptor who was responsible for determining that they safely applied their theory into

practice. All participants were eager to share their stories about the time they became aware of the person who eventually became the one they would identify as their mentor.

Each participant reported that their mentor transitioned from another role. Most were formally assigned to a preceptor who would eventually take shape as a mentor, but the mentor role had not been formally assigned. The evolution of the mentor role was also an informal, organic transition for all except Harold, whose preceptor offered to be his mentor.

Two subthemes emerged to produce the essential evolution of the mentor theme: Transition from Preceptor/Leader and the Evolving Relationship Complexity in Personal and Professional Connections.

Subtheme I: Transition from Preceptor/Leader: Formal and Informal. All the participants conveyed that their mentor transitioned from a preceptor or nurse leader role at the start of their nursing practice. Beyond their initial introduction and practical skills development, the participants described a relationship that developed with their mentors. Their connections were personal, professional, and beyond the expectations of the preceptor's responsibilities, primarily focused on their competence in nursing practice.

Sophie shared the story of how it began for her as a new nurse:

> My nurse manager assigned a person who was going to train me. I started as a nurse on nights in the emergency ICU.... I was a new grad there. I didn't know very much, but I was also motivated to learn. I asked a lot of questions.... [She] was my preceptor, and now I see her as my mentor.

Katie told the story of her nursing career beginnings, which appeared fast-paced and focused. She reminisced on how much she learned from her preceptor and described the transition to being mentored in this way:

> The policy [of the organization] is that whenever you are a new RN, nurse, that is, an employee, you get six weeks of preceptorship. So, you are assigned a nurse, one nurse, that's the only nurse you are given.... You work the same tour that she works and the

> same hours, so you work with her every day, whatever day she's on. After the six-week preceptorship is finished, you have feedback from education, the nurse manager, and your preceptor.... If you need more, you probably need to be mentored, or you need more time in order to be functional on the floor. So, I got the same person I was assigned as a preceptor; she continued mentoring me because this was my first job as a nurse.

While thinking back to the time that he met his charge nurse, Harold's reflection sparked a memory of the initial transition from charge nurse to his mentor:

> I never had that plan to go into leadership...but I also didn't know what was out there. And [my mentor] helped bring those potential roles to light for me. It was in those early goings on when I was in the four- to six-month period and was just in a touch base. A "Hey, how are things going" type of conversation...it's early, but I'm starting to figure [out] where I want to go with my career. And it was in that conversation [he said], "Hey, I could be your mentor." And I was like, "Absolutely! [SMILES] I'd love that!"...you know, from there, it kind of just...took off.

Harold also recalled that after this conversation with his newly established mentor, a preceptor offered to work with him, but his mentor said, "No, he is with me!" This experience left a lasting impression on Harold, indicating that this relationship was meaningful and that his mentor took his well-being seriously.

Subtheme II: Evolving Relationship Complexity in Personal and Professional Connections. Barbara revealed how impactful the personal and professional connections she made with her assistant nurse manager on the night shift were for her:

> I had never had a leader that I could say I could relate to where I was in terms of race or in terms of gender because I always say that I can't separate being a Black woman from anything, especially overnight [shift], having this person who looked at me and said that she saw herself take an interest in me.... And to this day, I have talked to her before I even had the current position that I have. I spoke to her about it. We talked about the pros and cons. And we talked about where it could lead and just having that conversation continuously.

Rachel remarked that her preceptor and teacher had become her friend. The transition from being precepted to being mentored felt like a friendship. She described it this way:

> I called it a friendship. *Hey, can I run something by you? Hey, what do you think of this?* I knew it was mentorship, but...I didn't ever start a conversation with "I'm sorry to bother you. I know we haven't spoken or I'm sorry to bother you. I'm sure you're busy." It was like, *Hey, how are you? I want to run something by you. You're busy? I'll call you back.* So, I was very comfortable with our relationship. I was very comfortable with my skills because I knew she had been a part of that. And I was comfortable that she would never say, *Why are you calling me?*, you know, or anything along those lines.

Harold also shared a personal and professional connection with his preceptor. He had another preceptor who he described as stern, which made him nervous and unsure. He shared how she was different than his mentor in the following way:

> So, the difference between her, I would say, and the mentor was the fact that he was a male nurse, and I was a male nurse; we got along, not that I didn't with everybody, but, you know, we were able to get along on a personal level, too. And we would meet up outside of work periodically, not often, but every now and then, and then hang out or grab a drink or whatever. I could speak very frankly with him.

Harold and his mentor still meet and connect for personal and professional reasons, including discussions about career opportunities.

Sophie reflected on the personal connection she had with her mentor:

> She saw a bit of me in her; I saw something there; she shared a lot about herself...and her nursing journey with me, and I felt like she did that because something probably resonated in me or of me resonated for her...it felt very motherly. She definitely treated me a lot like she would a daughter.... I will never forget her.... She's amazing. And, you know, we keep in touch. Now, every so often, we'll text each other. She always knows what's going on in my life.

Essential Theme 2: Creating a Safe Space for Change

The milieu of the workplace was an important motif in all of the participants' stories. Some shared that they received support from their coworkers, whereas other participants shared the absence and presence of a nurturing environment. Despite the help they received as newly practicing nurses, a common thread of the environment, which was a place where "nurses eat their young," emerged repeatedly. The expression coined by Meissner (1986) still seemed to be a universal way to describe the unkind behaviors and personalities presented at the start of a

participant's career. Elisabeth shared the following about her interactions with some of her coworkers in the absence of a safe space:

> I did have some really negative incidents that happened early on in my nursing career where they would be very, very mean. I used to cry all the time. They would say you're stupid, you don't know what you're doing. You should've never chosen to be a nurse.

Although Elisabeth eventually experienced a safe space during her bedside nursing practice, she confided that until that happened, her safe space came from her family. At a pivotal moment in her career, her family reminded her of why she had become a nurse and encouraged her to remain in the profession.

It was important for the participants to share the challenges they experienced as bedside nurses to highlight their perception of how meaningful being mentored was by creating a safe space for them. This space was free from criticism, bias, and conflict and inspired the sharing of ideas and concerns free from judgment. When asked what it was like for his mentor to create a safe space for him, Harold described it as a "trusting relationship." He stated, "When you have trust that there is somebody who's got your back, that's looking out for you." The discussions were "off the record" in a way that was "honest and non-punitive." Harold clarified further by saying:

> Having that safe space, if you will, with those conversations is probably one of the more important components of a mentor-mentee relationship.

The two subthemes that comprised the essential theme of Creating a Safe Space were Offering Oneself and Providing Nonjudgmental Guidance.

Subtheme I: Offering Self. Within the theme of creating a safe space, the nurse leaders shared their perception of how their relationship with the mentor provided an experience beyond what they expected. Jacqueline described her mentor as supportive and available in the earliest stages of her nursing practice, unlike her colleagues. She shared:

> I think she is one of the people that made me stay more, I guess she gave me positive reinforcement for staying even in the nursing career, because not everybody's nice: whether it is employees or staff or interdisciplinary staff or patients and families, right? So, having a person always there, I think, to lean on and say, "Is this right?" Is this right that the person is doing that or like my one experience that I had mentioned previously was about my first code experience.... This was after right the precepting time, and I was on my own and went to open a code cart because my patient was having a heart attack. And nobody would help me, none of the other nurses, like it was, "Well if they're gonna open the code cart, we pay for that when you open the code cart."... You know, I didn't really understand what the big deal was because then I guess I would have to get another code cart. But you know, even after that, and going down [to her floor] and reflecting and just running that scenario with her made it nice to talk; that made her special to me, And I didn't ever feel like I was a burden to her to explain an experience.

Rachel had the experience of having a mentor who was a former professor, and she shared that her nursing clinical experience also provided an awareness of the extra effort that was made for her:

> With mentorship, there's confidence in talking about things that maybe a preceptor [might] say, "You know what we'll leave for the next shift; don't worry about that." And I don't necessarily think all the preceptors are doing that at all. I don't mean to allude to that, but it is task-oriented, for the day, it is not long-term. And that's what I appreciated from my few mentors because I am not with them. I have left my other job, and we talk about it every week. And the other one I talk to, as much as I can possibly talk to her, and she bounces things off me as well...that is [an] honor. Because you actually value my opinion. So, I think when or if someone's going to be given that moniker, that is my "mentor," that's an honor. You are not just my preceptor. That is how I see it, anyway.

Subtheme II: Providing Nonjudgmental Guidance. Jacqueline recalled the patience she was afforded by her preceptor turned mentor.

> She was patient with me. [It] really started with precepting, but then even after precepting, she was the one I would always go to ask for more. So, not a specific time... just somebody that was always there if I had a question about anything in nursing, any experiences...

Rachel reflected on the guidance provided by her mentor, who made corrections in her practice that allowed her to improve:

> She would say, "You did great on this!" or "I wasn't so happy with this, but let me tell you why I wasn't happy." "You had everything structured, but you left out x, y, and z, you made yourself vulnerable. That is where you need to work on."

Another mentor offered Rachel this advice about working through a problem:

> So, let's look at this situation; let's talk about it. Let's work through it.... Don't be afraid to talk about whatever it is you're afraid to talk about. You know, you have to have that one person in your corner.

Essential Theme 3: Pearls in Clinical Practice

All the participants shared a common thread of receiving pearls of wisdom from their mentors in clinical practice. Most recalled exactly when those lessons were implemented—in the most critical times. The bonds they created with their mentors forged a caring practice that would continue in the years to follow.

The knowledge shared with each participant offered a path towards best practices, effective communication with interdisciplinary staff, and recognition of their gifts, which could eventually lead them to other roles in nursing. Their stories brought to life the experiences of receiving these "pearls" and their transformations in practice and leadership today.

The two subthemes that arose from the essential theme of pearls of clinical practice were Bonding in Caring Practice and Bridging in Leadership.

Subtheme I: Bonding in Caring Practice. On the first night after completing orientation, Sophie had one of the most memorable nights of her nursing career. She took me back to the time that she recalled so vividly of a patient in the Intensive Care Unit with multiple co-morbidities and severe respiratory distress. Sophie recalled every step she had taken in caring for and reviving her patient, and while reflecting on the events of that night, she recognized that her mentor had prepared her for everything that transpired. Sophie relayed the following thoughts:

> ...I just remember standing there and thinking to myself, okay, so [this is] my first night off of orientation; I guess this is as bad as it could get.... It was a big production, but I don't think I would have ever been ready for that. I even anticipated what may have

> happened to that patient if [my preceptor] was not there. [In a way] she was there. It felt like she was there...her voice was there helping me through that, like, stay calm. This is what you need to do. What do we anticipate is going to happen for the patient? What do we need to get ready for the patient, that kind of stuff? I felt like it was because of her that I was able to make it through that night that was my first night off orientation. And I tell that story to a lot of my students and my orientees because it's going to happen. [The] worst-case scenario is going to happen to you, and then you're just going to feel more confident in how you approach things afterwards. What I did appreciate was how much she encouraged me not to rely so much on the [medical] residents because she said it was very clear that nurses are like your gateway of protection for the patient.

Hanna recalled a pivotal experience involving the care she witnessed for a nun in the neurology unit. This experience inspired her advocacy for her patient, who needed their dog at the bedside.

> There was a nun who had come in with a brain tumor. And she was bald. And this nurse that I was working with said, you know, she's a nun, she's always had some covering. And she went and she got one of those dish towels [or surgical drapes] to put it around her head and pinned it in the back. And I thought, wow, that is really nursing, you know, to see something like that where you've taken an individual you've learned [about them], you know how to do that. And I can give you an example of how I used that when I was a head nurse.... I was working in the [organization], and I had a patient who was blind. And the dog's name was Nesta. So, [the patient] came in with the dog. And I had all of the night security guards and orderlies, and everybody was trained to take Nesta for a walk. And then, of course, Nesta had a heart problem. So, we had to get special food for [the dog]. And I was away on a weekend, and I came back, and the dog was gone. I said, what happened? Well, they had a night security guard who was a substitute and didn't want to take the dog for a walk. I was livid! So, I went down to Administration and said, "What can I do to get this dog back?" And he said, "Get the dog, get the doctor to write. Man must have a dog." So, I did, and the dog came back that afternoon. But you know, that little thing with [the nun] and putting the head covering on sat in my mind forever. And I did all kinds of other little things that were spin-offs of it. And I just kept evolving it, but [my mentor] was the original impetus for it.

Rachel shared the pearls of wisdom she learned from two of the mentors she worked with:

> Again, patient care, patient care, patient care, do the right thing...you need to be able to go home and put your head on the pillow at the end of the day. And if something is wrong, let's look at what went wrong. Is it a person? Is it a process? It wasn't like, oh, you did this wrong. What were you thinking? No. Let's talk about it. Explain it to me. Let me understand what was going through your mind. Okay, at the end of the day, this might have been better; you could have done something else here. But it was never like, cut you

off at the knees and throw you to the wolves. Both of them were like that. And they're still like that.

Harold's mentor taught him lessons in prioritization and critical thinking, which he still uses today:

> And so early on in my career, I will give you a good example: He worked in Charge. I had a patient who was a renal transplant patient, but the transplant was not doing so well. [They] had been transplanted sometime before and having some [complications]. It was a very tough and sad [situation]. And I remember being very young in my career, and I was wondering what I was going to do here. I was at such a loss. And he pulls me out of the room. And he's like, "Listen, first of all, take a deep breath," and gave me that perspective. Think about what this person is going through and think about the medical things to social services. He asked, "What is the first thing we need to do?"...but he would never give me the answers. And *you* tell me, "What is the biggest priority?"... So, then, what's the next thing? How do we prioritize this down?... What I hadn't even realized at the time is [that] he is pulling me out of the situation and de-escalating me as well. Now, being a leader, I get it. And there happened to be a harp player that was coming around. And they were there for the patients, but he pulled them aside, sat me down in the hallway, and had the harpist play for me. It was funny, but it got me to relax and calm down. And he actually de-escalated me, reset me, and had me come up with, you know, a game plan of attack. So, I remember early on how am I going to do this job type-of-moment and having the support of a mentor there to walk me through, you know, the steps of what to do. You find the solutions yourself, but I think [my] mentor allowed me to come to the solutions, helping guide me to the right answer. And I think that was a nice example [during] my bedside nursing.

Subtheme II: Bridging in Leadership. Barbara gave an account of how her mentor prepared her for a leadership role by initiating questions for her to consider:

> She was the one who asked me, "Okay, well, when are you going back to school? When are you going back to school? What are you going to do now? You can't stay here; you have to decide. Are you going to be the manager of a unit? Are you going to manage something else? Are you going to learn about other things? Like, what else are you interested in?" But all in the realm of leadership. She very much believed that I should do something in leadership.

Hanna explained that her mentor role modeled the responsibility that prepared her for leadership. She described to me the details shared by her mentor that led to her taking on the Charge Nurse role:

> "You have to be the one responsible for the team." This is part of our role; we are here to help improve patient care. My admiration for the mentor was leading to admiration for [my] colleagues.... What I picked up from that early mentoring was that it's not just the day-to-day work, [but] that it's the respect and the relationships that you develop with your colleagues and peers.

Amy's mentor also discussed the responsibility of the nurse's role and, more specifically, to be ready to do work when and where you can. Her mentor reminded Amy:

> [You] wouldn't wait for the PCA [Patient Care Associate] to complete the transfer [of the patient]; I wouldn't be waiting for somebody to do somebody's job; I do not have to be waiting for somebody else.

Sophie acknowledged her mentor for giving her the confidence to consider leadership:

> Mentoring really gave me the confidence to get my start in a leadership role. I was in awe of her and aspired to be like her in many ways. She was a fantastic nurse and so smart. I wanted to be like her because I knew she knew the answers to my questions.

Essential Theme 4: Transitioning from the Nest to Flight

The participants in the study recognized that a transition occurred for them in their development and the scope of their role. There was an initial knowing of being in a relationship that was supporting their nursing practice. This trusting relationship was followed by acknowledging that their mentor had taken a distinct interest in their professional development. In some situations, the narratives shed light on opportunities the nurse leaders were given to fully appreciate their nursing scope and expand their wings beyond their bedside role.

The two subthemes that revealed themselves were Taken Under a Wing and Given Flight to Greatness. These subthemes merged to create the essential theme, Transition from Nest to Flight.

Subtheme I: Taken Under a Wing. Katie recalled that her mentor supported her in gaining learning opportunities.

> She was willing to share, willing to share her knowledge and experience. And that is what we need: people to share...let the profession grow and teach for each one to teach one. We did have that [program].... It is a system wherein we do the train-the-trainer. You would get taught, and then you come back, and you teach the rest. And it's [a program] we keep so we can capture everybody. For example, someone on the night will teach one or two, or two, three people in the night to do certain things. And you do it easily, too, on a day to teach another, and you find everybody. Everybody was taught these things...and that helped. Nevertheless, [my mentor] was a teacher.

After Evelyn experienced orientation in her critical care unit with a preceptor unwilling to share information with her, she had an alternative experience with another nurse. This nurse volunteered to take her under her wing in hopes of preparing Evelyn to care for critical care patients. She told her story in this way:

> There was one nurse there who was the same ethnicity [as me]. And she was subjected to the same thing...she was like a forerunner, you know, she was there before. She was active...and she knew a couple of things.... She would say some things to us... give us warnings, and stuff like that. So, mentoring changed from day to day. If I were mentored by her, there was so much that we learned because she was more open. She was open to sharing information. And she made the environment more relaxed. And she laughed a lot, a lot of times, you know, silly laughter, but she laughed a lot. She knew her work. She wasn't afraid to share information with you and was like that across the board. You know what I mean? And I think part of what helped to shape her whole persona was because of what she encountered before, you know, her own personal experience. She just wanted to make it better for other people.

Barbara described how her Assistant Nurse Manager recognized a spark in her and introduced her to the scope of leadership within her unit and hospital on the night shift:

> She said, "You seem more interested in what happens next than most other people." She encouraged me by taking me to the ANM [Assistant Nurse Manager] meeting; she took me to other meetings we had. There was one meeting where all of the assistant managers and overnight leaders would be. I wanted to see more and learn more about things from the managerial perspective. And she helped to facilitate me going, you know, assist her in meetings and approaching her manager to do stretch assignments so that I could do other things and learn more about not just being the nurse in charge that day. But also, as a manager, what about the budget? Who does that? How does that work out when there is a quality issue? What channels does that go through to try and figure out how I could be more effective as a leader and take on more leadership responsibilities? So, that was something that was directly related to her.

Subtheme II: Given Flight into Greatness. Amy captured the notion of figuratively getting "pushed out of the nest" with the freedom to fly and recognize her own greatness. She described that experience in the following way:

> She just let me go; she let me do everything on my own; that transition…from watching what I was doing to just feeling confident, provided instruction about what to do so I was prepared; two weeks after, I was taking all her cases like I was running as a nurse. You have got six patients to start by the time you finish you might have like ten patients. These are all yours. You're on your own.

Amy continued talking about the confidence instilled in her that allowed her to fly beyond her comfort zone:

> ...It was the confidence, not just in me, it was not just the confidence in my preceptor. There was also confidence between the other nurses I worked with and the nurse manager or assistant nurse manager who ran the floor. They're like, okay, [Amy], she can do things or given in a certain situation. If you could do things sooner than expected, [you would not be] taking care of patients down the [hall]. I was taking patients right next to the nurse's station, which meant they were critical patients. I didn't know that. I'm like, oh, I'm not all the way there. I'm here! What does that even mean? It was new to me; everything was new to me in this country. And I figured, okay, if they put me close to the nursing station, that's taking care of serious patients then. The transformation was fast for me. I only stayed there one year and had numerous experiences.

Hanna shared her experiences of being mentored by her head nurse, who also allowed her to develop her research knowledge. It began with her mentor creating an awareness about how to make a staff-patient assignment that led to an appreciation of how to lead and an understanding of the significance of clinical research. Hanna shared this story with me about a time while she was making the patient assignment for the staff:

> ...That is when she said to me, you know, it's important to take into account not only that these aren't just names on a piece of paper, you want to think about, you know, who are they, on the other hand, you don't want to assign one person down the hall, and another one, like a half a mile away, you know, so you've got to come with a happy medium. The other thing that was so interesting was that they were actually doing some research projects there. And I said I am not doing that. I had so much to do. I have two new patients coming in. She said, "You know what, [Hanna]? This is part of our role that we are here to help improve patient care. And you can't do that unless we have data."

Essential Theme 5: Honoring the Transformative Experience

This final theme of Honoring the Transformative Experience was the most clear, impactful, and impassioned theme. In each interview, when taking themselves back to the pre-reflective moments of being mentored, the participants recognized that the mentor was responsible for their transformation. Moreover, each participant became aware that they had been transformed. They were confident, capable, caring leaders who had traversed the unknown of professional nursing practice and survived their individual reality shock.

This transformation was fueled by kindness, patience, wisdom, guidance, opportunities, and a space to grow and develop. Each participant acknowledged how much they valued their individual mentorship experiences and how their mentors contributed to their personal and professional development. It appeared as though the revelations occurred during the interview, allowing them to pay tribute and honor their mentorship experience. Creating a pause, a space to reflect, gave the participants time to reflect on its meaning. By reflecting on the qualities and pearls bestowed by their mentor, they realized that they had now become their mentor.

The lessons, effective communication, and giving of time and space were now leadership qualities the participants passed on to novice nurses. They shared how they were deliberate in creating similar experiences for their colleagues while breaking the cycle of negative behaviors and culture. As members of their mentor's legacy, they were now creating their own legacy by paying it forward. At the end of the interview, each participant was offered an opportunity to share any additional thoughts about the mentoring experience that may have yet to be discussed or elaborated upon. All participants provided their individual "A-ha!" moments of gratitude and awareness of how they had transformed into the leaders they had become.

Two themes surfaced: On Becoming and Creating a Legacy. These two subthemes emerged first and were then integrated to create the essential theme of Honoring the Transformative Experience.

Subtheme I: On Becoming. Toward the end of our interview, Franklin revealed the connections he has with his mentors. After spending 8 weeks with his mentors during his nurse externship, he professed that he is passionate about the same specialties as his mentors today. One works in quality and research; the other is a great clinician. The experience of learning from exemplary clinicians also inspired him to teach and continue championing clinical excellence. He shared the following insights on his becoming like his mentors:

> I want to add...I don't know if there is a correlation with [mentorship]. But I think [my former preceptor] is doing a role more like quality research. And as of 2020, I have a role in quality and research. So, I don't know, if [in the] eight weeks that, you know, spending time with her, there was something subliminally...shaping up. [He smiles.] Naming all those values [of my mentors] is very interesting. Seventeen years later, I ended up in the same [specialty]. And then with [my other mentor], she was [a] very strong clinician...she was really good, you know, and had really good bedside manners, too. And in the end, *right now*, I am threading into looking at patient experience data. Is there a connection [of my mentoring experience] in there? It is hard to tell until you're deep into your career. Maybe there was something there that [I] didn't completely neglect. But years later, these things got there!... And getting into education, which, you know, a big percent of being an educator is to have mentorship skills.

Hanna disclosed her revelation of a full-circle moment of having her mentors pour knowledge, time, and guidance into her and now being a mentor:

> I learned that I translated tapping into what is special in my own mentoring of others. And that was so pivotal in the development of my career. It is not something I was seeking or felt I needed, but once the mentorship [relationship] was established, it taught me a lot about how to be a mentor.

Sophie shared how she embodies her mentor when given or seeking the opportunity to mentor someone else:

> Every time that I started a new position, a new job, I always thought about her. And in a way, I model how I am as a preceptor. And I mentor other people through how she kind was with me. She is definitely the first; she's like, you know, there is patient zero, she's like mentor zero, and [it's a] pay-it-forward kind of thing in my mind. I find myself mimicking how she was. I will never forget her; I think I do this because of her. I mirror a lot of her approach to how she was teaching me.... I find myself doing the thing where I am also looking out for other people; the essence of her is always there.

Amy articulated that she constantly considered what her preceptor would do in certain situations. She thinks of her most when

> I am precepting another person and [consider]the level of confidence that I should see in that person to let her be on her own. And that is something that I learned from my mentor; every time I get somebody to be precepted, I put on that version of *her* in me; I become one with [my mentor].… And then every time I would think, what would she have done, if it was this scenario? What would she have thought about if it was this scenario? Then, I would try to make things better. In my current job, I do not have a mentor; I have no way of knowing what is right. [Yet] even today, when I go back to the floor, those people remember me. Then I did something good there. [Smile].

Jacqueline reflected on how the experiences she has had with her mentors have carried on in her ways of being a mentor. She stated, "I always put myself in other people's shoes." She never wanted other people to feel like she did in her first 3 years of nursing. Jacqueline shared the following qualities of her mentors that led to her transformation:

> [My mentors] were very patient...listening, always listening. So, listening to others explain their story; I think that's one of my positive qualities and characteristics that help me grow in my role and provide feedback for others.

Barbara expressed her gratitude for having role models who were mentors and helped her normalize excellence in the faces she had rarely seen in leadership positions:

> I had this leadership team where my manager was Black, and so was my assistant manager during the day and the person at night who took an interest in me. So was my educator; this is a very unique situation. I knew it was unique, but they tried to make it seem like, no, this is normal, you can do this, and more…it inspired me.

Evelyn had experienced an absence of mentors at the beginning of her nursing career, and she had yet to find a mentor who helped fill all the required knowledge gaps. She acknowledged

that not everyone with the wisdom to share wishes to share it with others. Evelyn expressed her gratitude for the mentor she did have, who graciously prepared her to be a better nurse and, eventually, a better leader—someone who had suffered similar inconveniences and hardships in the workplace and persevered. Evelyn admitted both her negative and positive experiences: "Because of her, I don't see defeat." She shared the following about becoming her mentor:

> You have to be good *yourself*. Try to be good yourself, good at whatever you do, and be willing to share and make somebody better than they really are. And if you try to make yourself better, you're going to be looking at somebody who appears to be doing better than yourself. You'll try to emulate that person. And as you become the best version of yourself, you will try to pull others along with you because it is not just about self-aggrandizement, if you want to call it that, or anything about the self. It is about what you do for other people because this person who you are helping is going to [help] lots of other people, you, yourself will never come in contact with. Right? And it will ripple on and on over the ages, even after you're dead and gone. So, if I, the mentor, make the experience positive in terms of learning and in terms of just interacting, it will keep the vibe alive, you know, it will make the person...pass on the positive vibes to other people.... And that's the way I see mentoring; all you have to do is be good to yourself. So that you will have something to share with other people who have nothing to share. You go and do a good job.

Subtheme II: Creating a Legacy. In his current managerial role, Harold offers a safe space to those in need and recognizes potential the same way his mentor recognized his potential. Harold shared a recent example of how he mentored an individual for his succession plan:

> I pulled him [mentee] aside a couple of weeks before I knew I was leaving for a couple of months, and they delayed my transfer over to give an opportunity for my current unit to backfill positions. So, I pulled them aside, and I was like, listen, here's what's going to happen in the next few months; opportunity is going to be available to you. You have what it takes to get there. Let me show you how to do it. Let me give you the roadmap, you know, my roadmap, you know, and I coached them a little bit, and I had pulled them up. I use the tactics that I learned from my mentor; I never give them the answers. You know, make him find that but guide them there.

As a leader focused on nursing excellence, Jacqueline shared how her experience of being mentored has supported her nursing practice and career. She considered the organization's current mentorship programs but expressed concerns about creating an inorganic connection that

might not be as meaningful as her relationship that grew organically. What she did know for certain was that the experience of being mentored helped her become who she is today:

> I am the nurse I am today because of how [my mentors] shaped me from the beginning. So, it's always nurture versus nature. Right? The experiences with them… growing as a clinical nurse have shaped me into the nurse I am today and mentoring others because I don't want to turn people away. There are no silly questions. There are good [questions]. I can read the room better when you know something is not going well. Or say, "Tell me about that a little bit more." So, I do think those experiences shaped me and have developed me into the mentor that I would be [and] that I am today.

For someone with contrasting experiences, Elisabeth talked about how both her supportive and unsupportive experiences informed her future career choices:

> The whole eat young mentality was why I got my master's and wanted to go into education. I wanted to fight that so the next generation [of nurses] knows that this is not how we should be training each other. We are supposed to be very loving and nurturing; nurses are nurturing. We should be a supportive community. And so, my dream goal, my end goal, was always to be in academia, where I could teach other students.... So, once I grew into my comfort zone as a nurse, I always volunteered to take students to precept... because even though I knew I had such a bad experience, I didn't want anyone else to have those experiences…. I want to teach them grace and mercy because then they go off. It's that butterfly effect, so they go off and [provide] grace and mercy. And that is how you make that change.

Franklin wondered about all the mentors who had offered their gifts to him and encouraged him to exceed beyond his current standing. They supported him in bite-size pieces long enough to accomplish a new achievable goal. In recognizing these gifts, he is also determined to share those lessons with others who need a mentor:

> [I think back on] the encouragement I received from one of my mentors to help co-write a nursing journal article. I may not have said yes at the time, but she told me to "just write" and was leading by example by participating in this scholarly effort. Now, when I want to be in a cardiovascular space, I can write on my résumé that I was one of the earlier nursing articles about transcatheter valve therapies. That was true mentorship. When the time comes, pay it forward. Be patient and be available to others you mentor.

Interpretive Statement

The findings from this study provided insights into the lived experience of being mentored as a bedside nurse in this diverse group of nurse leaders. The interpretive statement was created by synthesizing the five essential themes into one thought: *The lived experience of being mentored as a bedside nurse encompasses the evolution of the mentor relationship, which creates a safe space to receive pearls of wisdom in clinical practice when taken under a wing until the time comes to take flight into greatness while honoring the transformative experience.*

Summary

This chapter described the process of the phenomenological inquiry and research into the lived experience of being mentored as a bedside nurse. The topic of the lived experience of nurse leaders who were mentored as bedside nurses has not yet been studied. Investigating the experience of being mentored began through reflection on the interview process. I then read and re-read the transcripts for the interviews, listening to the audio recordings for accuracy, reviewed my journal notes, and immersed myself in the participants' reflected stories. This method allowed me to identify essential themes and subthemes that were then verified collaboratively by my participants and my sponsor. Through the analysis process, the participants' descriptions shed light on the hidden meaning of their words. The meanings were synthesized as an interpretive statement representing the phenomenon's essence and are discussed further in the next chapter.

Chapter 6: REFLECTIONS ON FINDINGS

> It is not your duty to finish the work, but
> neither are you at liberty to neglect it.
>
> -Pirkei Avot 2:16 (2024)

This qualitative study illuminated the meaning of the lived experience of nurse leaders mentored as bedside nurses. Van Manen's (1997) phenomenological method was applied to explore the participants' experiences, describe each experience as it surfaced, and attempt to interpret its meaning. The findings may contribute to the body of knowledge and literature regarding mentoring and illuminate opportunities for personal and professional growth in nursing through early mentoring.

This chapter discusses the supporting documentation for synthesizing the data. The five essential themes or essences uncovered in this research were the following: (a) Evolution of the Mentor Role, (b) Creating a Safe Space for Change, (c) Pearls in Clinical Practice, (d) Transition from the Nest to Flight, and (e) Honoring the Transformative Experience. These themes are further examined through explanations defined by the literature and the theoretical model chosen to navigate this study. Limitations, implications, artistic expression, and recommendations follow.

Synthesis of Data

In this study, 11 participants were asked to describe what it was like to be mentored as bedside nurses. Their experiences were shared within the context of the essential themes outlined and how they supported or compared to the literature.

Essential Theme 1: Evolution of the Mentor Role

An evolution is described in the *New Oxford American Dictionary* (2024) as "the gradual development of something, especially from a simple to a more complex form." The Evolution of

the Mentor Role theme described the transformation in the preceptors (and leaders) for whom the study participants perceived an ultimate transition into the mentor role. To meet all the demands required to gain competency in nursing practice, it is crucial for the preceptor/leader to extend their activities and functions and assume the role of the mentor (Gogoi, 2020).

All the participants consistently recounted their initiation into their clinical practice as bedside professional nurses. They shared the experience of having an assigned or unassigned preceptor as they embarked on their clinical practice. The experiences shared where the preceptor established a positive relationship with the bedside nurse during orientation were impactful as a transition to practice. The literature supported that a one-on-one relationship between preceptors and new nurses is important for an effective orientation (Alonso et al., 2022; Chen et al., 2021). However, negative experiences with a preceptor, as described by some of the research participants, seemed to undermine the learning of the new nurses and encouraged turnover (Epstein & Carlin, 2012; Lynn & Redman, 2005). This correlated with the two participants who shared that without their mentor or family support, they would have left nursing during that time.

Each participant also reported how the mentor evolved from one role to another over time. Most often, these formally assigned preceptors emerged as mentors to the participants. However, the identification of a mentor was not always acknowledged at the time the mentor emerged. Many participants admitted recognizing their colleague as their mentor years after their experience. Yet, the participants were consistent in describing how their mentor had surpassed their perception or expectation of what a preceptor does.

A few participants expressed that their organization assigned a mentor when they were promoted into a leadership role; however, they did not identify or define those formally assigned

mentors as their mentors in this study. Evidence suggested that formal mentoring programs where dyads are assigned to one another do not have the same benefits as naturally occurring, informal relationships (Chao et al., 1992; Ragins & Cotton, 1999). Informal mentoring allows mentors and their mentees an opportunity to get to know one another before deciding to nurture their relationship without the pressure of committing to a formal relationship (Johnson & Ridley, 2004; Ragins & Kram, 2007). The basis for most participants acknowledging and favoring an informal route to being mentored may be attributable to the personal and social interactions that developed with their mentors. Informal mentorship naturally occurs and is often focused on a need identified by the mentee (Lentz & Allen, 2007). This type of mentorship can positively impact nurses at every level of their careers. Relationships that evolve into informal mentor-mentee relationships with fellow nurses and nurse leaders can be some of the most impactful and meaningful connections a nurse may experience throughout their journey in nursing (Lal & Turner, 2024). Formal mentorships, however, are arranged partnerships that often arise from a formal program and have specific goals to achieve (Kwan & Lopez-Real, 2005). Mentors and mentees involved in the informal "well-matched mentorship" connection (Johnson & Ridley, 2004, p. 108) are believed to derive greater value and satisfaction.

The evolving complexity of the relationships that developed while being mentored became a special subtheme for the participants. Variations in how the relationships developed and what was personally and professionally meaningful were consistent in the stories shared. Research literature has recognized that a range of complex relationships occurs during mentoring that go beyond mutual learning and knowledge sharing (Crisp & Cruz, 2009; Gogoi, 2020; Grossman, 2012). The participants made connections based on their perception of similarities in

culture, gender, race, personality, personal life roles, and interests. Personal connections that created friendships transformed their relationship into a lifelong gift.

Essential Theme 2: Creating a Safe Space for Change

Safe space is a term dating back to the late 20th-century women's movement to describe places that were physically and emotionally safe to be in. The term is primarily used in, but not exclusively to, activist and pedagogical communities (Roestone Collective, 2014). All the participants described what it was like to experience support or lack of support as they began their practice as bedside nurses. The support that surfaced eventually created a safe space for them. The participants shared their perceptions of this space, allowing them to be vulnerable because there was a sense of trust; this space was void of judgment and filled with opportunities to improve and change. The safe spaces existed on telephone calls at late hours, in a manager's office to be consoled about the stress experienced in caring for an acutely ill patient, and during conversations considering professional opportunities when confidence and support from anyone else was lacking. They reflected on how their mentor made themselves available to speak, listen, answer, or ask questions that would assist in putting the pieces together while practicing as a novice or advanced beginner. The psychological safety and psychosocial support in this space differed from any other relationship that developed in the nurses' orientation to practice.

For those who shared the positive qualities exhibited by the mentor, it was a nurturing experience that helped them to grow personally and professionally. Moreover, for those who had experienced negative interactions with fellow nurses, the sense that their mentor had gone above and beyond what was expected was a quality that prevented them from leaving the profession. There was a sense of awe and surprise that someone would stand out that way and stand up for them in such an unforgettable way. Vance (2003) reminded us that "first and foremost, we are

humans and require a human relationship of caring, support, and encouragement from good mentors" (p. 43). By developing mutually beneficial relationships, providing a shoulder to lean on, and giving them a platform to openly share their feelings and experiences, mentors create environments where human connections can thrive (Lal & Turner, 2024). The participants inferred that creating a safe space allowed the participants to be recipients of caring in addition to preparation for future success.

Essential Theme 3: Pearls in Clinical Practice

Every new nurse graduate or nurse entering a new specialty is challenged by bridging theory into practice. The nurse leader participants all reflected on moments when they were required to apply the knowledge acquired in nursing school to render patient care. The weight of having the responsibility to care for human life was not lost on their novice selves. The mentors imparted the practical skills required to practice safely and the knowledge to develop a caring practice. Further introspection of their bonding of caring practice and bridging into leadership led them to acknowledge how most of those experiences transformed them into the professionals they are today.

The participants responded positively to the caring practice that was role-modeled for them. Although the initial introduction to the bedside was disorienting for most, the nurse leaders recalled their pre-reflective experiences of the moments their transformation occurred. Mezirow (1997) structured his theoretical definition of transformation around changes in frame of reference, which are "structures of assumptions through which we understand our experiences. They selectively shape and delimit expectations, perceptions, cognition, and feelings" (p. 5). The participants' frame of reference changed with each experience and lesson presented by the mentor. The process of experiencing, followed by self-reflection and discourse with others,

results in a paradigm shift in how the learners view the experience and themselves (Briese et al., 2020).

The participants' stories highlighted the exact moment the changes in their caring happened. They were encouraged to think critically and execute best practice habits. Learning and applying new habits in patient care were described as a continuous process. However, the participants appeared to make sense of that process and those experiences at the exact moment when they had the sole responsibility of executing those skills, habits, and caring behaviors.

This theme of reflecting on the pearls of clinical practice carried on in the shared experiences of bridging toward leadership. For the participants, there was an understanding early in the relationship that a leader was defined by their actions and not their title. As nurses in leadership positions, they admitted having a deeper appreciation of their formative years with their mentor, receiving examples of how they could lead and become role models during the everyday responsibilities of their shift at the bedside. The leadership qualities they secured as a bedside nurse have remained with them and developed throughout their professional journeys.

Essential Theme 4: Transitioning from the Nest to Flight

All participants conveyed a sense of transitioning from the bedside scope of practice to additional areas of interest and/or roles. They reflected on the mentor's focused interest in them. The mentor's "willingness to share" and provide protective behavior indicated a sentiment of "That's my mentee!" Kram (1985) identified two broad categories of mentoring functions: career development and psychological support. The participants' transition from the nest to flight represented experiences in their professional development; however, the sense of what that was like to be supported, that the mentor "had their back," was a theme I did not find when reviewing the literature. The lived experience of being taken under a wing with a specific purpose by the

mentor, who eventually lets them take flight to soar beyond their station, was described as meaningful and unique.

Succession planning is a commonly used term and business strategy for transferring leadership responsibilities to another employee to ensure a smooth transition in an organization's operations. In healthcare, nursing has adopted this concept to mitigate staff and leadership shortages (Al Hajri, 2024). The participants in this study who identified nurse leaders as their mentors were all mentored to move toward success and greatness in their future. Their mentors purposefully sponsored them for opportunities that created additional connections in administration, scholarship, and advanced practice.

It is important to clarify that mentoring relationships may differ from other developmental relationships in the workplace, such as supervision and leadership (Allen & Eby, 2007). According to the leader-member exchange (LMX) theory, leaders differentiate between followers rather than applying one leadership style with all members (Dansereau et al., 1975; Graen et al., 1982). Some employees enjoy high-quality exchanges with their leader, as characterized by an increased sense of mutual trust, respect, and obligation. In contrast, others experienced a low-quality exchange, fulfilling the job description requirements without contributing anything extra. The participants credited the former description of high-quality exchanges with their mentor-leader as transformative in their nursing career.

Essential Theme 5: Honoring the Transformative Experience

Although the focus of this study was for the participants to share their lived experiences of being mentored to provide meaning to the phenomenon, it became clear that recognizing their mentor as a source of their transformation was as important as the experience itself. Transformation is a comprehensive concept, referring to the fundamental, enduring, non-linear

change encompassing technological, economic, political, cultural, social, and environmental dimensions (Feola, 2015; Linnér & Wibeck, 2019; Patterson et al., 2017). The literature on transformation has grown in recent years. While the growth represents a broadening and deepening of available scholarship on transformation, this study's essential theme of honoring the transformative experience offers an insight into how the participants were shaped by the experience of being mentored.

In all of the interviews, the participants' discussion led to a description of the gratitude for all that had been given to them and shared with them by their mentors. They all included a personal reflection of the nurse they have become today because of the person their mentor was with and for them. For most of the participants, there appeared to be an "a-ha" moment as they shared what was, at times, an emotional, passionate recollection of their experience. It was as though they surmised their own meaning of being mentored after sharing their stories.

All of the participants had at least one mentor whom they chose to honor with their transformative experience. Those who recalled negative experiences with potential mentors acknowledged and used those feelings to fuel their purpose of never repeating those behaviors and making it better for those who follow in their footsteps. In their review of mentoring in academia, Dunham-Taylor et al. (2008) proposed that the activities carried out by mentors in the mentoring process can lead to transformation in mentees, positively or negatively. The "spiral up" (p. 341) or positive activities include monitoring and encouraging role transitions from novice to expert (Benner 1984) and promoting the use of talents and skills while creating future nursing leaders. When a "spiral down" (Dunham-Taylor et al., 2008, p. 341) activity occurs, the presence of horizontal hostility, hazing, and a culture of nurses eating their young mitigates the potential for a transformation to emerge.

The transformations for the participants were most striking in the way they embodied their mentor and how the wisdom shared by the mentor allowed the participants to "pay it forward," creating a legacy for the mentor, themselves, and the profession. On becoming their mentor, the examples provided included, but were not limited to, recognizing "a spark" in their mentee that they wished to ignite, sharing a holistic picture of caring nursing practice, and finding meaning in that practice, in addition to exhibiting empathy by "putting themselves in other people's shoes." Sincere gratitude was expressed for having mentors who normalized excellence and the awareness that they had the confidence and experience to impart their pearls of wisdom to others who needed them.

By honoring the transformative experience and recognizing who they have become, the participants also shared stories of how they consciously passed these experiences on to new nurses. The participants who had mentors in scholarship are now teaching and researching. The nurse leaders guided in an administrative path are actively seeking out potential leaders to replace them if needed. In this study, an interesting finding in the theme of creating a legacy was that negative experiences were a strong motivator to educate and actively seek opportunities to mentor. By purposefully passing on knowledge, the participants all hoped to improve the culture and future potential of nursing.

The model (Figure 1) illustrates the participants' experiences by representing the lived meaning of being mentored as a bedside nurse in the acute care setting.

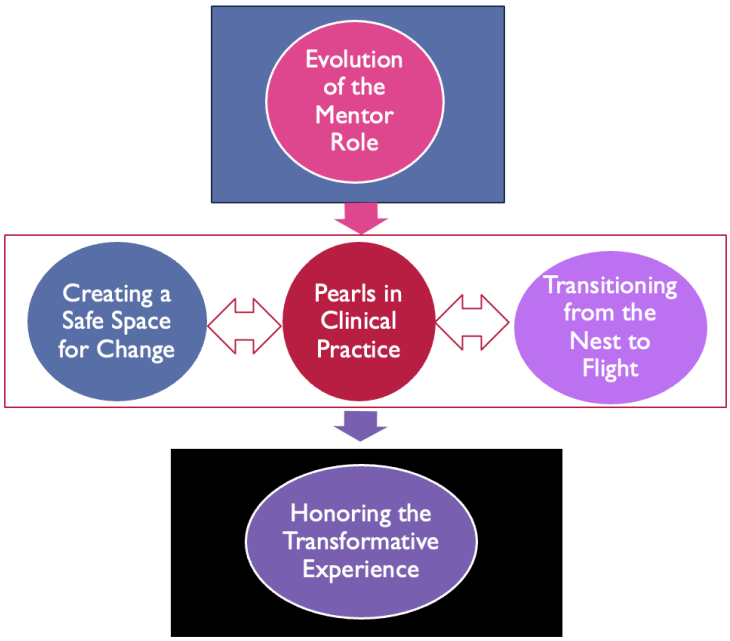

Figure 1. *The Five Essential Themes of Being Mentored as a Bedside Nurse in the Acute Care Setting*

Thematic Statement of Reflection Using the Theoretical Framework of Sense-making

The essential themes of this study were synthesized and resulted in an interpretive textual statement of the experience of being mentored as a bedside nurse. The interpretive statement, created by synthesizing the five essential themes, reads as follows: *The lived experience of being mentored as a bedside nurse encompasses the evolution of the mentor relationship, which creates a safe space to receive pearls of wisdom in clinical practice when taken under a wing until the time comes to take flight into greatness while honoring the transformative experience.* Extensive reflection on the essential themes, the interpretive textual statement, and a significant literature search were done. Weick's sense-making process in his theory of organization most closely reflected the experiences that led to the essential themes shared by the nurse leader

participants. The application of sense-making allowed for an understanding of the meaning of being mentored in the five essential themes.

The framework of *sense-making* helped clarify the participants' experiences in all the essential themes. This concept allowed for a better understanding of how the experiences described by the participants led to an awareness and a deeper understanding of what mentoring means to them. Weick (1995), a social psychologist, communication theorist, and organizational theorist, pioneered the sense-making concept in his organizational theory and greatly influenced organizational studies. Sense-making involves the ongoing retrospective development of plausible images that rationalize people's actions (Weick et al., 2005). By turning circumstances into a situation interpreted explicitly into words, sense-making serves as a springboard into action (p. 409).

The participants employed the process of sense-making in their experiences while being mentored. Sense-making as a process is ongoing, instrumental, swift, social, and easily taken for granted as having a central role in changing human behavior (Weick et al., 2005). It tends to occur when the current state of the world is perceived to be different from the expected state of the world. For the participants in this study, the expectations of their entry into nursing practice differed from what they experienced. Weick (2005) stated that sense-making is about the interplay of action and interpretation rather than the influence of evaluation on choice. When action is the central focus, interpretation, not choice, is the core phenomenon (Lant, 2002; Laroche, 1995, p. 66; Weick, 1993, pp. 644-646).

In Essential Theme 1: Evolution of the Mentor Role, participants entered a new chapter and often the first introduction of their nursing careers. The introductions to nursing practice included a new work environment, employer, professional responsibilities, colleagues, and

communication styles. As described by Kramer (1975), the participants all shared a sense of *reality shock* that was unfamiliar after experiencing successful graduation and passing the licensure exam. Reality shock in sense-making can be interpreted as the experience of being thrown into an ongoing, unknowable, unpredictable streaming in search of answers to the question, "What's the story?" (Weick et al., 2005).

In her work, Meryl Louis (1980) described sense-making as a thinking process that uses reflective thoughts to explain surprises. The participants expected to be welcomed and taught in their new work setting. Some participants shared their experiences of not having a preceptor or having different preceptors, which was discrepant from their predictions of having a person dedicated to their orientation. Louis (1980) posited that discrepant events or surprises trigger a need for explanation and a process through which interpretations of discrepancies are developed (p. 241). The interpretations or meanings attributed to the surprises are an outcome of sense-making.

The interpretation of the mentor evolution was a common thread for the participants, whose meaning of the preceptor role was surpassed by the relationship that developed, moving beyond their expectations. Once the disruption of their expectation occurred, the participants reflected on how this relationship was different. Their often formally assigned preceptor had informally become their mentor. The relationship for many evolved beyond their professional training and into a friendship. For example, Sophie recalled her mentor treating her "a lot like she would a daughter." Intra-subjective meanings applied to experiences like these shared by the participants are meanings that are solely connected with the individual. Making sense of these experiences or *cues* occurs after what Weick (1995) referred to as a disruptive event that was

unexpected yet prompted an interpretation into a new meaning of mentor. They all derived meaning from the experience they interpreted as being mentored.

In Essential Theme 2: Creating a Safe Space for Change, the participants experienced relationships that engendered trust, support, guidance without judgment, and confidence with statements like "You did great on this!"

When using the lens of sense-making in storytelling, Maclean et al. (2012) stated that language constructs and gives order to reality as individuals seek provisional resting points that offer plausible accounts of equivocal situations (p. 20). According to Weick (2012), the construction of "plausible accounts of equivocal (or ambiguous) situations" is often treated as interpretive work of sense-making (p. 145). Participants like Elizabeth, whose initial experiences were negative in their clinical setting, interpret themselves and the world around them by producing meaning. During that sense-making process, those with negative experiences considered leaving the profession. The disruptive event of having a mentor offering to be their "go-to person" allowed the participants to reflect on their previous experiences and create a new meaning for being mentored.

The participants' sense-making about the meaning of a safe space was inter-subjective. Creating a safe space for change to be fostered was a shared meaning between the participants and their mentors. Understanding that the mentor was available to discuss concerns, be available after working hours, and listen without judgment created an inter-subjective sense through conversation and nonverbal behavior, allowing for a sense of shared meaning.

The encapsulation of a major theme Weick frequently termed the "recipe" for sense-making is "How can I know what I think until I see what I say?" (Gioia, 2006, p. 1713). It is an interesting way of stating that understanding does not guide action as much as action guides

understanding. The concept of sense-making supports the experiences shared by the participants in Essential Theme 3: Pearls in Clinical Practice, who gained an understanding of caring practice and leadership through action or doing. Their mentors shared knowledge about critical thinking and how that translated into the caring practice of their patients. The participants were asked to consider "next steps," culturally competent care, and preparing for the "worst-case scenario." Schutz's (1967) treatise argued that people can only know what they are doing or what they have been doing after they have done it. As the participants moved forward in their practice, they needed to look back to understand what they did and what that meant. All participants described their experience of this sense-making in individual stories about their first emergency without their mentor. It was after the emergencies, when they had the opportunity to act in caring for their patients or take on a leadership role, that they gained meaning through understanding.

For Essential Theme 4: Transitioning from the Nest to Flight, the participants interpreted their experiences of support and sponsorship from their mentor as a transition from where they started, protected and led out of the "nest" to the occasions provided for them to "take flight" and explore new opportunities. The participants made sense of their mentor's willingness to share information with them and guide them toward different avenues to utilize that information. The avenues included involvement in committees, access to leadership events, and advice regarding continuing education and career advancement plans.

Dialogical sense-making explores how people create meanings around transformations through various social interactions (Woroniecki et al., 2024). The understanding emerges from a dialogue or conversation between two or more parties. It is an interactive process where meaning is developed and refined through exchanging ideas, questions, and responses, emphasizing mutual understanding and collaborative meaning-making. The continued support, knowledge-

sharing, and sponsorship of new opportunities allowed sense-making for the participants in this study.

The final Essential Theme 5, Honoring the Transformative Experience, was a profound, impactful, and transformative interpretation for all participants. This theme emerged when sense-making gave meaning to the wisdom imparted by the participants' mentors that transformed them into who they became from who they were. The process of seeking to make sense of their environment (in this case, the clinical setting) involved retrospectively reviewing their lived experiences into meaningful parts, labeling them, and making connections. The sense made of becoming their mentors and creating a legacy was retained in their minds as "cause maps" (Weick, 1979). The cause maps indicate the importance of carrying out the tasks and how they are interconnected.

The participants sustained the relationships with their mentors and the behaviors or ways of being interlocked over time. With each lesson or action, they gained an understanding of how to deal with residual equivocality or disruptive ambiguity. The process is not linear and requires ongoing reflection, which the participants shared during the interviews. They all shared that the awareness of becoming their mentor and the passing on of wisdom and guidance came long after the actions themselves. Understanding their actions inspired them to honor their mentor in what they interpreted as a transformative experience and the adaptation of new behaviors. The participants also acknowledged the opportunity for them to contribute to the nursing profession by being mentors themselves.

The interplay between intersubjective meaning, which creates shared ways of being between more than one person, and generic subjective meaning, a concept that has meaning in a group of people's organizational roles, makes organizations adaptive (Weick, 1995). Generic

subjective meaning involves developing roles that have meaning to the group after entering into conversations where the new terms are used. Although the impact of these transformative experiences on organizations was not an essential theme in this study, I believe it is important to consider the possible impact of change on organizational culture when ascribing the meaning of being mentored.

Weick's (1995) view of organizations is that they are not things or objects as a natural system, but they emerge from people's needs. From this perspective, organizations may be seen as adaptive systems that are capable of changing and having an effect on the world around them. Adaptation works by using a very specific way of communicating and finding meaning that allows for a shift in how action is taken and understood.

In organizations, there is an interplay between people's freedom or autonomy to shape and create their own meaning and the control and efficiency in the generic when there is an understanding of the terms or roles of the structure of people's activities. The shared lived experiences of the participants in this study have illuminated the sense-making process to interpret the essence of being mentored.

Limitations of the Study

A limitation of this research study is that the findings cannot be generalized. Generalizability is a challenge for qualitative studies and their findings. The focus, instead, is placed on its rich context and theoretical understanding and not the transferability of the findings in similar settings or situations. What was revealed in the findings was particular to the lived experiences of the nurse leaders who participated in this study. Although there was a requisite saturation of themes from the participants, this study represented a small sample of experiences from the nurse leaders. Eleven participants were interviewed: nine females and two males.

Notwithstanding, the sample gender breakdown was representative of the nursing profession, with the male representation slightly higher at 18% in this study, compared to the national average of 12.6% (Bureau of Labor Statistics, 2024); it further denied the study findings from generalizations.

Video conferencing platforms, such as Zoom, used in this study, are tools to conduct research by facilitating remote interviews and collection of data. By offering remote access to participate in this research study, I was afforded the opportunity to include nurse leaders in different states of the country. However, it is possible that a variation in comfort level with using this technology existed. I cannot be certain if using this platform positively or negatively affected the experiences shared during the interviews.

Lastly, when conducting a phenomenological study, the researcher becomes the instrument. The data collected from lived experiences shared by the nurse leaders were interpreted through the knowledge I acquired in my studies, research, phenomenological workshops and conferences, and an understanding of research methodology. The hermeneutic phenomenological research interview services two specific purposes: (a) as a means of gathering experiential narratives that lead to a deeper, richer understanding of the phenomenon of interest, and (b) as a vehicle to develop a conversation relationship with the participant to gain a greater insight into the meaning of the phenomenon (van Manen, 1997). As a beginning researcher, I appreciate that phenomenological interviewing is both a skill and a cognitive process that develop over time and with experience.

As the sole researcher conducting this study, I kept a journal to reflect on my thoughts before and after the interviews, bracketing my assumptions and identifying any biases to establish validity. Earlier pre-interview journal entries documented my concerns about being the

instrument through which these stories were filtered. These were followed by post-interview thoughts regarding the process and phenomenological method of interviewing. When "trusting the process" of interviewing, the participants openly and honestly shared their experiences. Keeping my assumptions and biases at bay was an exercise I performed before, during, and after the interviews. My experience facilitating mentoring programs made it crucial to bracket my assumptions and identify biases to unearth the meaning of being mentored. By doing so, I remained open to receive and interpret the essence of the phenomenon. The participants and an experienced phenomenological researcher reviewed the themes to validate further the thematic analysis gleaned from the interviews.

Implications

Understanding the mentoring experience can add value to the nursing profession, particularly for novice nurses and nurse leaders inspired to pursue careers in clinical settings, healthcare administration, academia, and other organizations. This study has various implications for nursing practice, education, and organizational leadership. The concept of mentoring in nursing is widely studied (Block et al., 2005; Chandler, 2011; Chao, 1992; Eby et al., 2008; Lorentzon & Brown, 2003; Nickitas, 2014), with growing opportunities to conduct research on the lived experiences of those being mentored. The findings of the study will add to the body of research about mentoring in addition to the literature interpreting the unique part that mentoring plays in nursing practice.

The most important implication of this study is that the nurse leader participants honored a transformative experience. This is an essential theme that has not yet surfaced in nursing research. The subthemes described how the participants embodied their mentor's values and knowledge and created a legacy of nurses they chose to mentor to pay their gratitude forward.

These research findings can potentially change or improve organizational culture in healthcare settings.

Another crucial finding in this study, which has implications for patient care and patient outcomes, was the mentor's contribution of knowledge, which demonstrated ways of caring in nursing practice and taking on leadership roles in the clinical setting. Sharing information and expertise takes time and self-confidence on the part of the mentor. Someone who does not feel empowered cannot empower another (Grossman, 2012). Nursing leadership has an opportunity to identify nurses in mentoring relationships to foster continued growth and development in their professional journey.

Reflections on Researcher's Experience

When considering a phenomenon to study, I chose a subject I had the most questions about. I had not had the experience of being mentored as a bedside nurse, and when searching the literature, I identified a gap that left me wondering what it was like. As a nurse with over 20 years of experience at the bedside and in nursing education, I started to consider all the attributes written about mentors and the positive outcomes for the recipients in organizational systems. However, identifying my mentor or the perceived benefits of having a mentor escaped me. I remained curious and focused on the phenomenon and eager to learn.

While conducting this study, I have appreciated different insights. Nurses have and experience a culture that is unique only to nursing and often understood only by nurses. In reading my journal, I recalled my personal *phenomenological nod* to stories that were relatable to my own. Amid life and death experiences that would seem traumatic for most people, nurses find ways to access their knowledge, intuition, poise, and sense of humor. There was a general and recognizable thread of feeling unprepared, recognizing the reality shock after the celebrations of

graduating, and feeling an awesome sense of responsibility for another human. The nurse leaders shared familiar stories while I remained challenged to bracket my perceptions and honor those of the participants.

I learned that nurses from different generations had varying onboarding experiences, which added to the pressures of becoming competent and prepared for all of their responsibilities. Yet the stories all seemed familiar and true to the experience of being a bedside nurse. I felt their angst about knowing medications, maintaining patient safety, and managing their time. Throughout the generations, those concerns remained consistent.

When posing what it was like to be mentored, I was concerned about how each individual would define a mentor. When they began talking about preceptors, it was as if they read my mind, allowing me to ask them how they defined them and if there was a difference. Their definition of a preceptor was consistent with that in the literature; however, describing how they identified their mentor from the preceptor role became more nuanced. When the nurse leaders attempted to define their mentor, it came in the form of experiences, how they felt to have a person like that in their life and professional journey, and the sincere appreciation for where they have arrived because of them.

I was reminded that this sample of leaders is trained to use a straightforward, objective form of "nursing speak" that primarily focuses on the facts. However, they were unwavering in their need to find words and true expressions that told the story of their experience. They wanted to honor their experience and their mentor.

During the interviews, journaling, and reflection process, I felt emotions about bullying, work-related stressors, and the fear of not knowing. I worked in a high-acuity critical care unit where critical thinking and skills acquisition were paramount. The staff was very serious, for

good reason, and they were not welcoming to new graduates without work experience. I also remembered how my preceptors were skilled, knowledgeable, and supportive of my clinical development, and I took a moment to honor them for my professional success.

I am honored to have received, interpreted, and shared the stories of these 11 nurse leaders. I intend to herald the significance of being mentored and consider research opportunities to highlight ways of providing a transformative experience for all mentored nurses. I want to ensure that the opportunities presented to those who are mentored are impactful and sustainable. I remain hopeful that the legacy of nurses transformed by their mentoring experiences will continue to pay it forward.

Artistic Expression

In phenomenological research, images, symbols, fictional stories, music, and poetry may be used in the analysis and reflections to reveal and elucidate the essence of the phenomenon. These artistic expressions may also serve to uncover the themes and clarify the phenomenon being examined. A genuine artistic expression is not simply a representation of an event in the world; more precisely, it transcends the experiential work into an act of reflective existence (van Manen, 1997, p. 97).

This photograph of the murmurations of the starlings provides an image of individual and holistic connections that are made to allow a transformation to emerge. While migrating during the winter months, starlings fly together to form a large group or murmuration. They fly together to protect each other from predators and their roost below while moving forward in the journey to their ultimate destination. This image illuminates the essence of being mentored as bedside nurses. The shape-shifting clouds of starlings appearing in the photograph (Figure 2) may be interpreted as analogous symbols of caring relationships, a safe space to learn and grow, and

continued guidance. In this study, some participants suffered challenges that initially impeded their development, not dissimilar from the starling's threat of predatory danger. This murmuration, however, depicts a continuous transformation of becoming. Through the process of reflection, the participants uncloaked the experience of being mentored, which ultimately led to their personal and professional transformation.

Figure 2. *Very Impressive Starling Murmurations* (Photo credit: Daniel Biber)

Recommendations for Nursing Education and Organizational Leadership

When reflecting on the findings of this phenomenological study, I considered the recommendations that can benefit different areas within the nursing profession. The study findings highlighted informal mentoring relationships as having a life-long impact on individuals embarking on their nursing practice or being introduced to a new specialty. The presence of preceptors who proactively create a welcoming culture in the clinical setting and are willing to teach and mentor their fellow bedside nurses provided role models to resemble. Setting an

expectation of how-to role model professional behaviors and support new nurses is an important opportunity to change negative cultures in the profession. Educators and clinical and administrative nurse leaders can change culture by setting expectations around positive and negative behaviors and embodying the standard of a leader in a healthy work environment.

In academia, nursing schools can incorporate education about bullying into their curricula to better prepare new nurses and break the cycle of bullying among nurses (Gillispie et al., 2024). Role-playing, simulation, and reflective writing are examples of ways to introduce nursing students to supportive behaviors. In studies (Pickens-Taylor et al., 2024; Tuomikoski et al., 2020) where training programs were implemented for nurses to mentor nursing students, registered nurses became more confident and competent in their mentoring skills. Improving a mentor's competence also mitigated disparities for at-risk students and increased their communication skills and components of self-confidence, including positive thinking, preparedness, prioritization, time management, and organization.

Recommendations for nursing leaders and administrators in the organization include creating opportunities to promote mentoring in formal or informal connections. Creating positive spaces where learning can flourish within all levels of the organization may foster mentoring relationships that, in turn, foster personal and professional development. Positive behaviors exhibited by all nurse leaders may impact healthy work environments and inspire nurses to support nurses. Nurses at the bedside who have positive experiences being mentored have the ability to perpetuate a culture of nonjudgmental guidance and significant transformation. Advancing a mentoring culture is necessary and timely for the profession and every nurse who can help develop this professional network by beginning early (Grossman, 2012).

Recommendations for Further Study

Despite numerous studies and research conducted on mentoring within many different professions and contexts, there is still a great opportunity to investigate the experience of being mentored and learn about its meaning in nursing. There are insufficient data on the lived experiences of bedside nurses and their perceptions of mentoring. This study helped reveal the transformative effect of mentoring bedside nurses as perceived by the nurse leader participants.

For future studies, it is beneficial to study the impact of teaching and exposing nursing students to the positive attributes of mentoring and the benefits of personal and professional relationships. I invite researchers to work with my findings and knowledge discovery to examine the lived experience of being a mentor and if there is a correlation between themes and transformational experience. In this study, the participants contributed stories about how mentoring transpired through informal relationships. There remains a paucity of research about how informal mentoring occurs and the value of these connections in an organization related to professional development and staff retention.

Lastly, research that validates the claims about mentoring bedside nurses in the clinical setting would be instructive for healthcare organizations. As with the sense-making process, it is important to look back at the expectations organizations have set for mentoring relationships to journey forward in a way that creates positive outcomes for bedside nurses and their work environment.

Summary

This chapter presented the synthesis of data into a thematic analysis supported by the literature and the conceptual model of sense-making, allowing for interpreting and understanding while searching for meaning. Furthermore, the limitations of the study, implications,

recommendations for nursing education and leadership, and recommendations for future study were considered. In closing, a reflection of my experiences, including an image for artistic expression, was presented to make clear the phenomenon of being mentored as a bedside nurse.

Epilogue

The road to completing this dissertation was replete with twists and turns, stops and starts, and wonder about the unknown. An ongoing reflective process inspired me to be open to different ways of interpreting the mentoring phenomenon. The descriptions and phrases that circulated in my mind were initially very subtle and failed to form a clear picture.

One evening, after my participant interviews, I dreamed about all the stories shared with me. I saw an image of the molecular process of osmosis, which was my interpretation of how the mentors had figuratively *poured* their knowledge, experience, caring, and a piece of themselves into these participants, who honored them by sharing their stories of gratitude with me.

I woke up from my dream, opened up my laptop computer, and wrote the following:

The Osmosis of Mentoring

> *Osmosis: the pouring of solvent particles from a space of higher concentration to a space of lower concentration. The particles comprise ideas, experiences, caring, and knowledge that are not lost as passed along but grow differently as they settle into a new space. The use and development of these particles do not occur overnight, nor is the awareness of given pearls of wisdom realized at the moment of their transition. An experiential and transformational shift is honored, and personal and professional responsibility is awakened in the recipient to continue the transference of these particles.*

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Appendix A

Inclusion Criteria for Eligible Study Participants

	Criteria	**Met**
1	You are currently in a nurse leader role	
2	You were mentored as a bedside RN	
3	RN with a minimum degree of Bachelor of Science in Nursing	

Appendix B

Informed Consent

TEACHERS COLLEGE
COLUMBIA UNIVERSITY
525 West 120th St. New York, NY 10027
212-678-3000 | www.tc.columbia.edu

INFORMED CONSENT

Protocol Title: Finding Meaning in Mentoring: Lived Experiences of Bedside Nurses in the Acute Care Setting
Principal Researcher: Nicole Jie, MA, RN, CCRN, NPD-BC, Teachers College
917-830-6414, mentoredRNstudy@tc.columbia.edu

INTRODUCTION You are invited to participate in this research study called "Finding Meaning in Mentoring: Lived Experiences of Bedside Nurses in the Acute Care Setting." You may qualify to take part in this research study because you are currently a nurse leader who was mentored while working as a bedside nurse.

Approximately ten people will participate in this study, and it will take 45 minutes to 1 hour of your time to complete the interview. Audio and video recording is part of this research study. If you decide that you do not wish to be recorded, you will not be able to participate in this research study.

WHY IS THIS STUDY BEING DONE? This study is being done to understand what it is like to be mentored as a bedside nurse from the nurse leader's perspective.

WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?
Participation in this study is voluntary. If you decide to participate, you will be interviewed by the principal investigator (PI). The interview will take place in a quiet environment and at a convenient public or virtual setting and time. The study will take up to 2 hours of your time and will consist of the following steps:

- You will be asked to complete a short survey that will ask you basic demographic and nursing profession questions. (5-15minutes);
- One audio and/or video recorded interview (via Zoom) (45 minutes to 1 hour). I will alert you when I am about to start and end the audio and/ or video recording. During the interview, you will be asked about your mentoring experience(s) as a bedside nurse. I will take some notes during the interview;
- After the audio and/or video recording of the participant is written down (e.g., transcribed), it will be emailed to you about one week after your face to Zoom interview. You will then be asked to review your transcription, take notes, and identify any areas that you would like to reflect upon (30-minutes);
- Lastly, I may request one follow-up email for verification of themes that were identified and connected to your statements will be discussed (15 minutes). You will be contacted up to 90 days after your initial interview.

WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY?
This is a minimal-risk study, which means the harms or discomforts that you may experience are not greater than you would ordinarily encounter in daily life while taking routine physical or psychological examinations or tests. However, there are some risks to consider. You might feel embarrassed to discuss your experience with mentoring. You do not have to answer any questions or share anything you do not want to talk about. You can stop participating in the study at any time without penalty. If problems such as mental health issues arise, the number of your workplace employee health will be provided where you can go for help.

I have taken precautions to keep your information confidential and prevent anyone from discovering or guessing your identity. The use of a pseudonym instead of your name and all information will be kept on a password-protected computer and locked in a file drawer. The master list of participants is also kept locked and separate from the list of pseudonyms. The transcription company that will transcribe the audio recording of the interview is Otter.ai and they have a non-disclosure agreement to further guarantee confidentiality of their work.

WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY? There is no direct benefit to you from participating in this study. Participation may benefit the profession of nursing and nursing education to better understand the meaning of mentoring.

WILL I BE PAID FOR BEING IN THIS STUDY? There are no costs to you for taking part in this study. You will be paid $25 via Amazon gift card upon completion of all the processes.

WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?
The study is over the interview and follow-up meetings are completed. You may leave the study at any time, even if you have not finished without penalty. If you leave the study early or do not complete all tasks you will not qualify for the gift card.

PROTECTION OF YOUR CONFIDENTIALITY The PI is taking precautions to keep the identity of each participant and their interview answers confidential. A pseudonym will be used to organize data instead of your actual name. All electronic information including interview recordings will be kept in an encrypted folder. The folder will be stored on the Teachers College (TC) Google Drive. There is a password and virtual firewall protecting the computer. All physical forms of data will be stored in a locked file drawer in the researcher's home. The file drawer will be kept in a locked room that is only accessed by the PI. Data will be kept for the required duration of three years. After that electronic data will be erased, and physical data will

be shredded. This data includes all audio recordings, transcripts, written notes, informed consent, and demographic information collected from the interview.

For quality assurance, the study team, the study sponsor, and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

HOW WILL THE RESULTS BE USED? This study is being conducted as part of the PI's/researcher's dissertation. The results of this study will be published in journals and presented at academic conferences. Your identity will be removed from any data you provide before publication or use for educational purposes. Your name or any identifying information about you will not be published.

WHO MAY VIEW MY PARTICIPATION IN THIS STUDY

Only the PI will know your participation in this study and view your interview. Transcription will be performed using an internet program and artificial intelligence.

CONSENT FOR AUDIO AND/OR RECORDING Audio and video recording are part of this research study. You can choose whether to give permission to be recorded. If you decide that you do not wish to be recorded, **you will not be able to participate** in this research study.

_____I give my consent to be recorded.

_____

Signature

_____I do not consent to be recorded.

_____

Signature

OPTIONAL CONSENT FOR FUTURE CONTACT

The PI may contact me in the future for information relating to this current study:

Yes ____ (Initial)
No_____(Initial)

WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?

If you have any questions about taking part in this research study, you should contact the principal investigator, Nicole Jie, at 917-830-6414 or at mentoredRNstudy@tc.columbia.edu

If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email IRB@tc.edu, or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027, Box 151. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.

PARTICIPANT'S RIGHTS

- I have read the Informed Consent Form and have been offered the opportunity to discuss the form with the researcher.
- I have had ample opportunity to ask questions about the purposes, procedures, risks, and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at the researcher's professional discretion, such as not meeting the inclusion criteria to participate in the study.
- If, during the course of the study, significant new information that has been developed becomes available, which may relate to my willingness to continue my participation, the researcher will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- Identifiers may be removed from the data. Your data will not be used in further research studies.

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- I should receive a copy of the Informed Consent Form document.

My signature means that I agree to participate in this study:

Print name: _____**Date**: _____

Signature:

_____

Appendix C

Demographic Data Form

Demographic Intake Survey

Today's date (month/day/year)

_____

Preferred gender pronouns

- ○ she/her
- ○ he/him
- ○ they/them
- ○ all of the above
- ○ other _____

Gender

- ☐ Male/Man
- ☐ Female/Woman
- ☐ Non-binary / third gender
- ☐ Prefer not to say
- ☐ Not listed _____
- ☐ Transgender _____

Current Age:

Ethnicity/Race:

- [ ] Native American
- [ ] Asian
- [ ] Black/African American
- [ ] Hispanic/Latino
- [ ] White/Caucasian
- [ ] Multiple ethnicity
- [ ] Other (please specify _____)
- [ ] Alaskan Native
- [ ] Pacific Islander

Nursing Education (include year of graduation): select all that apply

- ○ Diploma DN _____
- ○ Associate degree AAS _____
- ○ Bachelor's degree BSN _____
- ○ Master's degree MA, MSN _____

○ Doctoral degree PhD, EdD, DNP

_____

Education: Additional degrees earned (enter degrees and year)

☐ Diploma _____

☐ Associate _____

☐ Bachelors _____

☐ Masters _____

☐ Doctorate (e.g. JD, MD) _____

Is nursing your first profession or career? If not, what was your role prior to becoming a nurse?

○ Yes

○ No _____

How many years have you worked as a registered professional nurse?

_____

Which shift did you work as a bedside nurse? (answer all that apply)

☐ Day shift

☐ Evening shift

☐ Night shift

☐ Per diem

☐ Part time

- [ ] Full-time
- [ ] Flex shift
- [ ] Other _____

Specialty/Specialties of the unit you worked in as a bedside nurse

_____

City, State(s) where you were employed while practicing at the bedside

_____

_____

_____

_____

_____

Current position/job title and place of employment

_____

How long have you worked in a nurse leadership role? (years/months)

_____

Appendix D

Mentoring Study Recruitment Flyer

Seeking Nurse Leaders to participate in a study regarding their experience as mentored bedside RNs

Nicole Jie, EdD(c), MA, RN, CCRN, NPD-BC
Principal Investigator/Doctoral Candidate
Teachers College, Columbia University

Call or Text: 917-830-6414
Email: mentoredRNstudy@tc.columbia.edu
This study has been approved by the
TC IRB Protocol #24-172

The purpose of this study is to discover the meaning of mentoring through the lived experiences of nurse leaders who were mentored as bedside nurses.

The eligibility criteria:

- You are currently in a nurse leader role
- You were mentored as a bedside RN
- RN with a minimum degree of Bachelor of Science in Nursing

Risk: Minimal
Benefit: No direct benefit. Help contribute to the nursing profession by sharing your experience

Also ...

- **Time commitment**: up to 2 hours total
  - Complete survey: 5 minutes
  - Interview: 45-60 minutes
  - Review of transcript and themes: 30 minutes
  - Discuss study: 15 minutes
- **Location:** Virtual via Zoom

- Compensation:
  - Participants who complete the study will receive a $25 Amazon.com electronic gift card

Title of Study:

Finding Meaning in Mentoring: Lived Experiences of Bedside Nurses in the Acute Care Setting

Teachers College
COLUMBIA UNIVERSITY

TC INSTITUTIONAL REVIEW BOARD 2024

Scan QR code below for registration