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Understanding Registered Nurses' and Student Nurses' Positive Mentorship Experiences in Jeddah (Saudi Arabia) Using Appreciative Inquiry

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A thesis submitted to City University London for the degree of Doctor of Philosophy

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Dedication

This thesis is dedicated to

My parents

Matoug and Nawal

for their love, encouragement and continuous support

My husband

Thamer Albahiti

for his love, care, support and patience

My daughter

Alia

for bringing happiness to my life

My sisters and brother

Jehan, Shereen, Rania, Shatha and *Majed*

for their love and support

Acknowledgments

Declaration

I declare that this thesis is my own work and that no part of it has been submitted in support of an application for a degree at any other university or other learning institution. All quotations have been distinguished by quotation marks, and the sources of information acknowledged.

Signature:

Date: 23-10-2015

Abstract

This thesis presents work conducted for a structured doctorate consisting of four main components. The first element is a case study investigating the current practice of mentorship in a clinical setting in Jeddah, Saudi Arabia. The qualitative case study was conducted in a government nursing college and its associated government hospital. Data were collected through individual interviews (2) with nursing coordinators; semi-structured focus groups (8) with mentees (n=3), mentors and clinical educators (n=3), lecturers (n=1) and head nurses (n=1); and finally, documentary analysis. The findings show that neither mentors nor mentees were happy with the current arrangements. Mentees believed that mentorship did not benefit them, and mentors seemed to resent the request to devote time to mentees. Both parties need to approach the other with more empathy, appreciating their difficulties and respecting their individual choices and wishes. Mentors also pointed to a lack of coordination between university and hospital, and both mentors and mentees felt that the mentorship process lacked clarity. Devising and putting into practice a new policy could lead to important positive changes in mentors' and mentees' experiences and relationships.

The second element of the structured doctorate, undertaken after the case study, is the best evidence literature review. The aim of the review was to examine published studies on mentorship in nursing from the perspectives of both mentors and mentees in order to obtain a holistic view of mentorship experiences. A critical evaluation of these published studies is presented, reviewing the definitions of mentorship in the literature and highlighting the sparse literature on nursing mentorship in Saudi Arabia. Next is a critical overview of the nursing mentorship experiences in Islamic countries. Mentors' and mentees' views on mentorship are discussed. The final section summarizes the findings and attempts to use them to answer the literature review questions whilst highlighting the gaps in the literature.

The third element is the main study, which emerged from the literature and builds on the case study. It aimed to investigate the factors contributing to positive mentorship experiences in nursing in Jeddah by exploring mentors' and mentees' positive experiences. The qualitative study was conducted from the theoretical perspective of appreciative inquiry (AI). Data were collected in semi-structured focus groups (total of six) with mentees (n=3) and mentors (n=3) at three settings. The key contributing factors to positive mentorship experiences and the main themes from data analysis are communication; involvement; encouragement; reciprocity; students' sense of fear; mentors' role, including its characteristics, preparation for it and feedback; and organisational-level processes and resources, such as time availability, workload, allocation and college-university collaboration. It is recommended that a consensus definition of mentorship be issued to avoid conflict in roles and expectations, that systems be developed to give mentors time to spend with mentees and that mentors attend a mentorship training programme to gain understanding of the process and be prepared for their role.

The fourth element is the dissemination artefact and plan, which communicate the findings to develop education, policy, practice and research. A briefing for stakeholders contains an overview of the study and key findings. An outline of a mentorship training programme and a draft handbook for local use in Saudi Arabia are proposed. The dissemination plan explains how the researcher plans to disseminate the artefact.

Abbreviations

AI: Appreciative inquiry

BSc: Bachelor of Science

CASP: Critical Appraisal Skills Programme

CPD: Continuing professional development

CPR: Cardiopulmonary resuscitation

ER: Emergency room

KSA: Kingdom of Saudi Arabia

MOH: Ministry of Health

MOHE: Ministry of Higher Education

NC: Nursing coordinator

NMC: Nursing and Midwifery Council

NVC: Nonverbal communication

PBUH: Peace be upon him

RN: Registered nurse

UK: United Kingdom

USA: United States of America

VC: Verbal communication

WHO: World Health Organisation

Glossary of Terms

Key terms used throughout the thesis are explained below.

Appreciative inquiry: An approach to organisational development that positively promotes organisational change by appreciating what the organisation does best (Cooperrider, Whitney and Stavros, 2008), based on the belief that all organisations have some systems and practices that work well

Mentee/preceptee: A student nurse who is advised, trained or guided by a mentor/preceptor

Mentor/preceptor: A nurse who supervises and assesses the students in their clinical setting and facilitates their learning process (Nursing and Midwifery Council, 2004).

N.B. During the research, the terms 'mentor', 'preceptor', 'mentee' and 'preceptee' were used interchangeably by the participants and the researcher, reflecting international differences in parlance.

Peak experience: A state in which an individual feels more powerful or that something extremely valuable has happened (Maslow, 1998)

1   Commentary one: Introduction

As a structured doctorate, this thesis has four elements: a case study, a best evidence literature review, a research study and a dissemination artefact with a dissemination plan. Section 1.3 explains the structure of the thesis and these four elements. To ensure continuity, the thesis also presents three commentaries that connect these elements and through which they are discussed.

1.1   Overview of commentaries

1.1.1   Commentary one: Introduction

This chapter, entitled 'Commentary one', explains the three commentaries that link the different elements of the thesis together. It discusses the rationale for the study and the researcher's motivation (section 1.2) and describes the thesis structure (section 1.3). Next, the elements of the thesis are outlined, with an explanation of how they link together and their relevance to the contemporary context in which the study was conducted (section 1.4). The researcher then provides an overview of nursing mentorship in Saudi Arabia (section 1.5), and finally discusses the conceptual framework (section 1.6).

1.1.2   Commentary two: Comparison of methodological approaches of the case study and the main study

This commentary, which is discussed in detail in Chapter 6, compares methodological approaches and findings related to the first and third key elements of the thesis: the case study on mentorship (Chapter 3) and the appreciative inquiry (AI) investigation into mentorship (Chapter 5). A matrix displays the findings from the two studies, demonstrating which groups raised the study-specific aspects of mentorship. This process starkly illustrates the different findings from the two studies; although different

groups raised some similar and overlapping points. A comparison of the findings using themes (e.g. confusion about what the term 'mentoring' means, and student motivation) enabled the generation of a list of improvements for future nurse mentoring initiatives in Saudi Arabia.

1.1.3 Commentary three: Conclusion and recommendations

Commentary three, presented in Chapter 8, outlines the implications of the studies for future research, the professional development of those involved and the improvement of national standards in Saudi Arabia.

1.2 Rationale for the doctoral study

The impetus for this doctoral study arose from the researcher's personal experiences and a growing understanding of the relevant literature. The researcher was a nursing student in Jeddah, Saudi Arabia between 1999 and 2003 and participated in nursing mentorship as part of her training. Once qualified as a nurse, she worked for two months as a surgical nurse in a government hospital in Jeddah and mentored nursing students. Through this first-hand experience as both mentor and mentee, the researcher gained a basic understanding of mentorship practices in Jeddah. Furthermore, she worked as a nursing lecturer, teaching nursing students who were pursuing a Bachelor of Science (BSc) degree, and as a clinical instructor for nursing students, performing clinical rotations in several Jeddah hospitals two days a week. These positions allowed the researcher to observe clinical placement situations and receive continuous feedback from the nursing students. In addition, she was a student in the Jeddah college and hospital that participated in the case study (identified as the nursing college and the hospital) and, thus has experience of being a mentee studying in this specific college.

However, these specific experiences have both advantages and disadvantages. In terms of advantages, the experiences afforded the researcher a deeper understanding of what the participants have experienced. In addition, although the researcher's clinical nursing experience did not include some of the areas of clinical expertise that the participants had, her nursing background enabled her to understand the majority of the terms they used and the context of their shared experiences. On the other hand, among the disadvantages were the researcher's pre-conceived ideas concerning what some of the participants might feel, which could lead to bias. However, being aware of this enabled the researcher to put her assumptions aside as far as possible throughout the study.

In 2005, the researcher studied for a Master of Science (MSc) degree in Professional Education in the United Kingdom. This gave her the opportunity to investigate the features of the nationally recognised UK nursing mentorship programme, its regulatory framework and the manner in which the outcomes were assessed. After successfully completing her Master's degree, the researcher took on the role of academic tutor (lecturer) and taught student nurses on a BSc Nursing course at a private nursing college, and worked as a clinical instructor in the hospitals associated with the college in Jeddah. These roles gave her a valuable insight into the development of student nurses, since she experienced being both a nursing lecturer and a mentor and received direct, continuous feedback from the students whilst observing their clinical practice. Consequently, the researcher was able to reflect on the structure, content and delivery of the Saudi Arabian nursing mentorship process in which she participated as both a mentor and a mentee. Moreover, the additional knowledge of practices in the UK enabled the researcher to view the process in Saudi Arabia from two perspectives: as an insider and as a partial outsider who also understood UK conceptions of mentorship.

This dual perspective enabled her to plan her doctoral research from a position of cross-cultural understanding.

Mentorship in Saudi Arabia follows a specific procedure (For more details, see section 1.5.4). Based on her own experiences as a nursing student, and the student feedback she received as a lecturer, the researcher noticed that the quality of relationships and communication between many mentors and mentees is inadequate. For example, many mentors apparently fail to support students sufficiently during their placements. This may be a consequence of initial unwillingness to act as mentors, work overload, lack of time management skills, ambiguous job descriptions, or a lack of specialist training in how to mentor.

The next stage of the researcher's academic and professional development, as a PhD student in the UK, has allowed her to read more widely, and understand more deeply, the western literature on nursing mentorship practices. This facilitated her to observe the mentorship process in Saudi Arabia from the outside and the inside, holding two different points of view. According to ethnographers and anthropologists, this process of de-familiarisation, or of viewing the familiar as strange, is a useful way to perform cross-cultural comparisons, making it possible to discover social and cultural generalisations (Spiro, 1992). Undertaking this thesis from the UK enabled the researcher to conduct her research from a more objective perspective, making more rigorous cultural comparisons than if she had stayed in Saudi Arabia.

The various experiences of the researcher helped her to devise the preliminary research questions, including whether nursing mentorship in Jeddah is well defined, and how to improve the quality of mentor–mentee relationships. The researcher believed that helpful insights could emerge from an exploration of mentorship practices in Saudi

Arabia through the perceptions of nurses, students and academics. It was anticipated that analysing the perspectives of these three groups would facilitate recommendations to be made about how to enhance the status and experience of those participating in the mentorship process and the quality of outcomes for the individuals, hospitals and nursing colleges concerned.

Saudi Arabia remains a developing nation, which has historically relied on an expatriate workforce for professional knowledge and skills. Moreover, Saudi nationals perceived a career in nursing as less desirable than most other professions (Miller-Rose, Chapman and Francis, 2006; Tumulty, 2001). However, the Saudi government sought to encourage Saudi nationals to work in the roles occupied by expatriates, and to provide high-quality health care for its population (Tumulty, 2001).

The mentorship period in the clinical setting was found to be critical to the experiences of student nurses, as it influenced their motivation to acquire full qualifications (Grossman, 2013). Moreover, mentors played a key role in enabling the transition of students from a theoretical understanding towards successful, confident application of these principles to live patients (Corlett et al., 2003). In many cases, mentors determined not only how much their students learned during the clinical practice period, but also the quality of their experience and its impact on their confidence as professionals (Neary, 2000a). Furthermore, these qualities were often found to be relevant when determining whether a student meets professional nursing standards and wishes to continue pursuing a career in nursing (Hodges, 2009). The quality of the relationship between mentors and mentees affected mentees' learning, especially when the two parties had different expectations (Hodges, 2009; Spouse, 1996). High-quality mentoring relationships were found to motivate mentees, increase their self-esteem and confidence, assist in

socialising them within the institution, improve their future career prospects and allow them to maximise their capabilities (Neary, 2000a). Similarly, the benefits for the mentor included continued learning and development, and greater job satisfaction and appreciation within their organisation (Hodges 2009).

The main characteristics of a good mentorship experience were identified as mutual respect, reciprocity, trust, having clear expectations, commitment to the relationship, shared values, individual connection and partnership (Straus et al., 2013; Earnshaw, 1995; Spouse, 1996). In addition, the time offered to mentees to link theory to practice, with sufficient time available for mentoring activities and creating partnerships, is equally important in establishing a good mentorship experience (Hodges, 2009; Finnerty et al., 2005; Darling, 1984). Where mentors understood the position of supernumerary employees, and had previously encountered them, mentees were regarded as partners during the periods of their education (Wilson-Barnett et al., 1995). Indeed, Kram (1985), Ragins and Cotton (1999) and Darling (1984) proposed that identification, mutual attraction and liking were the main interpersonal activities related to the development and support of a good mentorship experience. Furthermore, Allen, Eby and Lentz (2006) found that mentees were most fulfilled during their mentorship when they were involved in the matching procedure, had frequent meetings and were set clear goals and objectives. In addition, it was necessary for mentors to have knowledge of the curriculum, course information and knowledge of the criteria for assessment in order to generate an effective mentorship experience (Spouse, 1996; Jinks and Williams, 1994; Rogers and Lawton, 1995). At the same time, effective communication, openness and frequent interaction made the mentor-mentee relationship robust, leading to favourable results (Hodges, 2009; Noe, 1988). Furthermore, high-quality mentorship was characterised by relevance, mutuality, interdependency and reciprocity (Huston and

Burgess, 1979). Other key features of a successful mentor-mentee relationship included providing guidance, showing care, patience, compassion and loyalty (Fawcett, 2002).

However, while a good mentorship relationship requires both parties to offer something to the overall process, the onus is on the mentor to make an effort to create a sense of belonging and control for the mentee (Fawcett, 2002). This is important because if the mentee feels they are not gaining as much as they would like from the mentorship, there will be negative impacts on certain aspects of the mentorship relationship, including their attitude and behaviour, which may encourage the mentee to seek alternatives (Fawcett, 2002). On the other hand, a positive mentorship experience relies to some extent on the mentees creating a connection with the mentors, in order to establish a partnership and ensure that their attitudes, expertise, enthusiasm, willingness, openness and character demonstrate that they are keen to learn (Huybrecht et al., 2011; Webb and Shakespeare, 2008; Hodges, 2009). In addition, feedback is an important element of the mentor-mentee relationship (Huybrecht et al., 2011; Greene and Puetzer, 2002; Gray and Smith, 2000; Phillips, Davies and Neary, 1996). Good mentors use feedback during teaching and mentoring; however, some students have issues receiving constructive criticism from their mentors (Gray and Smith, 2000), but it is necessary for them to be given performance feedback in order for them to reflect on their development and achievements, and to set goals and targets for their future progress (Webb and Shakespeare, 2008; Greene and Puetzer, 2002).

In order to ensure the quality of a mentorship experience, there are several key quality indicators that can be used to evaluate it. These include having clear goals, objectives and expectations of the relationship, as well as personal targets, which facilitate personal growth and development (Greenhaus, Callanan and Godshalk, 2000; Hodges,

2009; Eby and Lockwood, 2005). Hence, the provision of training for both parties is important, as is a system of evaluation of this process, not only for both parties, but also for others who might have had some involvement in the process, such as head nurses or college instructors (Allen, Eby and Lentz, 2006; Gibb, 1994; Gichigi, 2009; Greene and Puetzer, 2002; Forret, Turban and Dougherty, 1996; Cunningham, 1993; Webb and Shakespeare, 2008). In general, the data required to assess these quality indicators can be collected through informal conversations, documentation of the mentorship process and questionnaires (Gibb, 1994).

Ensuring consistency in the quality of the mentorship experience is important, and this can be achieved through using learning contracts, establishing ground rules, having transparent policies and guidelines, identifying roles and expectations, using student handbooks that offer guidance to the mentees, having a training programme and handbook for mentors and regularly evaluating this process (Gichigi, 2009; Hodges, 2009; Neary, 2002). In addition, educational bodies, such as nursing colleges, must monitor and control practice, in order to reduce instances of disorientation and uncertainty (Andrews and Wallis, 1999). In order for mentorship to be effective and consistent, robust communication is essential for mentors, practitioner teams and any individuals responsible for the education of nurses (Andrews and Wallis, 1999).

Finally, it is difficult to gather precise details of the costs involved in mentorship, since many of them are hidden (Ragins and Scandura, 1999; Grossman, 1998). Staff time is incurred when nurses need to take time out of their work environment to mentor students, but it is expected that mentors will give this time to the role (Kram, 1985; Halatin and Knotts, 1982). The cost associated with staff time is more likely to involve mentors using their own time to catch up on paperwork relating to the mentorship

process or their patients' care, which they must complete prior to going off duty (Gibb, 1994). However, there are some costs that can be quantified, such as the cost of training, where a programme exists requiring attendance at a study day and where replacement staff are required to cover patient care for a shift (Gibb, 1994). Arguably, a higher quality of care, higher retention rates and an increase in staff commitment facilitates lower turnover and thus, any associated costs can be balanced against the potential benefits (Barton, Gowdy and Hawthorne, 2005). In addition, some mentors believe that a related benefit to them is the unique feeling of fulfilment and achievement they get as a result of facilitating mentees to develop and succeed (Ragins and Scandura, 1999).

It is clear from the literature that, despite the aforementioned rewards of fulfilment and personal satisfaction, the success of nursing mentorship relies on the goodwill or sense of duty of staff undertaking mentorship roles, which usually carries no concessions, no reduction in workload and no recognition or remuneration. This approach is regarded by many as unacceptable and unsustainable. Myall, Levett-Jones and Lathlean (2008) support the notion that if mentorship is to be of sufficient quality and the mentor's role is to be recognised as important, there should be a shift away from such practices and alignment with approaches in other professional arenas. Myall, Levett-Jones and Lathlean (2008) maintain that mentors deserve enhanced organisational support, providing them with protected time to attend training programmes and meetings with mentees, and improvements in partnership working between colleges and clinical settings, thereby establishing fruitful collaborative relationships between academics and qualified nurses responsible for nursing students. Jokelainen et al. (2013) agree and further assert that poor organisational support for mentors and no extra reward for their work contribute to poor standards of mentorship. Wilson (2012) and McCarthy and Murphy (2010) likewise indicate how mentors can exhibit feelings of being burdened

by their role, which can be exacerbated by the lack of resources, particularly time, and insufficient recognition from management for their efforts undertaking this role. In other professional arenas this would be considered unacceptable and would not be tolerated, especially in corporate settings where mentorship interventions have successfully evolved and the benefits of mentorship programmes to companies are undeniable (Underhill, 2006). Indeed, many companies choose to hire in and pay for mentors' expertise (Ensher and Murphy, 2005). In addition to business settings, mentorship in medicine and education are well established with remuneration of mentors resulting in increased job satisfaction (Ramani, Gruppen and Kachur, 2006; Sambunjak, Straus and Marušić, 2006; Gibson, 2004; Martinez, 2004).

The need for more formal recognition and tangible rewards for mentors' efforts has been widely recognised as a driving force of sustained quality in mentorship (Biggs and Schriner, 2010; Kemper, 2007; Neumann et al., 2004; Stone and Rowles, 2002). For instance, remuneration could take the form of an education day with pay, a salary increase, or decreased work duties during the mentorship period (Ramani, Gruppen and Kachur, 2006; Canadian Nurses Association, 2004). Meanwhile, recognition could include mentors' names being published in newsletters, personal thank you letters from senior nursing staff, or preferential shift scheduling (Canadian Nurses Association, 2004).

Chapter 4 reveals that the published literature concerning nursing mentorship focuses almost entirely on the western perspective. Saudi Arabian mentorship practices, and the experiences of those involved in them, are largely unexplored and undocumented. This thesis intends to contribute to original knowledge to this area, and it is hoped that the

findings will be of relevance not only to Saudi Arabia, but also to others, particularly other countries in the region of Saudi Arabia.

1.3 Structure of the thesis

This study was conducted as a structured PhD. Under City University London doctoral regulations, structured PhDs must include the following distinct elements:

- A case study or situational analysis demonstrating the researcher's reflective practice and the skills and knowledge required to improve reflective practice

- A best evidence literature review to identify strengths and weaknesses in the evidence base and make recommendations for future research, focusing on evidence-informed practice

- A substantial research study with a consistent focus on developing practice

- A dissemination artefact and plan which aim to maximise the impact of the doctoral study by supporting the application of the findings while recognising the many interdependent stakeholders in practice and research

- A commentary which links the previous elements and explains their significance. This thesis has a three-part commentary, as outlined in section 1.1.

This thesis is organised as follows:

- Chapter 1, 'Commentary one', provides an introduction to the thesis.

- Chapter 2 discusses the impact of ethnicity, culture and power relationships on nursing mentorship in Saudi Arabia.

- Chapter 3 presents the case study of mentorship conducted as part of this doctoral thesis. This chapter discusses the research aim and questions, methodology, and findings of the case study.

- Chapter 4 introduces, discusses and critically evaluates the literature on mentorship in nursing.

- Chapter 5 presents the main study—an AI into mentorship—and discusses the research aim and questions based on findings of the case study (Chapter 3) and the gaps identified in the literature (Chapter 4). The researcher then describes the research methods employed and the findings of the main study.

- Chapter 6, which is the second commentary, compares the methodological approaches of the case study and the main study and compares the findings obtained from these contrasting methodological approaches.

- Chapter 7 presents the dissemination artefact and plan.

- Finally, chapter 8, which is the third commentary, summarises the findings, discusses the limitations of this thesis, states its contribution to knowledge and suggests the implications and recommendations arising from this research.

1.4   Thesis development

1.4.1   Overview

The research was conducted in three main stages. First, a case study investigated the current practice of nursing mentorship in a clinical setting in Jeddah from the perspectives of clinical nurses, student nurses and academics. In the second stage, literature on nurse mentorship in western nations and in Islamic countries with similar cultural characteristics as Saudi Arabia was reviewed. The first and second stages defined the research questions for the third stage, or the main study. An AI approach

was selected for the main study to explore facts, feelings and opinions about mentorship.

The researcher approached the thesis from a social constructionist perspective (section 1.6) based on the belief that social meaning, understanding and knowledge proceed from interactions and negotiations between social groups. Therefore, it accepts that multiple realities exist, as all individuals interpret reality differently to create truth (Gergen, 1994). Thus, the different research methodologies and methods employed in the case study and the main study enabled the researcher to explore and analyse these truths, to deliver outcomes that contribute to knowledge.

A critical evaluation of the empirical findings suggested a significant gap in the literature review related to communication, which emerged as a fundamental issue. Therefore, a new section on communication was added to the literature review (section 4.4.7). The research findings reported in this thesis suggested an outline of a mentorship training programme and a draft handbook, which could be used as a framework by Saudi hospitals and nursing colleges to clarify expectations for mentorship and to enhance the prevailing culture of mentorship. The outline of a mentorship training programme and the draft handbook are presented as artefacts in the thesis. A plan for the dissemination of the research findings was also designed.

The key elements of the thesis are outlined briefly in the following sections.

1.4.2   The case study

An exploratory case study design was selected for the initial investigation into nurse mentorship practices in a clinical setting in Jeddah. Employing an exploratory qualitative approach enabled the researcher to gain in-depth insights into stakeholders' perceptions of mentorship practices as lived experiences (Yin, 2009). Focus groups

were used to collect data from mentees (student nurses), mentors (registered nurses (RN)), clinical educators, nursing lecturers and head nurses. Individual interviews were also conducted with two nursing coordinators organising activities between the nursing college and the hospital. In addition, pre-focus group interviews and discussions with gatekeepers (hospital and nursing college senior managers) provided a contextual understanding of mentorship practices in the hospital environment.

1.4.3 Best evidence literature review

Once the findings of the case study were analysed, categorised, discussed and recorded, a review of literature on mentorship in the nursing context was undertaken. The review included published academic research in the United States, Europe and Australia and a small number of studies examining mentorship in Islamic countries (Turkey and Jordan). The literature review was divided into seven categories: definitions of mentorship, studies focused on nursing mentorship in Saudi Arabia, on nursing mentorship in Islamic countries, on the perceptions of nursing students, on the perceptions of nursing mentors and on the perceptions of both groups and finally, the influence of communication on mentorship outcomes.

1.4.4 Main study

The aim of the main study was to investigate factors contributing to positive mentorship experiences in nursing in Jeddah. The following research questions emerged from the literature review on mentorship and the findings of the case study:

- What are mentors' and mentees' understandings of mentorship in nursing in Jeddah, Saudi Arabia?

- What are mentors' and mentees' positive experiences of mentorship in nursing in Jeddah, Saudi Arabia?

- What factors contribute to mentors' and mentees' positive mentorship experiences in nursing in Jeddah, Saudi Arabia?

The guiding research philosophy adopted was AI, which assumes that all organisations internally develop good practices. When making reform decisions, good practices which have developed locally must be recognized, allowing for a positive effect on the implementation of organizational change. Especially applicable to studies on organisational development, this philosophy aims to identify the positive elements of local practice as perceived by participants and to extend and enhance these elements in order to improve future practice and the quality of performance outcomes. This philosophy, thus, directly contrasts with the more common problem-solving approach which focuses on finding and rectifying deficiencies.

The participants (mentors and mentees) were asked to analyse their positive experiences and to reflect on the circumstances which would present ideal positive experiences of mentorship in the future. To achieve this role-specific focus, focus groups were used as a data collection method. Participants were encouraged to share their peak experiences and to discuss what factors they thought would contribute to their ideal experience of a future nursing mentorship.

1.4.5 Dissemination artefact and plan

The structured doctorate requires the creation of an artefact to communicate the findings of the thesis and to develop practice. In this thesis, the artefact is the outline of a mentorship training programme and draft handbook designed for local use in Saudi Arabia in the preparation of mentors. This programme was designed to highlight the key goals of the mentorship initiative and to delineate the roles and responsibilities of the participants. In addition, this material acts as a programme framework outlining each

step of the mentorship process. A dissemination plan discussing how the researcher plans to disseminate the artefact was also designed.

1.5   Overview of nursing mentorship in Saudi Arabia

1.5.1   Introduction

Clinical placements are crucial in helping student nurses to gain the required clinical skills and knowledge to care for patients in hospital settings (Murray and Williamson, 2009). Mentorship allows student nurses to learn from qualified professional nurses during their clinical placements (Fawcett, 2002). The nursing profession has employed mentorship practices for many years and these have evolved from one-to-one mentoring to more collaborative efforts (Grossman, 2013). Although mentoring is not restricted to student nurses, and can involve senior and junior nurses, in this thesis, the term mentorship refers to the facilitated learning of student nurses.

1.5.2   History of nursing in Saudi Arabia

Nursing in Saudi Arabia was established in the time of Prophet Mohammed, PBUH, when Kuaibah Bint Sa'ad Al-Aslamiyah 'Rufaida Al-Aslamiyah' nursed the Muslim armies during the holy wars (Miller-Rosser, Chapman and Francis, 2006; Tumulty, 2001). Rufaida is considered the first Muslim nurse. During the holy wars, she and a number of Muslim women gave first aid and drinks of water to the wounded and dying and kept them safe from the elements (Jan, 1996).

Rufaida set up a tent inside a mosque to give nursing assistance outside wartime, train women as nurses and educate the community on matters of health and social support. Rufaida's father was a leading healer, and she learned from him and improved her nursing abilities. She nursed both male and female patients (Jan, 1996). After her death,

Muslim women continued the practice of nursing both during and outside wartime (Miller-Rosser, Chapman and Francis, 2006; Jan, 1996).

1.5.3 Nursing education in Saudi Arabia

The 20th and 21st century history of nursing education in Saudi Arabia includes separate initiatives led by the Ministry of Health (MOH) and the Ministry of Higher Education (MOHE), which merged in 2008. First, with the cooperation of the World Health Organization (WHO), the MOH set up the first Health Institute Programme in 1958, launching modern nursing education and training in Saudi Arabia (Aldossary, While and Barriball, 2008). Initially, this one-year programme recruited 15 Saudi men after they finished elementary school. These men graduated as nurses' aides (Alhusaini, 2006; Al Thagafi, 2006; Miller-Rosser, Chapman and Francis, 2006; Al Osimy, 1994). The programme was later extended to three years by the MOH and began to accept male and female graduates from secondary school to study in new health institutes across the country (Alhusaini, 2006; Miller-Rosser, Chapman and Francis, 2006; Al Osimy, 1994).

The MOHE, rather than the MOH, introduced the first Bachelor of Science (BSc) degree to the nursing programme in 1976. A Master of Science (MSc) degree in nursing was later introduced by the MOHE in 1987 (Miller-Rosser, Chapman and Francis, 2006; Tumulty, 2001). Completion of comprehensive elementary and secondary education was required prior to enrolment on the BSc in nursing programme (Alamri, Rasheed and Alfawzan 2006; Berhie, 1991). Both these higher education programmes were open to female students only (Alhusaini, 2006; Berhie, 1991). BSc in nursing graduates were considered professional nurses, with the right to pursue a Master of Science degree in nursing, to qualify them as specialists (Saudi Commission for Health Specialties, 2014).

By 1990, the MOH had established multiple health institutes offering nurse education programmes, 17 for women and 16 for men (El-Sanabary, 1993). In 1992, junior colleges were set up to improve the educational standards of Saudi nurses and to teach high school graduates (Abu-Zinadah, 2006; Alhusaini, 2006). Graduates received a diploma in nursing and were classified as technical nurses (Saudi Commission for Health Specialties, 2014).

The MOH used to graduate nurses through its health institutes and junior colleges (Aldossary, While and Barriball, 2008). However, the MOHE took over these educational programmes in 2008, aiming to increase the standards of nursing education (Almalki, Fitzgerald and Clark, 2011). In addition, only Saudis are accepted in these educational programmes. According to the Ministry of Health (2012), in the 2012–13 academic year, student nurses in various universities numbered 3,961. Nearly 99% were of Saudi nationality, 86% (n=3397) were Saudi females, and 13% (n=525) were Saudi males (Ministry of Health, 2012).

To obtain a bachelor degree in nursing in Saudi Arabia, student nurses have to complete a five-year programme (Almalki, Fitzgerald and Clark, 2011). Four years are spent studying at university, starting clinical placements in the second year. The final year, which includes training and rotations in the hospital, is called the internship year.

In addition, continued education is essential for Saudi nurses but is lacking in almost every MOH hospital. Almost all hospitals have a training department providing limited nursing in-service education, such as cardiopulmonary resuscitation courses, language courses and orientation. Despite concentrated attempts to improve specialist training for Saudi nurses in especially problematic areas (quality management, infection control, clinical expertise), a lack of educational materials and resources create difficulties for

nurses trying to remain up to date with health care techniques and knowledge. Some non-ministry hospitals have sufficient resources and material, but these are not available to MOH staff (Tumulty, 2001).

1.5.4 Process of mentorship in Saudi Arabia

In Saudi Arabia, the BSc nursing degree includes 4 years of classroom instruction and a 12-month internship. Clinical placement of nursing students starts in the second semester of their second year at the college. In clinical settings, mentorship is practised and follows a certain procedure in which RNs are identified as mentors and assist in student nurses' learning. First, the head nurse of the hospital staff is consulted by the college staff about the placement of students for 2 days a week (7 hours per day) for 2 semesters. The head nurse then assigns student to mentors, who are changed every week. Given the limited availability and significant time commitment of the mentors, nurses working in the system do not believe retaining the same mentor for the entire time of the mentorship period is feasible. Students have very limited control of the process. They are not given the name of their mentors in advance, nor are they offered a preliminary visit to the hospital to meet their mentors or discuss issues relating to their placements. On the same day of the placement, students are assigned to a RN who acts as their mentor without prior arrangement.

The structure of mentor-mentee relationship has yet to be studied in depth in Saudi clinical settings, although it has in other healthcare systems (Edgecombe, Jennings and Bowden, 2013; Sullivan, Pokhrel and Lim, 2010; Murray and Williamson, 2009; Wilkes, 2006). Literature on the mentorship experiences of student nurses and RNs in the context of Saudi healthcare is lacking. Student nurses in Saudi Arabia have to complete five years in college, compared to only three years in many other developed

countries (Almalki, Fitzgerald and Clark, 2011). The length of training allows for further mentorship during student nurses' various clinical placements. The number of expatriate nurses in healthcare settings might also have an impact on mentorship in the Saudi nursing profession, as differences in language and culture might affect the mentor–mentee relationship (Aldossary, While and Barriball, 2008). In addition, the high turnover of nurses and the increased demand for healthcare in the country could result in the less availability of mentors to facilitate student learning.

Identifying the requirements for the roles and responsibilities of mentors in Saudi Arabia is necessary to determine whether nursing students receive appropriate support. As stressed by Myall, Levett-Jones and Lathlean (2008), developing standards for mentorship would ensure that student nurses gain competence and confidence in caring for patients. Investigating the experiences of both mentors and mentees in Saudi Arabia can help determine whether trainees receive sufficient support, education and training to perform their roles independently. The findings of this study could inform the MOH and MOHE about the status of mentorship and gaps in practice in Saudi Arabia, leading to improvement of the mentor–mentee relationship. By exploring the individual experiences of mentors and mentees in clinical settings, these conclusions can also highlight the factors contributing to positive mentorship experiences.

1.5.5   Researcher's background and experiences

In planning and carrying out this study, the researcher was influenced greatly by her own background and experiences (section 1.2). Therefore, it was important to outline her reflections at the beginning of this study (section 3.2.8) in order to increase the trustworthiness of the data collection, analysis and interpretation.

1.6 Conceptual framework: Social constructionism

The conceptual framework was developed based on the researcher's beliefs, values, experiences, epistemology and theoretical perspectives, as suggested by Miles and Huberman (1994). The researcher's experiences as an educator and student informed the research design. The social constructionist epistemology reflects her belief that understanding of the world is constructed through social experience and dialogue (Gasper, 1999; Ernest, 1999; Gredler, 1997; Prawat and Floden, 1994; Schwandt, 1994). The philosophy of social constructionism suggests that individuals influence the reality they view and experience and create their realities through the meaning and understanding that are socially produced (Burr, 2003). Social constructionism holds that there is no single reality but, instead, a composite of the multiple realities of individuals' views, interactions and shared understandings (Gergen, 1994). All individuals' views are considered valuable and deserving of respect and attention (Crotty, 1998). Social constructionists believe that social meaning, understanding and knowledge are grounded in interactions and negotiations within and between communicating social groups (Burr, 2003; Kukla, 2000; Gredler, 1997) and attention to these interactions should influence the generation of new theory (Cooperrider and Whitney, 2005).

In this study, the researcher aimed to discover, describe and synthesise multiple truths through the examination and investigation of different and competing concepts, views and arguments (Gergen, McNamee and Barrett, 2001). Broadly speaking, qualitative methods are suitable for studying individuals within their cultural context (Morrow, Rakhsha and Castñeda, 2001). An approach employing individual interviews, focus groups and appreciative inquiry activities was designed to provide an effective means for dialogue and clarification of values with participants in this research (Ritchie and

Lewis, 2003; Sundli, 2007). The researcher's inquiry concentrated on the social interactions and activities in which individuals participated. In this approach the role of language becomes active rather than simply a form of expression (Burr, 2003); an approach through which individuals can begin to build their environment. In addition, it was important to recognize the manner in which an individual makes sense of a given experience and the wider social influences that play a part in shaping that meaning (Martin and Sugarman, 1999).

Understanding and interpreting the meanings constructed by participants depends on certain factors, such as rapport, context and culture, since the contextual grounding is necessary for understanding participants' constructions of meanings attached to their experiences (Morrow, Rakhsha and Castñeda, 2001). In conducting individual and focus group interviews, it was important to establish a relationship with the participants and be an active listener during the discussion (Mills, Bonner and Francis, 2006). The conduct of a constructionist investigation involves a transformation of the relationship between the researcher and the participants, and requires the researcher to focus on the nature of her interactions with participants and to analyse this (Mills, Bonner and Francis, 2006).

The interaction that takes place between the researcher and the participants generates the inquiry data (Guba and Lincoln, 1989). In individual and focus group interviews, the researcher and participants exchange dialogue, a process that highlights the complex nature of the research topic and provides detailed data to support exploration of meanings (Craig and Douglas, 2005). Thus, the interviews become a forum for the construction of knowledge and for active dialogue and interactions between individuals,

leading to mutually created knowledge (Hand, 2003; Fontana and Frey, 2000; Collins, 1998; Reinharz, 1992).

In relation to learning and mentoring practice, the researcher considers knowledge as a product of the social and cultural interaction between mentors and mentees (Ernest, 1999). This interaction occurs both between them and also in relation to their context and pertaining to their culture (Gredler, 1997). Reality is considered to be produced by individuals through their activities and interactions, communally creating the characteristics of their environment (Cunliffe, 2008; Kukla, 2000), with learning considered to be a social function, not simply isolated in individuals, or influenced by outside sources, but interactive and social, created through shared activities (McMahon, 1997). Therefore, mentorship can be better understood by focusing on how various individuals (particularly mentors and mentees) communicate and interact with each other (Kim, 2001).

Social constructionism is usually used by instructors to encourage student-centred learning (Murphy et al., 2005). Indeed, concepts of learning within social constructionism presume that knowledge construction occurs as a result of interactions that transpire within the self through reflective thinking, as well as interactions that transpire within collaborative and communicative effort with others (Vygotsky, 1978). The philosophy of social constructionism has numerous implications for the use of collaborative learning methods. With constructionism, better learning takes place when knowledge is the consequence of a construction of reality (Brooks, 1990).

In nursing mentorship, it is the interactions and discourse between mentors and mentees, and their social activities and traditions that are responsible for the creation of knowledge (Prawat and Floden, 1994; Gredler, 1997; Gasper, 1999). Consequently,

learning in this context needs to be participatory, communal, collaborative and proactive, and to be seen as the development and construction of meanings rather than the giving and receiving of knowledge (Bruner, 1996). Several definitions of mentoring are connected to social constructionism and its cognitive apprenticeship model, including collaboration, modelling, interaction, communities of practice and scaffolding techniques (Murphy et al., 2005).

However, there are some critiques of the use of social constructionism. One of these is that the theories of certain social constructionists are underpinned by the idea and role of language to such an extent that they omit aspects external to language (Cromby and Nightingale, 2002). A second concern is the questionable extent of externality that one can achieve in relation to an environment in order to examine and analyse it (Cromby and Nightingale, 2002). Moreover, consideration has to be given to the issue of how humans make choices and changes in their environment if, indeed, these things are products of historical, social and cultural influences (Martin and Sugarman, 1999). Guba and Lincoln (1994) suggest that quality criteria for constructionism are not well elaborated, and additional scrutiny is required. Morrow (2005) posited further criteria in an attempt to broaden the concept of constructionism criteria. He includes the extent to which participants' meanings are understood in depth (Ponterotto, 2005) and the extent to which a mutual construction of meaning between researcher and participants exists (as well as construction being explained) (Morrow, 2005). With regard to mentorship and learning, even if constructionism is seen as beneficial and valuable, and constructionist learning strategies are devised, there are few guidelines for the assessment and implementation of the constructionism approach itself (Bonk and Cunningham, 1998).

Furthermore, Sandelowski (2000) warns that the constructionist's concepts are formed, devised or created from the available information and what the constructionist finds is what they themselves create. On the other hand, constructionists have a greater chance of including the position of the researcher as co-constructor of meaning and to see this as essential to the interpretation of the data (Sandelowski 2000). Approaches to managing this subjectivity have been referred to as "monitoring of the self" or "bracketing" (Peshkin, 1988), or have been labelled as "rigorously subjective" (Jackson, 1990). Without the presence of an articulated perspective with regard to subjectivity, constructionist researchers are vulnerable to questions concerning whose perceptions are being defined within their study findings (Morrow, 2005). Indeed, questions arise about the balance between developing friendship with the participants and maintaining the distance that will enable professional decisions and judgments to be made (Lincoln and Guba, 1985; Torres and Baxter Magolda, 2002), while Guba and Lincoln (1989) argue that constructionists believe that the inquirer and those who are the focus of inquiry cannot be separated.

2 Nursing mentorship in Saudi Arabia: Recognizing the importance of ethnicity, culture and power relationships

2.1 Introduction

This thesis is concerned with the relationship between mentors and mentees in Saudi

Arabia. As such, the broader context of social relations in the region must be

considered. Saudi Arabia is comprised of a heterogeneous mixture of ethnicities from

around the Gulf region and further abroad (Maisel and Shoup, 2009). The shortage of

Saudi nursing staff means that Saudi Arabia has a long history of recruiting expatriate

or immigrant nurses to staff their hospitals (Zakari, Al Khamis and Hamadi, 2010;

Miller-Rosser, Chapman and Francis, 2006). For instance, a major hospital in Riyadh

employs up to 95% expatriate nursing staff, from 40 different countries (Aboul-Enein,

2002). Day to day relations between co-workers are influenced by the diversity of ethnic

and cultural backgrounds within the nursing workforce (Adahl, 2009). Naturally,

ethnicity, culture, structures of power, identity and belonging have a significant impact

on nursing practice when mentees and mentors from different backgrounds have to

work together. This is amplified in cases where professional hierarchies of expertise and

experience may or may not correspond with cultural and ethnic structures of power.

This chapter begins with an overview of Saudi Arabia. It then outlines the composition

and culture of the nursing workforce and finally considers the influences of ethnicity,

culture and power relationships on mentorship in this context.

2.2 Overview of Saudi Arabia

The Kingdom of Saudi Arabia is the largest Arab country in the south west corner of

Asia at approximately 2,240,000 square kilometres, with Red Sea and Persian Gulf

coastlines (Central Department of Statistics and Information, 2015). The 2014 census

reveals that the population is approximately 30,770,375 of whom 20,702,536 are Saudis, and that Islam is the religion of the entire national population (Central Department of Statistics and Information, 2015).

2.3   The composition and culture of the nursing workforce in Saudi Arabia

Saudi Arabia has a longstanding shortage of Saudi nurses and high nurse turnover (World Health Organization, 2006; Abu-Zinadah, 2004). Expatriate nurses continue to make up a large proportion of the country's nursing workforce (Ministry of Health, 2012; Almalki, Fitzgerald and Clark, 2011; Harry, 2007; Al-Ahmadi, 2006; World Health Organization, 2006). According to Tumulty (2001) and Marrone (1999) demand for local nurses is high in Saudi Arabia and the Saudi healthcare system has made efforts to employ and retain more locally trained nurses. However, in 2012, Saudi nationals accounted for only 36.2% of the nursing workforce and the proportion was even lower in 2008, at 29.1% (Ministry of Health, 2012). Most expatriate nurses employed in Ministry of Health (MOH) hospitals are Indian or Filipino (Tumulty, 2001). Although English is the official language of the workplace for healthcare professionals, Arabic is the predominant patient language (El-Gilany and Al-Wehady, 2001). It is therefore vital for nurses to understand sufficient Arabic to enable appropriate nurse-patient interaction, as well as for the purpose of nurse education (Al-Mahmoud, 2013; El-Gilany and Al-Wehady, 2001). However, a large number of nurses (Saudi and expatriate) do not speak English as a native language, and many expatriate nurses are not fluent in Arabic either (Simpson et al., 2006). Aldossary, While and Barriball (2008) argue that increasing the number of Saudi nurses would facilitate more culturally appropriate care and they suggest that delivery of care is more efficient if nurses and patients share the same culture and language. Culture is an important determinant of contextualisation, which Saudi nationals might be better placed to

understand than expatriates (Aldossary, While and Barriball, 2008). The Saudisation policy, which has gained significant government policy backing since 2004 (Tumulty, 2001) seeks to increase the employment of Saudi nationals by giving them priority in the recruitment process (Al-Dosary and Rahman, 2005). Preference is given within the profession to Saudi nurses in an attempt to encourage recruitment and retention of locally trained healthcare workers (Al-Dosary and Rahman, 2005), and a study by Bach (2003) suggested that immigrant healthcare workers are very often limited in their career paths by their expatriate status, with little account taken of their training and expertise because it has been acquired elsewhere. Limited pay, irregular working hours and the poor public image of nursing make recruiting sufficient numbers of Saudi men and women difficult (Al-Sa'd, 2007; Abu-Zinadah, 2004; Al-Hydar and Hamdy, 1997; Jackson and Gary, 1991). The nursing profession in Saudi Arabia is not perceived to be of particularly high status and therefore it is not widely viewed as a desirable career for Saudis (Marrone 1999).

Genders are usually segregated in Saudi society, including health care institutions and universities (Tumulty, 2001). However, there are not enough male Saudi nurses for male patients, as no Saudi university offers a Bachelor of Science (BSc) in nursing for men (Tumulty, 2001). The nursing diploma in Saudi Arabia offered by the Ministry of Health (MOH) is the only level of nursing education available for both men and women, while the BSc degree in nursing offered by the Ministry of Higher Education (MOHE) is available only to women, which creates another hurdle for the Saudisation of nursing (Tumulty, 2001). Consequently, foreign nurses are employed to fill the shortage (Almalki, Fitzgerald and Clark, 2011).

In addition, data from the Ministry of Health show that in 2012, 59.5% of hospitals in the Kingdom of Saudi Arabia (KSA) were operated by the Ministry of Health, 31.5% were private sector hospitals, and 9.0% were run by other government agencies (Ministry of Health, 2012). They further reveal that the number of nurses in all health sectors is growing: 139,701 in 2012, up from 101,298 in 2008 (Ministry of Health, 2012).

2.4 The impact of ethnicity, culture and power relationships on nursing mentorship in Saudi Arabia

2.4.1 Ethnicity and culture

Although the terms 'ethnicity' and 'culture' used in the following discussion have similarities, they may be usefully distinguished from each other. Ethnicity is usually employed when the cultural attributes of an individual, such as nationality, language, or religion are under consideration (Drevdahl, 2001). Conversely, culture generally relates to the customs, normative behaviour and practices of a certain group, in which bonds between members of the group may take a number of different forms, such as racial origin, religion or nationality (Fenton, 2003). According to Locke (1992), culture is attained and dissipated through symbols, including techniques, beliefs, organisations, corporeal objects and normative behaviour. According to Nowottny (2008), culture is a concept consisting of various aspects, including the assumptions, customs, practices and beliefs governing the lives of a particular group of individuals. All people possess their own distinct culture that is the sum of their personal experiences and experiences shared with other individuals (Hofstede, Hofstede and Minkov, 2010). As Hofstede, Hofstede and Minkov (2010) point out, such experiences are related not only to the immediate social groups to which individuals belong, but also to the broader society. Therefore, the culture that individuals identify with influences their views and attitudes towards other

people, depending on whether or not they share the same culture (Triandis, 2003).

Consequently, individuals rely on their culturally-shaped beliefs, conventions and

outlook to create a social hierarchy, according to which they label the people they come

into contact with (Triandis, 2003). Each culture also includes a series of intrinsic

elements that are not readily visible or accessible to individuals who do not belong to

that culture. These hidden elements are the assumptions, beliefs and customs that both

arise from and shape a specific culture (Rosinski, 2003). Despite being hidden, the

intrinsic cultural elements are often reflected in extrinsic acts but, even so, they cannot

normally be deciphered by individuals from a different cultural background (Rosinski,

2003). The misunderstandings that can emerge from the inability of people from

different cultures to read each other's intrinsic cultural elements is a major source of

contention in the context of mentoring relationships (Rosinski, 2003). These definitions

all point to an understanding of culture that emphasizes that it is learned rather than

innate, and is not predetermined or genetic. This means that wherever culture operates

there is the possibility of acquiring it, and this may impact on nursing (Leininger and

MacFarland, 2006). Accordingly, there is a need for mentorship to address the

possibility of adaptive stress or 'culture shock' when nurses, particularly those recruited

from other countries, lack the required cultural knowledge, skills or sensitivity

necessary to practise in a new environment (O'Brien and Ackroyd, 2012; Sherman and

Eggenberger, 2008). According to a study conducted in Saudi Arabia by Bukhari

(2011), to overcome such potential problems, the success of cultural integration of

nurses should be considered prior to recruitment. International nurses should prove that

they are accepting of the need to adjust to and work in a new cultural environment

before formal employment. Bukhari (2011) found newly hired nurses' lack of

knowledge and awareness of the Saudi culture before they arrive in Saudi Arabia has an

impact on their ability to adapt and settle in. Therefore, applicants for Saudi nursing positions should be provided with comprehensive and accurate information on the Saudi culture, healthcare system and role requirements by the recruiting agent (Bukhari, 2011). Sherman and Eggenberger (2008) propose that to help promote cultural understanding, nurses who have similar experiences or backgrounds prior to their transition to the new environment should be used as mentors. However, concurrently, organisations should build an environment that respects and values the diversity and individuality of all staff, providing them with suitable support systems (Sherman and Eggenberger, 2008).

Culture, race and ethnicity are widely resonating terms in every society (Jirwe, Gerrish and Emami, 2006). Nagel (1994) describes ethnicity as having a fluid form that constantly changes the institutional culture, as opposed to Omi and Winant's (2014) idea of ethnicity as being constantly moulded in single instances by societal forces. Likewise, Nagel (1994) argues that ethnicity within social institutions is created and recreated in various stages to realise competing visions from a society's ethnic composition. There is broad agreement that culture influences effective cooperation between nurses, as much as between nurses and patients (El-Sanabary, 1993). One of the major issues relating to Arab Muslims in hospital is the need to understand the cultural context of providing them with nursing care (Mebrouk, 2008). Leininger and MacFarland (2006) pointed out that understanding culturally-specific nursing care increases in conjunction with nursing expertise. Leininger and MacFarland (2006) defined cultural care as multiple aspects of culture that assist an individual or group to improve or deal with their health condition, including illness. Aldossary, While and Barriball (2008) and Alamri, Rasheed and Alfawzan (2006) have pointed out the benefits of increasing the number of Saudi nationals within the healthcare system as a

means of providing more culturally focussed care, which can be better delivered through shared culture and language. As a result of the diverse nature of the workforce, nurses need to develop essential knowledge, abilities and a keen sensitivity to their workplace, including an awareness of linguistic and religious sensitivities related to gender and normative practice (Burnard and Gill, 2009). In the Saudi context, ethnicity and culture play a powerful role deeply connected to religion as the majority of Saudi Arabian's population are Muslim and practise an Islamic way of life (Al-Shahri, 2002). It is therefore important for expatriate nurses to appreciate the significance of Islam for Saudis, local constructions of honour, the ties of the extended family and the ways in which women are protected within the culture (Mebrouk, 2008; Aboul-Enein, 2002). In keeping with such requirements, individuals who have immigrated to Saudi Arabia from other countries and are working as nurses in hospitals there are given orientation training to help them gain basic knowledge of Saudi family dynamics, language, and culture (Aboul-Enein, 2002). In addition, a wide range of strategies are employed to enable them to acquire skills related to language, such as participation in Arabic language classes, to ensure that the language does not create obstacles to care, as well as communication with their Saudi counterparts on the subject of the cultural aspects that must be taken into account when working in an international context (Aboul-Enein, 2002).

Another cultural issue relevant to nursing mentorship in Saudi Arabia is that hospital care and nursing education are both gender segregated (Tumulty 2001). This gender difference emanates from Saudi culture and socialisation, which encourages the segregation of women and men in the majority of social settings, including workplaces, leisure facilities, mosques and schools. Thus, female Saudi nurses may not be willing to nurse men (Almutairi, 2012; Tumulty 2001; Hamdi and Al-Haidar, 1996). These

challenges, together with cultural constraints restricting the times that some students are permitted by their families to spend on the wards (e.g. no night shifts) limits the time for students to be mentored and increases pressure on mentors to deliver support within a reduced time frame (Tumulty, 2001). Saudi female nurses and their families often request to work only morning and early afternoon shifts (Tumulty 2001). Furthermore, Lawler's (1991) UK study found that sensitive issues relating to the body in the context of nursing can be related not only to cultural and family contexts, but also to nursing training and mentorship. She found that there were significant differences in nurses' reactions to the initial performance of nursing care that includes touching patients' bodies, not only because of their family upbringing but also because of being newly introduced to nursing practice (Lawler, 1991).

With regard to mentorship, mentoring relationships have been uncritically and unquestionably accepted as the foundation for fostering learning, advancing careers, and helping mentees learn the workplace culture (Greene and Puetzer, 2002). Daloz (1986) described mentors as translators of the environment as they help mentees to gain an understanding of the culture in which they work. However, communication issues can arise between mentors and mentees because of cultural and language differences (Jirwe, Gerrish and Emami, 2006). In addition to potential communication problems due to language difficulties, there is also the issue of how non-verbal communication varies depending on cultural background (Anderson and Wang, 2009). For example, hand and arm gestures, touch and eye contact can be culture-specific. For example, in Muslim culture, touch between individuals of the opposite sex is generally considered inappropriate (Feghali, 1997). Meanwhile, whereas eye contact is considered appropriate between people in Western culture as a sign of being attentive and honest, in Middle Eastern cultures it can be deemed disrespectful, rude or a sign of sexual

interest (Arnold and Boggs, 2011; Feghali, 1997). It is therefore crucial that mentors support their mentees in intercultural communication by helping them align themselves with practices consistent with Saudi cultural norms. In this way mentors can help mentees avoid miscommunication, whether verbal or non-verbal (Arnold and Boggs, 2011). Mentors must also enhance their knowledge of communication techniques, adult learning styles and conflict resolution, and fully appreciate principles of effective adult learning (Gleeson, 2008; Almada et al., 2004).

The process of allocating mentees to mentors is influenced to a considerable extent by cultural, societal and demographic factors and although compatibility within mentoring relationships is not guaranteed by this (Johnson-Bailey, 2012), Gonzáles-Figueroa and Young (2005) argued that mentees prefer to be mentored by someone of the same ethnicity. Moreover, Campbell and Campbell's (2007) US study found that mentees matched with mentors of similar ethnicity were more satisfied and more successful, resulting in better group cohesion and mentorship. In addition, male mentors favour male mentees, while female mentors favour female mentees as they both feel more comfortable working with a partner of their own sex (Kalbfleisch, 2000; Sands, Parson and Duane, 1991; Ragins, 1989; Kram, 1985). Given the potential challenges of such situations, as well as their potential to create power imbalances, it is imperative for such issues to be addressed by mentors in the mentoring process (Donetto, 2010). However, according to Campbell and Campbell (2007) research on the significance and effectiveness of matching gender and ethnicity is quite mixed. Johnson-Bailey (2012) and Straus et al. (2013) stated that, above all other considerations, respect between mentors and mentees and willingness and enthusiasm for cooperation are the main factors determining the success of mentorship.

However, several other factors have a significant impact on the mentoring process and whether or not its outcome is positive. Kochan (2013) argued that cultural factors play a crucial role in shaping people's behaviour and attitudes. In addition, the way that mentorship is organised reflects the way that the society within which the mentorship is undertaken functions (Kochan, 2013). Therefore, it is essential to adopt a cultural perspective when attempting to understand the processes and mechanisms that influence mentoring relationships (Kochan, 2013).

Having an understanding of different cultures is not only desirable it is necessary because of globalisation (Goddard, 2010; Triandis, 2003). One of the effects of globalisation is that people from different cultural backgrounds now come into contact easily and on a regular basis, and this interaction between people from different cultures can have a considerable effect on the development of mentoring relationships (Kochan and Pascarelli, 2012). Approaches to mentoring are shaped and influenced not only by the cultural customs of the individuals involved, namely the qualified nurse and the nursing student, but also by the cultural norms that are upheld by the institutions that have a say in the mentoring processs (Kochan, 2013). Therefore, a careful assessment of all these aspects must be carried out during the process of formulating and implementing mentorship because, as Kent, Kochan and Green (2013) have warned, if this does not happen, it may lead to misunderstandings and conflicts that could, in turn, affect the outcomes of the mentoring process.

The structure of mentorship depends to a significant extent on the norms, values and practices that are enforced by the institution responsible for initiating the mentorship. As Kochan and Pascarelli (2003) observed, the areas in which the effect of organisational norms, values and practices is felt most strongly are the goals and

objectives of mentorship, the manner in which the two parties in the mentoring relationship communicate and interact with one another, and the outcome of mentorship. Furthermore, according to Chikunda (2008), the relationship between mentor and mentee can be disrupted by cultural discrepancies that permeate the social context in which this relationship unfolds. Kochan and Pascarelli (2003) also drew attention to the fact that, in addition to organisational values, norms and practices, mentorship is also shaped by the culture associated with the society in which it is initiated, particularly with respect to the amount of funding given, the aims of the mentorship and the level of control imposed. In addition, every society is governed by a series of aims, rules of conduct, norms, practices and customs that influence the organisation's culture (House et al., 2004). Moreover, House et al. (2004) added that individuals in positions of power, the other people involved, and the nature of the interaction between them have a decisive effect on organisational culture. Similarly, Kochan (2013) argued that both individual and organisational cultures are subject to a process of integration and absorption into the societies in which they exist.

In order to facilitate analysis of the mechanisms underpinning the effects of culture on mentoring practices, Kochan and Pascarelli (2012) built on work conducted by Mead (1970) and Carroll (1990) on the topic of culture classification. They developed a framework for approaching mentorship from different perspectives. This framework was made up of three parts, namely, traditional, transitional and transformative (Kochan and Pascarelli, 2012). The purpose of these parts was to support the development of the mentoring relationship by contributing to outlining the cultural objectives that the relationship aimed to achieve, as well as helping to establish the roles that the mentor and the mentee were expected to fulfil (Kochan and Pascarelli, 2012).

Within a traditional (conventional) functionalist approach, mentorship is hierarchical and an experienced mentor guides a less experienced mentee (Hansman 2002). The relationship is characterised by the transfer of cultural and technical knowledge from mentors as educators to mentees as learners (Darwin, 2000). This type of approach to mentoring may be challenged from the radical humanist perspective. The radical approach encourages dialogue, horizontal relationships and risk taking as a way of building new knowledge, so, mentoring is no longer a 'top down' functional approach to learning support but involves collaboration between colleagues (Jeruchim and Shapiro, 1992). The partnership becomes one of openness and both partners are able to be trusting and enjoy a cordial relationship beyond their professional roles. However, the issues that may arise from this approach tend to be the paradoxes seen when a mentor is also cast in the role of supervisor (Darwin, 2000).

Kochan (2013) highlighted that the final aim within the transitional approach (the second aspect of the model), is to facilitate particular transformations. Within an extant culture, nurturing the progression of more innovative and original practice may be attained by two different means, introducing or altering beliefs that are related to a different culture, or alternatively assimilating the beliefs of a different culture into a native one. However, as noted by Laden (2000), discrepancies existing between a mentor and mentee arising from different cultural backgrounds can have adverse implications for the transitional mentoring relationship. Likewise, Geber (2003) mentioned that the interaction between mentor and mentee and the development of the mentoring relationship can be negatively affected by the dominant cultural beliefs and values in the organisation where the two parties are working. As such, Kochan (2013) proposed that the success of this type of mentoring practice depends on the level of

awareness that the mentor and the mentee have with regard to cultural prejudices, as well as the cultural norms that apply in a given setting.

The transformational cultural type of mentoring is geared towards the creation of a new future and is unconcerned with the past (Kochan, 2013). In this type of culture, mentors and mentees aim to create a new culture and the relationship involves the engagement and empowerment of all the individuals involved (Klein, 2003). In a transformational culture, mentors and mentees must adopt a flexible approach to allow the creative process of discovery to happen (Kochan, 2013). However, Kochan (2013) drew attention to the fact that the absence of a fixed structure can also cause problems. However, in spite of this drawback, Kochan (2013) maintained that as long as it is founded on sound principles, determination and earnestness, the transformational cultural type of mentoring can have a wide range of favourable implications not only for the mentor and the mentee, but also for the related institutions and the wider society. Since the mentorship within organisations reflects the society, they must strive to accommodate the changing models and world (Hendricks, 1996). That is, the race, gender, sexual orientation, class and ethnicity of mentors or mentees should not be an obstacle affecting the quality of the learning experience (Koberg, Boss and Goodman, 1998; Whitely, Dougherty and Dreher, 1991; Yoder, 1997; Hughes, 1988).

2.4.2 Power relationships

Mentoring has long been used as a way of passing on knowledge while supporting culture and talent with a view to securing leadership for the future (Hansman, 2002). Asada (2012) described the mentor as a person in possession of extensive knowledge and experience, using his/her achievements to assist the intellectual or professional

development of the mentee, whose task it is to assimilate the skills and knowledge acquired from the mentor and apply them to grow professionally.

Traditional mentoring practices generally involve the assumption of knowledge and power on the part of the mentor; with the mentee being protected, guided and sponsored (Hansman 2002; Collins, 1983). Darwin (2000) argued that mentors should be high up in terms of an organisation's hierarchy, an expert in their area, powerful, invested in the progress of their mentee and prepared to devote time to the mentoring relationship. In spite of this, Kochan (2013) emphasised that mentoring can give a mentee a sense of disadvantage and non-fulfilment, if he/she is merely a passive recipient of knowledge and skills from the mentor. Issues of different levels of power can therefore affect the relationship and how effective the mentorship is (Hansman 2002).

Noe (1988) suggested that the main factors differentiating mentoring relationships from other relationships in organisations are the comparative authority and power of mentors, the level of identification between mentors and mentees, and the strength of emotional investment. Students' mentoring experiences can be regarded as a function of the socially construed power relationship between the two parties that is designed to disadvantage some groups of students while advantaging others as the power mentors exercise can be either empowering or disempowering (Cleary, 2003; Hansman, 2002). For example, registered nurses (mentors) are considered superior to students by virtue of their knowledge, and sometimes they simply pass on the knowledge regardless of the students' ability to conceptualize (Darwin, 2000). Consequently, the power mentors exercise and have over their students may not always be helpful (Kram, 1985). The biggest issue concerning mentoring relationships is negotiating the interests and power of mentors and mentees to help realise the best outcome (Donetto, 2010). Power issues

within institutions and organisations always affect the mutual relationship required to ensure the effective participation of students in their mentoring experiences (Beech and Brockbank, 1999).

Foucault (1980) believed there is a direct link between knowledge and power and saw knowledge as a form of power and a means through which power relationships are transmitted. Foucault (1973) argued that power is an instrument through which the power of societies, groups and governments can operate. His view differed from that of other theorists in that he saw power as something that can be a creative force, driving society, rather than a negative concept (Crampton and Elden, 2007). Foucault (1980) believed that power did not belong to one person or group but rather was dynamic and changeable, diffusing and spreading among groups. Central to his thinking is the concept that power is not distributed linearly but diffuses in such a way that it is all around us (Foucault, 1980). This contrasts with the more formal view of mentorship where power is held over junior colleagues by those more senior than them (Darwin, 2000). Foucault's (1980) view is more in line with the radical humanist approach and revolves around the interdependence that should develop between groups of people. Conversely, where there is power, there is also a lack of openness and resistance within the power relationship (Hansman, 2002). An example of resistance to change may be seen in clinical practice where reflection may be discouraged, leading to maintenance of the familiar power relationships advocated by dominant groups who want to maintain their own view of reality (Foucault 1980). However, although the power relationships can affect the relationship between mentors and mentees, Beech and Brockbank (1999) found that power and knowledge can work in the opposite way to hierarchical power relationships between mentors and mentees, as mentees used their knowledge as a means to assess their mentors, which supports Foucault's idea that power and

knowledge work on both seniors and juniors (Foucault, 1980). In addition, according to Foucault (1980), modern medicine and its historical transition have evolved from autonomy to teamwork.

In mentor-mentees relationships, mentors may also practise power through the assumptions and expectations they have about their mentees (Phillips-Jones, 1982). It is interesting to note that, in general, when choosing someone to mentor, the senior person tends to choose the individual most like themselves, thus perpetuating the existing structure of the organisation (Whitely, Dougherty and Dreher, 1991). It was known that in the past, those with a lower socioeconomic status were likely to receive less mentoring than those from higher socioeconomic groups (Whitely, Dougherty and Dreher, 1991).

However, power and authority are fundamental and have caused barriers to open communication in the workplace (Darwin, 2000; Wilson and Elman, 1990). Beech and Brockbank (1999) argue that in cases where the rapport between the mentor and the mentee takes the form of a relationship of authority, the transparency and freedom of the rapport will be adversely affected and growth will be diminished. The reason for this is that the balance of power between the mentor and the mentee, which puts the latter at a disadvantage, restricts the way in which the two parties can communicate and interact with each other, resulting in the relationship between the mentor and mentee deteriorating over time (Beech and Brockbank, 1999).

In general, the ambitions of mentors and mentees differ (Kalbfleisch, 2002). Therefore, distinctions in status and duties, as well as the balance of power, affect how the two parties communicate and it surfaces in any conflicts that occur between them (Kalbfleisch, 2002). Beech and Brockbank (1999) observed that the development of the

mentoring relationship suffers if the power balance is inclined in favour of the mentor because the normal psycho-social factors are diminished. Such discrepancy in the power relationship between the mentor and mentee can give rise to specific behaviour. For instance, the mentee can either come to depend on the mentor completely or he/she can oppose the authority of the mentor (Beech and Brockbank 1999).

However, in circumstances where the mentor and mentee come from different cultural backgrounds, the mentee does not solely play the role of passive receiver of the knowledge and skills possessed by the mentor, but is also in possession of opinions and values, the understanding of which demands considerable effort on the part of the mentor (Beech and Brockbank, 1999). As a result, the relationship between mentor and mentee becomes more balanced, as the mentor is not only the mentee's superior, but also an equal as a result of having to pay close attention to what the mentee is saying (Beech and Brockbank, 1999). Fletcher (2007) highlighted the occurrence of this kind of balance of power in the context of the mentoring relationship, a balance ensuring that the mentor and the mentee are on the same footing.

Historically, the issue of power, and particularly its balance or imbalance in the context of nursing, was raised with the rise of the female nurse in the early twentieth century and her challenge to the male body. In the Saudi context however, such an issue can potentially be traced to the Prophet Mohammed's time, when Kuaibah Bint Sa'ad Al-Aslamiyah 'Rufaida Al-Aslamiyah' became the first female Muslim nurse to care for the wounded from the Muslim armies during the holy wars (Miller-Rosser, Chapman and Francis, 2006; Tumulty, 2001). It is clear that ordinary female and male relationships in society are dislocated in nursing, as female nurses become the primary caregivers, assuming the active role traditionally associated with males in society, while

males assume the passive, potentially recumbent position historically associated with females in society (Lawler, 1991). In the context of the Muslim framework underpinning Saudi society, this undermining of traditional gender stereotypes is potentially a significant factor in addressing the balance of power within the nursing profession, and mentees will have to engage with it. This is particularly relevant given that the Ministry of Health (2012) reported that of the 3,961 student nurses enrolled in various Saudi universities in the academic year 2012–13, 86% (n=3397) were Saudi females, and only 13% (n=525) were Saudi males (Ministry of Health, 2012).

Moreover, while the principles of mentorship should be similar for both genders, it is important to take into account their different perceptions, understanding and expectations rather than relying on the traditional mentorship models. It is also thought that women regard mentoring as a different relationship between colleagues from men (Hartsock, 1983). Due to cultural influences, men may regard the mentoring relationship as one where they have 'power over' a colleague, whereas women view mentoring as a source of power with a colleague (Ragins and Sundstrom, 1989). While conventional male mentoring relationships are based on the acceptance of hierarchy and concentration is on specific tasks, females tend to want more psychosocial and emotional support from their relationships (Kalbfleisch, 1997). Females frequently rely on their colleagues for mentoring, instead of seeking out the knowledge of those higher up in their organisation's hierarchy (Kram and Isabella, 1985). Learning within relationships is valued by women as a crucial developmental experience (Hartsock, 1983). It is therefore possible for women to find it less difficult than men to view a work relationship as one of empowerment rather than one of power and dependency (Kalbfleisch, 1997).

A modern approach to mentoring needs to consider not only gender issues but also the development of mentoring relationships between different age groups (Zey, 1984). Whereas, traditionally, an older worker would act as a mentor for a younger junior colleague, workforce mobility now means that older workers may need to be mentored to acquire new skills and their senior colleagues may be younger than them (Darwin, 2000). Zey (1984) perceived a mentor as being a more mature individual within an institution or organisation who supervises the progress of more junior peers' careers. Obviously, such a definition suggests a difference in authority and power, in that mentors have more power than their mentees. Nevertheless, Zey (1984) asserted that these functions bring about advantages for mentees, namely knowledge, protection, personal growth and career advancement. According to Gardiner (2008), within a mentor-mentee relationship, neither party should have control or exercise power over the other or show a directive approach, as this works against the process of empowerment which is the aim of the relationship. Instead, friendship, as an integral element of mentorship, ensures that mentees are able to make their own decisions, as well as taking responsibility for their own actions and behaviours (Kram, 1985).

2.5 Summary

The concepts of ethnicity, culture and power are particularly important in framing social relations and communication of mentors and mentees in the clinical environment. There are a number of issues relating to the composition and culture of the nursing workforce in Saudi Arabia that have an effect on the mentor-mentee relationship. These issues are underpinned by the longstanding shortage of Saudi nurses despite efforts and policies to employ and retain locally trained nurses. As a consequence there is diversity in terms of ethnicity and cultural backgrounds within the nursing workforce, and mentees and mentors from different backgrounds often have to work together. Intrinsic

cultural elements are often reflected in the way people act, shaping people's behaviour and attitudes towards others. For example, gender difference is a significant issue in Saudi Arabia, with women and men segregated in the majority of social settings. In this context, studies have found that male mentors favour male mentees, while female mentors favour female mentees. At times, a mentor or mentee's actions cannot be deciphered by individuals from a different cultural background and with the addition of language differences misunderstandings and ineffective communication can be a problem. Indeed, there is broad agreement that culture influences effective cooperation between nurses, as much as between nurses and patients, and there is evidence that nurses prefer to be mentored by someone of the same ethnicity. To overcome these issues, nurses must be aware of the sensitivities and customs arising from different cultural, religious and ethnic backgrounds, and orientation training is generally provided to facilitate better understanding. In this way the practice of mentoring can still have a favourable outcome as long as the mentor and the mentee respect each other and are willing to cooperate openly. The race, gender, class and ethnicity of mentors or mentees should not be an obstacle affecting the quality of learning experiences.

Although some argue that mentors should be high up in terms of an organisation's hierarchy, issues of different levels of power can affect the relationship required for effective mentorship. An alternative approach, which appears to be more conducive to successful mentorship, is where mentoring is no longer a 'top down' approach but involves collaboration between colleagues within an open, trusting partnership, regardless of age, status or gender.

In the multicultural environment of Saudi clinical settings, ethnicity, culture and power are at the forefront of individuals' experiences. These deep historical structures lie behind the everyday dialogue and communication of nurses in the clinical environment.

It is therefore important that a theoretical background is offered so that the research

findings which this thesis has presented in chapter 3 and chapter 5 can be viewed in an

appropriately broad context.

3   Case study: The perception of clinical nurses, student nurses and nurse academics of mentorship in nursing in Jeddah, Saudi Arabia

3.1   Introduction

As discussed in section 1.2, clinical experience is a vital part of nursing education, exposing students to the reality of their future career and helping them gain practical skills. In many countries, including the UK and Saudi Arabia, a large proportion of hospitals have mentorship programmes in which students are assigned to a staff nurse who acts as their mentor (Grossman, 2007). The mentor welcomes students into the clinical area, guides them through certain skills and practices and generally supports them throughout their placement. Mentors play a key role in clinical placements, sometimes even determining how much students learn and the quality of their overall experience (Hodges, 2009). Many studies have demonstrated that students recognise the benefits of having a mentor and recall mostly positive aspects of their mentorship experience (Earnshaw, 1995; Wilson-Barnett et al., 1995). A study by Webb and Shakespeare (2008) in the UK to investigate how mentors assess and make judgements about mentees' clinical competence found that the mentor-mentee relationship enhances the competence, confidence and personal and professional development of new nursing graduates.

Chapter 4 of this thesis examines the mentorship literature in more detail. Despite considerable research on mentorship in nursing in the UK and other western countries, a thorough search of the literature on the mentorship process in the specific context of Saudi Arabia found only one study, conducted by Bukhari (2011) investigating the nature of nursing preceptorship and its effect on nursing practice (For more details about Bukhari's (2011) study, see section 4.4.2). It appears that issues related to nursing

education in Saudi Arabia in general have received little attention in academia. The reason for the scarcity of literature in this area is unclear, but it might be that the role of mentorship in student learning is not considered a significant part of the development of nursing practice in Saudi Arabia. Consequently, the case study presented in this chapter was intended to be an exploratory study. The research questions were broad, with the aim of identifying certain themes and concepts in order to generate preliminary issues and questions pertaining to the subject of mentorship in Saudi Arabia.

This case study, for which data were collected from February 2010 to April 2010, aimed to investigate the current practice of mentorship in clinical settings in Jeddah, Saudi Arabia. The perceptions of clinical nurses, student nurses and academics were explored by asking the following research questions:

- What is mentorship?

- What is the current practice of mentorship in Jeddah?

This study is important and worthwhile because it was designed to begin the discussion of issues related to Saudi mentorship practices. In addition, it provided rigorous data on mentorship practice in an area which has attracted little scholarly attention so far. In Saudi Arabia there is no clear national policy or standards for nursing mentorship practice (Bukhari, 2011), unlike other countries where professional bodies have created standards for the mentorship practice of nurses. An example of this is the Nursing and Midwifery Council (NMC) in the United Kingdom which has set standards for mentorship practice to guide mentors, clinical educators and educators on how to support mentees' learning and assessment in clinical practice (Nursing and Midwifery Council, 2008). Therefore, carrying out this study in the context of Saudi Arabia was important to gain new insights and understanding of mentorship in a different context.

This was useful in exploring implications and offering recommendations for policy, practice development and future research to enhance mentorship and raise its profile in nursing in Saudi Arabia and beyond.

During the case study, the researcher and participants used the terms 'mentor' and 'preceptor' interchangeably, reflecting international differences in parlance. The role analysed, though, is clearly what is considered in the UK to be that of a mentor: a qualified nurse or midwife who supports a student nurse or midwife in a clinical placement during pre-registration training (Nursing and Midwifery Council (NMC), 2008). In the UK, a preceptor supports the learning and on-going development of a newly qualified member of staff in a defined post-registration period (Nursing and Midwifery Council, 2008). The interchangeable use of these terms in this case study in Saudi Arabia would not have occurred in the UK where both terms have clear definitions (Nursing and Midwifery Council, 2008), which are presented at the beginning of this paragraph. For more detail on definitions of mentorship in the UK and other western countries see section 4.4.1.

3.2 Methodology

This section first discusses the epistemology adopted and then describes the methodological approach, settings, ethical considerations, sample (the sample selection process and procedures to obtain access to participants), data collection methods, data analysis, reflexivity and quality of the study.

3.2.1 Epistemology

To explore and gain insights into the practice of mentorship in nursing in Jeddah, the researcher had to adopt an epistemology that could support such an exploratory study. The researcher selected an interpretivist epistemological approach. An interpretivist approach assumes that reality is constructed through meanings and understandings developed socially and experientially and that it is the people who form part of social reality who actually create it (Angen, 2000). That reality and the people who experience it cannot be separated (Weber, 2004).

In an interpretivist approach, the focal point of study is the various realities constructed by people as they interact and engage with a social setting. Truth is negotiated through interaction and dialogue (Weber, 2004; Roth and Mehta, 2002). An interpretivist approach involves posing 'what' and 'how' questions in an effort to comprehend a particular situation and it is suitable for use in qualitative research when the researcher intends to examine details of likes/dislikes, behaviours and motives that cannot be easily quantified (Lin, 1998). An interpretivist describes the manner in which an overall pattern is put into use in reality, taking into account multidimensional, perceived and qualitative issues and analysing the nuances that their specific circumstances produce (Weber, 2004).

The interpretivist approach, therefore, was appropriate for gaining insights into the current practice of nursing mentorship in Jeddah by exploring the perceptions, views and reality of those involved. The researcher was interested in using a qualitative method to understand and explore participants' subjective meanings, perspectives and experiences, which are socially constructed and best understood from an interpretivist stance.

3.2.2 Methodological approach

A qualitative research method was used in this study as the research questions required exploring valuable insights from individuals and their understandings of concepts (Barbour, 2008). The qualitative method allowed the researcher to investigate the context of individuals' lived experiences and behaviours and to analyse explanations given by those individuals (Barbour, 2008). Specifically, an exploratory case study design was selected in order to reflect on the current practice of mentorship in clinical settings in Jeddah.

Case study research investigates a particular issue by examining people in their typical environment (Yin, 2009) in order to gain understanding of context-specific behaviours or processes (Noor, 2008; Maxwell, 2005; Cassell and Symon, 2004). Case studies can be defined as 'empirical [inquiries] that [investigate] a contemporary phenomenon in depth and within its real-life context' (Yin, 2009, p. 18). In using a case study, the aim is to investigate the particularity, intrinsic uniqueness and complexity of the single case (Simons, 1996; Stake, 1995; Keeves, 1988).

In this case study, the researcher examined clinical nurses', nursing students' and nurse academics' perceptions of mentorship practices in Jeddah.

A case study design is useful in gaining a holistic understanding of the process of mentorship in Saudi Arabia (Hill and Jones, 2007). As noted earlier and discussed in the literature review in chapter 4, there is little research exploring mentorship experiences in Saudi Arabia. Conducting a case study allowed the researcher to undertake a preliminary investigation of the situation and provide baseline data for the main study. A preliminary literature review revealed that entry into the nursing profession by Saudi nationals is limited. Instead, the employment of foreign national nurses is prevalent, and some studies discuss the experiences of nurses of foreign nationalities working in Saudi hospitals (Suliman et al., 2009; Mebrouk, 2008; Miller-Rosser, Chapman and Francis, 2006; El-Gilany and Al-Wehady, 2001). Although the studies on mentoring in general focus on the experiences of foreign nationals (Suliman, 2010; Suliman, 2006; Littlewood and Harrow, 1999), understanding the experiences of nurses and students in the mentoring process in Saudi Arabia is necessary.

A case study can cover a single case or multiple cases, depending on the range of the phenomenon the researcher is investigating (Gerring, 2007). The mentoring process studied here involved two key organisations: a clinical setting and its collaborating college, referred to in this thesis as 'the hospital' and 'the nursing college'. Although the present study investigated two organisations, the phenomenon examined was contained within a single environment as experienced by participants. Therefore, the researcher utilised a single case study to explain the perspectives of mentees (nursing students), mentors (RNs), clinical educators, head nurses and nurse academics (lecturers). These diverse sources contributed complementary perspectives and enabled the application of data source triangulation, utilising data gathered from various parties and individuals involved in the mentorship process as outlined above (Kimchi, Polivka and Stevenson, 1991). According to Speziale, Streubert and Carpenter (2011),

triangulation is the integration of two or more approaches for investigating research questions to help raise confidence in the expected outcomes. The aim is to minimize the limitations associated with single research methods and improve the rigour of the study. Speziale, Streubert and Carpenter (2011) distinguish between four different types of triangulation methods, which are methodological, theoretical, investigator and data triangulation. All of these were considered when developing the research design, but the most appropriate one, given the nature of the study, was data triangulation. In addition to the different subjects involved, a number of tools were used, which were semi-structured individual and focus group interviews and a document review.

In exploratory case studies, the research question and formulation of hypotheses can be constructed and refined even during fieldwork and data collection. Exploratory case studies have been used in social research to prepare for larger-scale, more focused empirical research (Lin, 1998). In conducting exploratory case studies, the final protocols have to be determined through pilot projects (section 3.2.6.3.1). Questions in data collection tools are either added or omitted as a result of the pilot tests. Although the literature has recognised the difficulty of selecting cases (Seawright and Gerring, 2008), social science researchers have developed processes to guide novice qualitative researchers (Yin, 2009). In a potentially fruitful case study selection, abundant available information can be represented within a defined timeline (Stake, 1995). Yin (2009) argue that explanatory cases can serve quick, practical use for both researchers and practitioners.

3.2.3 Setting

The aim of this case study was to discover the current practice of the mentorship in a clinical setting in Jeddah. The study sites are two organisations administered by the

government of Jeddah, Saudi Arabia. Here, they are referred to as the nursing college and the hospital to ensure that confidentiality is maintained.

The first setting is a nursing college that offers a BSc in Nursing, which consists of four years nursing programme and a 12-month clinical internship. The second setting is a government hospital where the nursing students and interns in the nursing college undertake their clinical placements. This hospital accommodates up to 900 patients and serves the community by offering medical care to Saudi residents, training health care professionals and providing evidence-based practice. Contextual information about the research settings is not provided in this thesis in order to preserve their anonymity.

The two settings were selected because of the collaborative, partnership-based mentoring practice that they had implemented and their long history of mentoring large numbers of students. The organisations had worked with each other since the nursing college was established. The partnership involved the clinical practice of nursing students under the guidance of a practising RN from the hospital and a lecturer from the nursing college. The use of two organisations partially meets the need for a holistic understanding of the mentor–mentee experience in the field of nursing in Jeddah.

3.2.4   Ethical considerations

Obtaining ethical approval is among the most important aspects of research as it ensures that the rights and privacy of participants are carefully considered in the planned study (Cluett and Bluff, 2006). According to Guyatt and Schunemann (2007), every research study has the potential to harm both researchers and participants, for instance, in clinical trials investigating new drugs. Similarly, naturalistic inquiries seeking evidence on very sensitive topics have the potential to cause emotional stress to individuals (Karet, 2008). Karet (2008) demonstrated the potential of research to cause harm to subjects, both in

the United Kingdom and developing countries, and there is now increased public interest in participants' safety when any research is being conducted. Karet (2008) recognised the need for researchers to integrate specific principles of research ethics into studies undertaken. In addition, it has been recognised that in as much as audit studies do not need formal reviews by research ethics committees, most studies must incorporate ethical considerations that ultimately ensure confidence issues are addressed (Carey, 2000). Researchers have numerous ways of reducing risks, including reviewing health and safety requirements and ensuring subjects are fully informed about the research and are aware of any potential harm associated with the study. In this study, areas such as data protection, confidentiality, informed consent, potential harm and benefits, and the right to withdraw were clarified before commencing the research. The researcher followed the Royal College of Nursing (2009) standard guidance for research ethics carried out by nurses, which highlights, in addition to the areas already noted, that there can be additional issues, such as safety and vulnerability, although for this study these did not pose a problem

The study received ethical approval both in the UK and KSA. The study was approved by the School of Health Sciences Research Ethics Committee at City University London in the UK (Appendix 1, p. 391). Data collection was undertaken in Jeddah, Saudi Arabia, so ethical approval to conduct the study was also obtained from the Research Ethics Committee of the hospital (Appendix 2, p. 395) and the nursing college (Appendix 3, p. 399) in Jeddah.

Confidentiality, anonymity, the principle of informed consent and the right of voluntary participation were the major ethical issues in this study. Participation in this study was voluntary, and participants were informed that they were free to refuse to answer any or all questions and to withdraw from the focus groups or interviews at any point without

giving a reason and without any inconvenience to them. In addition, the researcher made every effort to ensure confidentiality and anonymity in the storage, analysis and reporting of data and provided an information sheet to participants explaining these procedures. The researcher ensured that participants and their responses remained anonymous and that identifying information was available to no one not directly involved in the study. Transcripts of focus group and individual interviews were kept confidential, with only the researcher and her supervisors having access to them (The data collection tools and process are discussed in detail in section 3.2.6). All the study materials and data were kept secured in a locked cupboard at the researcher's workplace. Computer files were password protected. In addition, all records will be treated as confidential waste when they are destroyed seven years after completion of this study. The UK Data Protection Act (City University London, 1998) was followed during this study.

All participants were given invitation letters and explanatory statements two weeks before the scheduled focus groups and individual interviews (Appendix 4, p. 403 and Appendix 5, p. 407). In addition, participants were asked to sign and return a consent form to the researcher before the focus groups or individual interviews (Appendix 6, p. 413). The researcher rechecked participants' understanding of the study and their consent for the audio recording immediately before all interviews and focus group sessions.

The process of gaining access to both settings in KSA was difficult, lengthy and time consuming, requiring several visits. Obtaining ethical approval for research involves significantly more face-to-face interaction in Saudi Arabia than in the UK, and visits were the most effective means of acquiring responses and checking the progress of

ethical approval applications. It was more difficult to contact the relevant people by email or telephone than to meet them face to face. However, once ethical approval was obtained, the process of negotiating access to staff and students to recruit participants was straightforward. The researcher met with the nursing director of the hospital and student affairs specialist of the nursing college and discussed the recruitment process and potential dates and times for conducting focus groups interviews (for more details on study participants' recruitment, see section 3.2.5.4).

3.2.5   Research sample

Purposive and convenience sampling techniques were used in this case study. Those invited to participate in the study were mentees (student nurses), mentors (RNs), clinical educators, nursing lecturers, head nurses and nursing coordinators. The selection of participants and the research settings were purposive and criterion-based (Mason, 2002; Patton, 2002a) (see section 3.2.5.1). They were selected as they possessed particular aspects or facets permitting more in-depth investigation and exploration of the core questions the researcher hoped to study (Ritchie and Lewis, 2003).

In this approach, the researcher intentionally chooses the most productive sample to address the research questions (Marshall, 1996). The power of purposeful sampling lies in determining and selecting cases that provide rich information to study in depth because such cases enable the researcher to learn a great deal about the central research topic, and it is the aim of the inquiry to develop in-depth understanding and insights (Patton, 2002b). Individuals were selected intentionally as they held a particular understanding, knowledge, perspective and experience related to mentorship (see section 3.2.5.1), and could contribute detailed information concerning mentorship experiences (Sandelowski, 2000).

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Convenience sampling was also used to select individuals from the purposively selected groups, based on their availability and willingness to participate (Gravetter and Forzano, 2011; Burns and Grove, 2007; Marshall, 1996). Although this sampling method is considered a relatively weak approach and could affect the quality of data (Marshall, 1996), convenience sampling is often used because it takes less time than alternative approaches and targets participants who can be accessed easily (Burns and Grove, 2003). In this case study, convenience sampling was inevitable because participants had to be drawn from people who were both readily available during the fieldwork period and willing to participate in the study (Burns and Grove, 2007). For example, the participation of mentors (RN) was limited to those who were in the hospital on the day of a focus group who had permission to leave their clinical areas and who were willing to participate in the study.

3.2.5.1 *Inclusion Criteria for selecting the study participants*

The diversity of participants' backgrounds was considered in recruitment to ensure that the phenomena investigated would be seen from the different perspectives held by the diverse population of the study sites. Registered nurses, clinical educators, head nurses, nursing lecturers, student nurses and nursing interns from different age groups, both genders and minority ethnic groups were represented in the sample. Table 1 shows the inclusion criteria for participants. The gender criterion was applied specifically to RNs, clinical educators and head nurses. Student nurses, nursing interns and lecturers from the nursing college were all female because the nursing college is an all-women's college.

Table 1: Inclusion criteria for registered nurses, clinical educators, head nurses, nursing lecturers, student nurses and nursing interns

Inclusion Criteria
Experiencing or having experienced nursing mentorship in a clinical setting
All ethnicities and both Saudis and non-Saudis (all nationalities)
Both genders
All age groups (among working-age adults)

3.2.5.2 *Exclusion criteria for selecting the study participants*

Any participant who had never experienced nursing mentorship in a clinical setting was excluded.

3.2.5.3 *Characteristics of the sample*

The following tables provide details of the composition of participants in the eight focus groups (Table 2) and individual interviews (Table 3) conducted for this case study.

Table 2: Characteristics of the focus group sample in the case study

Profession	Number of the focus groups	Number of participants invited for each group	Number of respondents in each group	Language used in the focus group
3rd year students in the bachelor of science in nursing programme (A)	1	12	6	A mix of Arabic and English
4th year students in the bachelor of science in nursing programme (A)	1	12	8	A mix of Arabic and English
Intern students in the bachelor of science in nursing programme (A)	1	12	10	A mix of Arabic and English
Staff nurses (B) + clinical educators	3	10 + 2= 12 (Group 1) 10 + 2=12 (Group 2) 10 + 2=12 (Group 3)	3 + 2= 5 3 + 2= 5 2 + 1= 3	English
Nursing lecturers	1	12	5	A mix of Arabic and English
Head nurses	1	8	4	English
Total	8	92	46	

A: mentees; B: mentors

Table 3: Characteristics of the individual interviews sample in the case study

Profession	Number of individual interviews	Number of respondents in each group	Language used in the focus group
Nursing coordinator 1	1	1	English
Nursing coordinator 2	1	1	English
Total	2	2	

As illustrated in Table 2, most participants (RNs, head nurses, clinical educators) were Filipinos and Indians. Only 3 participants were Saudis. The language used throughout the focus group discussions was English, which was language of the workplace and participants' shared language and has been part of their communication with colleagues and co-workers. Therefore, all participants effectively communicated their thoughts to the researcher and to each other.

Nursing students, who were all Saudi nationals whose native language is Arabic, were asked to speak the language with which they are most comfortable. A mix of Arabic and English was used during the focus group discussion. Similarly, the group of lecturers consisted of Egyptian nationals whose native language is Arabic. They also used a mixture of English and Arabic during the focus groups. The individual interviews of the nursing coordinators, who were both Saudi, were conducted in English as both participants had a good command of the English language.

The aim was to elicit understandings from participants with similar professional backgrounds and to gather them in one group, instead of mixing participants with different professional backgrounds in focus groups (see Table 2). This strategy ensures that participants can freely express and discuss their thoughts and opinions (Brannen and Nilsen, 2002). Some groups had mixed samples with different roles, such as staff nurses and clinical educators.

In total, 92 individuals were invited to participate, and actual participants in focus group discussions numbered 46 (see Table 2). For the individual interviews, the invited sample and the actual number of respondents both totalled 2 (Table 3).

3.2.5.4 *Access to sample*

In accessing the sample, the researcher realised that gatekeepers are essential for establishing credibility and a connection to the participants (Morrison et al., 2012; Sixsmith et al., 2003). Typically, access is controlled over several different levels. Individuals responsible for authorising the research are at one level and at another level are the individuals to be interviewed who are willing to give their time (Flick, 2009). The gatekeepers were guides to the community, assistants to recruitment and data gathering, and interpreters who could provide information about the community and the participants (Goldstein et al., 1996). Communication with gatekeepers was conducted showing due respect and recognizing the power structure of the community. It cannot be overstated how vital the support of gatekeepers is in beginning data collection and gaining access to participants (Morrison et al., 2012). Ultimately, the scope of the gatekeepers' power extends to granting or denying access entirely (Riskin, 1976). The researcher deemed an understanding of the power structure of the community to be the key to attaining the voluntary consent of participants (Blodgett, Boyer and Turk, 2005).

This meant the researcher needed to convince the gatekeepers about the value of the research to them as well as her own integrity to gain their support and cooperation (Martinez et al., 2012). The researcher experienced different levels of power and powerlessness in the course of the different stages of the research, as discussed in section 3.2.8. It was the researcher's responsibility to achieve a balance between her insider and outsider role, which first appeared when she tried to gain access to the required setting. In the beginning, she was an outsider seeking to gain access and to be allowed entry into the participants' world. As soon as the gatekeepers permitted the researcher to enter the setting her role changed to balancing her insider and outsider status (Sixsmith et al., 2003) by building relationships and reaching a level of

friendliness with the participants without losing her professionalism (Shaw, 2003). The researcher's relationship with the gatekeepers was developed as she engaged in professional and informal discussions with them. Developing this rapport with the gatekeepers was helpful in achieving insider and outsider balance (Blodgett, Boyer and Turk, 2005). For example, the gatekeepers introduced the researcher to the participants when she initially arrived at the setting, which was helpful in increasing acceptance of her presence and her research. Approval and support from the gatekeepers (the dean of the nursing college and the hospital director) helped in contacting and recruiting the participants, by making access easier. In addition, their backing increased trust levels among the participants, which in turn helped the recruitment process (Morrison et al., 2012). It was, therefore, of benefit to the researcher to cooperate with gatekeepers and other individuals who were deemed trustworthy by participants (Namageyo-Funa et al., 2014) because it facilitated increased trust and access levels and provided a location for the interviews to take place (Martinez et al., 2012; Yancey, Ortega and Kumanyika, 2006).

During meetings with the hospital nursing director and college student affairs specialist, potential participants, the process of inviting them to participate in the study and the dates for conducting the focus groups were planned and agreed. The hospital nursing director was responsible for sending invitation letters to the head nurses of the agreed-upon wards. Staff who would be on duty on the date of the focus groups interviews were invited to take part through letters (Appendix 4, p. 403) sent by department heads with an explanatory statement (Appendix 5, p. 407). Participants were asked to sign a consent form (Appendix 6, p. 413) and return it to the head nurses, who then sent them to the nursing director. The RNs, clinical educators and head nurses who participated in

this study were recruited from a range of units in the hospital: medical, surgical, paediatric, obstetric and emergency room (ER) departments.

In the recruitment of the nursing students, the college student affairs specialist gave invitation letters and explanatory statements to the student leaders for each degree level, who distributed them to the student nurses. Students willing to participate were asked to sign and return the consent form to the student affairs specialist. Lecturers were invited to take part in the study by e-mail invitations sent by the college dean, along with an explanatory statement. Participants were asked to sign a consent form and return it to the dean. Nurse interns were recruited by contacting the nurse intern leader, who distributed the invitation letters and explanatory statements to her colleagues and collected and returned consent forms to the researcher. The researcher contacted the nurse intern leader through the nursing coordinator supervising the intern. For the individual interviews, the researcher selected participants and directly contacted them by phone to set up an initial meeting to explain the study and data collection process and to schedule the individual interview.

Maintaining confidentiality and anonymity were particular challenges faced during the recruitment process because the nursing director, head nurses, student affairs specialist, dean of the nursing college and nurse intern leader were initially involved and thus power existed within the resulting relationships (Flick, 2009). However, once the participants were recruited it was essential for anonymity to be maintained from this point on. This was done by ensuring that participants and their responses remained anonymous and ensuring that information was not available to anyone who was not directly involved in the study. The researcher identified participants by a unique code, which meant that their real names were not used (Berg, 2007). In addition, no names

were used in transcripts or reports, and codes were employed to differentiate participants' quotations. The steps taken by the researcher to ensure confidentiality and anonymity in the analysis, reporting and storage of data are described in detail in section 3.2.4.

3.2.6 Data collection tools and process

Data were collected from focus groups and individual interviews. Orientation was achieved by holding pre-focus group interviews discussions with gatekeepers and reviewing documents related to hospital policies and nursing college guidelines.

3.2.6.1 *Orientation*

3.2.6.1.1 Pre-focus group interview discussions

Before collecting data from the focus groups, discussions were held with the gatekeepers. These meetings were not planned as a part of the data collection method, but while gaining access to the selected study settings, the researcher was had the opportunity to meet with gatekeepers. These meetings helped the researcher gain insight into and become familiar with the understanding of some involved in the mentorship process (gatekeepers). The meetings also clarified the differences in the uses of the terms 'mentorship' and 'preceptorship', as outlined in section 3.3.1.

Based on the pre-focus group interviews discussions with gatekeepers (section 3.3.1), the initial questions for the focus group and individual interviews' guide which were based on the research questions and literature review (Appendix 7, p. 417) were slightly modified. Questions about the knowledge and understanding of preceptorship and whether this concept is seen as different from mentorship were added (see Appendix 8, p. 421 for a sample of the final guide for the focus group and individual interviews). These questions permitted the exploration of new themes during the discussion. The

researcher asked some open-ended questions to seek clarification and to ensure that the interviewees accurately understood the questions.

3.2.6.1.2 Document Review

The hospital policies and nursing college guidelines relating to nursing mentorship were obtained and reviewed by the researcher to gain an insight into the content of these documents and a more detailed understanding of the current practice of mentorship in Jeddah.

3.2.6.2 *Individual interviews*

Two separate semi-structured interviews were conducted with two nursing coordinators (Nursing Coordinator 1 and Nursing Coordinator 2) whose role is to organise activities and coordinate between the nursing college and the hospital to gain further insight into the orientation process for students at the hospital. These interviews were conducted before the focus groups, and questions similar to those in the focus groups guide were asked to elicit participants' views and perspectives of the topic studied.

Both individual interviews were conducted in English (n=2) and lasted for approximately 40 to 60 minutes, which can be considered adequate for obtaining a satisfactory amount of qualitative information from respondents (Yin, 2009). In a similar approach to the focus group, the individual interviews were digitally recorded with participants' permission to allow the researcher to facilitate the discussion and code the responses. Participants were treated with dignity and respect.

First, the topic was introduced to the respondents, and operational terms were defined. The researcher also asked open-ended questions to seek clarification and to test whether interviewees correctly understood the questions. In addition, the researcher took notes

summarising the key points made by respondents so that the digital recordings could be cross-checked and compared with the notes.

3.2.6.3 *Focus group interviews*

3.2.6.3.1 Pilot focus group

In the focus group method a small group of people gather to discuss a previously defined topic in depth in an interview session of 1.5 to 2 hours (Patton, 2002a). A pilot study is generally a preparatory test of the interview topic guide questions, conducted before the main interviews with a sample of the study respondents to check if any changes need to be made to the research tools before the data collection stage begins (Santucci, Menu and Valot, 1982). The first focus group session conducted in this case study was treated as a pilot study to assess the effectiveness of the focus group topic guide and whether responses to the questions would generate data answering the research questions. No issues were identified, so no changes to the topic guide were needed, and the first interview conducted with RNs was included in the dataset.

3.2.6.3.2 Focus group interview process

As mentioned earlier, in focus group interviews a small group of people gather to discuss a previously defined topic in depth in a session of 1.5 to 2 hours (Patton, 2002a). Within the focus group, information and perceptions are generated from the interactions between the group members (Ritchie and Lewis, 2003; Morgan, 1997). The aims of the focus groups were to discover, explore and identify insights into the current practice of mentorship in nursing in Jeddah. The collection of qualitative primary data from focus groups presents many advantages. For example, group participation is among the best strategies to elicit expression of views because participants can support and contrast one another's experiences (Craig and Douglas, 2005). A focus group usually has a small number of participants (8–12) who provide information during an interactive group

discussion (Popham, 1992). The focus group's size determines the variety of viewpoints and level of participation (Stewart and Shamdasani, 1990). Bell (2005) posited that the main purpose of such interviews is to focus the discussion on a particular issue and discover opinions about it. Group discussions, therefore, are most vibrant when the topic of discussion significantly affects all participants (Krueger, 1994), as did perceptions of nursing mentorship practices in Jeddah in this study.

The focus groups were semi-structured, which allowed flexibility and encouraged participants to give their own broad and deep perceptions of reality (Dunn, 2005). According to Watson et al. (2008), semi-structured interviews are useful in conducting exploratory research because of their effectiveness at clarifying concepts and problems. Semi-structured interviews eliminate superfluous questions but also allow flexibility for researchers to follow up and explore in detail new aspects of relevant issues raised in participants' explanations (Dunn, 2005). As mentioned earlier in section 3.2.6.1.1, the initial questions for the focus groups' guide (Appendix 7, p. 417) were slightly modified. Questions about the knowledge and understanding of preceptorship and whether this concept is seen as different from mentorship were added (see Appendix 8, p. 421) for a sample of the final guide for the focus group).

As illustrated in Table 2, eight focus group interviews were conducted. The focus group samples were composed of:

- Three focus groups with mentees (one with 3rd year students, one with 4th year students and one with intern students in the college's BSc in Nursing programme)
- Three focus groups with clinical educators from the hospital and staff nurses who served as mentors.

- One focus group with nursing lecturers from the nursing college

- One focus group with head nurses from different hospital wards

For details on the number of invited and actual participants in each focus group, see Table 2.

All focus group sessions lasted for approximately 40 to 60 minutes because it was difficult for staff nurses and head nurses to be out of their wards for more time. This duration is considered adequate to obtain a satisfactory amount of qualitative information from a group of respondents (Yin, 2009). The respondent groups sharing similar educational levels, backgrounds and experiences readily understand the issues at hand in a short time (Segal and Hersen, 2009). Focus groups are seen as appropriate for gathering similar and differing views from participants with similar backgrounds (Krueger, 1994; Kidd and Parshall, 2000). Therefore, despite differences in nationalities (see section 3.2.5.3), participants with a similar professional level were placed in one group, instead of mixed with participants with different professional backgrounds.

All focus group sessions were digitally recorded with participants' permission to allow the researcher to facilitate the discussion and note responses (Kidd and Parshall, 2000). All participants were treated with dignity and respect. First, the topic was introduced to respondents, and then all operational terms with which they might not have been familiar were defined (i.e. mentors/preceptors, mentees/preceptees). Notes summarising the key points made by respondents were taken so that digital recordings could be cross-checked and compared with the notes (Kidd and Parshall, 2000).

3.2.7   Data analysis

The researcher independently conducted thematic data analysis (Creswell, 2003), 'a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail' (Braun and Clarke, 2006, p.79). The researcher followed Braun and Clarke's (2006) step-by-step guide for thematic analysis (see Table 4). Attending a five-day course on qualitative research at the University of Dundee in May 2010 and participating in workshops on thematic analysis designed by the course leader helped the researcher gain a deeper understanding of managing qualitative data. The collection and analysis of the data were carried out simultaneously, with the analysis concentrating on the social constructionism framework in order to examine and understand the experiences and perceptions of the participants.

The analysis of data, guided by the social constructionism framework, started with the process of the researcher looking for patterns of meaning in the data and issues of potential significance and interest (Braun and Clarke, 2006). Such patterns (themes) were recognized and categorized according to their significance in terms of the research questions but were also determined to be socially produced (Kukla, 2000). The data analysis was also informed by the researcher's way of constructing the meaning of issues as she tried to understand them (Powney and Watts, 1987). She examined the ways in which meanings, realities and experiences were constructs of a range of dialogues operating within society (Gergen, McNamee and Barrett, 2001). During the analysis, the researcher interpreted the meaning of the data related to mentorship using the idea of social constructionism in terms of objects and ideas within an environment being socially constructed, negotiated, reformed, restructured and organised by participants attempting to make sense of experiences within that environment in order to

comprehend them (Sarbin and Kitsuse, 1994). Therefore, exploring nursing mentorship experiences was subject to the influences exerted by social factors, such as ethnicity, race, gender, social status and language related to mentors, mentees and others involved in sharing their experiences regarding mentorship in nursing (Denzin and Lincoln, 1998). The researcher considered this perspective as an effective means of exploring and interpreting the data. The social constructionism framework allowed the reflection of reality while at the same time providing a means to explore the depth and complexity of that reality.

Table 4: Phases of thematic analysis, adapted from Braun and Clarke (2006, p.35)

Phase	Description of the process
1. Familiarisation with data	Transcribing data (if necessary), reading and re-reading the data, noting initial ideas
2. Generating initial codes	Systemically coding interesting features of the data across the entire dataset, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all the data relevant to each potential theme
4. Reviewing themes	Checking the themes' work in relation to the coded extracts (Level 1) and the entire dataset (Level 2), generating a thematic map of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	Final opportunity for analysis; selecting vivid, compelling extract examples; final analysis of selected extracts, relating to the analysis of the research question and literature review; producing a scholarly report of the analysis

The researcher did not use any data management systems as she found manually analysing data more convenient. The following subsection describes in detail the process of management and organization of the data collected and the subsequent development of conceptual categories and themes based on that data. See Appendix 9 (p. 425) for the analysis of a coded transcript from a sample focus group.

3.2.7.1 *Familiarisation and identification of a thematic framework*

Individual and focus group interviews with participants proved to be a source of rich data (Patton, 2002a). However, managing, organising and sorting of this type of data was a major challenge (Wolcott, 1994). It was vital for the researcher to immerse herself in the data in order to become familiar with the scope of the content. Familiarization with the data collected came about primarily as a result of carrying out the individual and focus group interviews and also the process of producing the relevant transcriptions for each. The researcher began the data analysis by transcribing the audiotapes of the focus groups and interviews and this was followed by an ongoing process of familiarisation. The process of transcribing interviews was very time consuming, but the transcription process was an efficient method of absorbing the information and becoming familiar with the data (Riessman, 1993). All the focus groups and individual interviews were transcribed in full by the researcher and this aided recall of the interviews and the analysis, allowing a better understanding of the data collected and immersion in the data (Dunne, 1995). These transcriptions were typically carried out between 48 and 72 hours after the interviews took place to minimise any potential data loss. An additional benefit of this was that it enabled ongoing coding and comparison of data during the data collection phase. Each transcript was read several times and compared with the notes taken during the sessions. Annotations were also made where relevant. A separate log was maintained showing connections between the research questions and pertinent data obtained from the interviews. An initial reading started to uncover meanings within the data and useful patterns that became clearer during the course of further reading, and revealed possible interpretations. This is the process of familiarisation with data, described by Braun and Clarke (2006) and Ritchie and Lewis (2003). During this process of data revision, an overview of mentorship, as understood

and described by the participants, became apparent and it was possible to discern common elements and differences related to perceptions in terms of participants' experiences in mentorship. This was an essential step in attempting to form the reality which they perceived (Braun and Clarke, 2006).

3.2.7.2   *Initial coding/indexing*

This stage of analysis consisted of extrapolating initial codes from the data. Codes are used to highlight aspects of the data that the analyst has identified as being of significance or interest and refer to the most basic elements of the data that can be examined in relation to the phenomenon (Boyatzis, 1998). After the researcher familiarised herself with the transcripts, she identified interesting elements in the data that led to the discovery of repeated patterns (themes) across the collected data. The descriptive method of open coding was then employed to categorise the qualitative data (Attride-Stirling, 2001). The development of an index based on emerging themes and the key elements of the interview guide provided a preliminary set of codes that could be assigned to various categories. This system of data coding provided not only the primary themes, but also subsets related to those themes. This data coding system was applied to each interview transcript. A degree of similarity between certain categories existed during the preliminary indexing, but this was not discounted as it was considered useful in terms of the inter-connections demonstrated and how these might enlighten future analysis. During the initial indexing stage the codes assigned to individual transcripts were maintained in individual files, and one of the primary tasks was organizing and managing the data collected in terms of the themes that had emerged. The process of indexing required close examination and sentence-level analysis of each transcript in order to interpret and assign meaning and complete the categorization of each interview. At this point, coding was done manually. The

researcher coded the data by annotating the text being analysed and using highlighter pens to identify possible patterns in the data. Once the researcher coded the data extracts, she was then able to identify the codes, and as a next step matched them with extracts that gave an example of that code. The researcher organized each code in its own computer file with memos attached. During this stage, the researcher decided to code as many potentially useful patterns (themes) as possible in case they became of interest later. As a result of this coding and indexing process, the data pertaining to the complete set of interviews became searchable and could be examined in more detail (Ritchie and Lewis, 2003), facilitating additional analysis and comparisons to be made in order to explore relationships within the data. Nevertheless, it was considered crucial to continually revisit the original set of data in order to re-examine categories still emerging (Wolcott, 2001).

3.2.7.3 *Searching for themes*

This stage of the research consisted of analysing the data once more via the codes to discover broad themes within the data. The process required the researcher to sort and organise the various codes into potential themes, and organise all the relevant coded extracts within these themes. The researcher analysed the codes in detail to discover exactly how they could be combined and linked together to form an overarching theme. The subsequent step of organising the data was the production of visual aids (charts and mind-maps) to facilitate better comprehension of the various elements and ideas emerging from working with the data and to assist the researcher in sorting the different codes into themes. The visual charting of the data involved the production of individual theme-specific charts associating each theme with the related data extracts. Subsequently, links were constructed between these comments, themes and the original research questions. During this stage, the researcher reflected on the links between the

codes, and between the themes, as well as between the different levels of themes: the major overarching themes and the sub-themes contained within them.

3.2.7.4 *Reviewing themes*

This stage commenced at the point where a list of possible themes had been drawn up. These participant themes were then reviewed, and assessed and refined by either discarding them or combining several themes into a broader theme or alternatively dividing a broader theme into separate more distinct themes. The researcher carried out two levels of reviewing and refining. In level one she reviewed the themes at the level of the coded extracts. The extracts grouped in a theme were all read and a coherent pattern was sought. If the pattern was weak or absent the researcher considered whether there was a problem with the theme or whether some of its data extracts were misplaced within that particular theme. The researcher dealt with each issue, either by moving extracts to a more suitable theme or discarding them from the analysis. In some instances the theme itself was modified so that a new theme was created. Once the participants' themes developed into a coherent pattern, the researcher was able to progress to the second level of reviewing at which she reviewed the themes at the level of the entire data set. The validity of individual themes in relation to the data set was assessed. The participant thematic map was also reviewed in order to assess whether it 'accurately' reflected the messages produced in the data set as a whole. The researcher decided it was necessary to reread the entire data set in order to gain insights into whether the themes truly reflected the data set and also to check for additional data within themes that may not have been coded at the previous stage. It was expected that re-coding would be needed as coding is a continuous process.

3.2.7.5 *Defining and naming themes*

This stage required a process to define and refine themes whereby the researcher re-examined the themes and analysed the data within each one. Data extracts for each theme were sorted into a clear and logically consistent account. The definition process was an examination of the essence of what each theme expressed and the aspect of data encapsulated within it. A detailed analysis of each individual theme was written. The message of each theme was pinpointed and the researcher considered how it fitted into the broader overall story based on the data collected, as well as how it related to the research questions. Each theme had to be examined individually but also in relation to the other themes in order to ensure there was no excessive overlap or repetition. Part of this refinement process included identifying any significant sub-themes existing within each main theme. At this point it was appropriate to consider replacing the working title of each theme with a more suitable title for the final analysis.

Furthermore, data that offered little or no insight into the research focus, or that were potentially inflammatory, were not presented in this study and were kept secure in a locked cupboard at the researcher's workplace. Computer files were password protected and will be treated as confidential waste when they are destroyed in line with the data protection policy linked to the ethical approval.

The literature review was beneficial to the researcher as it enabled her to use the information and insights gained as contextual knowledge, which improved the contextual understanding of the data collected during the research process. In addition, the literature review was employed to understand the before and after differences of the initial discovery process in the research study (Flick, 2009). Early reading of the literature facilitated the analysis by making the researcher aware of more subtle features

of the data (Tuckett, 2005). Elements and components of the data were examined for relationships and patterns. Sometimes this was done in connection with concepts and ideas derived from the literature, as from existing literature, the researcher was able to identify suitable codes for participants' statements and was able to know under which category or theme to place and categorize these codes. Furthermore, by reviewing studies others have previously done in mentorship, the researcher was able to draw on the knowledge that already existed and identify gaps. Therefore, the literature review was necessary during the planning stages of the research study as it helped to provide a baseline, shape arguments and show that findings of the study either supported, extended or contradicted existing research.

3.2.8 Reflexivity

The nature of this exploratory study required reflexive practice. In research, the term 'reflexive' can be defined as thoughtful, conscious self-awareness acknowledging personal biases that might affect the analysis of the data (Finlay 2002). These biases can come from the social background, assumptions, prejudices and behaviours inherent in the interpretivist approach to research (Finlay and Gough, 2003). Therefore, reflexivity plays an important role in making sure that there is an honest assessment of the researcher's beliefs, values, situational behaviours and assumptions, all of which could affect the researcher's study (Hardy et al., 2009; Porter, 1993). Reflexivity is a key part of both the interpretation process and the writing up (Mauthner, Parry and Backett-Milburn, 1998) as it challenges the research methodology, and increases rigour through the honest disclosure of influences, and the researcher's choices and decisions (Smith 1996; Webb, 1996). In research, reflexive analysis includes ongoing assessment of subjective responses and the research process adopted (Finlay, 2002). In the absence of a reflexive approach, it would have been difficult for the researcher to be aware of how

the context and meaning of the mentorship experiences being investigated were shaped by her decisions, actions and assumptions (Ortlipp, 2008).

The researcher has had direct experience of mentorship in Jeddah, both as a mentee during her nursing degree and as a mentor during her work as a staff nurse. She has also acted as a clinical instructor for nursing students undergoing rotations in a number of clinical settings in Jeddah. (See section 1.2 for further details about the researcher's background and experience.) The experience and related knowledge the researcher had accumulated enabled her to better grasp the complex issues associated with mentorship that were revealed during this study. The researcher considered herself as an insider researcher as she shares a language, identity and experiences with some of the participants in this study (Asselin, 2003). Being an insider researcher was helpful in gaining a more in-depth understanding of the participants that might not be accessible to an outsider researcher (Kanuha, 2000). The insider researcher can gain not only participants' trust, but also more acceptance and intimate access to them, even to groups that may be closed to the outsider researcher (Dwyer and Buckle, 2009; Cotterill and Letherby, 1994). However, it should be borne in mind that knowing too much or being too close to the research participants could undermine the reflexivity, objectivity and authenticity of the research (Kanuha, 2000).

Although shared connections between the researcher and participants were very useful and facilitated the research initially, it is important to know that this could have interfered with the research as it was progressing (Porter, 1993). For instance, participants may not have provided sufficient details about their experiences on the assumption that the researcher was already familiar with similar ones (Armstrong, 2001). Hence, in this study, the researcher paid close attention during the interviews and

discussions not to use leading questions associated with personal assumptions. This was to minimise the researcher's impact on participants' responses and in turn to minimise any negative impact on the trustworthiness of the study (Porter, 1993).

Watson (1999) argues that the researcher's personal experiences and association with the participants can affect her perceptions and she may find it difficult to separate her perceptions from those of the participants. One outcome of this could be that the researcher's experience, rather than that of the participants, ends up steering the direction of the interviews (Armstrong, 2001). This could then impact on data analysis, with the researcher highlighting the shared aspects to the detriment of existing differences, or vice versa (Devine and Heath, 1999). Therefore, during the research process, the researcher kept a reflective diary to examine and diminish the implications of the above issues and to evaluate the extent to which her experiences and assumptions may have influenced the manner in which she interpreted the data (Travers, 2001; Strauss and Corbin, 1998). Being challenged during the supervision process was also helpful in this respect.

During different stages of the research, the positionality of the researcher caused her feelings of both power and powerlessness to different degrees. 'Positionality' refers to the social, structural and organisational positions that an individual occupies and that determine the identity, social fields and power structures that shape how she interacts with others (Das, 2010). According to Lal (1996), the researcher usually dominates the balance of power, despite attempts to encourage participants to actively get involved. Even if participants were given opportunities to express their opinions and make comments on the issues which arose, in the end the researcher had ultimate control over

the data analysis and reporting of results, as well as influencing participants' inclusion and input.

Therefore, it was important for the researcher to be aware of the power differential between herself and the research participants (Wolf, 1996). In the data collection stage, it appeared that the participants were in control, as they possessed the information required and could decide whether or not to share that information, and to participate in the study (Hutchinson and Wilson, 1992). In contrast, during focus groups and individual interviews, participants may perceive the researcher as being in a position of power and control (Karnieli-Miller et al., 2009). The researcher had the impression that some of the participants perceived her as an expert who shared their experiences and concerns, and, in the light of her background, as someone who may have solutions to related issues, even though she tried not to behave or act as an expert and did not give answers or solutions.

However, it is important to note that the researcher had been away from Jeddah for four years, undertaking postgraduate study in the UK. She had not previously come into contact with any of the research participants and therefore the information they imparted was not likely to have been influenced by any affiliations. In this regard, the researcher made efforts to develop trusting relationships with the participants to ensure they provided honest and detailed information (Mills, Bonner and Francis, 2006), but she refrained from developing friendships with participants.

When the researcher collected the data, she strove to create a welcoming environment in which the participants would be comfortable and relaxed to encourage them to be more open about their experiences and views (Taylor and Bogdan, 1998). Furthermore, the researcher interacted with the participants in an informal and non-hierarchical

environment to afford them a sense of intimacy and balance of power (Blodget, Boyer and Turk, 2005). In addition, the researcher paid close attention to what the participants were saying to show them that their opinions were important. At the same time, the researcher refrained from passing judgement on participants' views when she did not agree with them personally. She defined her task as a researcher at this stage of the study as collecting data and not making personal judgements about it (Holloway and Fulbrook, 2001). The researcher was also careful to convey understanding of what the participants were saying (Collins, 1998). To give participants a sense of power and confidence, the interviews were carried out in the familiar environment of their workplace (Elwood and Martin, 2000). Another strategy that the researcher employed to reduce the power differential between herself and the participants was the provision of clear information with regard to the rationale behind the research, the aim and questions that guided the research, as well as anticipated ethical considerations (Reinharz, 1992).

During the data collection, the researcher tried to act as if she was unfamiliar with the topic being studied. Furthermore, despite sharing cultural ties with the research participants, the researcher may lack an understanding of the various subcultures. Accordingly, bracketing of assumptions was needed (Asselin 2003). In this study, the approach applied by the researcher, underpinned by self-consciousness, allowed the exploration of a range of issues related to ethnicity, power and social status, as well as how they affected the relationships developed during the interviews. In this way, the researcher was able to understand various aspects, such as how the participants perceived themselves and their interactions with other people. This also helped to shed light on mentorship and how participants' perceptions were constructed.

However, the researcher again had a position of power and control during the stage of data analysis (Brinkmann and Kvale, 2005). This is because once participants have shared their views and experiences, they no longer have control over them and the researcher has the ability to process those views and experiences in accordance with specific historical, political and cultural settings. Once the researcher was in possession of the data, her primary role was to give voice to the participants' expressed views and experiences by carefully analysing the data and identifying emerged patterns and themes (Mishler, 1991). This means that she had to draw on the conceptual framework (section 1.6) and research questions (section 3.1) formulated in accordance with the related literature review in order to interpret what the participants were trying to say. In order to minimize or eliminate any overt influences caused by the researcher's interpretation of the participants' perceptions and experiences, the data were constantly assessed and re-examined in relation to the research questions and detection of any inconsistencies in the findings (Kukla, 2000). In addition, ongoing revision of the research aim, research questions and topic guide for the interviews (Appendix 8, p. 421) assisted the researcher to target good data and to determine the level and extent of analysis (Kukla, 2000). Moreover, to ensure transparency of data interpretation, direct quotes from the interviews were used by the researcher. Nevertheless, the interpretation may not have been free of bias as the meaning of participants' experiences and views was processed through the researcher's interpretation.

In addition, a detailed audit trail was recorded to increase transparency and support examination of potential bias (Hoepfl, 1997). This was complemented by an ongoing discussion of related issues with the supervisors. Cross-checking of the data by the supervisors also facilitated assessment of the accuracy of the researcher's data analysis (Lincoln and Guba, 1985).

The significant and conflicting roles fulfilled by the researcher and participants contribute considerably to the complexity that characterises the relationship between the two sides. As Karnieli-Miller et al. (2009) argue, the participants are usually the storytellers who supply the necessary research data while the researcher is the philosopher of the research, the writer, the collector and analyser of the stories provided by the participants, and the publisher. In this study, the researcher had to deal with the delicate task of building trusting relationships with the participants whilst making sure that she did not get so close to them as to affect her professional judgement (Torres and Baxter Magolda, 2002; Wolf, 1996). Taking all these aspects into consideration, it is important to note that the self-consciousness process fostered by reflexive practices was beneficial in increasing awareness and identification of the power dynamics in the relationship between researcher and participants (Finlay, 2002).

3.2.9   Quality of the study

This exploratory case study conducted in one clinical setting and its collaborating college analysed the real-life situations of mentors and mentees in Jeddah, Saudi Arabia. Lincoln and Guba (1985) suggest that the criteria for judging the quality of qualitative research are credibility, confirmability, dependability and transferability.

Credibility was ensured in several ways. According to Shenton (2004), developing an early familiarity with the culture of the study setting before collecting data is one way the researcher can maintain credibility. In this case, the researcher had previous experience as a mentee in the same settings, was immersed in the environment and culture investigated (see section 1.2) and was familiar with the culture of the study settings. Additionally, preliminary visits were made to the sites to review their policies and guidelines, and preliminary discussions were held with gatekeepers. Therefore, the

researcher had an adequate understanding of and insight into the settings involved, which supported credibility and dependability.

However, the researcher's own experiences, including familiarity with the settings, could have affected her understanding and interpretation of the context of the experiences explored (Finlay, 2002), so she adopted a reflexive approach throughout the study (see section 3.2.8). In a qualitative study, it is vital that the researcher be reflexive in order to remain aware of the effect of her own actions on the context of the phenomena studied (Cohen and Crabtree, 2008). In this case, the researcher kept a reflective commentary throughout the research process, recording her thoughts about the progress of the research, emerging patterns during data collection, obtaining ethical approval and obstacles encountered while conducting the study. In addition, regular meetings with the supervisors throughout the study challenged the researcher's assumptions (Lincoln and Guba, 1985). Frequent feedback from the supervisory team enabled the researcher to develop stronger justifications for the research design and methods used, which increased credibility (Lincoln and Guba, 1985).

The researcher approached confirmability by giving a detailed description of the methodology used and explaining the beliefs behind the decisions made (Lincoln and Guba, 1985). According to Miles and Huberman (1999), an important criterion for confirmability is that researchers acknowledge their own predispositions. As mentioned, the researcher kept a reflective diary to ensure that the study findings were the result of exploring participants' experiences and perceptions, not the preferences of the researcher. Additionally, all participants were given the opportunity to confirm the accuracy of the transcripts of the recorded focus group and individual interviews. The participants' affirmation of the accuracy of transcripts guaranteed that comments were genuine, accurate and objective, increasing the trustworthiness of the study (Roberts,

Priest and Traynor, 2006). In addition, an audit trail was maintained in order to examine the research process and data for consistency and to increase dependability (Hoepfl, 1997).

Transferability refers to how the findings of the study can be applied to other sample groups and contexts (Lincoln and Guba, 1985). In the present study, to help readers make informed decisions about transferability, the researcher has provided a detailed description of the research process, including the study situation, the context in which the investigation was undertaken (fieldwork sites) and the methodology used (Lincoln and Guba, 1985). The reader can therefore decide whether transferability has been achieved and whether the findings are applicable to other settings (Lincoln and Guba, 1985).

3.3 Findings

This section presents the findings of the case study. It first reports the findings from the pre-focus group discussions with gatekeepers and from the document review. Then, the findings from the focus groups and individual interviews exploring participants' perspectives on the mentorship process are presented thematically. The analysis identifies the most important themes and those repeated across all the focus groups and individual interviews conducted with different groups and individuals.

Although the focus groups and semi-structured interviews were conducted separately, findings with the same or similar patterns were merged to create a single set of themes. In this section, these themes are introduced, discussed and supported with quotations from participants. Using verbatim quotations is justified because these views can be demonstrated clearly and objectively only by participants' actual words. After the separate themes are outlined and discussed, they are compared to establish similarities, contradictions and gaps in participants' accounts. The findings from the pre-focus group interview discussions (orientation) with gatekeepers are also outlined.

Gatekeepers were the stakeholders who the researcher had to meet to obtain ethical approval and gain access to the settings and participants. Participants were assigned codes to ensure their anonymity. To distinguish quotations from different types of participants, the following codes were used:

G1H: Gatekeeper 1 from the hospital

G2H: Gatekeeper 2 from the hospital

G3NC: Gatekeeper 3 from the nursing college

G4NC: Gatekeeper 4 from the nursing college

G5NC: Gatekeeper 5 from the nursing college

N1, FG: RNs and clinical educators 1, focus group

N2, FG: RNs and clinical educators 2, focus group

N3, FG: RNs and clinical educators 3, focus group

HN, FG: Head nurses, focus group

L, FG: Lecturers, focus group

S1, FG: 3rd year nursing students, focus group

S2, FG: 4th year nursing students, focus group

I, FG: Nursing interns, focus group

NC1, II: Nursing coordinator 1, individual interview

NC2, II: Nursing coordinator 2, individual interview

3.3.1   Pre-focus group interview discussions

The main objective in conducting pre-focus group interview discussions with gatekeepers was to gain access to the settings and study participants. However, these discussions were useful in understanding the context of the study environment of the mentorship process. Participants' statements showed that upper-level management from the hospital and nursing college disagreed about the uses of the terms 'mentorship' and 'preceptorship'. In particular, the two groups contested who should be mentors for nursing students and interns. This disagreement is a key finding underpinning this study's conclusions, recommendations (Chapter 8) and artefact (Chapter 7).

The results of the analysis indicated that the hospital's gatekeepers believed that staff nurses were responsible for mentoring only interns, not nursing students, for whom college nursing lecturers were responsible. G1H states:

> *We don't provide mentoring for 2nd, 3rd and 4th year pre-registered nursing students. The nursing college lecturers are responsible for mentoring them; they are the mentors for them. Staff nurses are only responsible for mentoring the nursing interns.*

However, the nursing college's gatekeepers believed that staff nurses were responsible for mentoring nursing students.

> *The clinical staff nurses are supposed to mentor the nursing students. We don't do that. (G4NC)*

> *The mentors of the nursing students are staff nurses. (G5NC)*

These contrasting views demonstrate a lack of consistency between what the collaborating institutions view as mentoring, resulting in an unclear delineation of roles and responsibilities for both the nursing college and the hospital.

In addition, college and hospital staff perceived the words 'mentorship' and 'preceptorship' differently, perhaps because of their lack of familiarity with the word 'mentorship' compared with the word 'preceptorship'.

> *We don't practise mentoring here. We only do preceptoring. (G3NC)*

However, it should be noted that the hospital had different definitions for the two terms, with preceptors regarded as having less responsibility than mentors.

> *We don't practise mentoring here. We only practise preceptoring, and that is totally different from mentoring. Preceptoring means that the nursing student accompanies and shadows the staff nurse during shift hours. We offer a*

preceptorship programme for new staff, and we have polices about preceptorship. Mentorship is different. A mentor is a person who provides advice and who is a role model for the mentee, but we don't offer this. (G2H)

Neither setting had an agreed-upon definition of mentorship. In addition, gatekeepers in both settings noted conflicts among the roles and responsibilities of mentors, mentees and lecturers.

In summary, while the gatekeepers of the nursing college perceived that mentoring as the responsibility of the hospital nurses, the gatekeepers of the hospital setting believed that they did not offer mentorship but, rather, preceptorship. The differences between the two terms should be recognised because they can explain the differences between the nursing college's and the hospital's expectations for the mentoring process. The nursing college could not expect mentoring to occur when hospital management did not recognise or adopt the process in the hospital setting.

3.3.2 Document review

The hospital policies and the nursing college guidelines related to nursing mentorship, which the researcher obtained and reviewed to gain contextual information for the focus groups and individual interviews, revealed that no specific policy regarding mentorship existed and that no structure or process for mentorship was described.

The next sections 3.3.3, 3.3.4, 3.3.5, 3.3.6, 3.3.7 and 3.3.8 discuss the themes that emerged from the analysis of data collected mainly from the focus group discussions, as well as individual interviews.

3.3.3 Theme 1: Workload and time constraints as factors hindering mentorship

Mentoring process is not embraced by the hospital, as evidenced in the pre-focus group discussion. As noted in the earlier findings, preceptorship was given more emphasis

than mentorship, and the process did not include important features associated with mentorship.

Within this context, the time constraints and the workload of staff nurses were identified as key factors that hindered mentorship. Participants in the individual interviews and nurses in the focus groups agreed that combining teaching and working during their shifts was difficult because their workloads required that they care for seven to nine patients in a shift. While nurses highlighted that assigning students to certain nurses would lighten heavy workloads, participants indicated that mentoring students slowed, rather than sped up, nurses' work.

> *Having to give an explanation, as well as providing patient care, means it will be a long process to do that dressing. Maybe we can look at it in five minutes.... It will prolong the time it takes for one dressing by maybe fifteen or twenty minutes, so if they have lot of patients, it will not be effective teaching. So, of course, we want to finish our work first, don't we? (N1, FG)*

The nurses described preceptorship as a heavy responsibility and a stressful duty that their intensive workload made more difficult.

> *It takes time to introduce them [students] because we have our own work and then, apart from that, if we are primary nurses, [we] have to provide patient care as well as teaching, so it takes time. (N1, FG)*

The nurses implied that they were uncertain of their duties as preceptors as the role was not properly specified in their job description. They did not receive any information from the college about what was expected of them or the students.

Nurses pointed out that the uneven distribution of preceptorship was detrimental to students. Another time issue arose from student nurses' working hours, which were

limited to the morning and midday, so they did not learn about work performed in the afternoons.

> *For example, they come around 8:00 to 12:00 or 1:00 pm, so we'll have some procedures after 1:00 pm. We cannot cover all the procedures with them. (N3, FG)*

3.3.3.1 *Subtheme 1: Absence of warm relationships between nurses and students*

This subcategory describes the effect of workload on the mentoring process. The analysis revealed that some nurses had more than one preceptee, which affected the establishment of warm relationships between the mentee and mentor. The absence of a close relationship with mentees was especially marked in the case of ER nurses, who suggested that more time and better communication with students would help to resolve this problem.

> *If nurses handle seven patients a day and I also have a preceptee with me, I have to teach her, as well as doing my work.... That's why I believe they should reduce the workload: So I have time to spend with her, not on the workload. (N2, FG)*

Nurses' workload and its effect on the mentorship process were viewed differently by students. Student and intern participants said that they felt that preceptors were bored with teaching and that participants felt themselves to be a burden when nurses were busy. According to students, the number of preceptees hindered good communication, as at times, up to three students were assigned to just one nurse.

> *Sometimes you feel that you are a heavy burden on your preceptor and that you are not accepted because she has a lot of work which she wants to get done quickly; you are slowing her down. I hate this feeling. (S1, FG)*

Students' feelings of discomfort caused by the workload of their supposed mentors and the number of assigned mentees are important because students tended to withdraw when nurses appeared unfriendly and uninterested in teaching.

> *If I am with a mentor who doesn't accept me, I try to withdraw and teach myself and to spend time with other staff nurses to learn from them. Sometimes I change my preceptor by accompanying a different staff nurse who is willing to help. (S1, FG)*

Students might perceive nurses who struggled with time issues and heavy workloads as unfriendly and unwilling to teach. Students said that some nurses appeared not to enjoy their job, which discouraged them.

Despite this, the negative effect of these time constraints and mentors' attitudes on mentees' confidence was clearly demonstrated.

> *Some mentors don't even say a good word such as "you are doing a good job" to support me. (S2, FG)*

However, mentees were able to provide information about the qualities required by mentors to enable a close relationship to form between the mentor and mentee. They highlighted the importance of qualities such as skills, knowledge, support and cooperation in terms of mentors' attitudes being reciprocated by mentees and strengthening the working relationship.

> *If my mentor was good and cooperative with me…I would be willing to do anything and to help her in any task. (S2, FG)*

Mentors who had these qualities motivated their mentees and the reciprocation of a good attitude by the mentee was thought to lead to the development of a warm relationship that facilitated successful mentorship.

The mentor should provide skills, knowledge, communication, support, and share experience, trust, and being social to build a strong relationship with the student. (S1, FG)

In terms of the key quality indicators for such a mentor-mentee relationship, mentors provided insight into the importance of an awareness of policy and what is expected of both partners in the mentorship.

If the mentor is not aware of the policy, what to do, how will she even teach the student? (N3, FG)

To be a good mentor we need a handout at least about what they expect from us. To teach them, to guide them. (N1, FG)

There should be clarity from the beginning of the year about the role and expectations regarding mentorship and set a clinical learning plan for the students…we need to be aware of our role and our responsibilities as well. (S2, FG)

From the mentees' point of view, these key quality indicators were based very much on training and feedback for mentors to improve their performance.

The hospital could provide obligatory training courses for mentors to help them improve their teaching skills and to teach them how to deal with the students. (I, FG)

Further points included the importance of goal-sharing in order to strengthen the relationship, along with clear instructions from the beginning of the mentorship in terms of what the objectives are and how to get the most out of the mentorship.

We need a meeting at the beginning of the internship, so that we feel prepared

before we start. (I, FG)

In addition, a good rapport is thought to be important to achieve good quality

mentorship.

For a strong relationship between mentors and students, there should be a good

rapport between the preceptor and the student. (N3, FG)

3.3.3.2 *Subtheme 2: Lack of support for nurses*

Nurses' workload led to the identification of a further sub-thematic category. The focus

groups revealed that nurses acting as preceptors did not feel supported because their

heavy workload was neither reduced nor re-arranged to accommodate their additional

responsibilities.

Like the head nurse and deputy cannot give much support for them. Because

they are also getting pressure from these two areas. Education department and

administration. So we should get support first from these two areas. (N3, FG)

Available hospital policy documents indicated that the hospital administration did not

offer the preceptorship programme (see section 3.3.2). In addition, participants indicated

that mentorship offered by the hospital was not fully supported in all aspects of

implementation. Consequently, the nurses believed that mentorship was not structured

to allow them to manage their time while working their shifts and attending to their

preceptees. Head nurses agreed with the staff nurses that preceptors needed to have

fewer patients in order to fulfil both roles.

Preceptors should not have a heavy load, no more patients. She should be given

less patient compared to other staff. (HN, FG)

3.3.4   Theme 2: Issues of student motivation

It was noted in all the focus groups (with both students and nurses) that some students displayed a lack of interest and motivation and did not want to learn or develop themselves professionally for their future career. The lack of clear objectives from course leaders and the need to concentrate on college-related skills, such as report writing, instead of bedside care and other clinical skills, contributed to this lack of interest. Students appeared to not show interest in hands-on skills that they could only develop in a hospital setting.

The nurses felt that communication with students was one way as students did not try to communicate with preceptors. According to nurses, students should also take responsibility for their learning by approaching preceptors and asking questions.

> *They should be active, and the initiative should come from them. If, for example, I want to learn how to improve an aspect of my nursing practice, I could approach my preceptor and ask, 'Can I do it by myself?', or something like that. The rapport and the relationship with the preceptor should come from the student also. (N3, FG)*

It is important to note that this impression might have resulted from students' perception of nurses as burdened with work. This theme is linked to the previous theme (section 3.3.3). The lack of quality time with preceptors negatively affected students' motivation, while, in turn, low levels of student motivation lowered the time that preceptors feel they needed to devote to students.

Nurses pointed out that student motivation directly affected them and that having preceptees interested in learning motivated them to teach. However, some preceptees were reluctant to learn, taking frequent breaks and refusing to work with some patients. While some nurses seemed to lay the blame solely on the students, others argued that

student motivation depended on good planning and structure and recognised nurses' responsibility for supporting preceptees and ensuring they were motivated.

> *From the first day, you know if they're interested or not. When you don't find someone, for example, who will train them and orientate them in the department, especially if it's very big, they will have no interest. And when I speak to some of them, they say 'I'm not interested because I don't know what this place is. (N2, FG)*

Head nurses recognised that preceptees needed to be more committed and dedicated in order to benefit more from their preceptorship. Head nurses saw communication between the nurses and students as inadequate as preceptees failed to co-operate or take any initiative. Head nurses noted that language barriers also contributed to this dysfunction. They pointed out that some preceptees were reluctant to undertake certain jobs and lacked discipline and punctuality, often starting their shifts late or leaving early or during working hours without notifying anyone.

> *For example, today I had a 3rd year student in the unit and, you know, her tutor was searching for her. Four times, she came to me [asking], 'Did you see this student? (HN, FG)*

Participants stated that, along with students who appeared unmotivated, others did not behave well and 'refused to take orders' from preceptors.

NC 1 and NC2 who act as coordinators between the nursing college and the hospital also pointed to students' lack of interest in clinical practice. However, the nursing coordinators mostly felt that cultural differences were to blame for this attitude, as discussed in section 3.3.7.

3.3.5   Theme 3: Concerns about mentors

Nursing lecturers had predominantly negative views of the nurses, whom they regarded as lacking in confidence and experience. Nursing lecturers argued that the quality of preceptorship depended on nurses' personality and that some nurses did not have a helpful personality and so did not co-operate with students effectively. Some lecturers went so far as to say that some nurses did not have the talent to pass on their knowledge, even if they had the necessary experience.

> *And I think they are not confident of themselves because they have very limited experience. (L, FG)*

> *Sometimes more experienced people don't have a talent for passing on their knowledge. They don't have talent in the way of communication, in the way of teaching. (L, FG)*

Contesting staff nurses' complaint that teaching put them under additional stress, lecturers argued that nurses could have benefited from preceptees helping with tedious tasks.

Nursing lecturers seemed to have quite simplistic and occasionally conflicting views about the concept of preceptorship. Some viewed it simply as shadowing (following a preceptor around and watching her at work, rather than being involved), aimed at helping students achieve their clinical objectives. However, others viewed preceptor's role as providing guidance and support, as well educating the student.

Nursing lecturers also made conflicting statement about the duty to act as a preceptor or mentor. Lecturers argued that doing was in nurses' job descriptions but also voluntary. Nurses, however, maintained that acting as preceptors was not in their job descriptions (see section 3.3.3).

This is in her job description to accept the student shadowing [her]. (L, FG)

If she accepts this volunteer work, she will do it well. If she does not accept it, she will not be cooperative with the student. (L, FG)

3.3.6 Theme 4: Coordination and infrastructure support

Nurses agreed that preceptors did not receive any support from the college or the hospital and had minimal interaction, if any, with the hospital or college. The nurses noted a lack of planning and structure and pointed to an urgent need for policy reform.

For me, I cannot say there is support. Not less or more. No support. (N3, FG)

For a number of reasons, nurses appeared to harbour some feelings of resentment about having to act as preceptors in addition to their busy schedule. Firstly, they felt that preceptorship was not their responsibility and not listed in their job descriptions. Secondly, they complained that preceptorship duties limited the time they could give to patients and that there was a need for the hospital to either hire staff specifically for this work or to introduce monthly shifts for nursing and preceptorship.

Nurses raised the issue of the college clinical instructors' requirement that nurses allow preceptees to carry out certain procedures. Nurses did not appreciate this pressure, arguing that letting preceptees perform procedures was against policy and that the nurses bore responsibility for any problems that might arise according to hospital policy requiring them to assess students' competence before permitting them to perform any procedure. This concern appears to be a highly important point because most groups and individuals pointed to it as a source of conflict between preceptors and preceptees.

There is no questioning because if I let her do things that could go wrong with a patient, … it could affect patients' lives. (N3, FG)

So that's why we have policies.... But if the clinical instructor is not aware of the policy and what to do, how will she even teach the student? (N3, FG)

Even with nurse interns, if they are not competent, then you have to go with them, and the policy requires me to countersign what they do. (N3, FG)

Nurses admitted that they felt more responsible for interns than students. One, nurses felt that mentoring students was the college's responsibility. The evident lack of communication between the hospital and the college contributed to this view. More structure, including check-lists and planning, were needed for better relationships with students as nurses did not know how much students had learned. This lack also created conflicts when students could not understand why they were not allowed to do simple activities, such as giving medication. Amid a lack of proper planning and a clear understanding of rules, policy and advice from the college, students ended up blaming the preceptor.

And sometimes they ask, 'What is this heparin? Can I give this injection?' The staff doesn't know, we don't know whether they are allowed to give it. (N2, FG)

They are not allowed to give it. In the policy, before the intern can be exposed to the unit, they have to be competent at least. (N2, FG)

Such issues contributed to nurses' feelings of resentment, which resulted in nurses more readily noticing and emphasising the flaws in the system and college policies.

Head nurses were in a good position as managers and administrators to comment on flaws in the system. In focus groups, head nurses highlighted a perception of a lack of interest and discipline among preceptees and were critical of the nursing college's approach to organising and structuring the mentorship process. Head nurses argued that one obstacle to good relationships between preceptors and preceptees was the limited time that mentees spent on the ward. In addition, for the sake of convenience, their

mentors were changed frequently. Relationships thus lacked the continuity necessary for building good rapport and establishing patterns.

The high number of students in the unit, sometimes 12 to 15, made providing effective mentorship impossible. According to head nurses, all students arrived during the few peak months, and rearranging this schedule would be beneficial.

> *During the peak season for workload, we have more students here. (HN, FG)*
>
> *Yeah, you know, the second, third and fourth years and interns … they all come at the same time. (HN, FG)*

Head nurses also raised the issue of policy. The nurses explained that nursing lecturers and students were either unaware of the policy or asked nurses to contravene policy.

Head nurses insisted that the expectations of nursing lecturers should be communicated to nurses and that nurses should be made aware of the curriculum and be provided with a check-list of objectives for students. Head nurses also pointed to a need for greater involvement by college staff. For instance, the nursing lecturer could assess the procedures that students carried out.

> *So they should have a check-list, you know, what are the things they have to complete when they come, for so many weeks to the department. (HN, FG)*

Head nurses also complained about disorganisation in the administration of the hospital's orientation course. Head nurses stated that, once completing the hospital's orientation course, nurses were no longer supported but expected to pursue continued support through frequent training.

According to head nurses, better mentoring results could have been achieved if staff members who wanted to be a preceptor were trained as not everyone was suited for the role. For instance, preceptors were said to need at least some background in education.

Especially if you are going to mentor somebody, you should know something about education, evidence-based research and things like that. (HN, FG)

Head nurses agreed that there should be better communication between the college and the hospital and that students should be made aware of nursing patterns so that they arrive at a reasonable time in the mornings and work to a satisfactory standard. The issue of poor student motivation, discussed in section 3.3.4, suggests that students' late arrival might stem from a fundamental lack of motivation, which needs to be addressed.

Student and intern participants voiced an overall negative view of preceptors. When asked during the focus groups whether they enjoyed their time with mentors, both students and interns replied that it depended on the mentor. They said a good mentor was friendly, knowledgeable and willing to teach, but only a few nurses had these characteristics. However, during the focus groups, students and interns acknowledged that the less than perfect relationships between mentors and students were due largely to the lack of coordination between the college and hospital, not the shortcomings of nurses. Despite somewhat harsh criticisms of mentors, students and interns recognised the lack of coordination as the real source of their dissatisfaction.

Student and intern participants agreed that they did not feel supported by nurses, clinical educators or their college. They defined their source of support as themselves, friends, family and, interestingly, patients.

There is support … there is good support from family and friends. (S1, FG)

There is support from patients. … They always make us feel happy. (S1, FG)

A main source of dissatisfaction was the assessment process. Students and interns felt a lack of trust because their college's clinical instructors evaluated their work during their placements without any clinical observation. Students thought the mentors who

observed them should also have had a say in assessments. In addition, NC 1 and 2, who participated in the individual interviews, pointed out that evaluations by the head nurse did not benefit students and interns as she was not fully informed of preceptees' performance. Instead, NC 1 and 2 thought, preceptors should have conducted the assessments.

Students felt dejected and useless when they were not allowed to perform what they called 'simple procedures' under supervision, such as 'giving medication to patients'. Students felt caught between their nursing lecturers who asked them to carry out procedures and nurses who would not allow students to do so. It is not clear whether students were aware that hospital policy prohibited nurses from letting students carry out procedures. Lecturers also complained about this issue and gave examples of disagreements with nurses over whether students were permitted to perform certain procedures. In some cases, students voiced extreme dissatisfaction with their relationships with mentors, saying they felt 'invisible', 'frustrated' and even 'abused'.

In individual interviews, NC 1 and 2 also highlighted certain procedural flaws in the current mentorship system and admitted that it did not benefit students. The nursing coordinators argued that too many students were in the hospital at the same time and did not receive effective mentorship due to staffing shortage. The nursing coordinators also regarded the amount of time students spent in each ward as insufficient to learn and become familiar with the units' practices. Like the staff nurses, NC 1 and 2 drew attention to the hospital's lack of support for students.

> *They need support, but from my perspective, I cannot see that they are getting*
> *support from our hospital, maybe a little support but still not enough. (NC1, II)*

Although some information in this section links to the previous theme of workload (Theme 1: Workload and time constraints) presented in section 3.3.3, this section mostly discusses the lack of structure and planning by the college and hospital.

3.3.7 Theme 5: Ethnicity and cultural differences

In this key theme, nurses and students voiced somewhat intolerant views of others' cultures and nationalities. According to the Saudi students who participated in the focus groups, Saudi nurses were more friendly and helpful than nurses of other nationalities. One student commenting that Saudi nurses were empathetic as they, too, went through the same route. A variety of negative comments were made about cultural differences, such as criticisms that nurses of some nationalities grouped together and that foreign nurses resented Saudi students who they believed did not need to work. A number of students stated that foreign nurses saw Saudi students and interns as future rivals.

> *As we are Saudi, she knows that as citizens we have priority to be recruited and take positions. (I, FG)*

> *We keep hearing the same question when we go to each unit. … They keep asking us, 'Are you going to work here in this unit?' They are afraid that we could take their positions.' (I, FG)*

Students also pointed out the language barrier with foreign nurses, which could make communication difficult.

Nurses agreed that language and cultural barriers created problems. Cultural barriers might have resulted in a reluctance of female mentees to work with male patients or on night shifts, as gender segregation is a widely respected Saudi cultural norm. Language barriers might have hindered rapport between preceptor and preceptee, effective learning and the development of preceptor's and preceptee's confidence.

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Interviews conducted with NC 1 and 2 revealed concerns that some students had a serious lack of motivation (see section 3.3.4). NC 1 and 2 stated that, due to cultural differences, some students simply wanted a BSc degree but not to practise nursing as a career. Problems arose from some people perceived nursing as an unsuitable job for women in Saudi culture and from the inability of some Saudi students to work night shifts or long shifts because their husbands or families would not allow them to do so.

> *You know some people in our country do not see nursing as a good job for a girl, especially if she is working with males or if she is working at night. (NC2, II)*

3.3.8   Theme 6: Suggestions for improvement

This last theme relates to the earlier themes. Most points in this theme appeared in earlier themes, allowing this theme to pull together the strands of the discussion to highlight suggestions from nurses, academics and students for improving the experience of preceptors and preceptees. Among these, the most common suggestion was for colleges to more clearly plan and outline their expectations of preceptors and preceptees. This need was supported by nurses' view that preceptors' role should be made clear to students. Nurses also suggested that preceptors be selected from amongst nurses with relevant training or knowledge in order to more effectively balance the workload. Further, nurses suggested that benefits be offered to better motivate those acting as preceptors.

> *They should be motivated because now there is no benefit, no appreciation. Thus, they think, 'Why should I be the preceptor? (N1, FG)*

Lecturers also supported this improvement, suggesting introducing such benefits as higher salary, reduced working hours and fewer patient assignments. The need to

introduce new policies, preparation programmes and selection criteria for mentors was also highlighted.

> *She should have some promotion and, for example, an increase in salary, a decrease in working hours. I don't know, other alternatives. (L, FG)*

A fourth suggestion for improvement, made by nurses, was that the hospitals reduce the number of patients assigned to preceptors in order to increase their time availability. Nurses argued that this would enable providing training to all nurses in a unit and that a standardised orientation plan for staff should be introduced in each unit to avoid losing time.

> *I think we have to prepare a package orientation for the staff, tailored so that you do not waste time. (N2, FG)*

A fifth suggested improvement, made by lecturers, was that the concept of preceptorship should be broadened to include mentoring. This all-encompassing term includes supporting students not only in the hospital but also outside of it in their academic progress and personal development. Some lecturers see themselves as mentors and believe that a mentor should be an educator and an advocate. They suggested that it might be better for preceptors to mentor students, as they accompany students during clinical placement tasks.

Finally, students suggested that the preceptorship process could be made better by improving communication between the hospital and the college. They argued that there should be better coordination between the hospital and the college and that, most importantly, mentors should be provided with students' academic programme, curriculum and clinical placement objectives. College and hospital policy should also agree on what students may and may not do.

It would be better if the head nurse introduced me to the mentor, to talk to her about my check-list and clinical objectives and ask her to try to help me in achieving that.... This is the least she could do. (I, FG)

Students and interns state that, to feel as if they were assessed fairly, mentors should be assigned at most one or two students and that more college instructors should be based at the hospital during student shifts. Students and interns seemed to place great value on their placements as an opportunity to learn about their future career and thus wanted some sort of control over the process. They suggested that the hospital evaluate mentors and that students be allowed to give feedback about their experiences to the head nurse. The suggestion of the need for greater communication between the hospital and the college was supported by NC 1 and 2, who also stressed that better coordination among the unit, hospital and college was needed to improve both students and mentors' experiences. The nursing coordinators agreed with nurses that college instructors should do the mentoring or at least observe students during their clinical placements. Finally, nursing coordinators pointed to the need for better planning, suggesting that students be given more support and fewer assignments so that they can make the most of their time at the hospital.

3.3.9 Summary

The findings of this case study revealed similar patterns that could be merged into six themes. The first theme concerned workload and time constraints that had a negative impact on the mentorship process. The preceptor/mentor had a heavy nursing workload of seven to nine patients a shift. This workload limited the amount of teaching that the nurse mentor could accomplish. Mentors also felt a lack of certainty about their duties, the college's and nursing students' expectations of the clinical practice experience and whether mentorship was part of nurses' job description. Consequently, the mentor felt

unsupported by hospital administrators, which failed to take nurses' extra duties into consideration and appropriately adjust their workload. The mentor–mentee relationship was strained, especially in busy areas of the hospital, such as the ER, where the mentees felt that busy mentors lacked enthusiasm about teaching and saw mentees' presence as a burden.

Student motivation was the second theme that emerged. In all focus groups, mentors and mentees commented on some mentees' apparent lack of motivation and interest in clinical practice. College lecturers set no well-defined objectives and gave priority to theoretical learning, while mentees appeared to lack interest in learning the hands-on skills required to obtain qualification. Poor relationships resulted from a confluence of factors, including the lack of quality mentor–mentee time, mentees' perceptions of being a burden and some mentors' negative attitudes. These factors transformed mentoring into order-giving and order-taking, decreasing student motivation.

The third theme involved concerns that mentors exhibited negative attitudes, including a lack of confidence and experience. Some lecturers expected mentees to shadow the experienced mentor, as in a preceptorship, others expected the mentor to provide advice, guidance and support as if acting as a mentor. An additional conflict arose regarding whether the mentor was compelled to undertake this role or whether the role was voluntary. Mentors also expressed uncertainty about the nature of their role and its voluntary or compulsory nature.

The fourth theme is coordination, infrastructure support, the lack of support for mentors and mentees from either the college or the hospital and minimal, if any, interaction between mentors and these bodies. Mentors expressed resentment for several reasons: Mentorship was not regarded as their responsibility and limited time spent caring for

patients, and the expectation for mentees to perform treatments contravened policy. Mentors bore responsibility for patient care and were liable for any negative outcomes. The college provided mentors no checklists of what the mentee was expected to accomplish in clinical practice, another sign of the lack of support. Mentees became frustrated and lacked confidence because they were not allowed to carry out what they regarded as basic treatments. In addition, it emerged that mentors were not given adequate training to effectively perform their mentoring role and could not provide an objective assessment of mentees' practice. The assessment process was also separated from clinical practice, as the college lecturers assessed mentees without observing them in the hospital or including the mentor in the assessment procedure.

Cultural differences and language barriers arose from what the researcher considered mentors' and mentees' intolerant views of others' beliefs and nationalities. Language was a major communication issue between the groups. The mentees were all Saudi nationals, and most of the mentors expatriates. The Saudi mentees felt that they were resented because they could take the jobs of the expatriate mentors once they were qualified. In addition, Saudi cultural norms reduced mentees' willingness to work with male patients or at night. Mentors also perceived the mentees as uninterested in a nursing career but merely interested in obtaining the degree.

The final theme, suggestions for improvement highlighted the findings of the previous five themes. Suggestions for improvement were that:

- Colleges should plan and outline their expectations.
- Mentors should be chosen from among nurses who have received training and have excellent knowledge relevant to the role.

- Nurses should be rewarded for acting as mentors in order to improve their motivation.

- The number of patients assigned to mentors should be reduced.

- The concept of preceptorship should be expanded to full mentoring.

- Improving communication between the hospital and the nursing college should improve the outcomes of mentorship.

The overall conclusion from this case study is that mentees did not feel that mentorship benefitted them and that mentors resented the extra workload for devoting time to mentees' development. Reflecting these feelings, the college and hospital each blamed the other for the shortcomings of the mentorship.

3.4 Discussion

3.4.1 Theme 1: Workload and constraints

One of the key issues that arose in the discussions was that nurses' workload and other commitments did not allow them enough time to devote sufficient attention to their mentees. In addition to many nurses' responsibility to care for between seven and nine patients on a shift, the outcomes of the focus groups discussion also suggested that many nurses did not have a clear understanding of their duties as mentors, which hindered communication with mentees. Indeed, nurses' heavy workload resulted in many students' complaining that they did not have a close relationship with their mentors, which negatively affected the students' confidence. The data gathered from nurses suggested that their workload should be reduced to allow them more time to spend with students. The difficulty that nurses faced in combining their significant workload with mentoring students was exacerbated by the lack of any significant form of support given to nurses. It was suggested that a more structured preceptorship should be introduced to reduce the nurses' workload in light of their additional mentoring responsibilities.

These findings are largely corroborated by the findings of the literature review, which also suggest that time and administration issues are significant barriers to effective mentorship. Shannon et al. (2006), for example, found that nursing mentors faced a significant workload, which hindered their ability to provide effective mentorship, also attributed to poor administration of the placements. However, rather than suggesting that nurses' workloads be reduced, Shannon et al. (2006) argue that more communication with nurses about their responsibilities was necessary. Jones, Walters and Akehurst (2001) linked nurses' workload to the hospital's economic realities, which required staffing cuts reflected in decreased student numbers.

In this context, the findings of the literature review suggest that, given mentors' workloads, the ineffectiveness of mentorship can also be attributed to students' unrealistic expectations. Gray and Smith (2000) found that students began their mentorship believing that their mentors would have sufficient time and availability to constantly work with and supervise students and to address all their concerns. Nahas (2000) confirmed this view, finding that Jordanian students expected a high level of support and care from their mentors but, as their mentorship progressed, became disillusioned because of their mentors' limited availability.

In addition, mentees provided insight into the features comprising a warm, caring relationship, including goal-sharing, support and cooperation from the mentor, which can then be reciprocated by the mentee. Key quality indicators included clear understanding of the expectations of both parties involved in mentorship, as stated by the mentors, and training and feedback to improve mentoring skills, as stated by the mentees. The literature supports the key quality indicators noted by mentors and mentees, with the main characteristics of a high-quality mentoring relationship including mutual respect, reciprocity and clear expectations (Straus et al., 2013; Earnshaw, 1995, Spouse, 1996). Furthermore, as discussed in chapter 2, there are cultural considerations when examining the qualities of the close, warm relationship that should develop between a mentor and mentee. Where there are differences in culture, the development of such a relationship may be difficult due to the differing expectations of the two parties in the relationship. Therefore, it is important to note that exactly what these key quality indicators are within an individual mentor-mentee relationship depends on the parties in the relationship, as they are likely to be affected by cultural background (Rosinski, 2003).

3.4.2   Theme 2: Issues of student motivation

The findings suggest that, in many cases, students lacked motivation in their mentorship and were reluctant to develop hands-on skills in the hospital setting. The findings of the case study suggest that this results in only one-way communication between nurses and students, with students failing to communicate with their mentors. This dysfunction might be due to students' unwillingness to burden already busy nurses with extra work. However, nurses complain that students' lack of motivation translated into a lack of discipline and punctuality, which decreased the quality of the relationship between nurses and students. In addition, nurses suggested that the lack of motivation caused students to be rude and to refuse to take responsibility. Nurse participants suggested that issues of student motivation could be addressed by introducing a more structured mentorship.

A structured mentorship scheme, as discussed in the literature review, would entail a programme encompassing all aspects of students' learning. Educators with specialised knowledge of theory could facilitate formal learning, while nurse practitioners with experience in the application of formal learning facilitate informal learning. Shannon et al. (2006) found that a combination of both formal and informal learning made the mentoring experience beneficial for both mentors and mentees in their study. A structured mentorship scheme is seen as offering an enjoyable experience, enabling preceptees to lighten workloads (Shannon et al., 2006).

The findings of this case study differ slightly from those of other studies in this area. Bradbury-Jones, Sambrook and Irvine (2007), for example, conclude that students' disempowering experiences were due not to the absence of structured mentorship but, rather, to whether students were encouraged to learn and given sufficient scope to use their own initiative. Bradbury-Jones, Sambrook and Irvine (2007) suggested that action

by mentors is required to improve student motivation as disempowering incidents occurred when mentors failed to demonstrate sufficient understanding, inhibited students' acquisition of certain skills or curtailed their responsibility. The view that mentors are responsible for arousing enthusiasm in their students is supported by Papp, Markkanen and Bonsdorff (2003), who suggest that students need to feel appreciated and supported in order to maintain their motivation and self-esteem.

However, some groups of mentees may be at a disadvantage due to the power that their mentors have over them, derived, for instance, from sources such as distinctions in status (Kalbfleisch, 2002), top down relationships (Darwin, 2000), psychosocial factors, or the positions held by the mentors (Beech and Brockbank, 1999). For example, as mentors are often in positions of authority this can have an effect on how they treat their mentees (Hansman 2002), which, in turn, will have an effect on their communication and contribute to the barriers that are present between mentors and mentees (Wilson and Elman, 1990). Thus, positions held in clinical settings and the perceived psycho-social advantages or disadvantages, or top down relationships, which may be present can all impact on mentoring relationships.

One further possibility is that the lack of interest and motivation demonstrated by some mentees may be underpinned by an imbalance in power between mentor and mentee. Indeed, Hansman (2002) notes that a mentor may use their superiority to either empower or disempower the mentee, which, in the latter case, can lead to the mentee opposing the authority of the mentor, as demonstrated in the findings of the current study.

3.4.3 Theme 3: Concerns about mentors

The most significant concerns about mentors were voiced by nursing lecturers, who were sceptical about the quality of nursing mentorship and believed that quality depended to a large extent on the personality of the nurse. The outcomes of the focus groups conducted with lecturers also revealed concerns that nursing mentors did not fully understand the aim of their role. Lecturers viewed mentorship simply as a shadowing process not involving significant interaction with the student. This finding is important because lecturers' views are supported by the administration's (gatekeepers') view of the differences between preceptorship and mentorship. For instance, in the focus groups discussion with nurses, some nurses viewed their role as a mentor as voluntary, and others perceived it as a key part of their job. Nurses who viewed the role as voluntary saw it as mentorship, while those who viewed it as part of their jobs saw it as preceptorship. There is a need to define what constitutes preceptorship and mentorship to ensure that nurse preceptors provide better, more effective mentorship to novice nurses and student nurses.

The view that the effectiveness of the mentorship depends to a large extent on the personality of the mentors is echoed by Elcigil and Sari (2008). They found that the success of mentorship relies on the mentor's possession of high levels of teaching ability and nursing competence and a range of personal characteristics, including strong communication skills, a considerate manner, patience, empathy and the ability to provide useful, constructive criticism (Elcigil and Sari, 2008). This argument suggests that mentorship experiences might not be consistent but vary according to mentors' personality and range of knowledge of educating novice nurses. This problem could be rectified by ensuring that all mentors are carefully selected based on their personality traits and have a clear understanding of their roles as mentors.

3.4.4   Theme 4: Coordination and infrastructure support

The outcomes of the focus group discussions conducted with nurses indicate a pervasive lack of strong organisation and structure in the mentorship. This lack gave rise to feelings of resentment among nurses and could limit the possible benefits of clinical placements for nursing trainees and negatively affect the relationships between mentor and mentee, and mentor and college. The findings of this study suggest that a lack of structure in the mentorship process and nurses' resentment at the requirement to act as mentors while performing their other duties had a negative effect on student motivation, the effectiveness of the mentorship process and the relationship between mentors and mentees. These effects could have a negative impact on the strong, caring relationship mentors need to maintain with preceptees in order to positively influence their early careers. The outcomes of the focus groups discussion suggested this problem could be rectified by better communication between the hospital and college. Students also expressed dissatisfaction with the low levels of support received from nurses and evaluation by college instructors who had not observed them closely.

These findings are supported by Lofmark et al. (2009), who found that mentors' dissatisfaction was frequently caused by a lack of effective communication between the university and the hospital. Lofmark et al. (2009) concluded that effective collaboration between university teachers and staff working in practical fields is required. However, Myall, Levett-Jones and Lathlean (2008) suggested that it was not poor university–hospital communication but unrealistic expectations and ineffective training of mentors that were responsible for most communication problems between mentors and mentees, and they argued that effective training was needed for mentors to adequately train and support their students.

Furthermore, in this study mentors were changed frequently, leading to a lack of continuity, rapport and established patterns or routines for mentees. This is likely to have contributed to the negative feelings expressed by the mentees regarding the mentorship process. This is well supported by the work of Gichigi (2009), Hodges (2009), and Neary (2002), who highlight the importance of ensuring the consistency of quality within the mentor-mentee relationship, which that cannot be achieved if mentors are changed frequently. The processes of setting ground rules, learning contracts, identifying roles and expectations, and having transparent policies and guidelines have been shown to avoid issues within a relationship (Neary, 2002). It is difficult to ensure consistency among mentors, meaning that the mentee is unable to feel confident in their own role and that of their mentor. Indeed, the practice of frequently switching mentors, observed here, is in stark contrast to the advice offered by Andrews and Wallis (1999) who suggest that practice must be controlled and monitored to reduce disorientation and uncertainty. Moreover, the difficulty of building a rapport has been shown to form an important part of the mentor-mentee relationship (Hodges 2009) in the context of constantly changing mentors.

3.4.5   Theme 5: Ethnicity and cultural differences

The outcomes of the interviews and focus groups discussion suggest that cultural differences negatively affect relationships between mentors and mentees. The attitudes emerging from the interviews and focus groups discussions were slightly intolerant of cultural differences and criticised nurses and students of the same nationality for grouping together. Nurses also suggested that students' motivation problems were, to some extent, due to cultural norms. Students with limited freedom to work with male patients or to work extended hours and night shifts faced difficulties. In addition, the

outcomes of the interviews and focus groups discussion suggested that some nurses saw Saudi students as future threats due to the priority the law gives to them.

Along studies in the wider literature examining the mentorship process within a multicultural environment, Nahas (2000) found that Jordanian students did not have similar levels of intolerance. The present study supports the notion that diversity can be associated with heightened tensions in the mentorship process and its accompanying relationships. The closest support of this claim in the literature review is Nahas' (2000) conclusion that cultural differences can result in different values, practices and cultural beliefs, which could greatly affect the learning process. The lack of focus on the possible effect of cultural intolerance on mentorship experiences within the existing literature might be due to the concentration of studies on the experiences of foreign nurses working in Saudi hospitals and on the difficulties encountered by nurses due to cultural and religious restrictions (El-Gilany and Al-Wehady, 2001).

These cultural differences are clearly highlighted in the finding that Saudi students were seen as a threat to their non-Saudi mentors, in part due to the Saudisation policy, which seeks to increase the number of Saudi nationals employed in the country (Al-Dosary and Rahman, 2005). Further evidence is provided by Al-Dosary and Rahman (2005), who note that in Saudi Arabia, preference is given within the profession to Saudi nurses, in an attempt to encourage recruitment and retention of locally trained healthcare workers. The Saudisation policy has gained significant government policy backing since 2004 (Tumulty, 2001) but, although it is understandable in terms of its aims, it is not beneficial for mentor-mentee relationships between non-Saudi and Saudi nurses. Indeed, the findings here suggest that the feeling that Saudi students are more entitled to jobs in Saudi Arabia than expatriates is having a detrimental effect on the relationship

between non-Saudi mentors and Saudi mentees, breeding resentment and uncertainty within nursing teams.

Further problems arose around the perception that nursing is not a desirable career for Saudis, as described by Marrone (1999). The literature suggests that this is due to limited pay and irregular working hours (Al-Sa'd, 2007; Abu-Zinadah, 2004; Al-Hydar and Hamdy, 1997; Jackson and Gary, 1991), which may be an issue for Saudi women due to the limited number of hours they are able to work (Tumulty 2001). This is a further factor likely to contribute to the difficult mentor-mentee relationships observed here where cultural understanding was lacking. Tumulty (2001) describes how limited time on the ward restricts the time available for mentoring students and increases the pressure on mentors to deliver support within available time frame.

In line with the negative aspects of non-Saudi-Saudi mentor-mentee relationships described above, the focus groups reported that mentees found Saudi nurses more friendly, helpful and empathetic than nurses of other nationalities, with negative comments made about mentees from other cultures due to their lack of understanding about the Saudi culture. These findings are supported by Gonzáles-Figueroa and Young, (2005) who highlighted that mentees prefer to be mentored by someone of the same ethnicity. A study carried out by Campbell and Campbell (2007) in the USA found that mentees matched with mentors of similar ethnicity were more satisfied and more successful, which resulted in better group cohesion and mentorship. Cultural issues were also highlighted in the reluctance of female mentees to work with male patients due to the gender segregation that emanates from Saudi culture encouraging segregation of men and women in the majority of social settings (Almutairi, 2012; Tumulty, 2001; Hamdi and Al-Haidar, 1996).

3.4.6   Theme 6: Suggestions for improvement

Students did not feel supported by nurses, hospital or their college. This finding suggests that the mentors play a key role in clinical placements, determining how much students learn and the quality of their overall experience. The findings suggest a number of improvements to the mentorship process. Firstly, the university should clarify the roles of mentors and mentees to ensure that both parties hold realistic expectations. Secondly, mentors should be selected from among nurses with appropriate training in order to increase their likelihood being effective mentors. Thirdly, mentors' motivation could be increased with a number of incentives, such as extra salary and reduced working hours. Fourthly, considerations of mentors workload is necessary, workload and number of patients assigned to mentors need to be reduced to allow them to spend more time with the students. Fifthly, the relationship between nursing mentors and mentees should be expanded to include supporting mentees' personal development and academic progress not only within but also outside the hospital. Finally, it was suggested that the mentorship experience could be improved through better structure and planning, including reducing preceptor workload, providing one-to-one mentor–mentee relationships and arranging clinical placement times to allow to observe different procedures throughout the day.

The recommendations' focus on reducing mentors' workload reflects the findings of Shannon et al. (2006) that workload and time constraints have a negative impact on mentorship. The recommendations of the case study also accord with the literature review findings' emphasis on the need for training (Myall, Levett-Jones and Lathlean, 2008; Jones, Walters and Akehurst, 2001) and improved structure and continuity during mentorship (Beecroft et al., 2006). Specifically, providing training for both parties has been shown to be important in order for goals, responsibilities and expectations to be

achieved, and to facilitate a more successful mentor-mentee relationship (Allen, Eby and Lentz, 2006; Greene and Puetzer, 2002; Forret, Turban and Dougherty, 1996; Cunningham, 1993).

However, Kaviani and Stillwell (2000) argue that encouraging increased communication between mentors and mentees is a key to improving the quality of mentorship.Thus focusing on the one-to-one relationships between mentors and mentees is more important than focusing on wider issues. This notion is supported by Hodges (2009) and Eby and Lockwood (2005) who state that a quality mentorship experience is based on setting clear goals, objectives and expectations of the relationship, as well as personal targets, all of which are achieved via excellent communication. These key quality indicators are grounded firmly in the one-to-one relationship between the mentor and mentee, and facilitate personal growth and development (Greenhaus, Callanan and Godshalk, 2000). Indeed, it has been suggested that mentors must have an early discussion with their mentees in order to identify their current capabilities and needs, and determine what they expect to learn from their placement (Gray and Smith, 2000). Further communication between the mentor and the mentee can be encouraged with frequent meetings (Straus et al., 2013), and regular evaluation of the mentorship experience, which helps to improve performance on both sides (Gichigi, 2009; Webb and Shakespeare, 2008; Greene and Puetzer, 2002).

3.5 Conclusion and recommendations

3.5.1 Summary

An exploratory case study design was used to explore the practice of mentorship in one clinical setting and its collaborative college in Jeddah, Saudi Arabia. Pre-focus group interview discussions, focus groups, individual interviews and document review were conducted to provide a rich insight into this real-life situation.

Analysis of the data and the themes suggest that neither mentors nor mentees were happy with the mentorship process. The students believed it did not benefit them, and the nurses seemed to resent the demand to devote time to the students. Both parties were inclined to blame the other for their difficulties. This response is natural as these parties were directly involved in and affected by the flaws in the system and, thus, stood as an immediate target of blame when under undue stress. This pattern was continued by college staff, who blamed the hospital, and nurses and senior hospital managers, who blamed the college. The preceptors expressed a more neutral opinion, pointing to a lack of coordination. While nurses strictly followed hospital policy (those working in a foreign country especially need to be careful in adhering to rules and regulations), students followed the university's apparent wishes and directives. Therefore, the underlying issue and the actual clashes are between the hospital and the college. Reaching agreement on repeated issues (e.g. whether students may perform certain procedures, who should evaluate their progress) could achieve important positive changes in mentors' and mentees' experiences and relationships. Nurses and students also need to approach one another more empathetically, appreciating their difficulties and respecting individual needs.

The findings of this study will benefit mentees, mentors, lecturers, head nurses, clinical educators, senior managers of clinical and academic organisations by raising awareness of important issues in nursing education that require further and enhanced recognition. The results might also help improve the collaboration between colleges and hospitals in developing a positive clinical environment for preceptors and novice nurses.

3.5.2 Discussion of strengths and limitations

This section provides a discussion of the strengths and limitations of the case study. This study captured qualitative data on the different perspectives of mentees (nursing students), mentors (RNs), clinical nurses and nurse academics. This increased the strength of the study, as these diverse perspectives complemented each other and allowed data source triangulation using data collated from several parties and individuals involved in the mentorship process. The topic was addressed from various perspectives, including those of pupils and educators.

The use of a pilot study strengthened the study as it allowed the researcher to examine the focus group and individual interview questions, decreasing the risk of bias. The semi-structured focus group interviews resulted in a rich description of perceptions of mentorship in nursing. In addition, all participants were volunteers, so there was no risk of introducing a selection bias in the sample group. However, all participants were female due to the nature of the college. Audio-recording enhanced data collection, enabling the researcher to facilitate the discussion, code responses, focus on participants and take notes during the discussion (Kidd and Parshall, 2000).

The researcher's previous experience as a nursing student (mentee) in the study's setting gave her understanding of and insight into the situation, posing a potential source of

bias. However, the researcher was fully aware of this challenge and made every effort to avoid bias and maximise the trustworthiness of the findings (see section 3.2.9).

Obtaining ethical approval was hard and time consuming (see section 3.2.4). Recruitment was also difficult, especially among nursing students, whose free time in busy schedules did not coincide with the researcher's availability. Consequently, it was not easy to rescheduled focus group discussions to accommodate participants' availability. Most focus group discussions had five respondents, but one group had to be rescheduled because two staff nurses could not attend while their wards were busy. However, only three staff nurses attended the rescheduled focus group, so it had to be rescheduled again. Two participants withdrew before another focus group discussion, one due to discomfort at being audio-recording and one to sickness.

On a few occasions, some group members dominated the discussion, so others did not speak up or spoke differently. For example, mixing clinical educators with staff nurses proved to be unproductive because the former dominated the discussion in most cases, and staff nurses did not feel free to express their views in front of the clinical educators. The two groups frequently shared different information and opinions, so it was best to maintain separate groups. This problem did not result from miscommunication or the differences in language used.

The venue of the focus group discussions was the least satisfactory aspect of the data collection. On some occasions, the rooms used were not appropriate for group discussions as the chairs were fixed to the floor. Another issue was that some focus group discussions started later than planned because of hospital scheduling errors. Two groups were allocated a similar start time by mistake. In addition, it took some time to gather the participants, perhaps due to the nature of their work and their busy work

environment. For this focus group discussion, only 30 minutes were available, which was insufficient for gathering rich data. In addition, the focus group discussion with the head nurses started late because the team found it difficult to get organised. As well, although the researcher explained the content of the consent form and its benefit of preserving participants' rights, some clinical nurses did not feel comfortable signing it.

Focus group discussions in Arabic were transcribed and translated into English. It must be acknowledged that translating transcripts from one language into another gives rise to certain difficulties, which might have an impact on the analysis. Although the researcher is reasonably confident of the quality of the translations, the possibility of meanings being distorted during the translation process cannot be excluded. The researcher decided to conduct the focus group discussions involving students and lecturers in Arabic mixed with English due to participants' fluency in Arabic. Some participants were not confident speaking in English. The other focus group discussions and the individual interviews were conducted in English. Fluency in Arabic and English enabled the researcher to communicate effectively with all participants. In addition, allowing participants to speak their preferred language enabled them to freely express their feelings and thoughts and to communicate effectively with the researcher during the discussion.

Not all data interpretations were checked by an independent party, such as peers or experts, which could have affected the study's findings. However, to reduce the risk of misinterpretation, the researcher provided a summary sheet for respondents to check to ensure their responses were accurate.

3.5.3 Provisional recommendations for practice and education

The findings of this case study have shown that there was no clear understanding about what mentorship should entail, which resulted in conflicting roles and expectations for mentors and mentees. In addition, there was no clear plan assigning responsibility for mentoring, assessing and evaluating students in their clinical placements. Therefore, effective strategies are needed, including a national mentoring policy in Saudi Arabia, clear job description for nurses' mentoring role and clear hospital policy and guidelines for mentoring practice.

Moreover, the findings showed a lack of communication and collaboration between the college and the hospital, in addition to insufficient support, training and preparation for mentors and mentees. Therefore, colleges and hospitals need to make arrangements to support and prepare nurses and students for clinical placements. This could be achieved by identifying mentors, designing clear learning objectives, allowing students to meet their mentors before clinical placements and creating mentorship training programmes for both mentors and mentees.

3.5.4 Recommendations for future research

The findings show that, although the mentorship process is generally viewed as unsatisfactory, it could be improved and restructured to maximise benefit for mentees and make it easier and more worthwhile and fulfilling for mentors. Many participants suggested key reforms, including clarifying expectations for mentors and mentees, facilitating closer communication between the college and the hospital and increasing mentors' motivation by giving increased benefits.

The research yielded few descriptions of mentorship which worked well. On reflection, this lack might have been due to the great amount of effort spent encouraging

participants elaborate on their mentorship experiences, this could indicate that they do not having anything positive to say about mentorship. However, questions asked during focus group discussions and individual interviews might not have been structured to encourage participants to provide further detail about their positive mentorship experiences. The way the research was conducted might have contributed to a skewed perspective of mentorship experiences. The methodological approach of the main study was improved so that undue emphasis was not placed on negative experiences but, instead, on encouraging participants to explore their positive mentorship experiences by appreciating what works well. This method can be used to discover the strengths of mentorship among a diverse team of nursing students and RNs, assisting them in discovering their strengths and identifying the key characteristics of successful mentorship.

A larger study using an AI approach can investigate the factors contributing to positive mentorship experiences in nursing in Jeddah, Saudi Arabia, by exploring the mentors' (RNs) and mentees' (student nurses) positive experiences in mentorship (Chapter 5). This aim emerged from the best evidence literature review on mentorship (Chapter 4) and from the findings of the case study (section 3.3).

4 Literature review: Mentorship experiences from the perspectives of mentors and mentees

4.1 Introduction

The aim of the literature review was to examine studies on mentorship in nursing from the perspectives of both mentors and mentees in order to obtain a holistic view of mentorship experiences (see section 4.3.1.1 for a full list of inclusion criteria). Studies from other health professions were also included. The studies had been published since 1980 and were in either English or Arabic. The search revealed that the majority of studies in this area have been conducted in UK, USA, Europe and Australia, with a few studies in Turkey and Jordan. Only one study has been conducted in Saudi Arabia.

The first section of this chapter outlines the literature review questions, while the second describes the search strategy used and the search results. The third section critically evaluates the findings of the published studies. It first reviews the definitions of mentorship in the literature and then discusses the sparse literature on nursing mentorship experiences in Saudi Arabia. Next is a critical overview of nursing mentorship experiences in Islamic countries. The chapter then presents a critical analysis of studies examining mentorship exclusively from mentees' point of view, exclusively from mentors' point of view and from the perspective of both mentors and mentees. These studies are also outlined in the reference grid (Appendix 11, p. 437). The final section of the chapter summarises the findings and attempts to use them to answer the literature review questions stated in section 4.2. This conclusion also identifies gaps in the literature related to nurses' mentorship experiences and how this thesis intends to fill these gaps.

4.2 Literature review questions

The review examines the literature in order to address the questions listed in this section. Although the thesis focuses on nursing mentorship in Saudi Arabia, these questions are framed by the broader context of all studies on nursing and mentorship. Applying these questions to nursing mentorship in general is likely to be a more fruitful strategy for this thesis because of the paucity of published studies on Saudi Arabia and other countries in the Middle Eastern region.

Literature Review Questions:

- What is the existing knowledge about mentors' and mentees' understanding and interpretations of the concept of mentorship?
  This question enabled exploring the broad concept of mentorship through different perceptions and expectations that mentors and mentees have of the process. This investigation assessed whether these groups' perceptions conflict and how their understanding of the role and importance of mentorship can be improved.

- What factors have an impact on the effectiveness of the mentorship process in nursing? How effective are the strategies used for mentorship and the preparation for mentors?
  Answering this question highlighted areas in which the experiences of both mentors and mentees can be improved. The subsequent analysis of mentorship experiences in Jeddah (main study, Chapter 5) were compared with the findings of the literature review in order to determine whether they concurred.

- Do barriers exist that hinder the effectiveness of the mentorship process in nursing?

This question highlighted key areas preventing both mentors and mentees from having positive mentorship experiences and helped identify areas for improvement.

- Are there gaps in the literature regarding the process of mentorship in nursing? What further research could be conducted to rectify this?

Answering this question was important to determining the role that the research conducted in this thesis can play within the existing body of research so that it makes valuable contributions, rather than merely repeating what has already been done.

4.3   Literature search

4.3.1   Search strategy

A literature search was conducted in October 2009 and updated in August 2014 to determine what has been published about mentorship in nursing. From the date the literature was first searched to reviewing the thesis for submission, the relevant databases were searched regularly to identify any relevant new studies. During this period (October 2009 to August 2014), new books published in this field were also reviewed. These repeated searches continued to demonstrate a paucity of literature focused on Saudi Arabia, finding only one research publication about mentorship in this region from 2011.

The databases searched were Ovid, Medline, Embase, CINAHL, Cochrane and Pub Med. The key search words were 'mentorship', 'mentor', 'mentee', 'preceptorship', 'students', 'nurses', 'coaching', 'support', 'factors', 'relationship', 'education', 'clinical placements', 'learning experience', 'learning environment' and 'supervision'. A

combination of these terms was used to search the title, abstract and contents fields of each bibliographic database (see Appendix 10, p. 433).

In the course of the literature review, the researcher did not depend solely on electronic searches of databases for published materials. She also carried out wide searches of the grey literature. Grey literature is comprised of unpublished literature and non-conventional material that are not available from commercial publishers (Aveyard, 2010; Alberani, Pietrangeli and Mazza, 1990). It includes theses, conference papers and abstracts, bibliographies, conference proceedings, reports, best practice documents, official documents and working papers (Alberani, Pietrangeli and Mazza, 1990). A major concern about using grey literature is the value and quality of the material and the lack of peer reviews (Bolderston, 2008; Hart, 2001). Accordingly, the researcher had to use her own judgement to assess the literature's quality (validity). In using grey literature the researcher was careful to evaluate by whom and when it was written, its purpose, where it was held and who provided it.

4.3.1.1 *Inclusion criteria*

The literature search included research studies from any nation, published between 1980 and 2014 and written in English or Arabic. Although there is a risk that some findings of studies published during the 1980s might be of limited relevance today, restricting the search to more recently published research would have limited the range of findings that could have been consulted and the insight achieved into the state of the research conducted in this area so far.

4.3.1.2 *Exclusion Criteria*

The literature search excluded any study not in the English or Arabic language, and studies that explored mentorship in a field other than nursing or health care, or that did not meet the stipulated inclusion criteria.

4.3.2 Search results

Research on nursing in Middle Eastern countries in general is limited; therefore, almost all of the studies reviewed were carried out in western countries. The initial search identified a total of 58 studies, of which 35 were journal articles, 11 books and 12 dissertations. The publication dates were fairly evenly spread throughout the years searched, suggesting that interest in this area has remained relatively steady and has not peaked significantly in recent years.

Although a wide range of studies were consulted, the literature review only refers to 16 which provide detailed explorations into key themes concerning mentorship, including the disparity between the rhetoric and the reality of mentorship, the conflicting expectations of mentors and mentees, the commitment shown by mentees and mentors and the effect of practical factors, such as the time availability of the mentor. These themes inform most research conducted in this area, and the studies selected explore these themes in detail or yield unique insights into them. In cases where more than one study explored the same themes, the most recent one was included to avoid repetition and increase the timeliness of the research reviewed.

Few studies on nursing practice in Saudi Arabia focus on the experiences of Saudi nurses. Most concentrate on the experiences of nurses of foreign nationalities working in Saudi hospitals or the difficulties encountered by Saudi and foreign nurses due to cultural and religious restrictions imposed on women in the country (Suliman et al.,

2009; Mebrouk, 2008; Miller-Rosser, Chapman and Francis, 2006; El-Gilany and Al-Wehady, 2001). A thorough search of the literature found only one study on the mentorship of nursing students in Saudi Arabia. However, a small number of studies treat nursing education in the country; for instance, some studies took an educational perspective and investigated Saudi nursing students' approaches to learning (Suliman, 2010; Suliman, 2006; Littlewood and Harrow, 1999). The reason for the lack of literature in this area is unclear. It is possible that nursing education has not been considered a research priority in the development of nursing practice in Saudi Arabia.

Although only one research study focused specifically on the experiences of nurses in Saudi Arabia, the review found strong similarities between the professional and learning experiences of nurses in studies conducted in western and Middle Eastern countries. The similarity of experiences across countries suggested that analysis of these experiences might yield useful insights into the experiences of nurses in Saudi Arabia. The intent, therefore, was to provide an overview of the mentorship experiences of nurses in many countries in order to inform the Saudi Arabian context.

In addition to the study by Bukhari (2011) which explored the nature of preceptorship and its role in clinical nursing practice in Saudi Arabia, studies conducted by Nahas (2000) in Jordan and Elcigil and Sari (2008) in Turkey were included to identify any differences in the experiences of nurses in Islamic countries and non-Islamic countries. The shared religious background of Saudi Arabia, Jordon and Turkey means that these studies' findings might be especially relevant to the topic of this thesis. This assumption is supported by Giger and Davidhizar (2004), who suggest that the process of training nurses and the role of hospitals in the education of nurses are similar across countries in the Middle East.

As mentioned in the glossary of terms, the researcher used the terms 'mentorship' and 'preceptorship' interchangeably, reflecting international differences in parlance. In addition, she used a combination of both terms when searching the literature (see Appendix 10, p. 433 for the list of key search words used in the literature search).

4.4 Critical evaluation of published studies

This section provides an overview of the existing research on the mentorship experiences of nurses. The key findings of research which provide useful insights into this topic are summarised, and a brief critical overview of the methodologies used and the assumptions on which the findings are based is given. Critical Appraisal Skills Programme (2009) was used to critically evaluate these published studies (CASP, 2009). Key aspects of the studies discussed in sections 4.4.1–4.4.6 are presented in a reference grid in Appendix 11 (p. 437).

Many studies have concentrated on mentorship practices in the UK and other western countries, including the mentor–mentee relationship (Jackson et al., 2003; Earnshaw, 1995; Hunt and Michael, 1983), frameworks or models for mentoring activities, preparatory courses for mentors (Phillips, Davies and Neary, 1996; Wilson-Barnett et al., 1995; Jinks and Williams, 1994) and effects on the mentoring process from the personal characteristics of mentors (Earnshaw, 1995; Rogers and Lawton, 1995; Darling, 1984). Some studies focus on mentorship from the perspective of mentees (e.g. Beecroft et al., 2006; Gray and Smith, 2000), and others from both mentees' and mentors' perspective (e.g. Myall, Levett-Jones and Lathlean, 2008; Neary, 2000b). Two studies (Lofmark et al., 2009; Shannon et al., 2006) focus exclusively on the mentors' point of view. Some studies also identify the key factors needed to ensure a successful mentorship and give recommendations for how to put such factors into practice

(Bukhari, 2011; Elcigil and Sari, 2008; Beecroft et al., 2006; Kaviani and Stillwell, 2000). The key themes emerging from the studies reviewed are the:

- Disparity between the rhetoric and reality of mentorship experiences

- Impact of mentors' limited time availability on the effectiveness of the mentorship process

- Relationship between mentors and mentees

- Extent of self-direction available to mentees during mentorship

The following sections discuss mentorship and the views of mentees and mentors of their mentorship experiences.

4.4.1   Definitions of mentorship

The UK NMC defines a nursing mentor as a nurse who supervises and assesses students in the clinical setting and facilitates their learning process (Nursing and Midwifery Council, 2004). The definition of mentoring in the UK appears to place a greater emphasis on supervision and assessment than in other countries. The process of nursing mentoring in the US, for example, appears to prioritise mentees' self-development (Smith, 2003). In Australia, terms 'nursing mentorship' and 'clinical supervision' are understood and used freely by nurses, but agreed-upon meanings and definitions for mentorship are lacking (McCloughen, 2006). As reported by Madison (1994) and Pelletier and Duffield (1994), nursing mentorship in Australia has received attention and recognition in the literature only in the last 10 to 15 years (cited by McCloughen, 2006). This suggests that the understanding of nursing mentorship in Australia is probably influenced by the UK and USA (McCloughen, 2006). There are few formal definitions of nursing mentorship within Saudi Arabia, possibly because the nursing profession is not accepted nor perceived as a respectable profession by the society (Bryant, 2003).

However, Morton-Cooper and Palmer (2000), identified that the key difference between preceptors and mentors is that preceptors' role is to assist nurses during their orientation to a new hospital, while mentors help nurses achieve personal and professional growth after the initial orientation process. Although Morton-Cooper and Palmer (2000) focused on the role of preceptors, its emphasis is on how preceptors support health care students on their placement programmes. The preceptors, therefore, can be seen as fulfilling the role of mentor. The aims of the study were to explore the factors influencing preceptors' decision to mentor students, to assess their skills and knowledge before supporting students, to evaluate the skills and expertise of other staff involved in the programme and to explore how preceptors perceived their role.

4.4.2 Sparse literature on nursing mentorship experiences in Saudi Arabia

A thorough search of the literature on the mentorship process in the specific context of Saudi Arabia revealed only one study by Bukhari (2011). Bukhari (2011) conducted a qualitative study to examine the nature of preceptorship and its role in clinical nursing practice in Saudi Arabia. The study explored stakeholders' (preceptees, preceptors, nurse managers, clinical resource nurses and nurse educators) understanding and expectations of a preceptorship programme in order to identify the factors contributing to success or failure in the programme. Preceptees in this study were newly hired nurses who had worked in another clinical setting in Saudi Arabia or abroad and had a minimum of one year of clinical experience. However, all preceptees and preceptors who participated in this study were non-Saudi and were of international origin, with different levels of education and experience.

Bukhari's (2011) study also sought to investigate the impact of preceptorship on the development of the clinical practice of the newly hired nurses. The sample consisted of

30 nurses (Saudi and non-Saudi) of various levels of education and experience currently working at one clinical setting in Saudi Arabia. Data were collected through semi-structured focus groups and individual interviews. The researcher also reviewed the clinical setting's policies related to preceptorship.

The results showed that preceptorship is crucial for the integration of newly hired experienced nurses into their new roles. Six themes emerged from the data: the definition of preceptorship, the influence of preceptorship on the provided nursing care, time issues, support, recruitment and its effect on the success or failure of the preceptorship and, finally, selecting and preparing preceptors (Bukhari, 2011). Bukhari (2011) suggested that there is a need for a concise definition of preceptorship and a clear policy to meet the preceptorship programmes' objectives. Recruitment processes should be examined to ensure that the preceptees' (newly hired nurses) qualifications and experiences meet the setting's requirements.

Bukhari (2011) captured the views of newly hired experienced nurses who were preceptees, not student nurses or interns. Although the study presents valuable insights into preceptorship, selecting only one clinical setting in Saudi as the only site for conducting this study prevented exploring a wide variety of perspectives and experiences of other nurses in Saudi Arabia. Additionally, only three Saudi nurses, in addition to preceptors and preceptees, participated in this study, so comparison to the non-Saudi participants was not possible.

4.4.3 Overview of nursing mentorship experiences in other Islamic countries

As discussed, the paucity of literature on nursing mentorship in Saudi Arabia has limited the literature review mostly to studies conducted in western countries. However, it is clearly useful to refer to studies of nursing mentorship conducted in countries

sharing similar cultural or geographic characteristics to Saudi Arabia as their findings likely will be more applicable to Saudi Arabia. Therefore, this section provides an overview of studies on nursing mentorship conducted among Jordanian and Turkish nurses. Jordan is a neighbouring Middle Eastern country with similar cultural and religious practices as Saudi Arabia. A large part of Turkey is situated in the Middle East, and though not a direct neighbour of Saudi Arabia, it shares similar religious practices and, therefore, likely is to yield some useful insights.

Nahas's (2000) study on the mentorship experiences of Jordanian nursing students focused on the cultural differences between the caring and non-caring interactions of Jordanian nursing students with their clinical teachers, including nursing students' communication and relationship patterns with their clinical teacher during their clinical placements. Nahas (2000) further analysed students' perspectives of their mentorship experiences and highlighted their expectations of their clinical teachers. A combination of participatory observation and interviews were used to collect data on the students. The findings of Nahas's (2000) study, based on a sample of 47 participants, revealed that Jordanian nursing students described their mentorship experiences as positive when their contacts with their mentors were conducted through negotiating, translating, mothering, sustaining, and transforming processes.

As discussed, the many shared cultural and religious practices of Jordan and Saudi Arabia means that some of the cultural differences identified in Nahas' (2000) study might be evident in Saudi Arabia. Nahas (2000) argues that cultural differences between educators and learners can result in differences in values, practices and cultural beliefs which can greatly affect the learning process.

In Nahas (2000) study, patterns relating to cultural differences repeatedly arose during analysis and appeared to be a source of tension between nursing students and clinical teachers. In particular, the expectations of Jordanian nursing students and their clinical teachers clashed. Jordanian students were likely to expect a high level of support and care from their clinical teacher and to build a close nurturing relationship. However, as the mentorship progressed, the Jordanian students experienced disillusionment because of the limited availability of clinical teachers.

As discussed in section 4.4.4, Gray and Smith (2000) found that a sample of Scottish nursing students, too, exhibited high levels of idealism at the beginning of their mentorship but gradually became disillusioned when the infrequent availability of mentors became apparent. This finding suggests that Jordanian students' high expectations at the beginning of mentorship might simply have been due to a lack of experience or a failure to hold realistic explanations about the mentor's role, rather than any inherent cultural differences.

Elcigil and Sari's (2008) study on experiences of nursing mentorship in Turkey also focused exclusively on students' opinions and experiences of mentorship. This qualitative research consisted of three focus groups of eight students who had completed their third year at nursing school. All the students already had practical experience in nursing in a variety of fields from clinical placements during their nursing degree. The results of the focus groups suggest that students expect effective clinical mentors to empathise with their students, communicate without prejudice, give positive and constructive feedback, provide useful information and allow students sufficient scope to carry out their own research, update their knowledge and learn new things.

In Elcigil and Sari's (2008) study, students interviewed in the focus groups suggested four key characteristics which should be present to ensure a successful mentorship experience. The first factor was a strong interpersonal relationship dependent on the mentor's communication skills and body language. The second key characteristic for mentors was a high level of teaching ability as students need mentors to provide them with information and advice about clinical practices. The third key characteristic was nursing competence as students felt that they would benefit more from working closely with mentors with high levels of competence and experience in their field. Finally, the students pointed to a number of personal characteristics, including thoughtfulness and patience, which increased the effectiveness of mentorship. Some students also suggested that mentors should smile more in order to build closer interpersonal relationships with their students. The researchers recommended that nursing mentors pay greater attention to their communication and evaluation skills during mentorship. Also recommended was clearly outlining the mutual expectations of students and mentors at the beginning of the mentorship, positive feedback from mentors, explicit evaluation criteria and giving students access to information, knowledge and experience.

The most striking aspect of the findings of Elcigil and Sari's (2008) study is that they do not differ significantly from those discussed later in this literature review, which also stress the importance of communication and evaluation in successful mentorship. These similarities imply that, despite cultural differences, there is no significant difference between the factors determining the success of a mentorship and what students are looking for from mentorship. Therefore, the findings and implications of research conducted in western countries might be equally applicable to a Saudi Arabian clinical context. However, further research needs to be conducted on a larger scale and in

different cultural contexts before it can be concluded that cultural differences do not significantly affect students' perceptions of clinical mentorship.

4.4.4 Mentorship experiences: The perspectives of mentees (nursing students)

As highlighted, the majority of studies in this area focus on the process of mentorship from the viewpoint of students' experiences. The findings of these studies are useful in highlighting how the mentorship process can be modified to improve students' experiences. Some studies focus on the emotional and psychological effects of nursing mentorship on students. One of the most significant studies was carried out by Gray and Smith (2000). Their longitudinal study used grounded theory to investigate the effects of mentorship on student nurses. Seventeen students from a Scottish college were asked to keep a diary of their experiences of mentorship during their clinical placements. Ten of these students were also interviewed five times over three years.

Gray and Smith (2000) found that students initially had an idealistic view of their mentors, believing that they would have sufficient time and availability to regularly work with and supervise students and address all of their concerns. However, as the mentorship progressed, students developed more realistic and flexible ideas and strategies, such as determining their mentors' preferences and following them to get favourable feedback for the assessment. Students also appreciated the importance of choosing good role models and becoming more independent from their mentors once they moved into their course and improved their skills and confidence. Although students quickly realised that practical issues, such as workload, time constraints and mentor's personal characteristics, prevented the ideal relationship they had desired, having a mentor remained an integral part of their clinical placement and made a valuable contribution to the development of students' nursing skills.

A study conducted by Papp, Markkanen and Bonsdorff (2003) used observation and unstructured interviews to explore the mentorship experiences of 16 student nurses working in Finland and identify the key factors in a successful mentorship. According to the findings, the four key principles necessary for an effective mentor–mentee relationship are appreciation, support, quality and self-direction. Specifically, it is important that student nurses feel that their efforts are appreciated in order to maintain their motivation and self-esteem. Support in the planning and implementation of nursing situations is necessary, with the mentor providing a strong professional example that demonstrates nursing best practices for students to follow. High-quality clinical practice and patient care are conducive to effective mentorship. Finally, self-direction is considered important. Although support from mentors is necessary during mentorship, students need to learn how to approach decisions and challenges independently in order to better know their potential and limitations and to strengthen their sense of responsibility and achievement. Papp, Markkanen and Bonsdorff's (2003) study concluded that students themselves are responsible for benefitting from their mentorship experience. Papp, Markkanen and Bonsdorff's (2003) study appears to corroborate Gray and Smith's (2000) findings. However, it is possible that Papp, Markkanen and Bonsdorff's (2003) emphasis on the importance of self-direction might have arisen from the mentors' limited availability for mentorship, which forcing students to be more self-directed.

Other studies focus on the potentially detrimental effects of inadequate mentorship on students. Lis et al. (2009), for example, explored the adequacy of mentorship provided to 229 psychiatry chief residents (doctors) in the US in 2004 and 2005. In the survey, 39 per cent of respondents felt that their mentorship experience was inadequate. Data analysis revealed that chief residents who had a clearly defined mentor were twice as

likely to feel adequately prepared to practise psychiatry on graduation compared to those who felt they did not have a clearly defined mentor. Lis et al. (2009) suggested that one key factor for ensuring effective mentorship is regular meetings between mentees and mentors (46 per cent of those interviewed stated that weekly meetings with their mentor are ideal).

Although Lis et al.'s (2009) study findings seem to suggest that mentorship plays an important role in students' feelings of preparedness on graduation, a number of methodological and research issues cast decrease the validity of the study's findings. Firstly, students' feelings of preparedness are highly subjective. What one student interprets as feeling prepared might not be interpreted the same way by another student. Secondly, while students who experience inadequate mentorship might state that they do not feel prepared, this does not necessarily mean that they are less prepared in reality. In other words, it is unclear whether students' self-perceptions correlate to actual preparedness. Arguably, it is more important to determine the effect of mentorship on students' actual preparedness than their perceptions of their level of preparedness. The issue of distinguishing students' perceptions and the reality of mentorship can be seen as a limitation on the conclusions that be drawn from all studies focused solely on students' experiences of mentorship. One could also posit that learning, by its very nature, is an individual experience (Billett, 2010), and thus, an understanding of different individuals' perceptions of their learning experience is essential if one is to gain greater insight into the phenomenon of learning.

However, findings of Ronsten, Andersson and Gustafsson (2005) suggested that the psychological effects of adequate mentorship on student nurses can be crucial in ensuring positive future experiences of nursing. Ronsten, Andersson and Gustafsson'

(2005) study examined the mentorship experiences of eight nurses in Sweden through a series of individual and focus group interviews conducted two years after the end of mentorship. The aim was to assess how recently RNs felt that mentorship had helped to develop their nursing competencies using the Sympathy, Acceptance, Understanding, Competence model. Probing on nurses' perceptions of their mentorship two years later was beneficial as it provided a reflection of how nurses felt their mentorship actually contributed to their professional development, unlike the study by Lis et al. (2009) which focused solely on students' expectations of how useful their mentorship would prove to be. However, one could also argue that deferring the research might decrease the accuracy of the nurses' recollections through the distortion of memory.

Based on the findings of Ronsten, Andersson and Gustafsson's (2005) study, it was concluded that effective mentorship helped to positively reinforce nurses' perceptions of themselves and improved their ability to approach the treatment of patients from a more holistic perspective. The most useful insight provided by this study is that effective mentorship appears to produce concrete improvements in nurses' abilities and to have purely psychological effects, including an increased capacity to reflect on patients' situations, work with other professionals and make decisions. The nurses expressed the view that the improved, holistic perspective and reflective approach which their mentorship enabled them to achieve in to their work resulted in improved nursing practices Again, though, this finding was based solely on nurses' self-perceptions, not any objective measures.

Findings similar to those of Lis et al. (2009) were obtained by Beecroft et al. (2006) in a survey on the mentorship experiences of new nurses at a US healthcare facility from 1999 to 2005. Beecroft et al. (2006) used a logistic regression analysis to determine

whether student nurses' experiences were influenced by demographic variables such as educational status. Like Lis et al. (2009), Beecroft et al. (2006) found that a successful mentorship was characterised by a high level of guidance and support from the mentor. The success of mentorship had a significant correlated with the number of occasions on which the mentor and mentee worked together. Beecroft et al. (2006) suggested that mentors can play an important role in the retention of graduates by increasing their confidence.

In addition to similarity findings as earlier research, Beecroft et al.'s (2006) study yielded a number of unique insights. Firstly, the survey revealed that the majority of mentees and mentors had very little knowledge of what to expect from mentorship; students' sole expectation was support from the mentor. Secondly, the key obstacles to regular meetings between mentors and mentees were issues such as lack of time and commitment. Mentors possessed insufficient knowledge to give career advice and inform students of networking opportunities. Thirdly, regular meetings with a mentor had a significant, positive correlation with the educational level of the new nurse. More highly educated nurses were more likely to meet regularly with their mentor and, thus, were more likely to receive effective mentorship (Beecroft et al., 2006). Possibly, more highly educated nurses are more likely to appreciate the value of mentorship and, therefore, are more likely to push for regular meetings. Alternatively, they might have better developed interpersonal skills, which aid in successful negotiations for mentorship meetings. Another possible explanation is that these nurses were more highly motivated, which might have encouraged mentors to help them more. The cause could have been determined if information about motivation levels had been included in the study.

A number of limitations affect the applicability and validity of Beecroft et al.'s (2006) study findings. Firstly, some new nurses did not answer all of the items in the survey, affecting the results of the analysis. Secondly, the survey questions were poorly worded and imprecise. For instance, one question asked nurses to state whether they met with their mentor 'on a regular basis'. Without an objective definition of 'regular', interpretation of this term might vary from nurse to nurse. Consequently, data on the regularity of meetings might not be valid. The meaning of such words should be clarified to ensure that the interpretation of responses is not subjective. In addition, the use of a standardised survey limited participants' ability to express their views about the complex issues involved.

Another study conducted by Bradbury-Jones, Sambrook and Irvine (2007) in the UK used a critical incident technique (CIT) to collect data between November 2005 and January 2006 and analyse how experiences of nursing mentorship could affect feelings of empowerment and disempowerment among nursing students. In this study, 66 nursing students provided 109 written critical incidents, detailing a range of empowering and disempowering incidents for content analysis. The findings of Bradbury-Jones, Sambrook and Irvine's (2007) study suggested that being understood, encouraged to learn and given a sufficient level of responsibility were crucial to ensuring a high level of empowerment in mentees. The majority of disempowering incidents reported by students were related to instances in which mentors demonstrated a lack of understanding, prevented students from learning specific skills or limited their responsibilities. Examples of disempowering incidents included situations where students were removed from learning experiences in order to be used as another pair of hands in another situation.

Bradbury-Jones, Sambrook and Irvine's (2007) study results suggested that feelings of empowerment help boost self-esteem, motivation and desire to learn among students, while feelings of disempowerment stemming from a lack of understanding, encouragement and adequate responsibility during the mentorship can give rise to feelings of low self-esteem and a desire to leave the nursing programme. However, the usefulness of these findings is limited by the CIT employed as the principal research methodology. This approach increases the risk that other useful insights not related to specific incidents regarding mentorship might have been missed. Additionally, the findings relied heavily on students' ability to provide specific examples of empowering and disempowering experiences, and some students failed to give sufficiently detailed descriptions of their experiences. Confining the analysis solely to students' perspectives runs the risk of failing to consider the practical issues that mentors might face, such as time available for mentoring.

4.4.5   Mentorship experiences: The perspectives of mentors (registered nurses)

Although the majority of studies conducted in this area have focused on students' point of view, two studies describe mentorship experiences from mentors' point of view (Lofmark et al., 2009; Shannon et al., 2006). These studies examined the experiences of mentors in guiding and supporting students, what mentors perceived as the most important factors in ensuring successful mentorship and the various barriers to successful mentorship.

Lofmark et al. (2009) explored the experiences of mentors in Sweden by looking at their experiences in teaching and social care, as well as nursing. A participation-oriented approach, which involved the collaboration of 4 researchers and 19 mentors, was adopted to carry out the research. Lofmark et al. (2009) found that mentors saw

themselves as a link between the university and the practical field and that effective communication between these fields about policy and practice issues was vital for the development of mentorship. The majority of problems for all three professions involved arose from a lack of appropriate contact between academics and professionals. The researchers concluded that quality mentorship can be guaranteed only if university teachers and staff working in practical fields collaborate effectively. This broad cross-professional approach presented advantages, highlighting issues and predominant attitudes specific to mentorship in the nursing profession and providing a more general understanding of the issues surrounding the concept of mentorship in other professions. Lofmark et al.'s (2009) study is important because the researchers attempted to use the perspectives of mentors rather than those of mentees, as most studies had done. The findings from the experiences of these participants can aid mentoring practitioners in improving their practices.

Shannon et al. (2006) focused specifically on the role of the preceptors of health professional students enrolled in the Spencer Gulf Rural Health School in South Australia. Shannon et al.'s (2006) study involved a paper questionnaire sent to 225 preceptors (with a 58 per cent response rate). The collected data were analysed statistically and descriptively for the open-ended questions. In the results, preceptors' key motivation for participating in the placement programmes was their desire to contribute to students' knowledge and skills and to help promote their careers. The most enjoyable aspects of preceptorship for preceptors was sharing students' enthusiasm for learning new things and desire to learn more about rural health care. Preceptors helped students develop new learning behaviours and experienced deep satisfaction from seeing students' skills, attitudes and confidence level improve.

The least enjoyable aspect for preceptors pointed out in Shannon et al.'s (2006) study was time pressure, simultaneously practising professionally and supporting students. This constraint resulted in an increased workload and lower income as time spent preceptoring students was unpaid. In addition, many preceptors criticised the poor administration of placements, highlighting a lack of communication and the follow-up of information. The key proposals made by preceptors were to improve the administration of the programme and communication between preceptors and academic instructors. While Shannon et al. (2006) provided rich information about preceptors' experiences, collecting qualitative data through, for example, focus groups and individual interviews could provide a more holistic overview of all the value differences, views and conflicts involved that are not mentioned in the researchers' study. However, Shannon et al.'s (2006) study findings are significant because they confirm those of Lofmark et al. (2009) that time and administration-related issues might pose significant barriers to effective mentorship.

4.4.6   Mentorship experiences: Perspectives of both mentees and mentors

A number of studies have examined the mentorship process from the perspectives of both the students being mentored and the mentors themselves. The majority of studies in this area involved asking nursing students and nursing mentors to keep activity diaries of their involvement in the mentorship.

One of the studies exploring the experiences of both mentors and mentees and which aimed to find commonalities between the two was carried out by Myall, Levett-Jones and Lathlean (2008). The researchers collected data in the UK through an online survey questionnaire for nursing students and a postal questionnaire for mentors. A total of 161 (10%) questionnaires from nursing students and 156 (21%) from mentors were returned.

The researchers found that many problems in the relationships and communication between mentors and students were due to a lack of training and clear expectations from both parties. Myall, Levett-Jones and Lathlean (2008) pointed out that the importance of mentorship in nursing students' clinical learning needs to be recognised, and due attention is given to adequately train and support mentors. Only then, the researchers argued, can mentors adequately train and support students. Myall, Levett-Jones and Lathlean's (2008) study found that, although the disparity between rhetoric and reality in mentorship experiences and national nursing mentorship standards existed, it was narrowing. The researchers suggested that introducing national standards in countries where mentorship forms a key part of preparation for nursing careers would be beneficial. Myall, Levett-Jones and Lathlean (2008) had low response rates, increasing the potential of bias. In addition, further insight could have been gained by speaking directly to students and mentors in interviews.

Jones, Walters and Akehurst (2001) conducted another study which examined both mentors and mentees' perceptions of on the mentorship experiences of pre-registration nursing and midwifery students in the UK. The study sample included 270 students and their mentors, who kept activity diaries for one week during mentorship. In addition, separate focus groups were conducted with mentors and students. Only 125 students and 117 mentors completed and returned the diary. Both diaries and focus group data were analysed to answer the research questions, returning results similar to those of Myall, Levett-Jones and Lathlean (2008). Jones, Walters and Akehurst (2001), though, were rather more pessimistic, concluding that there was a significant disparity between rhetoric and practice. In practice, mentors' limited availability prevented cooperation with students, which had detrimental effects on their mentorship experience.

The difference between the findings of Jones, Walters and Akehurst (2001) and of Myall, Levett-Jones and Lathlean (2008) can be attributed to changes in nursing and midwifery practice in UK. In 2001, formalised mentorship training was not mandatory in nursing and midwifery practice in the UK. However, by 2008, the Nursing and Midwifery Council (2008) had established clear standards for mentors to follow. Specifically, Jones, Walters and Akehurst's (2001) analysis of activity diaries revealed that students often worked shifts without their mentors present, while a large proportion of students deliberately arranged their working shifts for the weekends, evenings and nights in order to maximise the time that they could spend with their mentors. When mentors were absent, other staff members often filled their role. However, the results of the study suggest that the continued absence of mentors had detrimental effects on the educational and professional development of students.

An interesting insight that emerged from focus groups with students was that some students did not believe the success of their mentorship relied on their mentor's presence at all of their sessions. Rather, most students placed greater emphasis on the importance of having the same mentor, instead of being assigned a different mentor if their original one was unavailable. Students expressed the view that only one student should be assigned to each mentor. The study found that, in cases where a mentor was responsible for more than one student, both students received less individual attention. The focus groups with mentors revealed that the key barrier limiting their ability to effectively mentors students was the lack of time; recent staffing cuts were not reflected in decreased student numbers. Jones, Walters and Akehurst (2001) found that in cases where mentors were not typically present, students dedicated far less of their time to working alongside qualified staff as a caregiver. This finding suggests that the continued

absence of mentors likely has a negative effect on the educational experience of nursing students.

While Jones, Walters and Akehurst's (2001) study's combination of quantitative data (the use of tick boxes in the activity diaries and statistical analysis) and qualitative data (from focus groups) was beneficial, it is important to note a number of limitations that might reduce the validity of the findings. The study methodology consisted of an activity diary kept over one week of the mentorship in which the student and mentor were likely to be working together. This methodology raises the possibility that students and their mentors were more likely to have been working together regularly during this period than throughout the placements and that the results might not be representative of students' and mentors' experiences during the whole mentorship period.

A small qualitative study conducted by Kaviani and Stillwell (2000) in the UK evaluated the effectiveness of preceptorship programmes by assessing the perceptions of preceptors, students, and nurse managers and identifying the factors most significantly influencing the performance of preceptors. Two focus groups consisted of preceptors and of final-year nursing students, while two individual interviews with the nurse managers. Kaviani and Stillwell's (2000) study captured preceptors' views of formal preparation for the programme and of the preceptor role, while the students were asked for their thoughts about preceptors' effect on their learning experience. The findings are similar to those of Shannon et al. (2006) (see section 4.4.5) that mentors valued mentorship for the value they acquired from it and the support they could provide to students.

Kaviani and Stillwell (2000) concluded that preceptorship helped preceptors reinforce their own knowledge, identify their professional development needs, support the

socialisation of nursing students, establish students' learning goals and identify their learning needs. The results of Kaviani and Stillwell's (2000) study revealed that participants believed that the most important personal characteristics for a successful preceptor were a clear desire and willingness to act in the role of preceptor, an eagerness to share professional knowledge and skills, high levels of self-confidence the capability to recognise nursing students' latent personal educational needs, and the ability to update personal knowledge and skills. Other skills identified as crucial to ensuring the success of preceptors, expected to act as teachers, were a high level of skill in teaching, prioritisation and time management. Specific skills cited included coaching, communication, leadership, decision making, supervising and facilitation of self-evaluation. The participants in Kaviani and Stillwell's (2000) study also made a number of key recommendations for increasing the quality of the preceptorship. Suggestions included regular contact with other academic staff in order to increase support for preceptors, a greater acknowledgement by academics of preceptors' important role and a greater emphasis on the benefits of the role in order to attract other participants.

The focus group conducted by Kaviani and Stillwell (2000) elicit students' views of preceptorship. Students felt that preceptors' key role was to provide them with access to any needed support and to serve as a professional role model, which in the long term would benefit the practice setting and the organisation as a whole. Recommendations for improvements made by students included more effective use of practice preparation days before the start of the placement in order to enable students to build relationships with preceptors and establish mutual expectations; extension of preceptors' role to educating other staff members about the educational needs of nursing students; and a greater level of understanding about these learning needs. Kaviani and Stillwell's (2000) study usefully identified the perspectives of preceptors, students and nurse managers

and commonalities among them. In addition, the use of focus groups and individual interviews helped to provide useful information about students', preceptors' and nurse managers' views.

Neary (2000b) and Duffy (2003) conducted other studies on the role of mentors. Neary (2000b) distributed questionnaires to 300 student nurses and 155 nurse practitioners and conducted interviews with 70 students and 80 mentors from three nursing colleges in UK. Duffy (2003) held unstructured and semi-structured individual interviews with 14 nursing lecturers and 26 mentors in the UK. According to Neary (2000b), successful mentors should support their mentees in three ways: offering educational support in the form of assessing student practice and providing feedback to facilitate learning; offering psychological support and assuming the role of advisor, friend and motivator; and supplying managerial support by creating a learning environment conducive to effective mentorship. Neary (2000b) compared the support element of mentorship to providing newly RNs with scaffolding. Duffy (2003) added to these findings by suggesting that mentors should be accountable to students and provide them with honest feedback about their actions. Duffy (2003) found that nursing mentors tended to give students the benefit of the doubt, leaving students surprised if they failed their final year practice placement assessments. Duffy (2003) also found that many students were motivated by fear of failure and appreciated honest feedback from their mentors, which many failed to do because of the sensitivity of giving negative feedback. Duffy (2003) suggested that this problem could be rectified giving mentors training on how to sensitively and constructively provide negative feedback as part of the mentorship preparation process. Although the research by Neary (2000b) and Duffy (2003) offer significant insights, they failed to recognise the role of hospitals in mentorship, directing and supervising the roles and responsibilities of every practicing nurse.

4.4.7 Influence of communication on mentorship outcomes

The previous sections of the literature review critically analysed the mentorship experience, identifying positive and negative aspects of it. The researcher interpreted the factors studied as fundamentally dependent on the quality and nature of communication employed in the mentorship process. The term 'communication' was used frequently, but there were no descriptions of what its nature was or should be. Therefore, this section seeks to examine the nature of communication and its potential influences on the mentorship relationship outcomes. Although the impact of verbal (VC) and non-verbal (NVC) communication on interpersonal relationships has been widely studied, but a search of the literature on the influence of communication on the outcomes of mentor-mentee relationship found that much research stated the importance of communication and its content but did not approach how appropriate and effective communication could be achieved. The awareness and use of specific communication skills that have impacts on the mentorship relationship were not analysed, even though they are likely to be a critical factor from the beginning of the relationship until after assessment of the programme's value for mentor and mentee. For instance, Hodges (2009) suggested mentoring is highly complex process that could be negatively affected by poor communication in a nursing mentorship practice. This claim was supported by Race and Skees's (2010) article on improving outcomes from mentorship at all nursing levels.

Therefore, this section of the literature review critically appraises literature studies focused on effective communication and, in mentorship in general, what the term communication embraces and the techniques considered to make communication effective. Reviewed next are studies on student nurse communication, highlighting effective and ineffective 'how' and 'what' communication practices that were employed

or absent and their perceived consequences on student nurses and on their relationships with patients and mentors. The section begins with an overview of the fundamental concepts of effective communication to provide a basis for evaluating studies on communication in nursing mentorship.

Communication can be described as complex, continuous interaction between two or more individuals, who attribute meaning to events observed, either heard or seen (Sullivan and Garland, 2009). In effective communication, the message sent is identical or as close as possible to that received by the receiver. Effective communication is often hindered by a variety of factors, such as the receiver's past experiences, the current context, the parties; feelings about themselves, the nature of the relationship between sender and receiver, and the content communicated.

In a communications literature review, Jones and Le Baron (2002) found that communication is categorised as verbal communication (VC) and non-verbal communication (NVC), and both forms are involved in messages sent. However, these two forms of communication are often studied separately, as if they are independent, instead of operating simultaneously. The literature has emphasised the relative importance of one or two factors, rather than taking a more holistic approach to the signals sent and received. If the communication is spoken (VC), not only are the actual words heard by the receiver, but aspects, such as the tone of voice, pitch and speed, influence how the receiver interprets the actual words. Other aspects of communication include observing the sender's NVC or body language, such as eye contact, facial expression, gestures, head position, dress and posture (Sullivan and Garland, 2009; Pease, 2001).

Individuals' choice of words can also indicate their attitudes or feelings about the subject matter communicating and to whom it is communicating (Mehrabian, 1966). Mehrabian (1966) used the term 'verbal immediacy' to describe the degree of separation the sender places between herself/himself and the receiver. For example, in the mentorship relationship, 'we' is classified as immediate, and 'you and I' as non-immediate, giving mentees different impressions of their status. If the subject matter of the VC and or feelings towards the sender were negative, then more non-immediate words were likely to be used, as was often the case in clinical settings or therapy (Mehrabian and Wiener, 1966). A nervous sender was more likely to repeat the same words, omit words or include incoherent sounds (Mahl, 1959). The degree to which these factors were present in the words communicated indicated the sender's level of anxiety about the subject matter or recipient.

Argyle and Hinde (1972) described NVC as comprised of three distinct sources and operating modes: communication of a person's attitude and emotion to influence a social context, NVC to reinforce the VC and NVC as the sole form of communication. The nonverbal signals expressed by individuals through voice tone or facial expressions, for instance, provided information to the observer (receiver) about the sender's feelings, personality and interpretation of a VC or NVC from a sender (Argyle and Hinde 1972). Argyle and Hinde's (1972) study also found that individuals could more easily adapt their tone of voice than their facial expression. Argyle (1988) proposed that NVC was a key factor in social and professional interaction as eye movement, tone of voice, gestures and facial expression that individuals use, often consciously, could significantly influence the nature of the social relationship. Jones and Le Baron (2002) confirmed this finding. Argyle (1988) emphasised the importance of

NVC, evidenced by the extent of training given to individuals to understand its effect on interpersonal relations.

Argyle, Alkema and Gilmour (1971) studied the relative impact of VC and NVC and found that the receiver failed to notice the verbal cues and the words said when strong, especially unexpected NVC was present. The orientation of sender and recipient in communication and the interpersonal distance and relative orientation also indicate the effectiveness of communication. According to Mehrabian (1968), these factors can indicate, for instance, the warmth of the relationship and the degree of interest in the verbal messages communicated by the extent of direct eye contact, leaning forward, relaxation of body posture and the orientation of two bodies towards one another. However, Porter and Brinke (2009) suggest that mere observation of body language cannot reliably validate individuals' intentions, and less subjective evidence is needed, especially in cases where a wrong judgement could lead to negative consequences. The extent to which body language can be manipulated was also investigated by Rosenthal and DePaolo (1979). They suggested some NVC, such as facial expressions, can be controlled to an extent. The factor least easy to control was tone of voice. Rosenthal and DePaolo (1979) concluded that this NVC is the most likely indicator of a true attitude or feeling. Another study in a legal context returned conflicting results (Caso et al., 2006). Caso et al. (2006) examined the degree to which individuals adapt their body language to mask their attitudes or feelings and found that VC but not NVC could be adapted.

VC and NVC are discussed in order to acknowledge that the reception of a message can substantially reduce the accuracy of the message intended by the sender, a difficulty exacerbated by different cultural norms. For instance, Feghali (1997) researched the communication characteristics of Arab nations and found very different VC and NVC norms than in other countries. Such VC norms include repeating what had been said;

not directly indicating needs or feelings; lengthy elaboration of content, which other nationals would express in a few words; and affectiveness, or the framing of an argument or idea that appears as not logical or evidence based to a western individual. NVC differences include using many gestures, making direct eye contact with same sex.

The generic communication studies discussed here demonstrate the high level of skills needed to communicating effectively and to convey the intended message. Unintentional body language or word use can be a significant barrier to the receiver hearing the actual words spoken or feeling included or approved as worthy by another person. The sender's intended message could also be influenced by different cultural norms or previous experiences. The emphasis placed on developing understanding of communication skills and using them effectively, therefore, was justified, especially as NVC skills are the most difficult to alter but have an enormous influence on interpretation. However, the interpretation of body language should not be taken as definite sign but as an indicator of an individual's attitude or feelings.

4.4.7.1 *Communication in the nursing context*

Kinnell and Hughes (2010) highlighted mentors' and mentees' communication skills and techniques of communication as one of the most crucial indicators of the success of a mentorship. A study by Tower and Majewski (1987) suggested that effective and sensitive communication skills were desirable in nurses and one of the criteria used in the assessment for nursing qualifications. Scammell (1990) emphasised the concept of a communication continuum to support nurse managers in improving their relationship outcomes. The continuum assigns the general and specialist communication skills that clinical staff were perceived to need into five categories: 1) primary communication to initiate relationships, including basic people management skills and NVC active listening, as among the most skills important for mentoring; 2) secondary

communication, including VC and NVC competence, to maintain and develop relationships; 3) providing advice and accurate, factual information in a teaching, supervising or instructing role and knowing when to do so.; 4) primary counselling, including supporting a work colleague, listening without judgement and assisting with problem-solving; and lastly, 5) secondary counselling to helping those with mental health issues, requiring the ability to empathise appropriately and disclose information about self only to the extent necessary at as a specific time (Scammell, 1990). The need for the higher communication skills cited by Scammell (1990) was reinforced by the work of Morton-Cooper and Palmer (1993), who noted that the mentor's communication roles included those of counsellor, advisor, coach and facilitator.

In a quantitative study, by Nishizawa et al. (2006) found that student nurses used significantly less developed communication skills than experienced nurses and had limited communication with patients when interacting with patients in a simulated environment. Although the generalisability of these findings was restricted because of the simulated context, Nishizawa et al. (2006) suggested that mentors should proactively observe nursing students' VC and NVC skills and help them achieve more effective and appropriate communication. However, the sample was also limited to 26 students, whose body language was compared to 13 experienced nurses, who were all female. As well, the patient was a student nurse, which could have influenced the communication.

The methodology used in Nishizawa et al.'s (2006) study was useful in concentrating on specific nonverbal factors. For instance, the physical distance between the patient and nurse was found to be much less for experienced nurses (35.2 cm) than students (42.9 cm). The researchers suggested that a distance of less than 45 cm enabled good communication and open discussion. A variety of aspects of facial expression were also

monitored: the time the nurse directly faced the client, 274 seconds for students and 266 for nurses; looking down 8 and 6 seconds, respectively; smiling, 55 and 38 seconds, respectively; and looking serious, 237 and 260 seconds, respectively. Nurses also nodded more frequently than students (83 compared to 73 times), used more than twice the number of hand and limb gestures and leaned towards the client more, all of which suggested higher levels of NVC and aligned with Mehrabian's (1968) findings.

Rosenberg (2011) critically evaluated the communication skills that students needed to communicate effectively with patients and colleagues but to conserve their physical and mental energy, which was likely to be quickly depleted by the multiple demands of the role and interpersonal relationships. Students needed to emphasise maintaining open communication by expressing interest, respect and care through NVC and VC. Many of the general NVC factors identified by Nishizawa et al. (2006) were reinforced by Rosenberg (2011). For instance, Rosenberg (2011) pointed out that active listening was vital and would be conveyed to the patient as interest, care and respect through such body language as leaning forward and making regular eye contact. A student who avoided direct eye contact with patients and talked constantly, instead of listening, indicated a lack of respect and interest. The capacity to understand and to focus on a patient's NVC and VC was also considered vital. The patient response might not match the behaviours observed, and failure by the nurse to realise could result in serious health consequences for the patient.

According to La Plante and Ambady (2002), The effectiveness of feedback given by mentors or experienced nurse colleagues to individuals, such as student nurses, in the workplace is dependent on the gender of the sender and the receiver, who values different combinations of tone and content,. Therefore, supervisors should consider both tone and content when communicating with subordinates. La Plante and Ambady's

(2002) quantitative study exposed 30 individuals to one of four potential workplace conditions with different combinations of verbal and nonverbal content and tone in positive and negative from supervisors. Female supervisor's feedback encouraged more effective performance when the content was positive but the tone negative, whereas male supervisors employed negative content and a positive tone. La Plante and Ambady (2002) concluded that males and females interpret the same information differently, possibly because men prefer a highly competitive environment and found negative feedback challenging, unlike women. The combinations of positive and negative content and tone represented a mixed message scenario. The gender of both the supervisor and the subordinate influenced the effectiveness of the feedback in improving the subordinate's performance. A positive tone used by male supervisors was effective in all cases but most noticeably with male colleagues. The explanation given was that males had greater camaraderie between males because their traditionally higher workplace status made relationships among them less intimidating. Such solidarity between women did not appear to be present or a factor.

Rosenberg (2011) studied inconsistencies in messages, when the two NVC and VC channels employed might send conflicting signals in patient care. McCoombe (2006) and Finnergy and Pope (2004) also examined the effect of inconsistent messages in the demanding work environment of nursing students and mentors. McCoombe (2006) found that poor communication had a negative impact on the student. Perceived communication issues with mentors, lead to avoidance of encounters and feelings of resentment. For instance, students believed they could be an asset to an overworked team but felt uncomfortable asking for help. The negative perceptions of the mentor were resolved by students directly approaching the mentor and explaining their concern. Mentors' work imbalance had also caused them to make inaccurate judgements about

student nurses, perceiving them as reticent and uninterested in their student role. Once both parties recognised this communication gap, students progressed and took greater responsibility for their own learning, including building better communication channels with mentors (McCoombe 2006).

A qualitative study of mentor practice and competences by Finnergy and Pope (2004) that employed focus groups of mentors found that they had a number of concerns about communication. The goals of the study were to gather information that would be helpful in a best practice manual for mentors and to develop a standardised approach that would improve communication with the stakeholders concerned and increase consistency for students. The underdeveloped communication skills of some student nurses, which were attributed to youth, fear of patients and lack of experience, were highlighted by Finnergy and Pope (2004), along with mentors' difficulty in improve these skills because of their own workload. These studies by McCoombe (2006) and Finnergy and Pope (2004) reinforce Rosenberg's (2011) finding that the factors of heavy workload and exhaustion in the nursing context mean that communication techniques need to help the mentor and mentee conserve their physical and psychological health.

The incorrect interpretation of intended communication reported by McCoombe (2006) and Finnergy and Pope (2004) is also likely to occur because of a lack of cross-cultural understanding (Argyle and Hinde, 1972). In this case, negative causes attributed to both sides are a lack of awareness of the barrier itself and a lack of training in how to adapt practice to embrace differences and support the other party, such as a mentee, or an unwillingness to do so (Feghali, 1997). A study by Masango (2011) emphasised the need for the mentor to understand cultural diversity in order to maintain good communication focused on nurturing the mentee, while acknowledging that the more

experienced person acting as a mentor might be balancing many responsibilities that allow little time for reflection on such matters.

Finnergy and Pope's (2004) findings also demonstrated that mentors experienced difficulties accurately assessing students, as this required effective communication with the mentor's peers in the hospital or university, who were also likely to have observed the student in the clinical placement. In addition, the student might be assigned one mentor during the transition from the classroom to clinical practice but then work with other mentors. Finnergy and Pope (2004) concluded that communication strategies were required for this type of structural approach to be effective, which, in this case, employed a model of three- and six-way meetings. Only nine mentors participated in this study, so the generalisability of the findings is limited.

Conclusions from the these studies on communication techniques relevant to the student nurse and mentorship situations reinforced that VC and NVC techniques are crucial to building effective, positive relationships among mentors, mentees and patients, all of whom were a part of the mentorship process. However, the need for specific communication modes for conserving physical and mental health was identified as an additional consideration, requiring further research to develop.

4.5   Summary and conclusions

The majority of studies reviewed (Lis et al., 2009; Bradbury-Jones, Sambrook and Irvine, 2007; Beecroft et al., 2006; Ronsten, Andersson and Gustafsson, 2005; Papp, Markkanen and Bonsdorff, 2003; Gray and Smith, 2000) focused on mentorship experiences from the point of view of mentees. Studies concluded that the mentorship process could be modified to improve students' experiences. Although limiting analysis to students' perspectives risks failing to consider the practical barriers that mentors

might face, some studies (Lofmark et al., 2009; Shannon et al., 2006) focusing on mentors' viewpoint examined the experiences of mentors in guiding and supporting students, what mentors perceive as the most important factors in ensuring success and the various barriers that may inhibit successful mentorship. In addition, studies (Myall, Levett-Jones and Lathlean, 2008; Jones, Walters and Akehurst, 2001; Kaviani and Stillwell 2000) that examined the mentorship process from the perspective of both students and mentors asked both groups to keep activity diaries of their involvement in mentorship. A review of these studies revealed methodological limitations. For instance, Myall, Levett-Jones and Lathlean (2008) relied on a one-week diary to analyse student nurses' experiences in the mentoring process. As discussed, a one-week diary cannot holistically capture the mentorship process experienced by the student nurse.

The literature review suggests that little is known about mentorship in nursing outside a western context. Mentoring in nursing in Saudi Arabia has received little attention in the literature. The researcher realised that an exploration of the positive experiences of mentorship in Saudi Arabia is needed to develop mentoring among nurses in Saudi Arabia

This section summarises the findings of the literature review, focusing on answering the literature review questions outlined at the beginning of the literature review (section 4.2). Methodological and research issues which might affect the validity of the findings of the studies consulted are mentioned. This section also identifies any gaps in the literature that make it difficult to answer the research questions, presents recommendations for how further research might fill these gaps and explains how the main study of this thesis specifically aims to address these issues.

4.5.1 Research question one: What is the existing knowledge about mentors' and mentees' understanding and interpretations of the concept of mentorship?

The findings of the literature review suggest that students and mentors lack a clear understanding of what mentorship should entail. Gray and Smith (2000) concluded that there frequently was a mismatch between students' expectations and the reality of the mentorship. In particular, students typically had unrealistic expectations about the level of support and time they would spend with their mentors and were frequently disillusioned with their experiences by the end of their mentorship. This view was confirmed by Nahas (2000), who found that Jordanian students expected a high level of support and care from their mentors but became disillusioned as their mentorship progressed due to the limited availability of their mentors. These findings suggest a lack of certainty about what constitutes a mentorship relationship, at least among students. Additionally, Beecroft et al. (2006) suggested that the majority of nurses enrolled in a mentorship programme were unsure about what to expect and had only vague expectations of receiving support from their mentors.

The studies that focused on the experiences of mentorship from the mentors' viewpoint suggest that they typically perceive their role as providing a valuable link between the university and the practical field (Lofmark et al., 2009). Findings of Lofmark et al.'s (2009) study suggested that mentors typically have a more realistic expectations than mentees. However, Lofmark et al. (2009) found that mentors were sometimes frustrated by the disparity between their own and students' expectations as they sometimes expected students' level of knowledge to be higher than it was in reality.

Myall, Levett-Jones and Lathlean (2008) posit that a lack of knowledge and understanding of what to expect from mentorship can have significant detrimental effects on the quality of the mentorship experience for students. Myall, Levett-Jones and

Lathlean (2008) identified various communication problems in the relationships between new nurses and their mentors, which resulted from a lack of training and insufficient clarity about both parties' expectations for the mentorship. This finding was corroborated by Jones, Walters and Akehurst (2001), who noted a significant disparity between the rhetoric and practice of mentorship. Jones, Walters and Akehurst (2001) pointed out that in reality, most mentorship is characterised by low levels of interaction between students and their mentors due to time constraints restricting the availability of mentors. This situation impairs students' experiences of mentorship. The lack of clarity about mentors' role identified in this literature review contrasts with the clear definitions of mentorship and the roles of mentors as supervisors and assessors described in the wider literature on education, training and nursing. This disparity suggests that there remains a significant gap between the rhetoric of mentorship in the nursing literature and the reality of mentorship experiences.

4.5.2 Research question two: What factors have an impact on the effectiveness of the mentorship process in nursing?

Many of the studies analysed involved interviews with students and mentors seeking their opinions about the key factors needed to ensure the success of mentorship. Bradbury-Jones, Sambrook and Irvine (2007) concluded that an empowering mentorship depends on encouraging students to learn and giving them sufficient scope to use their own initiative. According to Bradbury-Jones, Sambrook and Irvine (2007), instances of disempowering incidents arose when mentors failed to demonstrate sufficient understanding, hindered students' acquisition of certain skills or limited their responsibility.

Papp, Markkanen and Bonsdorff (2003) built on the factors identified by Bradbury-Jones, Sambrook and Irvine (2007) and concluded that the successful mentorship is

characterised by appreciation, support, quality and self-direction. In short, students must feel appreciated during their mentorship in order to maintain their motivation and self-esteem. According to Papp, Markkanen and Bonsdorff's (2003) study, students must also be supported by their mentor who acts as a professional role model. The clinical practice in which their mentorship takes place must be of high quality, and they must be given sufficient scope to approach situations and make decisions independently.

Elcigil and Sari (2008) identified similar success factors in their study of Turkish nursing students. Elcigil and Sari (2008) suggest that successful mentorship requires the establishment of a strong interpersonal relationship between mentors and mentees. Mentors must possess a high level of teaching, nursing competence and communication skills; a range of personal characteristics, including strong communication skills, consideration, patience and empathy; and the ability to provide useful, constructive criticism. The similarity of these success factors with those identified in the other studies suggest that these factors override cultural differences and are necessary for the success of mentorship in any environment. However, it is worth noting that all of these studies focused on the qualities that the mentor must have to ensure a positive mentoring relationship without exploring the responsibilities and qualities that the learner must possess.

The most important success factor for mentorship identified in the literature review was continuity. Repeated moves to new placements and continuous absences of mentors resulted in feelings of disempowerment among students. This pattern was quantitatively demonstrated by Beecroft et al. (2006), who concluded that the perceived effectiveness of mentorship had a significant correlated with the number of occasions on which a mentee and mentor worked together, suggesting that the effectiveness of mentorship

depends on the level of guidance and support provided by mentors. In addition, Jones, Walters and Akehurst (2001) found that students whose mentors were frequently absent spent less time working with another qualified member of staff during their mentorship, implying that the absence of mentors has negative consequences for students' mentorship experiences.

Finally, Lofmark et al. (2009) focused on mentors' perceptions of the factors necessary to ensure effective mentorship. Their findings indicate that most problems that arise during mentorship are due to insufficient contact between mentors and the rest of the academic institution. Lofmark et al. (2009) suggest that collaboration between mentors and other academics contributes to the effectiveness of mentorship.

4.5.3   Research question three: Do barriers exist that hinder the effectiveness of the mentorship process in nursing?

The research reviewed presents a consensus that the principal barrier hindering the effectiveness of mentorship is a lack of time. According to Beecroft et al. (2006), the most significant obstacle to regular meetings and interaction between mentors and mentees is mentors' lack of time and commitment. Jones, Walters and Akehurst (2001) add that recent staffing cuts in many hospitals and clinical practices have not been reflected by equal decreases in student numbers, so mentors have a larger workload and more students. Considering that a lack of continuity and the continued absence of mentors have been reported to have detrimental effects on the mentorship experiences of most students, it is clear that a lack of time and commitment can pose a significant barrier to the effectiveness of nursing mentorships. Shannon et al. (2006) corroborated the findings of Beecroft et al. (2006). Shannon et al.'s (2006) study revealed that mentors often face significant time pressure due to the increased workload of mentoring students while also carrying out their clinical practice.

Other barriers to effective mentorship reported in the research include the unrealistic expectations of students and mentors. In some cases, students' expectations of mentorship were unrealistic, while in other cases, mentors' expectations of students' level of knowledge were too high. This disparity between expectations and reality seemed to be a significant obstacle to a successful mentorship experience (Shannon et al., 2006). In addition, Shannon et al. (2006) found that poor administration, specifically poor communication between the mentor and academic instructor, can affect the success of mentorship. Myall, Levett-Jones and Lathlean (2008) suggest that many of these issues could be rectified by the introduction of national standards clarifying the role of the mentorship and the responsibilities of each of the parties involved. This solution is supported by findings in the wider literature which indicate the need for an environment conducive to learning that provides students with opportunities to learn new skills for effective mentorship (Kinnell and Hughes, 2010).

4.5.4 Research question four: Are there gaps in the literature about the process of mentorship in nursing? What further research could be conducted to rectify this?

The review of existing studies exploring the process of mentorship in nursing has yielded some interesting insights, but clearly, there are a number of gaps in the literature. One of the most glaring gaps in the literature is that the vast majority of studies explore the mentorship process only from the viewpoint of mentees. Fewer studies examine the process from the perspective of mentors. Consequently, almost all the identified barriers to effective mentorships are related to mentors (e.g. limited availability of time etc.). No studies have considered that students might be responsible for actions that reduce the likelihood of effective mentorship. Mentorship is fundamentally a two-way process, and it is clear that its success is dependent on the cooperation of both parties. Therefore, the dearth of studies examining the mentorship

process from mentors' perspective suggests that the mentors' views of what is required for effective mentorship and issues which could prevent it have been neglected.

Secondly, the majority of studies have been conducted in developed western countries and regions (UK, USA, Europe and Australia). Very little research has been conducted on the mentorship experiences of nursing students outside western countries. Research conducted in developing countries to address this gap could yield interesting insights as the expectations that nursing students in other countries might differ due to cultural differences. In addition, the lack of adequately trained staff and hospital resources in non-developed countries might mean that the factors deemed necessary for effective mentorship might be more related to the availability of finance and resources than acknowledged in existing research, which has focused mostly on mentors' personal characteristics. There are also significant differences in how healthcare systems in different countries support and train mentors and mentees.

Conducting the literature review was highly useful and providing significant information to contextualise the study findings of this study. This information helped the researcher to suggest recommendations for policy, practice and future research in Saudi Arabia to improve mentorship experiences for mentors and mentees.

5 Main study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry

5.1 Introduction

Mentoring as a pedagogic form of support has found great support in the literature, with many researchers proclaiming that mentees have a professional advantage over the non-mentored (Chao, 2009). However, it can be argued that mentoring is a western concept, primarily practised and reported in western nursing and professional literature. In contrast, many non-western nations do not practise mentoring in nursing in a similar manner. While the mentoring literature highlights the positive aspects of mentoring in the western context, it is important for the researcher studying this concept in a non-western context to understand what is already happening and working in that context. Is any of it similar to mentorship in western contexts? Does anything different work well?

The findings of the case study completed early in this doctorate (section 3.3) to investigate and explore the current practice of mentorship in nursing in a clinical setting in Jeddah found that neither mentors nor mentees were satisfied with the current arrangement. The mentees believed that mentorship did not benefit them, and mentors resented the mandate to devote time to students. All parties were inclined to blame the other for their difficulties.

The case study findings (section 3.3.8) indicated that, although the present mentorship processes were widely viewed as unsatisfactory, it might be possible to improve and restructure mentorship to provide the maximum benefit for mentees and to make it easier, even worthwhile and fulfilling for mentors. The main finding of the case study was the need to realise that a lack of strong organisation and sound structure in

mentorship not only negates most of the benefits of the clinical placement but also creates mutual resentment between mentor and mentee, mentor and hospital management, and even mentee and university management. The findings suggest that, in the worst-case scenario, mentees are disheartened and dispirited by disappointing experiences, and mentors resent the extra work of mentoring responsibilities and even mentees, with whom they need a strong, caring relationship to positively influence their early careers.

5.1.1 Aim and research questions

The aim of the main study emerged from the best evidence literature review on mentorship (Chapter 4) and from the findings of the case study (section 3.3). Firstly, the literature review suggested that little is known about mentorship in nursing outside the western context. Secondly, it was noted that mentoring in nursing in Saudi Arabia has received little attention in the literature. Thirdly, the findings of the case study (section 3.3) indicated the need for changes to mentorship in Jeddah, Saudi Arabia. The researcher realised that the exploration of positive experiences of mentorship in Saudi Arabia could help to develop this mentoring system, as a positive way to create organisational change is by appreciating what the organisation does best (Cooperrider, Whitney and Stavros, 2008). This study seeks to address the research gaps by exploring positive experiences of mentors (RNs) and mentees (student nurses) in Jeddah, Saudi Arabia, using an AI approach (for more details on the AI approach see section 5.2.2.1).

Thus, the aim of this main study was to investigate the factors contributing to positive mentorship experiences in nursing in Jeddah, Saudi Arabia by exploring the mentors' (registered nurses) and mentees' (student nurses) positive experiences in relation to mentorship.

The following research questions were designed to map how mentorship was perceived and practised, under what circumstances it worked best, and how it influenced those involved. Framing the research questions appreciatively was intended to generate data on what was perceived as working well and could be used as a foundation for subsequent development. A short paragraph explaining each research question is provided.

1.   What are mentors' and mentees' understandings of mentorship in nursing in Jeddah, Saudi Arabia?

An understanding of the concept of mentorship forms the basis for developing the mentoring process in any organisation. People can have different understandings of that concept. Therefore, it is essential and worthwhile to discover how mentors and mentees perceive this concept before encouraging them to talk about their positive stories and to describe their best experiences related to the concept.

2.   What are mentors' and mentees' positive experiences of mentorship in nursing in Jeddah, Saudi Arabia?

An understanding of the ways in which mentors and mentees positively experience mentoring is also needed in order to deepen knowledge of how mentoring works best.

3.   What factors contribute to mentors' and mentees' positive mentorship experiences in nursing in Jeddah, Saudi Arabia?

Finally, it is important to identify and explore the factors that influence the parties involved to experience mentorship positively.

Overall, the researcher aimed to explore how positive mentorship in nursing was experienced and perceived in Jeddah, Saudi Arabia, and to investigate the factors that contributed to these experiences, contributing to knowledge and adding a new perspective to the academic discussion of nursing mentorship in non-western contexts.

5.2   Methodology

This section first describes the conceptual framework, methodological approach, research setting, recruitment process and research methods, including using the AI approach. The section concludes with a discussion of the ethical considerations, including the procedures used to obtain access to participants; data analysis; use of reflexivity; and, finally, the quality of the study.

5.2.1   Conceptual framework: Social constructionism

The research framework was based on a social constructionist epistemology consistent with the researcher's beliefs, values, experiences, epistemology and theoretical perspectives. The researcher's experiences as an educator and a student informed the research design. The social constructionist epistemology reflects her belief about how she constructs an understanding of the world through experiential dialogue and interaction. Social constructionism was discussed earlier in this thesis in more details in section 1.6.

5.2.2   Methodological approach

The study method is qualitative, with an AI theoretical perspective. According to Denscombe (2007), qualitative methods entail exploring perceptions and/or attitudes and delivering abundant and comprehensive information in order to make meaningful judgements (see section 3.2.2 for more justification of qualitative methods). Among qualitative research methods, an AI approach was selected for the main study to explore

positive mentorship experiences in nursing and to identify factors contributing to these experiences among a diverse team of RNs and student nurses in different clinical settings in Jeddah, Saudi Arabia. These disparate views complemented each other by considering the experiences of both those who learn and those who educate. An AI approach framed the research questions, data collection and data analysis for this study.

5.2.2.1 *Appreciative inquiry*

David Cooperrider and Suresh Srivastva developed the AI theoretical perspective during the 1980s while at the School of Management at Case Western Reserve University (Cooperrider, Whitney and Stavros, 2008). This approach to organisational development is based on the belief that valuable work happens in all organisations and that all organisations have something that works well. AI is a positive way to initiate organisational change by appreciating what the organisation does best (Cooperrider, Whitney and Stavros, 2008). In AI, the focus is on what works well and what is right, rather than on what is lacking (Bushe, 2000). AI assumes that what you need more of and what works well exists in all organisations, in contrast to traditional problem-solving methods that focus on problems that need to be solved. AI concentrates on positives and strengths that give life to the system, a perspective advocates assert is more useful than a focus on solving problems. According to Cooperrider and Whitney (2005), AI involves the discovery of the life and energy-giving components of a system when it is most powerful and effective by asking questions that encourage the participants to explore and discover positive potential.

AI has been described in different ways by various authors.

- A way of observing, thinking and seeking powerful, effective change in organisations (Hall and Hammond, 1998)

- A method for understanding a particular situation or event where change needs to be made (Cooperrider and Whitney, 2005)

- An approach that takes the principle of social constructionism of the world (see section 1.6) to its extreme positive domain, with high potential to generate theories (Gergen, 1990)

Gergen defines generativity as the:

> capacity to challenge the guiding assumptions of the culture, to raise fundamental questions regarding contemporary social life, to foster reconsideration of that which is 'taken for granted' and thereby furnish new alternatives for social actions. (Gergen, 1978, p. 1346)

AI encourages the creation and development of novel thoughts and theories that are able to result in social advancements (Cooperrider and Srivastva, 1987).

In contrast to AI, the traditional problem-solving approach assumes that organisational systems have deficits, obstacles and problems that need to be fixed and that organisational improvement requires identifying these problems, discovering their causes and finding solutions for them. In contrast, the AI approach assumes that all organisations have something that works well (Cooperrider, Whitney and Stavros, 2008) and do not treat the organisation as a problem to be solved. This principle is applied through systematic inquiry, using a set of positive questions to value the best of what is, to discuss the future of what might be and to construct what will be. AI encourages looking at possibilities and strengths, building on the hopes of individual, and shifting from deficit thinking to affirmation thinking. Deficit thinkers' could be inhibited from seeing the whole of reality. Using AI could assist in recognising the larger picture of reality.

5.2.2.1.1 Use of AI for research, instead of organisational development

The AI approach facilitates the development of new theory, as well as new change strategies and theory. Cooperrider, Whitney and Stavros (2008) argued that action research focuses primarily on solving organisational problems and, consequently, reduces the chances of developing new theory and understanding social reality. The basic AI process consist of 4 phases (the 4D cycle): discovery (What gives life?), dream (What might be?), design (How can it be?) and delivery or destiny (What will be?) (Cooperrider, Whitney and Stavros, 2008). Figure 1 presents the 4D cycle.

Figure 1: 4D cycle of appreciative inquiry, adapted from Cooperrider, Whitney and Stavros (2008, p. 5)
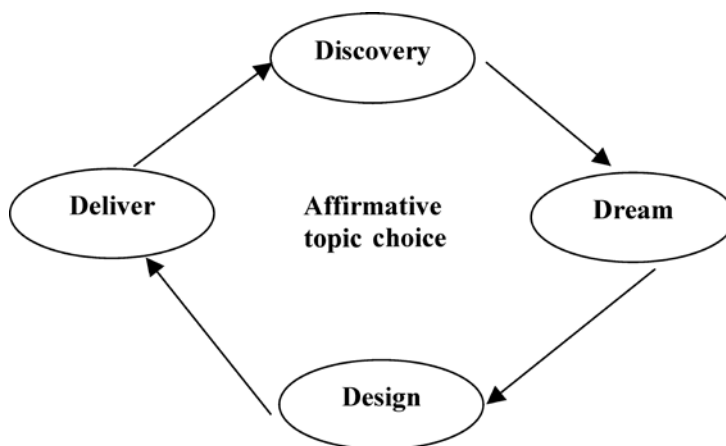
5.2.2.1.2 Studies using appreciative inquiry

The AI approach has been used as a social research method and in some studies as an organisational development intervention. Many studies have employed this approach across a wide range of fields, such as business, nursing, education, psychology and healthcare. For example, Meyer (2007) used AI to explore stakeholders' perceptions and experiences of the effectiveness of the Mental Health Community Psychology programme in Zululand, South Africa in order to identify challenges and opportunities for improvement. By engaging stakeholders and exploring their positive experiences of

the programme, Meyer (2007) discovered potential positive changes, effective strengths of the programme and opportunities for improvement. Meyer (2007) focused on positives and asked affirmative, appreciate questions to encourage participants to express their opinions and describe positive experiences.

However, Meyer (2007) stated that participants were selected because they: 1) were representative; 2) had extensive knowledge and experience of the project; 3) were prepared to talk about their understanding with the researcher and create a connection with him/her; 4) were amenable to experience. The researcher's ability to evaluate these factors is questionable as some of these criteria are purely subjective, such as openness to experiences and eagerness to talk about information and understanding Although participants had positive experiences of the programme and appreciated the internships, research and facilities it gave to the community, it became obvious that further finances were needed to obtain the necessary resources (Meyer, 2007).

In addition, the AI method has been used in educational research, as in Hummel's (2007) study exploring the peak experiences of teachers. A peak experience, as described by Maslow (1998), is the state when an individual feels more powerful or that something extremely valuable had happened. In Hummel's (2007) study, data were collected through semi-structured interviews, paired interviews, focus group discussions and documents created by participants. AI was found to allow participants to recall and share their positive stories. Thus, they could identify peak experiences and discover their strengths, as well as appreciate and validate themselves and others as worthwhile people. AI also helps Hummel (2007) discover the situations in which peak experiences happened. Finding of Hummel's (2007) study showed that AI could contribute to organisational development and effective teaching, and that it could be a useful method

in teaching and learning contexts, gathering information and exploring teachers' view of peak experiences in teaching and learning.

Hummel (2007) noted that the study was limited by the perceptions of the participants' peak experiences. However, this condition need not be considered to be a limitation as exploring participants' perceptions of peak experiences was the most appropriate way to answer the research questions and to seek useful, interesting findings. In addition, focusing on peak and positive experiences allowed the researcher to explore and identify the conditions in which these can happen, fulfilling the study aim.

In another study, Nemiro et al. (2009) used AI as a tool to investigate transformational change in recruiting and developing women teachers in science, technology, engineering and mathematics (STEM) disciplines. Participants were involved in all four stages of AI: discovery, dream, design and deliver. AI focus groups were conducted to initiate organisational transformation by discovering the current strengths of recruitment and career development. In Nemiro et al.'s (2009) study, AI enabled participants to design an action plan to improve the recruitment and career development of women in teaching STEM disciplines. Using AI in this study was beneficial as the main research goal was to build recruiting and career development efforts around what already worked well, instead of trying to fix what did not work well.

AI was also used as a transformational method by Miller (2007) in research to identify individual strengths and common values of caring relationships in a multicultural nursing unit. Ai helped to describe key characteristics of establishing caring relationships. It also aided nurses in discovering key themes and characteristics of developing positive relationships with colleagues and patients through the exploration of their powerful experiences and stories.

Yoder (2005) employed AI to explore the relationship between organisational climate and emotional intelligence. Leaders of a large, urban community college were invited to take part in AI sessions, including the four stages of the AI process. In Yoder's (2005) study, leaders were encouraged to share their positive experiences in interviews, involving questions focusing on affirmation and appreciation to explore the effect of emotionally intelligent leadership on organisational climate. Through the discovery of what provides a system with life when this system is at its best, the leaders identified key characteristics of emotional intelligence and their effect on the organisational environment.

AI has been widely used in public service organisations in education and healthcare (Cooperrider and Whitney, 2005). AI was used to enhance communication, increase nurses' involvement in decision making and raise cultural awareness and sensitivity in a study that looked at improving nursing practice and patient care (Havens, Wood and Leeman 2006). According to Havens, Wood and Leeman (2006), AI could change the organisational cultural and improved employee–manager relationships through the appreciation and engagement of the organisational employee in a positive dialogue. Thus, organisational change could be promoted, and the quality of care delivered to the patients increased. Studies discussed here showed that the AI method of engaging participants in activities and discussions which allow them to share stories and powerful experiences helps value themselves, others and their organisation, as well as recognise and building on strengths.

In the present main study, an AI approach was used to explore positive mentorship experiences in nursing at different clinical settings in Jeddah, Saudi Arabia.

5.2.3 Setting

Potential participants from three different settings in Jeddah where mentoring is practised, were invited to join in this study. Participants came from different cultures, backgrounds, genders and ages.

Various government and private clinical settings in Jeddah collaborate with government and private colleges with BSc nursing programmes and have nursing students practising in their clinical placements. Therefore, the researcher decided to study one government hospital, its collaborative government college, one private hospital and its collaborative private college in Jeddah. However, the researcher managed to undertake the study in only three settings, as the private hospital refused to give ethical approval to conduct the study. The three organisations involved in this study provided sufficient data to holistically understand the mentor–mentee relationship in the field of nursing in Jeddah.

Two study sites are administered by the government of Jeddah, Saudi Arabia: the hospital where the nursing students and interns of the nursing college undertake their clinical placements and its collaborative nursing college. The third site is a private setting, which is a nursing college. Both nursing colleges offer a BSc nursing degree, which includes 4 years of classroom instruction and a 12-month internship.

The settings involved in this study were selected because of the collaborative partnership for mentoring they had implemented. The partnership involves nursing students performing clinical practice under the guidance of a practising nurse from the hospital and an instructor from the nursing college. These settings have collaborated with each other since the nursing college was established and are appropriate for the nature of the research. Contextual information about the research settings is not provided in this thesis in order to preserve their anonymity and confidentiality.

5.2.4 Ethical considerations

The study was granted ethical approval in both the UK and the KSA. The study was approved by City University's research ethics committee in the UK (see Appendix 1, p. 391). Data collection was undertaken in Jeddah, so ethical approval to conduct the study was also required from the research ethics committees of the hospital (Appendix 16, p. 475) and the two nursing colleges (Appendix 17, p. 479 and Appendix 18, p. 483).

Ethical considerations were similar to those in the case study, as discussed in detail in sections 3.2.4.

5.2.5 Research sample

Purposive and convenience sampling techniques were used in the main study (Ritchie and Lewis, 2003; Mason, 2002; Patton, 2002b; Sandelowski, 2000; Marshall, 1996), see section 3.2.5 for a discussion of purposive and convenience sampling. A group of mentees (nursing students) from the two nursing colleges and mentors (RNs and teaching assistants) from the government hospital were invited to participate in this study.

Convenience sampling was also used to select individuals based on their availability and willingness to participate (Gravetter and Forzano, 2011; Burns and Grove, 2007; Marshall, 1996). Although this sampling method is considered a relatively weak approach that can affect the quality of data (Marshall, 1996), it is often used because it takes less time than alternative approaches and targets participants who can be accessed easily (Burns and Grove, 2003). In this main study, convenience sampling was inevitable because participants had to be readily available during the fieldwork period and willing to participate in the study (Burns and Grove, 2007). For example, the participation of mentors (RN) was limited to those who were in the hospital on the day

of the focus group who had permission to leave their clinical areas and who were willing to participate in the study.

5.2.5.1 *Inclusion Criteria for selecting the study participants*

The diversity of participants' background was considered in recruitment to ensure the representation of different perspectives from the diverse population of the study sites. Consequently, RNs and teaching assistants who were mentors and student nurses who were mentees from different age groups, gender, and ethnicities were represented. Table 5 shows the inclusion criteria for participants in this study.

RNs, teaching assistants and student nurses were invited to participate as this study explored positive experiences in mentorship. This target group could describe positive experiences from their involvement in mentorship.

Table 5: Inclusion criteria for registered nurses, teaching assistants, student nurses and nursing interns

Inclusion Criteria
Experiencing or having experienced nursing mentorship in a clinical setting
All ethnicities, and both Saudis and non-Saudis (all nationalities)
Both genders
All age groups

5.2.5.2 *Exclusion Criteria for selecting the study participants*

Anyone who had not experienced nursing mentorship in a clinical setting was excluded.

5.2.5.3 *Characteristics of the sample*

The following table provides details of the composition of participants in the six focus

groups conducted for this main study (Table 6).

Table 6: Characteristics of the six focus group samples in the main study

Participants' profession	Number of focus groups	Number of participants invited for each group	Number of participants in each group	Language used in the focus group
3rd and 4th year BSc Nursing students at the private college (A)	1	12	10	A mix of Arabic and English
Intern students in the BSc nursing programme at the private college (A)	1	12	5	A mix of Arabic and English
3rd and 4th year BSc nursing students at government college (A)	1	12	5	A mix of Arabic and English
Staff nurses from the government hospital (B)	2	12 (Group 1) 12 (Group 2)	7 6	English
Teaching assistants from the government college (B)	1	12	7	English
Total	6	72	40	

A: mentees; B: mentors

As illustrated in Table 6, all mentors who participated were Filipino and Indian, and all

mentees were Saudi. English was used in focus group discussions with mentors as they

all came from different nationalities. English was their shared language and the

language of the workplace, which participants used to communicate with colleagues and co-workers. All participants effectively communicated their responses to the researcher.

Nursing students, who were all Saudi nationals, were asked to speak the language with which they are the most comfortable. They used a mixture of English and Arabic in focus group discussions. For more details on the language used in each focus group, see Table 6.

Six focus groups were conducted. From the invited sample of 72, 40 took part in the focus groups. RNs who participated in this study came from a range of different units in the hospital: medical, surgical, paediatric, out-patient, oncology and intensive care units. For more details on the sample of the six focus groups for the main study, see Table 6.

Participants at similar professional levels were assigned to one group to elicit understandings of the phenomenon from those with similar professional backgrounds. Participants of different professional backgrounds were not mixed together to prevent discomfort and help participants freely express and discuss their thoughts and opinions. According to Brannen and Nilsen (2002), focus group participants are selected because they have similar educational backgrounds, professions and social status. Therefore, mentors and mentees were interviewed in separate groups.

5.2.5.4 *Access to sample*

Mentors (RNs and teaching assistants) and mentees (nursing students) were recruited through invitations (Appendix 13, p. 461) sent by department heads, along with an explanatory statement (Appendix 14, p. 465). Participants were asked to sign a consent form and return it to the researcher before the focus groups and interviews (Appendix 15, p. 471). The process of recruiting mentors (RN) and mentees (nursing students) was similar to the case study, as discussed in detail in section 3.2.5.4.

5.2.6 Data collection tools and process

5.2.6.1 Focus group interviews

5.2.6.1.1 Pilot focus group

A pilot focus group was conducted with third- and fourth-year nursing students, who were the first group to be interviewed in this study (see section 3.2.6.3.1 for definitions of focus group and pilot focus group). The pilot focus group was intended to assess the effectiveness of the focus group guide and whether responses to the focus group questions and activities would generate data answering the research questions (Santucci, Menu and Valot, 1982). Based on the responses obtained, no changes to the topic guide were needed, so data obtained from the pilot focus group were included in the study.

5.2.6.1.2 Focus group interview process

Data were collected through focus group interviews intended to discover, explore and identify insights into positive mentorship experiences in nursing in Jeddah. The focus group method involves a small group of people gathering to discuss a previously defined topic in depth in an interview session of 1.5 to 2 hours (Patton, 2002a). During the focus group, information and perceptions are generated from the interactions between group members (Ritchie and Lewis, 2003; Morgan, 1997). The collection of qualitative data from focus groups presents many advantages. For example, group participation is among the best strategies to elicit the expression of views as one or two participants can either support or contrast the experience of the other participants (Craig and Douglas, 2005). A focus group usually consists of a small number of participants (8–12), who provide information during an interactive group discussion (Popham, 1992). Twelve participants were invited to each group in this study. The size of the focus group determines the variety of viewpoints and level of participation (Stewart and

Shamdasani, 1990). However, Bell (2005) posited that the main purpose of focus group interviews is to focus the discussion on a particular issue and find out what participants think about it.

The focus group interviews were semi-structured, which permitted flexibility and encouraged participants to give their broad and deep perceptions of reality (Dunn, 2005). According to Watson et al. (2008), semi-structured interviews are highly useful in conducting exploratory research and effectively clarify concepts and problems. Their semi-structured nature eliminates superfluous questions but also possess sufficient flexibility to follow up on new aspects of the research issue and explore in detail the explanations supplied by participants (Dunn, 2005).

All the focus group discussions lasted for approximately 80 to 90 minutes as it was difficult for staff nurses and head nurses to leave their wards for more than this length of time. This duration is considered adequate to obtain a satisfactory amount of qualitative information from a group of respondents (Yin, 2009), especially if participants of a similar professional level and background are gathered in one group. According to Segal and Hersen (2009), respondent groups with common education levels, backgrounds and experiences quickly appreciate the issues at hand. However, the researcher took notes and used digital recorders during the focus group to allow the researcher to facilitate the discussion and code responses (Kidd and Parshall, 2000).

5.2.6.2 *Application of AI to data collection*

AI is a useful approach to identify the strengths of mentorship in nursing by assisting the mentors (RNs and teaching assistants) and mentees (nursing students) to discover their strengths and point to key characteristics of successful mentorship. In addition, AI gives a voice to mentors' and mentees' desires for their teaching or learning process and

helps them discover their strengths and develop more effective teaching and learning strategies (Cooperrider, Whitney and Stavros, 2008).

Participants were guided through the four stages of AI in semi-structured focus group interviews, with questions, prompts and some activities designed in advance. The topic was introduced to participants, and then all operational terms with which participants might not be familiar were defined (e.g. mentors/preceptors, mentees/preceptees). Questions were developed based on the research questions and literature review. A brief introduction to the AI method was presented to participants before the focus groups (see Appendix 12, p. 457). In this exploratory study, the purpose of the focus groups was to encourage group discussion and interaction in order to explore ideas, express views and concerns and discover not only participants' ideas but also their underlying feelings and opinions (Payne and Payne, 2004). Using AI was a positive way to encourage participants to share their success and enabled the researcher to discover and examine positive dimensions of the mentoring process, looking beyond any problems that need to be fixed.

Focus group interview questions were designed to prompt participants to share stories of their peak experiences in the mentoring process. In sub-groups of four, they carried out activities suggested by AI theorists and then reflected on their group work and shared their thoughts with the researcher and larger group. In studies that have used AI methodology, these activities have been shown to be effective tools to encourage participants to analyse their positive experiences, engage in dialogue and reflect on what circumstances make for the best and ideal positive experiences.

The AI process was started with interviewing and storytelling among all individuals involved. Participants were asked to describe their stories of their best past experiences

and use them to visualise the future. This was done by asking positive questions, which encouraged participants to share their best stories. Hand-outs with a series of questions were given out at the beginning of the focus groups to guide discussion.

The questions asked during the focus groups guided participants through the 4 phases of the AI process and provided some activities (see Appendix 12, p. 457). In the *discovery phase*, participants discussed and described their positive experiences. The questions asked in this phase were designed to determine what aspects of themselves and others (their mentors/mentees) most valued and what they want to carry into the future. Examples of activities carried out during this phase were answering the following questions.

- Would you please select one of the best stories shared by the group members? Then, create a list of the themes highlighted in the story and which you feel are important and contributed best to that story.
- From the list of themes, could you please select three to five themes you feel are important for positive experiences?

In the *dream phase*, the questions were intended to spark participants' imagination and encourage them to think and create great ideas and thoughts for the future. In the *design phase*, an activity helped participants build and construct positive images and possibilities of the future by creating provocative propositions. The activity was as follows.

- Draw a design map. In the middle, draw your dream of an ideal experience in mentorship. … Remember all the themes and core factors, both internal and external, that will influence the achievement of your dream.

In the *delivery phase*, participants developed strategies and action plans to achieve their dreams.

During the 90-minute AI dialogue, individuals spent 50 minutes describing their stories and experiences of the best of what is (*discovery phase*). In 15 minutes, they discussed the positive future they desire (*dream phase*). In another 15 minutes, they provided a set of provocative propositions (*design phase*). Finally, in 10 minutes, they designed an action plan (*delivery phase*).

Participants performed each activity in sub-groups, reflected on their group work and then shared with the researcher and larger group. In approximately one-and-a-half hours, the researcher could guide participants through all the steps in one session. At the end of the focus groups, hand-outs with participants' written notes from the group activities were collected and analysed.

5.2.7   Data analysis

The process of data analysis was similar to that for the case study (see section 3.2.7). However, the data in the main study were different as the focus group discussions involved storytelling by all the individuals involved, and participants described their best past experiences and carried out identified activities.

In addition, in the case study, the researcher did not use any data management systems as she thought it would be more convenient to analyse data manually. The researcher had not had any training using data analysis software and doing it manually would not require additional training, thereby saving time and enabling her to focus on depth and meaning. However, after the experience of analysing the case study data manually, the researcher decided to use data analysis software in the main study, for its convenience and to simplify data management.

In the light of the extensive and rich data collected during the individual and focus group interviews, consideration had to be given to how to best manage the data and avoid any loss of integrity or detail. In the main study, ATLAS.ti was employed to construct a comprehensive database in which to keep a record of all interview data and to support the data analysis (Peters and Wester, 2007). However, although applications such as ATLAS.ti are helpful in terms of supporting the storage, organisation and reorganisation of data, it has no analytical capability and is not capable of recognizing a relationship between theory and data, or deciding a suitable structure for the data analysis (Pope, Ziebland and Mays, 2000; Coffey and Atkinson, 1996). Hence, the researcher had to examine the data gathered in order to identify the emergence of patterns (Konopásek, 2008). However, ATLAS.ti facilitated the application of thematic data analysis and assisted the analytical process through memoing, coding, linking, and the use of network view functions (Rambaree, 2013). Memoing was useful for reflecting on the views and ideas of the researcher (Rambaree, 2013). As a tool this software enhanced the researcher's ability to carry out effective, systematic, well-organized and efficient data analysis (Rambaree and Faxelid, 2013; Konopásek, 2008; Lewis, 2004).

ATLAS.ti allowed basic coding, retrieval and complex organisation of data, as well as more advanced analysis, including the creation and combination of codes and using algorithms to recognize co-occurring codes in overlapping or nesting formations (Pope, Ziebland and Mays, 2000). Annotation of text was also provided if required (Pope, Ziebland and Mays, 2000). It also assisted the researcher to make links and connections between the codes and to develop higher-order categories (Weitzman and Miles, 1995)

Another feature of ATLAS.ti is the use of code families to filter the codes. Its query tool is constructed to permit a group of codes, called a code family, to be selected simultaneously, rather than dealing with each code individually. It also enables a supercode to be utilized to manage the code family, this recognizes and reflects any changes in the code family or if new codes are added (Woolf, 2012). The researcher was able to use its search and investigative functions to call up key words, phrases and similar coded data in display form for analysis (Saldana, 2009). The codes themselves can be searched for and found in the coded passages to highlight particular features, such as co-occurrence, overlapping, sequential patterns or proximity. These search tools and functions are able to electronically filter, retrieve, group, compare and link, assisting the researcher to use her own intellectual abilities to make deductions and connections, identify patterns and associations, interpret and extrapolate theory from the data (Lewins and Silver, 2007). Whilst undertaking the tasks of coding, exploring patterns in progress, and analytical memo writing, ATLAS.ti enabled the researcher to shift between these multiple analytical tasks. A few mouse clicks and key strokes could accomplish these and other classical and valuable research functions, including recoding and un-coding, renaming and deletion; merging and moving; grouping and the assignment of different codes to different lengths of passages of text (Saldana, 2009). See Appendix 21 (p.495) for an analysis of a coded transcript from a sample focus group using ATLAS.ti.

5.2.8 Reflexivity

In research, reflexivity can be defined as awareness of personal biases that might affect the analysis of the data. These biases can come from the social background, assumptions, prejudices and behaviours inherent in the interpretivist approach to research (Finlay and Gough, 2003). According to Hardy et al. (2009), reflexivity ensures that researchers acknowledge their assumptions and position the research in a framework of critical creativity, not personal biases. Reflexivity challenges the researcher's plan and methods, which could improve future research that is undertaken. Section 3.2.8 discusses how the researcher maintained reflexivity and shows how the researcher took her background into consideration in reflections on the studies and attempted to maintain the integrity of the research.

5.2.9 Quality of the study

In this qualitative study, trustworthiness was examined to ensure dependability, credibility, transferability and confirmability, which are the important criteria by which to judge the quality of qualitative research (Lincoln and Guba, 1985). Quality of this study was ensured by similar ways of the case study (discussed in detail in section 3.2.9).

5.3   Findings: The mentor–mentee relationship

Numerous discussions concerned the ideal nature of mentor–mentee relationships and mentors' and mentees' perceptions of the actions necessary to make such relationships effective. Data about the perspectives of mentors and mentees show that a number of key themes (factors) contributed to and support positive mentor-mentee relationships.

This section first discusses the important themes highlighted by both mentees and then by mentors as contributing to positive mentor–mentee relationships. Second, it describes the mentor's role, including important elements and characteristics identified by both mentees and mentors. Mentors' preparation for the role and feedback are also addressed. Third, this section explores some external (context) factors which could influence the ideal mentor-mentee relationship and were highlighted by both mentees and mentors. Examples include such organisational-level issues as the process and resources which influence time availability, workload and allocation.

Figure 2 illustrates the key themes discussed in this section and the relationships between them. In this diagram, the key themes are numbered according to the number of the section in which they are discussed. Communication was a key to all explored themes, so it is shown in Figure 2 as forming the background to the themes. The attitudes of mentors and mentees, mentorship workshops and continued professional development (CPD) training, and clarifying learning needs are included in the diagram as they are important factors in positive mentoring experiences. They are not numbered as they are not discussed as discrete themes in this section. However, they were raised repeatedly within most key themes in this section, indicating their centrality to positive mentoring experiences. Arrows in the diagram show the relationships between the

themes. All arrows are double headed to indicate that the connected themes affect each other in a two-way process.

Figure 2: Mentor–mentee relationship
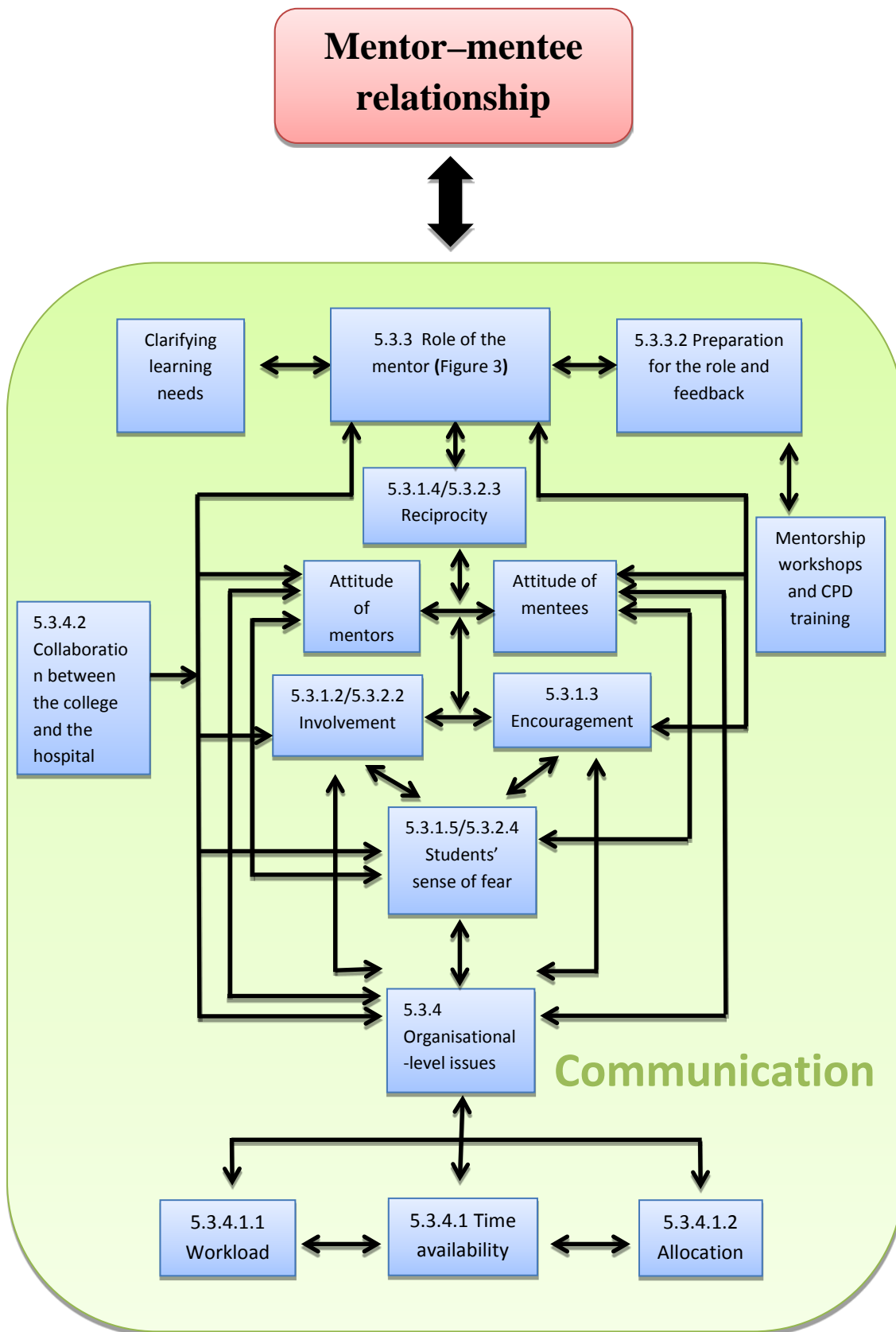
<u>**Coding of quotations:**</u>

Following the principles for ethical conduct of research, codes were assigned to participants to preserve their anonymity. To distinguish between quotations from different types of participants, the following codes were used:

(Mentee FG1): 3rd and 4th year nursing students at A College, focus group 1

(Mentee FG2): 4th year students at B College, focus group 2

(Mentee FG3): Nursing interns at A College, focus group 3

(Mentor FG4): Teaching assistants who are RNs at B College, focus group 4

(Mentor FG5): RNs at B Hospital, focus group 5

(Mentor FG6): RNs at B Hospital, focus group 6

5.3.1   Mentees' perspectives on the Mentor-Mentee Relationship

This section highlights the important themes identified by mentees as contributing to a positive mentor-mentee relationship. These themes are communication (section 5.3.1.1), involvement (section 5.3.1.2), encouragement (section 5.3.1.3), reciprocity (section 5.3.1.4) and student's sense of fear (section 5.3.1.5). Each theme is explored in detail in the following sections.

5.3.1.1   *Communication*

All the positive experiences discussed by mentees involved a good relationship based on good communication, including from both effective language-based communication and efforts by both parties to be open to interaction. Mentees agreed that both parties should be expected to pay special attention to communicating with each other and be

attentive to the other's needs. It was reported that the way in which the mentor and mentee 'got along' was the most important aspect of the mentorship experience, which is arguably the most important stage in learning to be a professional nurse.

> *Internal and external factors are good communication, and caring. …*
> *What are we going to do to achieve this are good communication,*
> *trust between students and preceptors, students showing interest to*
> *learn, students being on time and more professional, workshops that*
> *guide both the mentors and the students, show confidence. … Also, it*
> *is important for both mentors and mentees to receive and give help.*
> (Mentee FG1).

Mentees also expressed the view that patience and good communication are important in enabling the mentor to support the mentee's learning, even if their learning and teaching styles do not overlap directly. Mentees pointed out that every mentee might have a different learning style and needs and that effective communication could enable a mentor to identify and assess these needs (see 'clarifying learning needs' in Figure 2). It was also noted that mentees must feel that their mentor is open to questions. In turn, mentors think that mentees could signal enthusiasm and initiate learning that meets their current needs. An example of this view is presented in the quotation in section 5.3.2.1.1.

Many potential problems and solutions related to communication derive from simple linguistic problems. English and Arabic are spoken in these healthcare contexts, so ideally, all mentors and mentees would have a good command of both languages. However, some mentees were not competent in speaking English, and some mentors were not competent in speaking Arabic. Mentees also stated that some mentors speak English with an accent the mentees found difficult to understand. Most mentors were non-native speakers of English from India or the Philippines, for whom English was the

only language they shared with their mentees. When mentees were describing their wishes, one mentee stated:

> *Also that the preceptors have good and better language [skills] so that we can understand them. … Sometimes their English language is very good, but we can hardly understand their accent.'* (Mentee FG1).

When mentees were asked about their view of an ideal mentorship experience and the factors contributing to a positive mentorship, good communication between mentor and mentee was identified as crucial. One factor contributing to a positive mentor-mentee relationship is overcoming the language barrier, and one way in which a mentor can address this issue is to learn good body language. One mentee suggested that 'good body language' helped mentors and mentees to overcome language barriers.

> *My dream is good communication between the preceptor and the student. … External factors are positive body language, preceptors teaching at the level of students, overcoming language barriers. (Mentee FG1)*

Another suggestion about potential means of overcoming language barriers was for mentees to make a strong effort to establish a good relationship with each mentor.

> *To overcome the language barrier, [an] activity that could be done is that the student helps her mentor to build a good relationship with her.* (Mentee FG1)

5.3.1.2 *Involvement*

When asked about the most important aspects of mentee–mentor relations, mentees prioritised involvement after 'effective communication'. The mentors most involved

with their mentees, especially in trying clinical procedures, were described as the most helpful.

When asked to describe a powerful experience, mentees gave examples of when mentors engaged with them and involved them in tasks.

> *First of all because it was my first time to see and attend a code in the hospital... this itself was powerful. And, to be honest, what makes it more powerful is to have my mentor (X) with me because even when I met my objectives, she didn't tell me go and take a rest, as other nurses sometimes do.... Instead, she kept asking me to come and be involved. Although I spent two days in the ER unit, one day with (X) and the other day with another nurse, with (X) I learnt a lot more than on the other day. (Mentee FG1)*

Another mentee stated:

> *'I was assigned a mentor whom I admired. She was treating me as I were a staff nurse and as if I were one of them. ... For example, one day, they were doing CPR to one of the patients, and she asked me to come as if I were one of the staff. ... She made me feel that I am one of them.... She involved me and asked me to bring the medication and to help them in the CPR. ... Although it was my first time to see real CPR, but she engaged me in that procedure. ... I was with them. ... She asked me to stay with them, and you know that in the CPR, only the necessary team is allowed to remain in the room. ... She didn't make me feel that I am a student and that my presence at the time was not important; instead, she asked me to come and she engaged me in that situation. Although it was only one day that I had to spend in that unit, she didn't make feel that I was a stranger; she made me feel that I was one of them'. (Mentee FG1)*

Involving mentees in some tasks contributed to their sense of self-respect, self-esteem, trust, self-confidence and motivation (the relationship between involvement and

mentees' attitudes is illustrated in Figure 2). Feeling respected and demonstrating self-respect were considered important for building a good relationship. Mentees reported that important ways in which mentors showed respect for mentees' abilities and desire to learn were including mentees in as many activities as possible and appearing to be interested in teaching mentees. Mentees felt that, when mentors showed respect for them in these ways, their self-respect and confidence increased (the relationship between mentors' and mentees' attitudes is shown in Figure 2). However, mentees also discussed the importance of their own attitudes, enthusiasm and initiative (which supported involvement in clinical work) in establishing a positive mentor–mentee relationship (see section 5.3.1.4 for more details about reciprocity).

One mentee described her favourite mentorship experience with a nurse in the ER unit:

> *She was with me all the way. She helped me to meet my objectives. She was helpful with other nurses, and she helped me as well all the time. … One day, there was a code [cardiac arrest] in the hospital, and she came. And she took the lead in that situation. … She did the chest compressions and the CPR. Then she asked me to come and do it. Because I was so scared in the beginning, I didn't want to enter the room. She told me to come, and when she noticed that I was anxious, she told me to come inside the room and just stay and observe. She was taking care of my feelings. She said, 'You have to learn', and then she started to do the chest compression, and then she asked me to come and do it. It was obvious that the patient had already passed away, but I couldn't do it. The patient did pass away, and we stayed there, [doing] for resuscitation for 45 minutes. Then all the nurses left, but the family remained there. Then I met my objectives by supporting the family. I stayed with them, and I gave them water. … She said, 'I am so proud of you. I never thought that you could stay in the room'. … I remember that day I was supposed to have a clinical quiz after that incident… but my mentor talked to my lecturer and*

asked her not to give me the quiz right away. … She was really a great

person. She helped me a lot. (Mentee FG1)

Conversely, mentees believed that being told to 'just be my shadow' is an ineffective

technique, which bored some and made them less inclined to complete the training.

Consequently, they had a lower level of engagement in the process of mentorship.

5.3.1.3 *Encouragement*

Linked to involvement (Figure 2), mentors' encouragement of mentees in the clinical

setting was considered a key factor in establishing effective relationships. A balance

between encouraging mentees to take chances and making her feel supported was

described as the highest prerequisite for a powerful mentorship experience.

> *The thing I most value in my mentor is how she encourages me to do*
> *anything, whatever its difficulty. (Mentee FG3)*

This mentee also described how this mentor encouraged her 'courage' and 'passion'.

This produced a sense of pride, allowing the mentee to do the best job she could

(relationship between encouragement and attitude of mentees is illustrated in Figure 2).

A mentee pointed out:

> *Sometimes you feel unable to do it because you do not have enough*
> *trust in yourself, but when I meet the patient and do finish my work*
> *very well, I feel proud and independent.* (Mentee FG3).

The mentees stated that they wanted regular encouragement, willingness of mentors to

help them, positive reinforcement for tasks that they performed well and a feeling

comfort in the spaces where they worked. Mentees, though, did not specify what they

meant by feeling comfortable in their workplace. One mentee was asked about the

themes that contributed to her positive story.

My themes are: willingness to help, giving the student her time,
encouraging the students to do procedures, and being patient with the
students. (Mentee FG1)

Another mentee stressed the importance of encouragement to try difficult task whilst receiving close support from the mentor (see the last quote in section 5.3.1.2).

I remember one time when I had my training in the maternity ward.
My mentor was very supportive. She was encouraging me all the time.
She made me feel that I was doing a very good job. Even if I was
performing a simple procedure, she provided me with a positive
feedback and encouraged me. I remember she used to tell me 'very
good and well done' when I even performed simple procedures.
(Mentee FG2)

5.3.1.4 *Reciprocity*

Mentees identified reciprocal respect, enthusiasm, engagement and efforts to establish a positive relationship as important influences on the quality of the mentor–mentee relationship. Firstly, mentees highlighted the importance of demonstrating appreciation for mentors as a way to promote good mentorship (Figure 2). When asked about the factors contributing to their positive experience, most mentees mentioned respect. Mentors and mentees need to show respect to each other in order to establish a good relationship

The important themes (factors) are mutual respect, mutual
acceptance, more confidence from both, good resources, support and
the ability of the nurses to give knowledge and information. (Mentee
FG2)

Internal factors are show appreciation to the preceptors, show
interest, respect each –other. (Mentee FG1)

One mentee stated:

Also, I need to apply all the important factors on myself to be able to receive it from others. For example, if I want to be respected by my mentor, then I need to be respectful to her as well. So most of the factors and themes are mutual.' (Mentee FG2)

Secondly, mentees felt their enthusiasm and engagement supported a positive mentor–mentee relationship, encouraging mentors' enthusiasm and engagement with the mentees. Mentees used words such as 'keen', 'excited' and 'volunteer'. Mentees felt they should be enthusiastic about being asked to participate, volunteer their efforts and take the initiative. Initiative is a necessary part of the learning process, and mentors indicated that they preferred working with mentees who actively volunteered.

Mentees also described various ways in which they could demonstrate enthusiasm, including 'willingness to learn new things', 'mentee motivation', 'mentee accepting what mentor teaches', 'mentee initiative',' 'mentee helpful',' 'mentee professionalism',' 'mentee enthusiasm' and 'mentee putting in effort'. One mentee stated:

Sometimes it's important to ask her when you want to learn something. … You have to show her that you want to learn and that you are interested to learn. (Mentee FG1)

In addition to the importance of bringing an appropriately keen attitude to mentorship themselves, mentees had a number of preferences for the preparedness and keenness of mentors. Mentees were of the opinion that mentors must make efforts to prepare themselves and begin with the right attitude (see connections in Figure 2). Mentors must provide adequate time and instruction for their mentees to try new things. The mentors' willingness to try something new with their mentees is important for an optimal relationship.

Finally, one mentee pointed out that, to have an effective mentor-mentee relationship, the mentee needs to be able to establish a good relationship with the mentor. In a good relationship between mentor and mentee, the mentor will feel more motivated to mentor the mentee and further develop the relationship. This mentee stated:

> *My dream (in the middle circle) is to have beneficial relationship with the preceptor [mentor] to gain sufficient amount of knowledge. … The internal factors are well-designed objectives to meet the students' needs, high motivation, ability to initiate a good relationship with the preceptor.* (Mentee FG1)

5.3.1.5 *Students' sense of fear*

An important aspect mentioned by mentees was their fear of a new environment and the need for mentors to understand their insecurity when performing a procedure about which they had previously only read (see quotations related to students' sense of fear when performing new procedures such as assisting in CPR in sections 5.3.1.2, and inserting a cannula in section 5.3.3.1). In this sense, one of mentors' main responsibilities is to help mentees be less fearful and more confident. However, mentees also noted that some mentors could misinterpret a sense of fear as a lack of enthusiasm. Figure 2 shows that students' sense of fear could affect mentees' attitude and, consequently, affecting their mentors' attitude and willingness to teach and involve mentees in some tasks.

One mentee expressed the view that having a supportive mentor who guides the mentee during the learning process would help to overcome this sense of fear.

> *I believe that if I have a good preceptor and good guidance I could do it.* (Mentee FG1)

Another mentee said:

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'I was scared because it was my first time experience. My mentor made
me feel more confident and relaxed, and I really felt more independent
at that time. It was my first time to do cannulation, and I was very
scared, but my mentor said to me, 'You can do it'. I didn't think that I
could do it, but I did it.' (Mentee FG2)

5.3.2 Mentors' perspectives on the mentor–mentee relationship

This section discusses the same important themes which contribute to a positive mentor–mentee relationship but from the mentors' point of view. These themes are communication (section 5.3.2.1), involvement (section 5.3.2.2), reciprocity (section 5.3.2.3) and students' sense of fear (section 5.3.2.4).

5.3.2.1 *Communication*

As did mentees (section 5.3.1.1), the mentors felt that communication was an important aspect of a positive mentorship experience. When asked about the factors that contribute to positive mentorship experiences, mentors stressed the development of good communication with mentees.

> *It's establishing good communication with the students, establishing*
> *good communication between the mentors and the students in the*
> *hospital and also establishing the good relationship and very*
> *importantly the motivation.* (Mentor FG4)

Mentors had similar opinions to mentees that many potential problems and solutions in communication derive from simple linguistic problems. Mentors acknowledged the importance of the language issue.

> *I wish I had very good communication skills with different*
> *backgrounds, different languages, mother tongues and had a good*
> *way of communicating with them that would be an effective*

communication with them. I wish I had a good attitude and patience
with the students. (Mentor FG5)

A suggestion made by mentors was to learn the language in which mentees communicate, namely, Arabic.

My wish is that I could learn how to speak in Arabic because I know
the students are encouraged to speak in English. And then the second
thing is, as my colleague has said, we should be based on our clinical
specialities, but you have to go down to their level of understanding.
We should also learn how to speak in Arabic so that there is a two-
way process of learning. And then the mentors should have Arabic
classes, and the students should learn English. (Mentor FG6)

The mentors who mentioned specific examples of problems related to language barriers indicated that they could have been overcome more easily if the mentors had tried to be more open. The next section addresses the issue of openness.

5.3.2.1.1 Openness

Like mentees, mentors stressed the importance of facilitating open communication. They highlighted the importance of the mentee feeling supported and free to ask questions. Mentors also stressed the need for the mentees to be more open, discuss their needs and expectations and use more initiative to communicate what they did and did not understand.

While expressing her wishes, one mentor stated the following (see section 5.2.6.2 for how 'expressing wishes' fit into the data collection process):

And the third thing is a wish for the student to be a lot more open and
tell us what they want. … That's actually one of my wishes, too. … I
wish they come to us and tell us what are the objectives? What do they
want to learn today? But they never do that.' (Mentor FG5)

5.3.2.2 *Involvement*

Whilst mentors' involvement with their mentees was discussed earlier in this findings section from mentees' points of view (section 5.3.1.2), it is also important to examine this process from the mentors' perspective and to question why some mentors offer more learning opportunities than others. According to mentors, mentees' willingness to learn from new experiences varies, and mentors offer fewer opportunities to students perceived as less willing to learn.

Mentors discussed the need for mentees to be prepared to learn, not only technically but also in terms of desire. Mentors believed that mentees need to be 'engaged' and excited about their goals and learning. Mentors reported that mentees' willingness to participate and learn is important in encouraging mentors to teach mentees and help them to perform at their best.

> *Their [mentees] interest and dedication to learn is something that is very important because every day there are new things to experience. (Mentor FG4)*

Another mentor pointed out:

> *And in the last wish, I wish that most of the students who come here [hospital] would have a more willing attitude to actually learn something because this is not the ideal hospital to work. Nowhere in the world you can find an ideal hospital to work in, everywhere got ups and downs, and pros and cons but we make the best of what we have. (Mentor FG5)*

However, some mentors agreed with the mentees' opinion that their apparent lack of willingness might be linked to their fear (for more details, see section 5.3.1.5).

5.3.2.3 *Reciprocity*

As did mentees (in section 5.3.1.4), mentors claimed that it was extremely important for mentees to be good, attentive students and to understand the limits of what their mentors

can do to build a positive mentor-mentee relationship. In addition, mentors claimed that this relationship must be characterised by reciprocal (mutual) trust. They highlighted the importance of mentees demonstrating initiative, trust and appreciation for mentors to promote good mentorship (Figure 2). When asked about important factors contributing to a positive mentorship experience, one mentor stated:

> *Willingness from the students to learn … trust between the mentee and mentor.*
>
> (Mentor FG5)

Another mentor stressed it was important for mentees to show initiative by discussing their objectives and learning needs (see quotation in section 5.3.2.1.1).

5.3.2.4 *Students' sense of fear*

In some mentors' view, a main problem keeping mentees from remaining motivated was the sense of fear that could overpower their ability to continue learning, a situation that some mentors are not prepared to handle. Mentors also noted that the mentoring requires a great deal of patience to ensure that the mentee feels supported, even when scared about a new, daunting task.

> *Sometimes they* [mentees] *don't want to do it* [procedure] *because they are afraid because it is a real patient. So you have to show them first and then they try it, and you guide them to show them how to do it.*
> (Mentor FG6)

In addition, mentors mentioned that they must have a keen understanding of the fears and nervousness experienced by mentee and be aware of what behaviours might be comforting to a mentee who is scared at times.

5.3.3 Role of the Mentor

5.3.3.1 *Elements/characteristics of the role*

Mentees described a number of different elements of the mentors' roles: an advisor,

facilitator, instructor or teacher, guide, challenger, assessor and role model. More details

are shown in Figure 3.

Figure 3: Role of the mentor
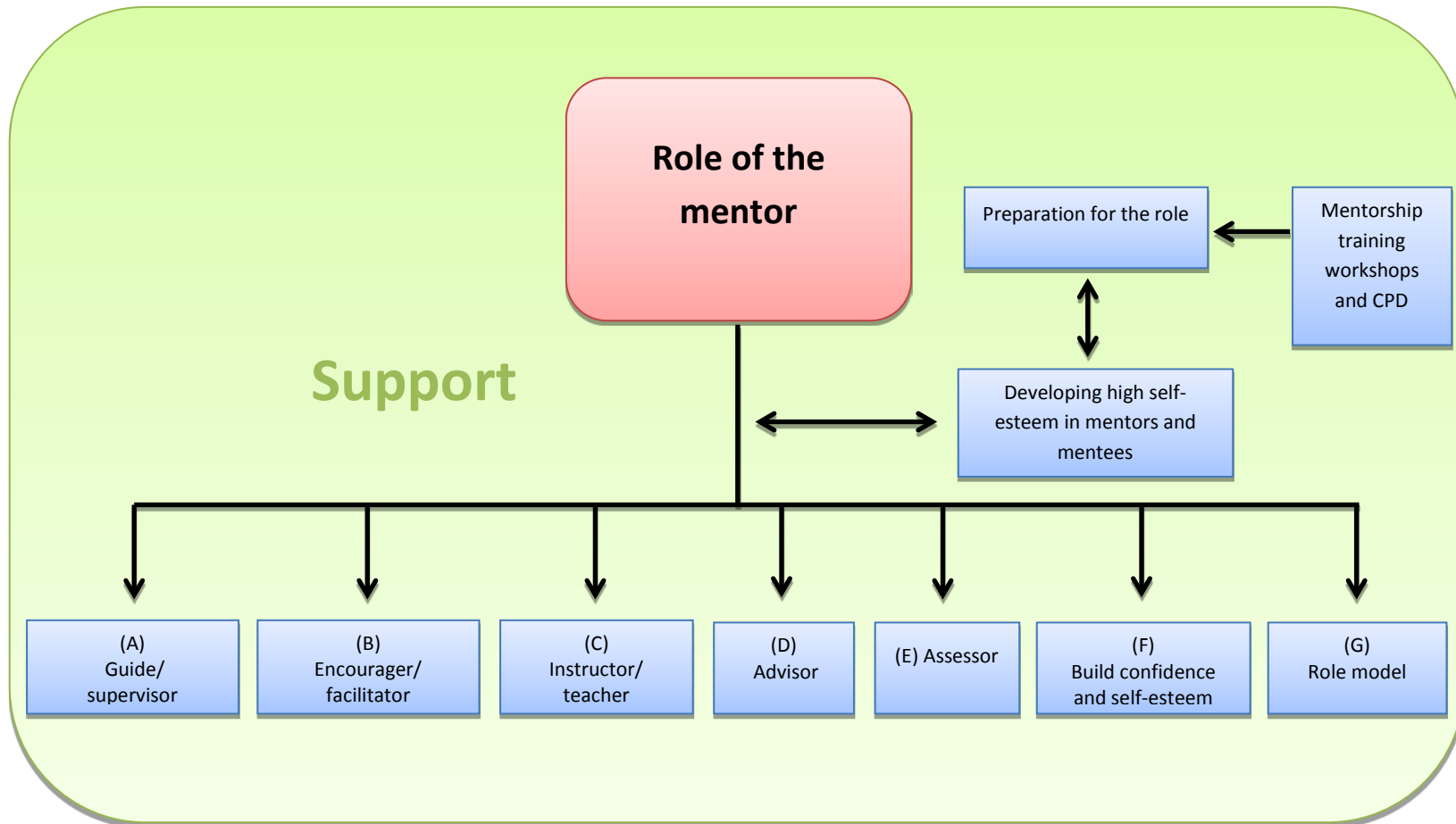
Mentors and mentees agreed that the mentor needs to guide mentees' everyday experiences in the hospital and share their knowledge and experience of the difficulties and challenges this might present (A in Figure 3). According to mentors, this should allow mentee to trust their mentor and become a better learner.

Mentees believe that the mentor must act as a guide when training the mentee. Mentees like to feel challenged but also supported. Many mentees talked about being asked to perform tasks in which they had not yet been fully trained but, with the mentor's help, still felt supported and able to complete the task. Mentees were often extremely scared when trying a procedure for the first time (see section 5.3.1.5).

Mentees began learning practical skills in nursing with no sense of trust in themselves or their skills, as all their training so far has taken place in a closed classroom and with simulated patients. They do not work with any patients until their first clinical placement in the second semester of their second year of nursing education. While this stage of training is primarily concerned with the mentee learning how to acting independently, the mentor needs to foster the mentee's sense of trust in oneself needs from the outset as clinical practice involves a transition from theoretical to practical learning (hence the need for the mentor to constantly supervise the mentee).

According to one mentee:

> *The mentors give help to students to build and gain self-trust because*
> *when you come here for the first time you don't have adequate trust in*
> *practical experience.* (Mentee FG3)

According to mentors, the mentee requires a variety of processes in this learning experience. The mentee needs support in the journey from novice student to qualified practitioner, which itself is the start of a continuous journey of improvement and the

development of new skills. Mentee cannot get there on their own; therefore, one aspect of mentors' role is that of guide. As one mentor stated:

> *The mentor nurse tries to advise the trainee student to proceed on the right track and help her to transition from being just a student to a qualified nurse.* (Mentor FG4)

Mentees mentioned that a key aspect of the mentor's role in the clinical settings is to help mentees to apply in practice what they have learnt in college. An especially important part of the mentorship relationship is providing the right support when mentees leave the college classroom environment, enter the clinical setting and begin to practise what they have already learned. At this time, a mentee might learn to be confident in work or may feel discouraged from trying new things. Mentees and mentors suggested that the best way to guide mentees is to involve and engage them in the mentors' work (see section 5.3.1.2 and 5.3.2.2). One mentee recalled an experience in which she felt supported because she received the guidance she needed from her mentors.

> *At the time when I was doing the cannulation, I was very scared. To be honest, I was thinking that I am doing a bad job and that I will not be able to do it. I was also thinking that she will take it out and put it in again. But she let me do it until the end, and I did it well. After that, I felt confident, and I believed that I could do and learn things even if I didn't do it or learn it in college.... I believe that, if I have a good preceptor and a good guidance, I could do it.* (Mentee FG1)

However, mentees criticised some mentors for focusing heavily on perfecting one skill set at a time without giving mentees a glimpse of what else was to come.

In addition, mentees reported that a crucial part of guiding and supporting mentees in learning clinical skills is attempting to keep them interested and engaged with the work

they are doing (B. in Figure 3). As learning process is partly dependent on the mentor having a hand in what the mentee is learning, it is important to keep the mentee interested in the material being covered. A key technique to accomplish this engagement is to provide mentees with adequate opportunities to try the work themselves. According to one mentee:

> *Some mentors are not interested in teaching you: They just do their job by making you observe and telling you 'just be my shadow'. (Mentee FG3)*

Involvement of mentees in nursing work was considered an important part of the mentoring role as discussed in section 5.3.1.2 and 5.3.2.2.

Additionally, mentees felt that the mentor should be prepared to show the mentee appropriate techniques, including through verbal explanation and manual demonstration of techniques (C in Figure 3). One mentee shared a powerful mentoring experience.

> *My first time to give an injection. We learnt how to give injections in the college, but we didn't apply it in the clinic at that time. So I was very afraid. My mentor told me, 'You have to give [the] injection now'. But I told her, 'I never did it before, and I am not sure if I know how to do ''t. … She said, 'It's OK. Now it's your time'. She taught me how to do it step by step. I felt that she was a good mentor because she was teaching me properly.* (Mentee FG1)

Mentees also mentioned that mentors should have the required teaching skills to teach mentees and that mentors should discuss patient cases more frequently with their mentees.

> *My dream is to spend more time in discussing patient cases, having nurse educators who are competent in teaching the students.* (Mentee FG2)

Mentors also discussed their role as instructor. However, they pointed out that it is also important to highlight what this entails for mentors learning how to best 'fit' with their designated mentee.

> *Well, it's just trying to, how can I say this, trying to moderate your*
> *own self to fit, just to work smoothly with this person.* (Mentor FG6)

The mentors noted that they did not always find fitting to be easy. However, they generally understand that it is not their responsibility to like mentees but to help them become professionals. On occasion, this meant working with a mentee who was not such a good 'fit' with their personality. One solution to this problem, according to a number of mentors, was to treat the job of mentor as one that involves constant learning. Not only the mentee but also the mentor should be learning. Some mentors included this in their dream.

> *Okay, so how to achieve this (dream) or what to do to achieve this*
> *ideal experience? I wrote here, one, developing standard institutional*
> *strategies to improve mentorship. And another is developing a habit*
> *or attitude of never stop learning as a mentor.* (Mentor FG6)

Mentors noted that it is crucial that a mentor never stops learning, even if that learning simply concerns how to deal with a problematic mentee.

In addition, mentees stressed the importance of mentors teaching mentees at their level of knowledge and understanding (refer to third quote in section 5.3.1.1) and understanding mentees' feelings. As with the mentees' perspectives of the positive mentor–mentee relationship, mentors highlighted the importance of learning how to teach, listen and react differently to various types of people.

Some students have different ways [of perceiving] what you're saying, so here you have to understand that each student has a different learning process and they improve in time. (Mentor FG4)

According to mentors, mentorship has two major aspects: perfecting the skills mentees already know and showing them their future professional duties. Some mentees stated that their mentors might have lacked ability in this area. A mentor state:

More showing them like the future more and the skills that they need to learn. (Mentor FG6)

Mentees noted that a major proportion of their learning in clinical practice results from attempting or being involved in many tasks. Mentors must support the mentee in this way, pay attention to how they respond to the mentee's efforts and consider how to sensitively identify the mentee's mistakes and provide advice on how to avoid such mistakes in the future. It is also important for mentors to positively encourage mentees when they have performed tasks well. In addition, mentees pointed out that mentors need to identify and show how to achieve the traits mentees needs to demonstrate in order that they can behave like qualified professionals.

Mentees mentioned that a good mentor gives advice (D. in Figure 3) and that they wanted more feedback from their mentors to feel supported. It was noted that mentors do not always provide positive feedback and constructive criticism. When asked to define mentorship, one mentee stated:

It is a relationship between the student and the nurse who provides continuous feedback. (Mentee FG1)

Another mentee described her positive mentorship experience and how supportive her mentor was,

> *After I finished, she gave me a feedback about what I did right and what I did wrong … and she told me to keep practice because this is something that I will do after I graduate.* (Mentee FG1)

Often in the simplest procedures, the most good can be done for the mentorship relationship. These simple procedures provide the best opportunities to build up mentees' self-confidence. If mentees feel that they are good at these basic tasks, they will be more inclined to try more complex tasks. Constant attention to positive reinforcement, even in minor details, therefore, was highly stressed in the mentees' discussions of what makes a good mentor.

Mentors and mentees highlighted that the mentor should continually assess the mentee's performance and provide feedback in a sensitive and accessible way (E. in Figure 3). Feedback was an important way for mentors to support mentees' enthusiasm and motivation. Mentors also noted the importance of having clear learning objectives in order to appropriately assess mentees' learning needs and progress (see quote in section 5.3.2.1.1). Mentors also highlighted the need to provide mentees with constructive feedback and to regularly assess and evaluate them.

> *My dream: to graduate students from our college who are knowledgeable and skilful. … I said before, positive supportive attitude; assist, help, evaluate them; good communications, positive assessment and evaluation; let them seek information, education.* (Mentor FG6)

Mentees pointed out that self-confidence is not only an important issue for the mentee but also for the mentor whose skills are also developed in this learning process (F. in Figure 3).

> *When the mentor is confident and trusts the student, this will empower the student and give her the courage to do something and will motivate her to learn.* (Mentee FG2)

Mentors also believe that a high level of self-esteem for both mentors and mentees is an important factor for a powerful mentorship experience. When asked for opinions on the factors contributing to positive mentorship, one mentor said:

> *Factors are helping to develop high self-esteem in yourself and in your mentee and having good communication skills.* (Mentor FG6)

Another mentor suggested that mentors and mentees need to have the required knowledge, skills and attitudes if they are to achieve high self-esteem.

> OK, *first I find knowledge as the most important thing because without the knowledge you cannot develop your skills. The second is I find the skills important, and then the third is attitude. If you have these three, then you have very high self-esteem as a mentor and as mentees.* (Mentor FG6)

Mentors noted that one of their main responsibilities was to act as a role model while supervising the mentee (G. in Figure 3). They acknowledged that mentees need role models and that mentors should demonstrate the appropriate attitudes and constantly update their knowledge to help guide the mentee. Acting as a role model concerns not only mentees' immediate nursing goals but also their idea of a future career in general. According to one mentor:

> *Mentorship means teaching the students the skills, knowledge and attitude for them to become a better nurse in the future. … It's like being a role model.* (Mentor FG4)

Many mentors stressed the importance of being a role model.

> *You should have a good attitude, knowledge, good knowledge of anything that you teach your student and the right skills.* (Mentor FG5)

In addition, mentees pointed to certain characteristics the mentor and the mentee both need if they are to empower each other. These are; communication, support, respect, patience, encouragement, trust, a collaborative approach, motivation, teaching skills, adequate knowledge, independence, initiative, confidence and adaptation to the surroundings. Mentees listed many of these characteristics when interviewed.

> *In order to have a powerful mentorship....first, the nurse has to be supportive, respectful, encouraging, believe in the student's abilities, collaborative, motivated, educator, have the ability to teach. ... The student has to have the knowledge, be independent, initiative, confident, respectful, collaborative. The student should have good communication skills to communicate with her mentor; also she has to be able to adapt to the clinical environment. ... Both should empower each other and have one goal and good communication skills.* (Mentee FG2)

Additional characteristics that were mentioned by mentors and which make mentors appear supportive were patience, a positive attitude, enthusiasm, fairness, a motivating approach, and skills and willingness to teach.

5.3.3.2 *Preparation for the role and feedback*

Mentees stressed that, in order to achieve the best mentor-mentee relationship, the mentor also needs to feel supported and encouraged to learn. Mentees suggested that one of the best means to support and encourage mentors is to offer them training and evaluation so that they do not lack confidence to perform the role. Mentees suggested that providing staff with mentorship training workshops would be highly beneficial at increasing mentors' awareness of the mentorship process.

My dream [in the middle circle] is to have a beneficial relationship with the preceptor to gain [a] sufficient amount of knowledge. ... To achieve this dream, the preceptor needs to be aware of the importance of her role, and there should be mentoring workshop for the mentors and for the students so that they can understand the dynamic of this process. (Mentee FG1)

Mentors also stressed the importance of continued professional development and the need for access to training to keep learning and improving.

As much as possible the mentor should attend workshop and updates or conferences related to mentorship and read journals or studies that were, or researches that improve the mentorship experiences. (Mentor FG6)

In my map at the centre, I put the mentor surrounded with factors which would make her mentorship more positive, like the workshop and the good communication. (Mentor FG4)

In this study, mentees indicated that the mentor must be interested in continuous learning and that training should include both professional development for nurses and the development of mentoring skills and knowledge. Mentees stated it is important that a mentor be knowledgeable, up to date with techniques and knowledge, willing to teach and learn and able to demonstrate evidence-based practice.

In addition, mentees said that mentors should be open to being evaluated. The mentees believed that they would benefit from spending a longer period of time with the same mentor and being able to regularly evaluate their mentors. Mentees pointed out that mentors should be open to constructive criticism to inform and aid their own development, just as they should feel able to constructively criticise their mentees. This belief was an example of reciprocity, which are discussed in sections 5.3.1.4

and 5.3.2.3. Mentees indicated that 'adequate evaluation and assessment' of their mentors would improve their relationships and the mentorship experience as a whole.

> *There must be an observation period for the mentors to supervise their practical expertise and the way they communicate with the mentee. This means evaluating the mentors on basis of educational and instructive ways for the nurses, so they can observe their actions and behaviour and find their negatives and positives.* (Mentee FG3)

5.3.4 Organisational-level issues: Processes and resources

Interpersonal factors are affected not only by the mentor or mentee but also by the conditions within the hospital in which the mentoring relationship takes place. Some of these conditions are internal to the mentorship process, and others are external. Mentees highlighted contextual (external) factors that could prevent the ideal mentor/mentee relationship. Contextual factors concern a number of characteristics in the setting (environment) that support a powerful mentor–mentee relationship: sufficient time, appropriate workload, proper allocation (placement) of mentees in the clinical setting and more collaboration between the college and the hospital. In addition, mentors and mentees highlighted the contextual factors of a suitable workplace in which mentors can mentor effectively and the mentee can learn adequately. These factors include the availability of an appropriate meeting room and sufficient preparation for the mentoring role (see section 5.3.3.2 for more details).

5.3.4.1 *Time Availability*

Mentees discussed the need for spend more time with the mentor and for the mentor to 'be there' whenever needed in order to have an effective mentorship. One mentee said of her ideal mentor:

> *She will always [be] beside me if I need her.* (Mentee FG3)

Time availability involves a number of different factors. Firstly, the mentor's workload may allow little spare time for mentorship (see section 5.3.4.1.1). Secondly, allocations (placements) for mentor–mentee pairings last only a short time, providing little opportunity to develop an interpersonal relationship or for the mentor to provide progressive, focused learning opportunities and effective mentorship experiences (see section 5.3.4.1.2).

5.3.4.1.1   Workload

Mentors and mentees pointed out that mentors must focus on clinical care for patients while finding time for mentorship. Mentees suggested a number of ways the hospital could mentors be as available as much as possible for mentees. These measures include giving mentors a non-excessive workload and limiting the number of patients for whom a mentor cares during the working day, in addition to her teaching and mentoring responsibilities. These contextual factors can prevent mentors and mentees from having enough time and patience for each other. One mentee described her wishes as follows*:*

> *My three wishes are that the preceptor has more time to precept, that the preceptor understands the importance of teaching and look at it as positive not negative experience. I wish her to be efficient and confident. … Specific activities that could be done are workshops, teach them how to manage work and mentor at the same time, assign students with mentors who are not loaded with patients and give money or a gift or certificate to the mentor to motivate her.* (Mentee FG1)

One mentee did not agree with this view, arguing that mentors need to be efficient and manage working and instructing the mentee simultaneously.

> *The nurses need to be efficient in doing that … because most of the preceptors find it a burden to mentor the students and to concentrate*

on their work at the same time. But what they don't know is that when she is working, she's actually teaching. So she can be efficient. She could tell the student, 'Now you can observe me doing this. I will not be able to teach you at this time, but when I am done, you can tell me what I did right and what I did wrong'. So this is efficiency, she can mingle working and instructing in her own critical way. She doesn't have to sit with the students if she is busy. She can adapt both and mingle them together. (Mentee FG1)

Additionally, mentees suggested that, when one mentor is busy with patients, other nurses should collaborate in helping mentees other than their own. Mentees noted instances in which mentors helped and guided mentees other than their own, such as when a mentor took on extra work helping a mentee not assigned to her because she believed the mentee was not getting enough attention.

However, mentors strongly wish to have a lighter workload in order to mentor effectively and spend more time with their mentees. When asked about her wishes to have a positive mentoring experience, one mentor stated,

Increase the staff nurse and recruit nurses specifically for the students to mentor them … Also decrease the number of patients assigned to the mentors. (Mentor FG4)

Another mentee said:

The need for more time … also to observe different cases of the patients in the hospital and also to allow more time for the mentors to discuss the cases with the students. Mentors could have more time by decreasing her workload and limiting the number of patients she's handling. (Mentor FG4)

5.3.4.1.2 Allocation

Mentees said that spending nine hours one day a week in a clinical placement was insufficient to develop a strong relationship with their mentors and wished to spend more time in the clinical placement and with their mentors. A mentee said:

> *One day from 7 am to 4 pm is not enough. … So I wish to spend more time in the clinical setting so that I could spend more time with my mentor because we will not be able to build a relationship if we are just spending one day in the clinic. … Actually we are not having enough time to get to know each other as I found myself next week assigned with another mentor, and you know every mentor has a different approach to teaching.* (Mentee FG2)

5.3.4.2 *Collaboration between the college and the hospital*

Mentors and mentees highlighted that the collaboration between the college and the hospital is crucial for a positive mentoring experience. When asked to describe three wishes to improve the mentoring process, a mentee said:

> *More effective collaboration between the hospital and the college because sometimes the nurse refuses the students and doesn't accept them.* (Mentee FG2)

Data showed that collaboration between the college and the hospital is crucial for the following reasons:

1. To provide an agreed-upon plan for the mentorship process

    For example, one mentor said:

    > *We have to have a plan because what's happening to us is that we've just been given students without knowing what is their background, what is their basic knowledge. So it's really difficult for us. And the hospital should have a communication*

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> *between this college to know what they expect us to do with*
> *their students.* (Mentor FG5)

2. To define the roles and responsibilities of the RN and the college instructor, and the mentors and mentees in the mentoring process. It was noted that RNs' and nursing students' roles as mentors and mentees conflict with expectations. Data showed that there is a disagreement among mentors and mentees about who is responsible for mentoring students.

   For example, when mentees were asked about their wishes to improve mentorship, one mentee said:

   > *the mentors need to be aware of the students' objectives and to have*
   > *courses on how to deal with the students and how to teach them because*
   > *most of the nurses ask us what do you want to learn... clear expectations*
   > *of both mentors and mentees.... also they could motivate the nurses by*
   > *making rewards or certificate to them.* (Mentee FG1)

3. To be able for the mentors and the academic instructors to communicate with each other more easily regarding the arrangement, planning and application of the mentoring process

   One mentee was expressing her wishes for a successful mentorship, she stated:

   > *more effective collaboration between the hospital and the college*
   > *because sometimes the nurse refuses the students and doesn't accept*
   > *them.* (Mentee FG3)

4. To identify clear learning objectives for the mentees (nursing students) so that mentors can teach mentees at their levels of knowledge and appropriately assess their needs.

   For example, one mentor said:

> *First of all, a mentor should have an idea about how the lectures are*
> *taking over in their class so that they can apply that in their teachings.*
> *The college should also work hand-in-hand with us to let us know*
> *what their objectives are and what the students need to learn today*
> *from us, and they can also assist us to teach the student. And probably*
> *we could be given a handbook of the students, you know.* (Mentor
> FG5)

In addition, when asked about their wishes to improve mentoring, one mentee said:

> *The mentors need to be aware of the students' objectives and to have*
> *courses on how to deal with the students and how to teach them*
> *because most of the nurses ask us what do you want to learn. … Clear*
> *expectations of both mentors and mentees.* (Mentee FG2)

Mentors stated that they sometimes do not even know what stage of the course a mentee has reached.

> *When I see the students, I ask them, 'What are your objectives for*
> *today?' because I don't know whether they are second- or fourth-year*
> *students. I need to know what they need to know so that we can*
> *implement things.* (Mentor FG5)

Another mentor agreed.

> *We don't know. … They have some kind of books, you know, they keep in the*
> *locker, but we don't know what is their level and why they are coming here [to*
> *the unit], so really we need to know.* (Mentor FG5)

Better communication and collaboration between both organisations is crucial. Mentors and mentees agreed that there is a need for the college to design a clear mentorship plan and provide more support to the mentoring process.

5.3.5   Summary

The following table (Table 7) summarises the agreement between mentors' and mentees' perspectives.

- √ or X symbols are used to record the simple presence or absence of themes in the mentee and mentor datasets.

- Repeated symbols are used to indicate the strength of *agreement* on the importance of each theme.

  √ Slightly agree

  √√ Moderately agree

  √√√ Strongly agree

Table 7: Summary of the agreement between mentors' and mentees' perspectives

Theme	Mentees	Mentors
Communication	√√√	√√√
Involvement	√√√	√√√
Encouragement	√√	√√
Reciprocity	√√	√√
Students' sense of fear	√	√
Role of the mentor	√√√	√√√
Preparation for the role and feedback	√√√	√√√
Organisational-level issues Time Availability		
Time Availability	√√√	√√√
-Workload	√√√	√√√
-Allocation	√	√
Collaboration between the college and the hospital	√√√	√√√

5.4 Discussion of the findings

This section draws together the published literature and findings of the main study and highlights the study's new findings in this area. New findings are examined in relation to being specific to this study but consideration will also be given to their wider applicability to mentorship in nursing. The study findings are discussed in a structured manner corresponding to that of the literature review (Chapter 4) and the preceding section in which the findings were reported (section 5.3). First considered are mentees' views of the mentor-mentee relationship and outcomes, followed by the views of mentors. Comments on mentors' learning and development needs and on effective communication channels and practices are including into those sections. Finally, the new knowledge that has emerged from the study is summarised.

5.4.1 Mentees' perspectives on the mentor-mentee relationship

Mentees' views of the mentees' personal qualities which should be developed to enable a successful mentorship were identified, and mentors' role in supporting individuals in developing these attributes was established. The mentees' personal characteristics identified by mentees as the most critical were a sense of self-esteem, self-confidence, enthusiasm for work, self-motivation, belief in their technical competence to achieve quality outcomes and respect for themselves and their mentors. Since the individual's self-perception of these qualities is purely subjective, this could result in over- or underestimation of them. Therefore, mentors need the skills to adapt how they communicate with mentees so as to encourage them to hold a realistic opinion without damaging their self-esteem. One of mentors' responsibilities is to support mentees in self-assessment of their knowledge, skills and attitudes and in identifying and addressing areas for development. Mentees want the mentor to be sensitive to their concerns and potential sensitivities, preserving self-esteem. The importance of self-

esteem derived from interactions with a mentor aligns to some degree with findings of Papp, Markkanen and Bonsdorff (2003), so far as the student nurses in this study suggested that effective mentorship could increase their individual self-esteem if they adequately prepared for their practical encounter.

In the present study, mentees also emphasised that their own preparation for practical tasks was a key factor in achieving an effective learning experience. Similarly, Beecroft et al. (2006) and Lis et al. (2009) reported that students' preparedness to practise their profession upon graduation was a key factor mentees highlighted when evaluating the effectiveness of mentorship. However, both these studies focus on the mentor demonstrating practice to mentee, not on complementary actions by the mentee (reciprocity was discussed in section 5.3.1.4/5.3.2.3), such as reading the relevant materials before learning how to apply theory to practice. Beecroft et al. (2006) also emphasised preparedness, that mentors and mentees should understand what comprised the mentorship process, instead of students having a vague notion of support.

A lack of clear expectations of mentorship was expressed by mentees and mentors in the research by Myall, Levett-Jones and Lathlean (2008) and by mentees in Gray and Smith's (2000) study. Similarly, in a study in an Islamic country (Nahas, 2000), a lack of clarity ultimately led to a gap between expectation and reality. In a number of ways, the mentors and mentees in the present study reinforced and significantly expanded on the practical details of what comprises this initial vagueness and its consequences for the key positive characteristics which should be developed. For example, the mentees expressed concern about not having defined ideas of how regularly they would see their mentor, what the relationship would be like, how to cope with the workload and how to make the mentor-mentee relationship positive and reinforcing one. Mentees, especially

those with only classroom-based experience, also experienced a sense of fear because of their lack of understanding of how to apply theory in a practical setting and of the guidance they could expect to receive from the mentor. This study provides important details about what specific processes should be involved in adequately preparing the mentee for the mentorship process and about the content of an initial training programme or information pack for mentors.

In addition, it was suggested that the preparation process include helping the mentee to develop a personal pathway from student to qualified professional, a planning process in which the traits of the latter should be defined for the mentee. In the UK, the NMC clearly outlines the competencies and qualities required of a newly qualified nurse and the nursing training to prepare for this. Universities work closely with partner hospitals and specify the NMC competencies to be assessed in practice at different points in the training programme. However, in KSA, this process is less formal and relies heavily on the socialisation in the clinical placement. Related to this point is the view that mentees should be involved in planning what they learn and what goals they wish to achieve in order to have a 'stake' in the mentorship. Some mentees described preparedness as the mentor finding out what mentees already know and discussing what they can expect their professional future to look like. Kaviani and Stillwell (2000) suggested that practice preparation days for mentors and mentees to build relationships before the start of placement could be helpful. These were also mentioned by mentees and mentors in this study as a solution to the preparation issues.

Gray and Smith's (2000) claim that the mentee comes to the mentorship relationship with an idealised view of continual support and availability from the mentor. In this study, there was an apparent lack of understanding of what mentorship entails, a

proportion of mentees expected the mentor to be available whenever needed. In the UK, the NMC provides clear standards for the preparation of mentors and their role in practice (Nursing and Midwifery Council, 2008), which can contribute to mentees' view of what support to expect. In KSA, there is not this degree of regulation of nurse training, and therefore, both mentors and mentees feel uncertain what to expect, what is required of them and how to negotiate and manage the placement.

In the mentee's view, the quality of the mentor-mentee relationship had a key impact on the development of key characteristics, described by mentees in a number of ways. Mentees must respect their mentor's professional competence but likewise be sufficiently respected by the mentor, who encourages mentees to independently meet the demands and difficulties of their role and developed their self-confidence and self-esteem. Several different examples in the study illustrate this pattern. The mentor must communicate to mentees that they are 'worthy' of receiving the support needed to develop professional skills and practice and to develop enough self-esteem to serve as motivation in difficult times. This approach helps mentees feel engaged with the mentor, but the perception that the mentor does not respect mentees or does not give them sufficient support this was correlated with decreased performance. The perception of a lack of respect from the mentor was often expressed through nonverbal body language.

Mentees reported appropriate behaviours and characteristics of mentors were exuding support of them and being both friendly and knowledgeable. Appropriate body language was also reported to be a key characteristic that reinforced a positive personal relationship in an earlier study in an Islamic country (Elcigil and Sari, 2008). Mentees repeated mentioned that the mentor's approach to teaching the application of theoretical

principles could support or hinder the appropriate development of technical expertise, self-confidence and self-esteem. The mentor could empower mentees, making them feel capable of carrying out an intervention for the first time. For instance, one mentee cited VC from the mentor conveying that 'you can do it' as providing motivation to overcome her fear. Another described that her mentor's guidance and support had given her the self-belief to overcome her personal barrier of 'being scared'. There was general agreement amongst mentors and mentees that mentees should be actively encouraged to try new things, even if they felt as if they were not fully trained to do them. Mentees claimed to experience feelings such as 'a sense of pride' when their mentors encouraged their 'courage' and 'passion' and expressed delight with their efforts. Praising for doing a 'good' job in even a simple procedure was appreciated and built confidence. When the mentee felt empowered, this led a feeling of trust in the relationship. Similar findings regarding mentors' attitudes towards and support of mentees and mentees' development of confidence, motivation, feelings of empowered and desire to learn have been found in other studies (Bradbury-Jones, Sambrook and Irvine, 2009; Beecroft et al., 2006; Papp, Markkanen and Bonsdorff, 2003). Were these circumstances are not the case, the effect could be long-term low confidence and esteem levels in mentees. Bradbury-Jones, Sambrook and Irvine, (2009) found such a situation and called such an approach disempowering.

The manner in which professional practice was learnt was fundamental to how and to what extent the key characteristics were developed in the individual mentee. The factors identified in this study as increasing mentees' motivation to learn were the mentor's professional standards, willingness to provide a range of opportunities for the mentee, allowing mentees to work to their capability level and enabling doing, rather than merely observing. These findings are supported by studies by Papp, Markkanen and

Bonsdorff (2003), Lis et al. (2009) and Beecroft et al. (2006). The mentor needed to allow mentees to make errors, ask questions and give feedback. This nurtures self-trust which increases learning by eliminating mentees' fear of making a mistake. Mentees stated that highest levels of confidence resulted from positive encouragement, a mentor receptive to answering questions and step-by-step explanations of techniques. Mentor feedback on errors, good points of practice and how to proceed the next time, delivered in a positive, reinforcing way, encouraged students to learn more. Mentees stated that a good mentor gives advice and that feedback was an important way for mentors to support mentees' enthusiasm and motivation. Similar findings emerged from a western study by Bradbury-Jones, Sambrook and Irvine's (2007) and a study by Elcigil and Sari (2008) in Turkey. For instance, Elcigil and Sari (2008) stated that useful, constructive criticism, patience, answering questions and nursing competence were four core aspects in effective mentorship.

For effective teaching, mentees emphasised that the mentor must have professional expertise (nursing skills and knowledge), agreeing with the findings of Papp, Markkanen and Bonsdorff (2003). Mentors must also employ up-to-date techniques to demonstrate their competence in the nursing field. Mentors regarded solely observing, acting as the mentor's 'shadow', to be an ineffective teaching technique. In an incident of ineffective teaching practice recalled by a mentee, the mentor refusing to let the mentee assist with a patient and referred to the patient as 'my patient', implying that it was inappropriate for the mentee to use her skills. This situation likely resulted in the loss of confidence and self-esteem.

An interesting point that emerged in the discussion of the learning experiences is the patient's role in the success of the mentee's learning experience. Mentees suggested that

hospitals should have support systems for the mentee if a patient refuses treatment. These procedures should include ensuring that patients are aware of the institution's status as a teaching hospital so that they could expect such an intervention. Mentees and mentors suggested that the mentor was placed 'in the middle' of a 'tricky' situation without such hospital processes.

Mentees also viewed learning from mentors as a mutual process. Mentors should share their skills, professional expertise, act as a role model and passion for the work, inspiring mentees to achieve high standards. Mentors should learn from mentees the newer techniques and theories. Mentees stressed that mentors should be prepared to develop their personal skills so they can adapt to diverse mentees and their stage of development, which might entail forgetting facts or learning to apply theory to a practical situation. In addition, it was vital that mentors continually update their knowledge to help to guide mentees and show them how to network effectively with other staff. Mentees strongly voiced the view that mentors should be willing not only to teach others but to continue their own systematic learning. Mentors, therefore, should be regularly evaluated by the mentees. The evaluation process should be unthreatening to mentees, who could feel intimidated and lose confidence in stating their beliefs.

In addition to the factors related to effective mentorship discussed previously, mentees mentioned other aspects of the environment and practices that kept them from maximising potential opportunities. Spending adequate time with the mentor was cited by mentees as a fundamental contributor to an effective mentor-mentee relationship and, hence, the quality of potential outcomes for the mentee. The mentor's availability was crucial to success but often was limited due to the mentor's own lack of interest, workload or imposition of hospital duties for an additional professional role. These

findings accord with those of Gray and Smith (2000). As also found by Jones, Walters and Akehurst (2001), the mentees, however, did not discuss adjusting their own arrangements in order to ensure they could spend time with their mentor. If the hospital recruited too many mentees, mentors would be assigned several students, which led to two barriers for effective mentorship. Each mentee received insufficient attention, and the mentor's workload became unmanageable unless the hospital limited mentor's work outside the teaching role. When some mentors are not available, mentees turned to mentors assigned to their peers, increasing pressure on those mentors. Alternatively, they might be assigned another mentor. This situation reflects the type of mentee disempowerment reported by Bradbury-Jones, Sambrook and Irvine (2007). Lofmark et al. (2009) and Shannon et al. (2006) discuss the hospital's role in creating barriers to effective mentorship. However, not mentioned is hospitals' over-recruitment of mentees. The large number of mentees assigned to a mentor as a result of increased student recruitment during cutting staff reductions was mentioned by Jones, Walters and Akehurst (2001) in a similar situation. Whilst possibly specific to the Saudi hospitals whose mentees participated in the study, this finding about the scale of student recruitment, could have wider applicability in the prevailing economic environment.

If the mentor was not supported or was discouraged from taking initiative during the difficult transition from the college to the hospital environment in the initial stages of mentorship, these factors all presented substantial barriers to effective mentoring. The lack of opportunity to actively participate in the practical application of knowledge in treating patients produced boredom among mentees and, eventually, withdrawal from the profession. Whilst Bradbury-Jones, Sambrook and Irvine's (2007) suggested that a poor experience with a mentor would encourage mentees to leave nursing, the findings of Beecroft et al. (2006) more closely align with the finding of this study that effective

mentoring processes increases retention of student nurses, although the importance of the initial stage is not emphasised. Given mentees' and mentors' comments about the lack of structured preparation for the mentorship programme, this factor likely is a widely applicable issue and significant in increasing retention levels in Islamic countries and elsewhere.

Mentors' inability to empathise with mentees' environment and life stage by recalling their own experiences and concerns at this stage result in the inability to anticipate mentees' reactions to the mentor's actions, VC and NVC. The mentee was likely to feel nervous and insecure about trying new procedures, and the mentor was often insensitive to these feelings, reducing the mentee's ability to overcome them. This problem could be alleviated by mentors sharing stories about their own mistakes or shortcomings at this stage in their career. The study findings suggested that often, the mentor has not discovered what drives the individual mentee to succeed in her personal goals, and that motivation might be very different from the mentor's at that career stage. A lack of understanding, especially when the mentee is unsure of her preferred career path, prevents the mentor from helping the mentee to devise a career plan and monitor progress towards it. While an empathetic approach might be generally expected in a successful mentor, its lack was not frequently expressed in the existing literature.

5.4.2 Mentors' perspective of the mentor–mentee relationship

Mentors' views of the existing mentorship process and the associated practices showed similarities to those of mentees, particularly regarding the support required and the key issues in optimising outcomes from the mentorship. Mentors held distinct views on the purpose and limitations of their role and the benefits of mentorship for their

development. These points are discussed in this section, along with the findings from the present study and the existing literature.

The preparation for collaborative working was identified as vital for the mentor, as well as the mentee, for achieving higher performance levels. Although mentees also identified this factor, mentors suggested that mentees must demonstrate their enthusiasm for learning in their willingness to volunteer to complete a task, rather than being assigned one by the mentor. Mentors also expected mentees to seek out new experiences, in which they were likely to find new opportunities for development, which increases knowledge transfer among peers, and collaborating in knowledge sharing as mentees observed or interacted with their mentor (Kaviani and Stillwell, 2000). Mentors held strong beliefs that mentorship worked best when mentee followed mentors' guidance in carrying out practical tasks.

While mentees were generally expected to do as the mentor instructed, there was one instance in which the mentee taking the initiative was actively promoted. This finding has two implications. Firstly, mentees expressed that being able to take initiative builds their confidence and self-esteem. The mentor's views could conflict with this development and hinder their motivation and self-belief, particularly if handled inappropriately by the mentor, as in the earlier example of a mentor stating 'do not go near 'my patient'. This finding also suggests the mentee's opportunities to volunteer to complete a new task are likely to be restricted by these conditions. As well, the mentee expressed the requirement to feel challenged but supported. Second, mentor might be restricting their own learning opportunities by not being open to mentees taking the initiative, despite the mentors' comment that mentees should engage creatively in the learning process.

Mentors suggested that their own development must be supported if they were to effectively support mentees, including maintaining their knowledge of current practices and techniques. If mentors did not do so and possessed less knowledge relative to mentees, it was likely to prove a barrier to mentors' effectiveness. Mentors also provided evidence that learning from the mentee was a vital part of their own development, especially for engaging in critical thinking of theoretical knowledge which added to clinical practice. This practice also supported mentees' application of theory into practice. Shannon et al. (2006) and Kaviani and Stillwell (2000) also found that mentors' held a positive attitude to mentoring and learning from students.

Although the present student did not explore motivations for become a mentor, other researchers, such as Shannon et al. (2006), found that such factors as driving the mentor's career progression and the joy in helping students to learn new things were motivators to becoming a mentor. Similarly to the findings of Lofmark et al. (2009), mentors cited the learning they experienced from the link between university classroom and the hospital practice as critical to the development of mentorship. Lofmark et al. (2009) went further, recommending that collaboration and communication about policy issues between the two agencies could better support mentees' transition.

Mentors suggested that some mentees were given more learning experiences than others due to their greater interest in learning, which concurs with the earlier remarks about volunteering. Mentors also highlighted student's level of fear as restricting learning, a situation worsened by some mentors' unwillingness to support mentees in their insecurities. Mentors were convinced that regular feedback and praise for good practice was needed to keep the mentee motivated and that this feedback should be accompanied

by comments on how to improve. Mentees also expressed this view. Mentors pointed out that mentees should undergo regular evaluation and receive feedback.

Mentors also mentioned the patient in regards to the tension between ensuring patient care and appropriate, practical mentee learning according to defined protocols. This finding which represents a barrier to learning is significant and widely applicable to a number of settings as without defined roles and protocols to ensure the patient's well-being, the mentorship process cannot proceed. This barrier can seriously inhibit learning and the development of the personal characteristics necessary for the high-quality professional practice to which mentees should aspire.

Mentors perceived their main function as a role model to stimulate students' interest in work and to preserve the patient's interests, as the mentor is ultimately responsible for the patient's well-being. In order of priority, mentors ordered their responsibilities to mentee as giving guidance, teaching and being enthusiastic about work. These findings are supported by Kaviani and Stillwell (2000), however, mentors in Kaviani and Stillwell's (2000) study specified the skills they felt were required for doing so.

Mentors felt that mentees had little awareness of mentors' workload issues, although some mentees suggested they were aware that these lead to mentors' lack of availability and replacement by other mentors. In one case, the mentee understood that her mentor continued to carry out her mentor role effectively despite her heavy workload. Mentors cited a lack of time and the feeling of being overburdened by many tasks as major barriers to success, confirming findings by Shannon et al. (2006) and Beecroft et al. (2006). Some mentors suggested that having fewer patients would enable them to spend more time on a longer term basis with mentees.

Mentors mentioned communication issues as a contributing factor to an effective mentorship experience, particularly language skills and getting to know more about the mentees' goals. This study was conducted in Saudi Arabia, the language issue, which is not mentioned in other studies, is likely to have a narrow applicability to countries where the mentor might not be a native speaker of the dominant language. However, Nahas (2000) did cite cultural issues as affecting the teaching and learning process in general, and language barriers could be included in this category. The specificity of this issue to this study and to similar countries is reinforced by mentors' comments that language differences affect learning. Although this remark could reflect the 'mothering translating' expectation of Jordanian nurses found by Nahas (2000), the mentor's lack of fluency in Arabic presented several barriers to effective mentorship. Sometimes, the mentee could not express their knowledge of ambitions in English, making supporting and assessing them more difficult. This factor likely seriously affected mentees' confidence, self-esteem and ability to relate effectively to the mentor. All mentors acknowledged that they needed to find ways to create an environment of open communication that encouraged mentees to ask questions and to avoid losing patience when mentees were too frightened to use the skills. The language barrier also made the transition from classroom to practical application in the hospital more difficult. Mentees did not specifically mention language as a factor in this period, but it does appear as if it could be a major factor in the barriers mentioned by mentees and reported in the preceding section.

The language differences and issues of open communication raised by mentors could be due to ethnicity and cultural differences between mentors and mentees. Evidence suggests that communication issues between mentees and their mentors may arise due to ethnicity or cultural disparities (Wilson and Elman, 1990). It has been shown that

these relationships thrive when both parties are from the same ethnic group (Campbell and Campbell, 2007; Gonzáles-Figueroa and Young, 2005). However, when mentors or mentees come from different ethnic backgrounds this can influence the effectiveness of communication between these parties. This may stem from a variety of factors, such as shared beliefs, cultural norms, or religious outlooks. Therefore, overcoming language barriers may not be the only factor that needs to be considered here. Differences in body language and cultural norms are also relevant, as are the beliefs that individuals hold about different ethnic groups. Thus, each of these factors should be considered when communication issues arise.

In Saudi Arabia, where there are a large number of non-Saudi nurses within the workforce, there are often cultural differences between mentors and mentees. In particular, these include the significance of Islam for Saudis, local constructions of honour, the ties of the extended family and the ways in which women are protected within the culture (Aboul-Enein, 2002). An awareness of these issues is paramount to optimise relationships between non-Saudi and Saudi mentors and mentees. Cultural awareness and understanding of family dynamics and language can be developed with orientation training for expatriate nurses (Aboul-Enein, 2002), providing non-Saudi mentors with the tools to provide understanding and support to Saudi mentees. Where this training is limited, it is important for non-Saudi mentors to ensure they are orientated as well as possible within Saudi culture, for example, making choices of Arabic language seminars and discussions with Saudi colleagues (Aboul-Enein, 2002). As Jirwe, Gerrish and Emami (2006) highlighted, there are likely to be communication issues between mentors and mentees due to cultural and language differences, but reducing these barriers enhances mentorship, leading to better outcomes for both parties.

In addition to the factors discussed above, the aspirations or aims of these individuals may differ, so mentors may have different goals from their mentees at work. This, in turn, may influence their communication as the two parties may be focused on attaining completely different outcomes, and as they communicate conflicts may arise between the two groups (Kalbfleisch, 2002). Of course, conflicts may also arise because various roles have competing priorities or status, which may affect a mentee's attitude towards their mentor or vice versa (Beech and Brockbank 1999). Thus, numerous factors can influence how mentors and mentees communicate with each other.

From both the findings discussed here and those present within the literature, it seems that the foundations of formulating an environment where these types of relationships may thrive can be derived from factors such as risk taking, the creation of open dialogue or the formation of new horizontal relationships that take precedence over existing institutional vertical ones (Darwin, 2000). Therefore, by moving beyond the traditional top-down relationships that exist in workplaces, the mentee and mentor are able to create a more functional approach to enable a supportive and creative learning environment to evolve. In turn, this promotes a partnership between these two parties, which can lead to openness in communication, where both share their vulnerabilities and trust is fostered. Therefore, this relationship takes on a new dynamic form that goes beyond the traditional mentor–mentee relationship, where power and authority have been fundamental or have caused barriers to open communication (Wilson and Elman, 1990). Furthermore, issues that may have arisen due to differences between these individuals are placed to one side. In this way, the problems associated with power or authority are removed as a new form of open communication evolves between the mentee and mentor. Thus, if both parties are willing to undertake a journey together to

enable them to forge a new means of sharing dialogue this can have a positive impact on mentorship experiences (Beech and Brockbank, 1999; Gardiner, 2008).

A large proportion of mentors preferred to have the option to volunteer to serve as a mentor, rather than having the duty imposed as an obligation. This preference might explain the lack of correlation of motivation to be a mentor with the finding by Shannon et al. (2006) that mentors volunteered for the role. Incentivises could motivate individuals to more willingly be mentors. Mentees tended to agree that mentors should receive rewards to encourage them to spend more time in the mentoring role. According to Shannon et al. (2006), the time spent mentoring students increased workload.

5.4.3   Summary

The findings of this study suggested that the views of mentees and mentors in Saudi Arabia are in quite close agreement with the findings of published research conducted in western countries and Islamic nations. However, several new findings have added to previously published knowledge. In addition, some factors mentioned in the literature review were not found to be present in this study, as stated.

As suggested by other studies, the mentor–mentee relationship is a vital one (Lofmark et al., 2009; Shannon et al., 2006; Jackson et al., 2003; Earnshaw, 1995; Hunt and Michael, 1983). The effectiveness of mentorship is influenced by the existence of defined processes and procedures, which have impacts on mentors and mentees. In accordance with previous studies, mentees suggested that the support and encouragement from mentors and their professional standards, knowledge and availability were vital factors. However, mentees emphasised the need to be actively, not passively, involved in patient care and to be allowed to use their initiative. Mentors also stated that the effectiveness of mentorship was increased by spending more time

working together with the mentor in the practical setting, which facilitated knowledge transfer.

Many key factors identified in this study, such as effective communication and mentors' time availability, agree with previous research. Factors cited by mentees included the importance of mentors' willingness to encourage mentees' initiative, adequate preparation, awareness of up-to-date techniques and knowledge and desire to learn from mentees who take the initiative. Caring for patients and recruitment of students by hospitals, which affected mentors' availability and the mentor–mentee relationship, were external factors that had an impact on that relationship.

Mentors raised the issue of language as a key aspect of communication and learning, along with sufficient training and support for continuous professional development. Mentors also mentioned the importance of mentees volunteering to try new experiences, being prepared by studying before engaging with patients and having their performance formally appraised. Mentors and mentees agreed that successful induction processes and procedures help in the initial transition and influence mentees' motivation. Empathetic treatment of mentees' feelings and actions by the mentor and helping to define goals and develop a career direction were important aspects in effective mentorship.

The literature review highlighted many gaps in research on mentorship of student nurses, which this study has closed to some degree. The present study has contributed knowledge of students' actions that increase the effectiveness of mentorship, as identified by mentors in this study. Mentors believed that the willingness of some mentees to volunteer increase their opportunities to learn. The degree of detail provided by mentees of what readiness for mentorship should look like is a useful contribution. In

addition, the patient's role in enhancing the mentee's experience in the hospitals had not been suggested in other research.

One cultural difference identified in this study's findings was the issue of language. This factor has not been mentioned elsewhere, likely because the majority of earlier studies were conducted in developed, western countries.

This study has highlighted issues of resources, including time, which other studies had mentioned. The issue of hospital recruitment of too many students had not been raised elsewhere. Additionally, a new resource issue that emerged from mentees' comments in this study was the need to increase patients' awareness that mentees might perform clinical procedures and to devise and implement appropriate protocols for doing so. The study also touched upon performance assessment for mentors and mentees. Previous research has addressed the assessment of mentees but not mentors. In this study, mentees stress the need for a mentorship training programme to achieve an effective mentor-mentee relationship. These factors highlighted in this study offer interesting possibilities for further investigation of their potential impact on increasing the effectiveness of the mentorship process. The findings of this study have added to the knowledge on mentorship in developing countries, which have received little attention in the literature. In addition, the study has raised a number of opportunities for further research.

The following chapter presents a critical evaluation of the effectiveness of the different methodologies used in this study. This appraisal focuses on the differences in the findings of the two studies as a consequence of using different approaches (case study and AI).

6 Commentary two: Comparison of the methodological approaches of the case study and main study

6.1 Introduction

The two studies reported in this thesis were intended to gaining a broad yet detailed understanding of the perceptions and experiences of mentorship held by nurses, student nurses and others involved in the mentoring process in Jeddah, Saudi Arabia (refer to section 3.2.5 for details on the sample of the case study (first study) and section 5.2.5 for the sample of the main study (second study)). The first study which was the case study conducted in one hospital and its collaborative nursing college had two research objectives: (1) to explore the perceived concept of mentorship in nurses' experiences and (2) to investigate the existing practice of mentorship in clinical practice. The second study, which was the main study, was based on the findings of the case study that demonstrated that the majority of those involved in the mentorship programme found at least some aspects of it unsatisfactory. In the main study, mentorship experiences were investigated by exploring the factors that contributed to a positive mentorship experience for the mentors and mentees. The research intended to make recommend specific interventions to support nurses' clinical practice and develop effective mentorship. For example, two contributions of the main study were the recommendation for frequent interpersonal evaluation between mentors and mentees and the use of constructive feedback from both parties during the mentorship process to improve nurses' competencies and self-reflection.

A different research methodology was chosen for each of the two studies, which were underpinned by the epistemology of constructionism and whose design and analysis resulted from the theoretical perspective of interpretivism. In the interpretivist approach

employed in the overall study, the researcher assumes that the reality experienced by individuals is inextricably linked to the meanings and understandings that they develop socially and experientially and that, therefore, social reality is created by the individuals who participate in it (Angen, 2000). The interpretivist inquiry concentrates on examining the differing realities created by individuals as they interact in a specific social environment; truth results from negotiation in interaction and dialogue (Lin, 1998) (see section 3.2.1 for more details on interpretivist approach).

The first methodology was a case study, which was useful in gaining an understanding of the process of mentorship in Saudi Arabia and undertaking a preliminary investigation that provided baseline data for the main study. Thus, the research aim and questions of the main study were based on the findings of the case study. However, the majority of the case study data were problem focused and provided very little information on what good quality mentorship might be like. Consequently, the main study utilised an AI approach, which focuses on discovering the positive aspect of a phenomenon, not on the deviations from what are considered the acceptable norms. The findings of the case study suggested that there were significant issues for both the mentors and mentees with the existing mentorship structure, particularly its implementation and monitoring.

The AI approach aims to promote organisational development by focusing on the valuable work being conducted within organisations. AI positively recognises that every organisation has developed some good practice when attempting to effect organisational change (Whitney and Trosten-Bloom, 2003) (see section 5.2.2.1 for more details on AI approach). AI is more concerned with the aspects of practices that the actors consider valuable and can be extended to future practice to make the organisation more

successful. AI thus clearly contrasts with traditional approaches that seek to examine barriers or deficits and find solutions for them. In order to achieve this, questions asked of participants are framed in a positive manner, so that the aspects of good practice and of successful mentorship that existed are identified.

The AI approach is especially relevant to the main study as it best suits the perspective and context of the investigation. First, the use of the AI approach supports the social constructionist perspective of the research, implying that the AI approach is beneficial for the interaction and communication between mentors and mentees. The AI approach promotes respect for the reality of multiple truths and varying perspectives whilst encouraging appreciation of knowledge and novel information offered by both parties. Second, as the case study (first study) revealed that mentorship was inadequate and that the emphasis was placed on negative mentorship experiences, it is appropriate to suggest that the AI approach is significantly relevant as it promotes self-discovery by both mentors and mentees and provides a compassionate climate for individuals to share and communicate revelations.

In the main study, participants were asked to analyse their positive experiences and to then reflect on what circumstances would present the best and ideal experiences of mentorship in the future. It was anticipated that new issues might emerge related to effective mentorship in a different cultural setting than those studied in published research. As well, the study might reveal new ways of implementing mentorship practices that invigorate participants through opportunities to exchange positive experiences, discover their strengths and validate their own worth.

However, the case study explored the topic broadly, perhaps at the expense of an in-depth understanding of one location (the hospital) and its collaborative nursing college.

The main study was restricted to one hospital and two nursing colleges, enabling greater depth of understanding to emerge, perhaps at the expense of broader knowledge about how the same phenomena manifest elsewhere. Thus, the two approaches were complementary. In addition, the data collection methods (see section 3.2.6 for the case study and 5.2.6 for the main study) enable an objective comparison of the findings related to use of different research philosophies.

6.2   Comparison of findings in relation to the research methodologies employed

As different methodologies (AI and case study) were employed, it was worth considering how these might have influenced the findings of each study. Thus, the researcher designed questions exploring 7 aspects of the research methodologies' impact on the findings (see Table 8).

Table 8: Questions exploring 7 aspects of research methodologies' impact on the study findings

1.	In what way did the different objectives for each study influence the findings? As expected or not?
2.	How did the first study inform and shape the second study, in ways which might not have been the case if first study had not been conducted?
3.	How did employing the four stages of the AI approach support or detract from the findings?
4.	In what ways, if at all, did that the possibility in the second study for participants to be invigorated by opportunities to exchange positive experiences, discover their strengths and validate their personal worth and the value of others in the organisation generate different outcomes?
5.	Did use of the AI approach in the second study drive participants to become involved in decision making, and did this affect the quality of information?
6.	Was communication enhanced by the AI method relative to the use of the case study method?
7.	To what extent did the combination of the two approaches (case study and AI) enable a greater, more in-depth understanding of the perspectives on mentoring held by a range of constituencies?

To begin to answer these questions, the researcher completed a comparative analysis of the findings and outcomes of the two studies (S1 and S2), presented in tabular form (see Table 9). The results of the comparative analysis (Table 9) demonstrate that information of a different nature was elicited from the two studies by the X coding, which identifies its source. The findings analysed are presented by theme. The source of the information recorded for each of the A–P themes is identified as S1 for case study and S2 for the main study using AI. The main comments relevant to each theme are summarised under that heading. The occupational role of the main participant(s) who provided the recorded viewpoint is identified in the column labelled 'origin'. The comments column

allows quick reference to specific points that the researcher would like to highlight. A key to the abbreviations used is given at the top of Table 9. Next is a discussion of each theme listed in Table 8 followed by the researcher's reflections on potential answers to the questions in Table 8.

Table 9: Comparison of the findings from the case study and the main study

Key: GK: gatekeepers, SN: staff nurse, STD: student, HN: head nurse, NL: nursing lecturer, NC: nursing coordinators, DR: document review, (2): comments specifically from the main study, FG: focus group, PI: performance improvement (recommendations/implications of the results)

Outline of findings	S1	S2	Origin	Comments
A. *Confusion about what is meant by the term 'mentoring'*				
We don't do mentoring of 2nd-, 3rd- or 4th-year students.	X		GK	Preceptoring means that nursing
We do preceptoring not mentoring.	X		GK	students accompany and shadow the
				staff nurse during shift hours.
The NL believed mentoring to be shadowing, following a preceptor round, and not getting involved but offering mentees guidance, support and help in obtaining clinical objectives.	X		NL	A mentor provides advice and is a role model. We do not offer this (GK) **Conflicting statements**
B. *No clarity over who is responsible for mentoring*				
Staff nurses NOT responsible for mentoring students.	X		GK	
Staff nurses responsible for ONLY mentoring interns.	X		GK,SN	
Staff nurses ARE responsible for mentoring students.	X		NC	
Hospital policy documents do not suggest that mentorship is offered.	X		DR	Linked to SN happier with interns
Mentorship is the college's responsibility.	X		SN	Agreed elsewhere by all in various
Flaws in system current scheme are not beneficial to students.	X		NC	forms
C. *Workload*				
Combining teaching and working during individual shifts is difficult (7–9 patients/shift).	X		All FGs SN	
Mentoring students slows down nurses' work.	X		SN, STD	Giving the explanations, the patient
I have the feeling of slowing the mentor down.	X		STD	must be considered as the first priority.

Outline of findings	S1	S2	Origin	Comments
D. *Stressful and other negative emotions*				
Mentorship is a big responsibility, the work environment is stressful, and the workload is too much.	X		SN	
Doing two roles is resented.	X		SN	
The college not giving information or guidelines is resented.	X		SN, HN	Flaws in system are noticed more.
Saudi students are resented by foreign mentor nurses because Saudi students do not need to work and are future rivals for work since the Saudisation policy.	X		STD	
Mentors fear letting mentees work practically with patients.	X		SN, STD	
Students have a sense of fear.		X	SN, STD	
E. *Roles and responsibilities not clarified*				
Duties are uncertain. Mentoring is not specified in the job description but is part of the job.	X		SN	Potential improvement and **conflicting statements**
Information from college of what is expected of them is not received.	X		SN, HN	Potential improvement
No clear objectives are given by course leaders … but expected mentees to concentrate on studies.	X		STD	Potential improvement e.g. more focus on report writing than bedside care
F. Practical difficulties with time				
Uneven distribution of preceptorship time means that students lose out.	X		SN	Potential improvement
Student nurses work only mornings until midday.	X		SN	Potential improvement
Opportunities for learning in the afternoons are missed.	X		SN	
SNs do not feel supported as their heavy workload is not reduced or rearranged.	X		SN	Potential improvement
The programme is not structured to help nurses manage time.	X		SN	

Outline of findings	S1	S2	Origin	Comments
G. Other Practical Difficulties				
Preceptor receives no support from the college or hospital.	X		SN	
Planning is lacking, and policy is needed.	X		SN,STD,HN	Potential improvement
Communication between the college and hospital is lacking.	X		SN, HN,STD	Potential improvement
The college provides no practical checklists for to what nursing students are expected to cover.	X		SN, HN	Potential improvement
Nurses have no idea of what the student knows.	X		SN, HN	
Preceptors are changed frequently for convenience, resulting in a lack of continuity in relationships and patterns.	X		HN	Potential improvement
All students 2nd to 4th year and interns arrive at same time of year; more organisation is needed.	X		HN, SN, NC	Mentorship not effective, too few staff (NCs)
The time spent by STDs in each ward is insufficient to become familiar with the units' practices.	X		NC	Potential improvement
The colleges do not make STDs aware of nursing patterns so that STDs arrive at the right time of morning and work to a satisfactory standard.	X		HN	
STDs do not get enough support from the hospital.	X		NC	
Saudi students encounter language barriers and communication issues with foreign nurses.	X		STD	Cultural
Language barriers and Saudi cultural norms result in Saudi nurses not wanting to work with male patients or do night shifts.	X		SN, NC	Cultural; also according to NC husbands and families do not allow and do not consider it appropriate for a woman to work with males or at night.
Patient refusal can affect the training programme and mentees' confidence.		X	SN	(2) new point not mentioned elsewhere or in literature

Outline of findings	S1	S2	Origin	Comments
H. Mentor-mentee relationship				
The nurse often has more than one mentee, which negatively affects the relationship.	X		SN, STD	ER nurse most affected
Preceptors find mentoring mentee boring.	X		STD	(2) Mentor demonstrating her effort (e.g. by helping mentees, taking on non-assigned work).
We feel we are a burden to SNs.	X		STD`	Up to 3 STDs per nurse at a time
Students tend to withdraw from process if not accepted by the mentor.	X		STD	
I spend time with other SNs instead.	X	X	STD	Mentors' attitudes to taking on other SN's mentees
I changed my mentor to another SN who is willing to help.	X		STD	
Students are not motivated.	X		SN	
Communication is not good because preceptors fail to cooperate or take initiative.	X	X	HN,STD, SN	(2) STDs' comment on coming prepared and with the right attitude and mentor facilitating open communication with STDs
Language barriers contribute to poor communication between parties.	X	X	HN, SN,STD	(2) English and Arabic need by STDs; student sometimes too scared to express themselves(Cultural)
Policy requires STDs to be assessed before attempting clinical practice.	X		HN,SN,STD	
Students do not understand why they may not do simple tasks.	X		STD	
SNs do not know whether STDs may do certain tasks.	X		SN	**Source of conflict between all parties**
Few mentors are friendly, knowledgeable and willing to teach.	X		STD	College blamed as no guidelines given to SN. Potential improvement
In cultural issues between mentors and mentees, Saudi STDs found Saudi nurses to be more helpful than mentors of other nationalities.	X		STD	Empathy from Saudi nurses who
Nurse of different nationalities grouped together.	X		STD	followed the same career path

Outline of findings	S1	S2	Origin	Comments
I. Suggestions for improvement in the mentor-mentee relationship				
Spend more time with the mentor.	X		SN, STD	Potential improvement (2) Mentor must be available.
Improve communication.	X	X	SN, STD	Potential improvement
Reduce workload of SN so they can spend more time with mentees.	X	X	SN, STD	Potential improvement (2) Hospital must assign mentors fewer mentees.
Preceptors need to have fewer patients in order to fulfil both roles.	X	X	SN, STD	Potential improvement
It is important to feel engaged with the mentor.		X	SN, STD	
SNs need to be more prepared for practice, have adequate time and instruction and come with the right attitude.		X	SN, STD	Potential improvement
Mentors should inspire the mentee and share learnt skills and knowledge.		X	STD	
Mentees need to gain a better understanding of the mentor's workload.		X	SN, STD	
J. Student Motivation				
Some STDs display a lack of interest, motivation and desire to learn or develop their career.	X		SNSTD	NCs felt this might be cultural.
STDs do not show an interest in hands-on skills that can be developed only in the hospital setting.	X		SN NC	Mentors' want STDs to come with positive attitudes.
STDs do not try to communicate.	X	X	SN, STD	
STDs should ask more questions.	X		SN	Potential improvement
Initiative should come from STDs.	X		SN	e.g. (1) Can I do it for myself? (2) show
STDs motivate SN to teach.	X	X	SN	willingness to participate, volunteer,
STDs are reluctance to participate.	X		SN	take initiative (1)
From the first day, you know if they are interested or not.	X		SN	STDs take frequent breaks and refuse to
Some preceptees are reluctant to take on certain jobs, lack discipline and are not punctual (start late, leave early, leave during working hours without notifying anyone).	X		SN, HN	work with some patients.
STDs do not behave well and refuse to take orders.	X		HN	Among those who do not appear
STDs do not feel supported by college or hospital.	X		STD all	motivated

Outline of findings	S1	S2	Origin	Comments
The assessment of STD is not trusted by STDs because college instructor assess their level of practice without observing them.*	X		STD all, NC	Potential improvement
Mentors should continually assess and give mentees feedback.		X	STD	(2) In approachable, accessible way
Some STDs merely want the BSc degree and not to be a nurse.	X		NC	(PI)
Students should come in every day, learn from other mentees and take more opportunities to observe and get involved.	X	X	SN	
K. How to improve student motivation				
Good planning and structure are needed.	X	X	SN	SN recognises their responsibility for
STDs often uninterested because there is no orientation to the big picture.	X		SN	motivating STD
Mentors must guide STDs through the initial stages of implementing training.		X	STD	(2) Giving guidance on 5 occasions (PI).
*Mentors should give input in clinical assessment		X	STD all	Potential improvement
Mentors make STDs feel more appreciated and build their confidence in a difficult task that is doable.	X	X	STD	Potential improvements based on specific interventions, not general
Positive experiences with challenging tasks increase interest and commitment to nursing (e.g. more overt communication and support).		X	STD	comments
STDs need to feel challenged but supported at the same time (balance).		X	STD	
STDs and mentors should both be fully prepared for the task.		X	STD, SN	Potential improvement—both will do a
STDs should be encouraged to try more things and repeat practices they have already successfully done to improve learning.		X	STD, SN	better job and be more objective and informed
Mentor should show STDs respect by involving them in as many activities as possible.		X	STD, SN	(2)STDs sometimes do not think they need to repeat the same technique.
Mentors provide positive feedback, even for doing simple procedures.		X	STD	

Outline of findings	S1	S2	Origin	Comments
L. Students' emotions				
STDs feel dejected and useless because they are not allowed to carry out simple clinical tasks	X	X	STD all	(2) Negative reinforcement discourages STDs. Just be my shadow, switching off and leaving are ineffective.
Trapped in the middle between SNs who will not allow them to do tasks and college instructor who demand them to	X		STD	**Conflicting statements by SNs and NLs**
Mentees need to be prepared in terms of self-esteem, confidence, technical skills, eagerness, respect for mentor and self-motivation to be worthy of being taught,		X	STD, all	
Mentors who provide confidence need to have courage and passion carry out a seemingly undoable task: creating a feeling of pride, trust in oneself and independence in STDs. The interplay between self-respect and mentor support is vital.		X	STD	(2) opposite emotions if a positive approach taken by mentor (PI)
A sense of fear mentioned was a major barrier for STDs that could be overcome them college instructor support.		X	STD	(2) Specific actions by mentees + large workload, new environment, new STDs
Mentees fear working practically with patients.		X	STD	(2) Mentor must show mentees the clinical procedure first, and then mentees will try it. They need the mentor to be patient.
Mentees must remain motivated and be kept so by the mentor constantly giving praise when they do well and suggesting how they can improve.		X	SN	(2) Specific actions of mentors mentioned by mentors
Mentees must be self-motivated.		X	SN	

Outline of findings	S1	S2	Origin	Comments
M. Preceptor motivation				
SNs need to be more committed and dedicated to get more from their role.	X		SN, HN	
STDs could help preceptors with tedious tasks.	X		NL	
If the SN does not accept a preceptorship, she will not cooperate with STDs. If she does, she will do it well.	X		NL	
When preceptors are allowed to carry out clinical practice against policy, SNs have the ultimate responsibility for anything that goes wrong.	X		SN	
Mentors are more motivated to work with interns than nursing STDs.	X		SN	
Mentees should show that they are trying to relate theory to practice.		X	SN	(2) Otherwise feel negative reinforcement and discouraged from learning. Initially no self-trust or experience working with any patients
Mentors must show mentees how to apply theory. Trust in self has to be fostered from outside the mentee by the mentor,		X	STD	
Mentor will not always find it easy to work with mentee, but it is the mentor who must 'fit' and constantly learn, even ways to work with a difficult mentee.		X	SN	
Developing standard institutional strategies could improve mentorship.		X	SN	(2) PI
N. Preceptor skills				
Mentor lack confidence and talent, have limited experience and the wrong personality and do not cooperate with STDs.	X		NL	NL predominantly negative about SNs
Poor communication, including non-verbal aspects such as mentor's body language and mannerisms, were highlighted as either improving or hindering support.	X	X	STD	
Chemistry with the STDs has the greatest effect on productivity.		X	SN	(2) Specific to main study
The mentor should empathise with the mentees' fears by reflection on her own at that stage of her career.		X	SN	Mentioned many times in various forms
The mentor should be good at giving advice and feedback in approachable ways.		X	STD	(2) Guidance on how to make the transition
The mentor should allow the mentee to have a stake in her learning, plan		X	STD	(2) Positive encouragement for task

Outline of findings	S1	S2	Origin	Comments
it together and help identify the traits characteristic of professionals.				completed and telling mentees how to avoid mistakes
The mentor should allow the mentee and respond carefully.		X	STD	
The mentor must be a good nurse, including have good patient skills.		X	STD	(2) PI
The mentor should have the mentee to watch her dealing with patients and supervise and give feedback on how the mentee deals with patient.		X	SN	
The mentor has to protect herself and the patient and make sure that the mentee uses the correct protocols.		X	SN	(2) Getting balance is tricky because there is so much to do at once.
The mentor must find out what the mentee knows, perfect those skills and holistically show mentees what their professional duties are, not one skill set at a time.		X	STD	(2) PI
The mentor must be confident and trust STDs. This will empower STDs and give them courage. Mentors skills also being improved during the learning process with the mentee		X	SN, STD	(2) STD is more confident when mentor demonstrates she is confident
'Don't touch my patient' has the effect of alienating STDs and decreasing their confidence.		X	STD	(2) can have long term effect on STD to extent of leaving profession
The mentor must find out mentees' dreams and goals and know what behaviour would comfort the mentee when frightened.		X	SN, STD	(2) Mentee often has goals but does not know how to accomplish them. SN
The mentor must listen to questions and not assume that mentee knows things she might not yet have learnt or have forgotten.		X	STD	mentees do not tell their mentor their goals.

Outline of findings	S1	S2	Origin	Comments
O. How to improve preceptor attitudes				
Employ extra staff specifically to reduce SNs' workload.	X		SN	Potential improvement
Introduce monthly shifts for nursing and preceptorship.	X		SN	Potential improvement
SNs receive no further development support after the orientation course.	X	X	HN	(2) Introduce on-going training (PI)
The SN should be given formal mentor training and know about evidence-based research, for instance.	X		HN	Potential improvement
Mentors should be selected on the basis of their education. Not everyone is suited for the role.	X		HN	Potential improvement (2) 4 responses of this
The mentee accepts what the mentor says.		X	SN	
Mentees describe qualities of good mentors as patience, attentive to mentor duties, awareness, enthusiasm, fair, mutual support, updated knowledge, networking with all staff and imparting practices to mentees.		X	STD	(2) ideal person specification from mentees
Mentees should spend more time in the hospital on a volunteer basis to show interest in learning more.		X	SN	(2) Volunteering in the hospital more
P. General improvements not specified earlier or clearly enough				
Colleges clearly plan and outline their expectations of preceptors and preceptors.	X		All	Not specified in the findings
Benefits should made available to nurses who act as preceptors, such as improved salary, reduced working hours and fewer patient assignments.	X	X	SN, NL, STD STD, SN	
Preceptors should have only one to two STDs.	X		SN, STD	(2) SN did not specify a number. STDs did in (1)
All nurses in the unit should undergo standardised orientation to help with time management.	X	X X	NL STD, NC	
Preceptorship should be expanded to embrace mentoring, including giving advice and education outside the hospital setting.	X		STD	
Communication with the hospital should be improved, and STDs provided with academic programmes, curriculum, clinical placement objectives and policies of what they may do.	X		STD	(2) Mentees should evaluate mentors regularly throughout training. Knowing
The HN should introduce STDs to mentors.	X		STD	mentors are constantly learning, too,

Outline of findings	S1	S2	Origin	Comments
STD should be invited to give feedback to the HN about their experiences in preceptorship.	X		SN	helps mentees relate to mentors.
Mentors should be formally evaluated.	X		SN	(PI) Evaluations by mentees should be anonymous.
Mentors stated that, unless their workload was reduced, evaluation of their mentoring would not be effective.		X	SN	(2) PI might not be realistic without this.
		X	SN	
Mentors stated that, without on-going training, they might become complacent. Not enough attention is paid to mentors' training while mentees are learning new techniques, which could create a knowledge gap.		X	SN	(2) PI for learning and development
Mentors need more resources.		X		
Mentoring should be voluntary.		X		(2)None specified other than time/staff
The mentee–mentor relationship should be longer term.		X		(2) PI

Table 9 identifies the insights gained from both studies and their overlap. The comparative analysis indicates the value of both methodologies in developing a more holistic understanding of the mentorship process as it occurs in this case. The findings analysed (themes A to P) listed in Table 9 are discussed. Themes which are linked together are combined under one heading.

Theme A: Confusion about what is meant by the term 'mentoring'

The responses recorded under theme A demonstrate that there was fundamental lack of shared understanding of the meaning of the term 'mentoring' among those likely to be most involved in shaping the programme for teaching student nurses professional practices. The lecturers' comments suggest they had little comprehension of the hands-on nature of students' experience in clinical practice as part of their assessment to become qualified nurses. Head nurses whose role was mainly administrative also had this view, and although the mentorship implied the element of giving advice, this was not understood by these two influential groups. The lack of a standardised definition of mentorship gave rise to different official policy in the two institutions and left no one ultimately responsible for administering the initiative.

Theme B: No clarity over who is responsible for mentoring

It was unclear which individuals or groups were ultimately responsible for the mentoring of students. Some head nurses believed that staff nurses were responsible, while others did not. The nursing coordinators, whose role was to act as liaisons between the hospital and college, stated that the staff nurses were designated as mentors. However, the two institutions had no policy documents confirming that a mentorship-like arrangement was an integrated, official part of nurses' training. Based

on this evidence, staff nurses interviewed did not feel that the responsibility was theirs. College lecturers perceived the staff nurses as responsible but only on a voluntary basis.

Themes C, D, E, F and G: Workload, stress and other negative emotions, unclear roles and responsibilities, time management issues and other practical difficulties

All groups believed that the professional patient care workload of mentors (theme C) was too great to permit effective teaching and mentoring of students. The fundamentally conflicting views of roles and responsibility were intensified by the anxieties of staff nurses and students, and the consequences of those feelings were noted in comments classified in themes D to G. Strong resentment was expressed about several aspects of the mentoring process, particularly systemic flaws, the scheduling of student training, lack of information from the college, and the socio-cultural aspect of Saudi students being rivals for future employment opportunities of foreign (non-Saudi). Foreign nurses saw the transfer of their knowledge to Saudi students as a threat to their own careers. Students also resented the lack of clarity in expectations for what they should achieve. Students pointed out that the emphasis remained on theory, not the improvement of their practical, professional skills. These first seven themes, which all result from looking at the experience in a critical manner, expose what are considered significant cultural and organisational flaws that detract from the basic goals of the mentorship initiative: to support the student nurse in gain the experience, confidence and skill level necessary required to enter the profession. These themes also indicate the positive interventions that the actors perceive would enhance the activity that is currently in place.

Themes H, I, J, K, and L: Mentor-mentee relationship, suggestions for improvement in mentor-mentee relationships, student motivation, how to improve student motivation, student emotions

The analysis demonstrates that, once participants considered the relationships between the different groups of actors, the views and opinions expressed in the case study reflected some personal measurements against what was expected. The positive focus of AI provided additional valuable insight into the operation of the mentoring process. The mentor–mentee relationship (theme H), though, elicited more negative responses than expected from the methodology used. The comments column summary suggests that some specialist departments in the hospital, such as the ER, are most burdened by the responsibility of acting as mentors to students. It is believed that the distribution of students among staff nurses might not be objectively planned as some have more students than others. The opinion from both students and staff nurses think that good preparation by both groups leads to more positive results is a significant finding.

Language differences as a potential communication issue were highlighted and were believed to reduce students' willingness to participate and to increase their anxiety regarding participation. Communication as a positive means to enhancing both mentors' and mentees' learning and development was found to be a crucial factor for both groups in a number of senses. The responses suggested that, in instances in which the communication was positive, the student experienced self-confidence or felt supported in trying new techniques or expressing opinions.

A positive response to themes G and H suggested that both students and mentors agreed about the continuation of the relationship and made similar suggestions for improving current practices. These similar views imply that implementing processes that integrate suggestions would be acceptable and support the needs of both parties. A key example

was the need for the mentor to be allocated fewer patients and mentees in order to allow more time for quality communication between the parties. This measure would also allow the mentor to prepare for that role more effectively.

The themes J, K and L focused on students' emotions and motivations as professionals and as mentees. Again, there was substantial agreement between mentors and mentees about the barriers to better performance outcomes. From the mentors' perspective, these appeared to centre on assumptions made about students, whereas students pointed to conflicts in their practical work and their theoretical studies, which might have been the root cause of the lack of motivation perceived by mentors. This implication implies that this factor might require further investigation.

A potential complementary factor was that students' capability and attitudes towards practical training were not considered in the overall assessment process, since the staff nurses' views were not consulted, and lecturers did not observe students in the clinical setting.

Staff nurses, however, did recognise their role in motivating students and stated that, when they performed this role, they felt positive about their mentoring role. Students expressed positive feeling of motivation when they were praised and openly encouraged to actively participate in the practical care of patients. Feelings of mistrust, engendered from being prevented from performing simple tasks, caused dejection in students and reduced the self-esteem, especially when lecturers were demanding that they carry out such practices.

Themes M, N, and O: Preceptor motivation, preceptor skills, improving preceptors' attitude

Three themes, M, N and O, focused on the context of the preceptor/mentor's role, assumptions about their lack of motivation and solutions to it. Responses came mostly from head nurses and lecturers. As other findings indicated that lecturers did not observe the mentoring relationship, their views seem to have no basis in evidence and, instead, highlight a recurring theme: the lack of communication. Lecturers' comments about staff nurses' lack of mentoring skills, too, are not evidence based.

Mentors and mentees agree that mentees must relate theory to practice, but common grounds for doing so do not appear to have been established. This perception is reinforced by the comment that some staff nurses appear to think that allowing students to treat patients is against hospital policy. The AI study addressed staff members' professional and mentoring skills and obtained generally complementary responses from mentors and mentees: VC and NVC skills, empathy and training for the role were key factors in positive practice. The constant reinforcement of these factors, combined with a lower patient and mentee load, was perceived to lead to a more positive attitude to the mentorship role among head nurses, staff nurses and students (theme O). Those directly involved in the hospital-based training supported the same measures as means to improve mentor performance and the quality of mentorship outcomes. This theme also revealed the profile of the ideal mentor from the mentees' perspective: patient, focused on mentoring responsibilities, supportive, up to date with current knowledge and able to communicate effectively.

Theme P: General improvements not specified earlier or clearly enough

The last theme, P, encompassed all the positive existing practices that could be reinforced and displayed together and solutions to overcoming perceived barriers. The key points were reducing mentor patient load, assigning nurses fewer mentees, giving standardised initial and on-going mentorship training, recruiting willing mentors and publishing policies and procedures for the mentorship initiative from start to finish, which can be commonly understood and include robust assessment of mentees and mentors.

6.3 Influence of differences in the two methodologies on the findings

The 7 questions in Table 8 that the comparison of the two methodologies sought to answer are considered in the context of their relevance to the outcomes and insights each provided.

1. In what way did the different objectives for each study influence the findings? As expected or not?

The objectives for each study were found to affect the outcomes. The first study sought to gain a broad understanding of mentorship and its current practice in a clinical setting in Jeddah, Saudi Arabia. The second study focused on valuable existing practices and their use in future strategic planning. The comparative analysis demonstrated that quite distinctive information emerged from the case study (S1) and the main study (S2) (Table 9), and that there was also significant overlap. In some ways, this was to be expected as the inclusion criteria for the participants in both studies were the same, and the second study was based on the findings of the first.

2. How did the first study inform and shape the second study, in ways which might not have been the case if first study had not been conducted?

The case study produced extremely valuable, significant insights that would have been lost without the input of groups, such as head nurses, nursing lecturers and hospital coordinators. Their input was positive, reinforcing information provided elsewhere and showing awareness of the need for change. They reinforced much of what was stated by the other groups, increasing the rigour of the study. Every group had the opportunity to state its views, which led to the discovery of a variety of ambiguities and opposing opinions. It also enabled the groups not involved in the second study to provide additional ideas for improving the existing system not mentioned in the second study. For example, nursing lecturers' assumptions about mentors were also highlighted and exposed flaws in the system when compared to students' report that the lecturers did not observe them in clinical practice but still assessed them on it. Thus, the first study provided a sound knowledge base from which to construct the main study. This process increased the likelihood that the objectives of the thesis would be accomplished, in other words, increase its trustworthiness. Some facts and opinions were expressed in both studies in a different manner.

3. How did employing the four stages of the AI approach support or detract from the findings?

The use of this technique affected how participants responded to discussion questions. The same point was often expressed in a different way, and a detailed account of what specifically should happen resulted, instead of a general phrase relating to a specific factor, positive or negative. For instance, communication barriers between parties were mentioned in the first study (section 3.3.7), but the second study drew out the various modes and circumstances in which these problems were manifested, such as body language, mannerisms and cross-cultural communication (section 5.3.1.1 and 5.3.2.1).

In the second study, participants also stated how language might have affected mentees' apparent attitudes and identified factors, such as mentors' need to express empathy and to go beyond students' apparent poor attitude or lack of knowledge, to consider how the students might be feeling. It was through this type of articulation that the employment of the 4D cycle could be detected.

Other examples include the transition from student to professional nurse, discovery of what clinical practice is like and the need for mentors to uncover students' goals and dreams and to help design a plan to achieve them. A similar pattern can be seen in how mentees develop all the personal qualities necessary for that transition. Mentees described how the mentor can enhance those feelings through specific techniques and actions. The more positive approach intended in the second study was achieved to a reasonable degree, but the first study provided a significant amount of the same suggestions for performance improvement. Table 9 demonstrates the important key information about improvements to the existing system that would not have been documented by the second study alone, many of the fundamental reasons for the flaws in the system and positive ways to minimise them were discussed in the second study. Hence, whilst AI was very advantageous in terms of drawing out the detail of what participants felt should be implemented, it would not have provided the kind of evidence for those actions without the first study taking place.

4. In what ways, if at all, did that the possibility in the second study for participants to be invigorated by opportunities to exchange positive experiences, discover their strengths and validate their personal worth and the value of others in the organisation generate different outcomes?

The second study provides significant evidence that both mentors and mentees discovered their strengths and validated their own worth and that of each other as a result of the use of AI. For instance, mentors and mentees both saw mutual learning as necessary. Both groups felt that mentors should continue to learn and develop themselves professionally. This gave mentors and mentees more confidence in the process and could result in better mutual relationships, providing evidence that the use of AI in the second study invigorated participants.

5. Did use of the AI approach in the second study drive participants to become involved in decision making, and did this affect the quality of information?

The process also enabled participants to examine further the impact of the hospital and the college on the mentoring process and to suggest practices that would make the mentorship a holistic, not compartmentalised experience. Recommendations also included offering training to mentors and creating clinical placement objectives and checklists. These points and others presented in Table 9 suggest that both mentors and mentees felt they were involved in decision making as the AI approach encouraged communication of needs from both parties.

6. Was communication enhanced by the AI method?

The AI approach used improved communication between mentor and mentees on many levels. Its use in the second study allowed determining the underlying assumptions, values and beliefs of the various groups from hospital and college. The approach facilitated communication and mutual understanding of ideas based on many of mentors' and mentees' personal beliefs and values. Therefore, the AI approach was valuable in its own right.

7. To what extent did the combination of the two approaches (case study and AI) enable a greater, more in-depth understanding of the perspectives on mentoring held by a range of constituencies?

The summary table (Table 9) suggests that rich information was obtained by using a combination of the two different research approaches in the two studies. If only one study had been conducted, it is arguable that obtaining such additional information and further insight may have been possible.

This discussion presents the differences in the two methodologies, and how these specifically influence the findings of this study.

6.4 Critique of methodologies and alternative approaches

This section starts with a discussion of the strengths and limitations of the methodological approach, data collection methods and analysis methods. It then explores how this study could be repeated and what alternative methods that could be employed.

Appreciative Inquiry (AI) approach was used in the main study to discover the strengths of mentorship in nursing experienced by a diverse team of mentors (RNs) and mentees (nursing students), who were assisted in identifying key characteristics of successful mentorship. According to Moore and Charvat (2007), AI assists participants to move from problem/deficit-based change to positive change. This technique has been widely used in social research and organisational development. It focuses on the positive, rather than the negative aspects of mentoring, and thus enables the strengths of the mentoring process to be identified and explored (Cooperrider, Whitney and Stavros, 2008). The researcher in this study made every effort to help participants identify and describe their peak experiences. The use of AI, and approaching the questions during the focus group

interviews in a positive way, yielded useful insights into mentorship experiences. However, one possible limitation of AI is that some participants may not identify their best experiences, preventing identification of the most effective aspects of their mentorship experience.

Other limitations included recruitment and the number of participants. Recruitment was difficult, especially among nursing students, whose free time in busy schedules did not coincide with the researcher's availability. Consequently, it was not easy to reschedule focus group discussions to accommodate participants' availability. Furthermore, the number of participants in some focus groups was less than the number the researcher had intended to include (see Table 6). However, the participants were recruited using convenience sampling in the first place, and the sample size was balanced against gaining rich data (Flick, 2009). In this exploratory study the researcher's aim was to gain insight into participants' mentoring experiences. The number of participants who took part in the study still enabled valuable findings to be made from the data, where quality and not quantity is the priority (Yin, 2009). In addition, the use of a pilot study strengthened the study, as it allowed the researcher to examine the focus group questions, decreasing the risk of bias (Santucci, Menu and Valot, 1982).

The main strengths of the semi-structured focus group interviews were that it provided detailed and rich descriptions of nursing mentorship experiences and allowed the researcher to obtain a great deal of information in a short period of time (Rabiee, 2004). They also led to a wide variety of views and opinions being discussed due to differences and diversity within the group, as each member of the group brought her own unique experiences and thoughts, as well as views and perceptions of specific cultural issues and social contexts (Billig, 1987). There was a great deal of debate, which disclosed the

meanings that participants created and delivered, as well as the way they negotiated and exchanged those meanings (Hand, 2003). Group discussions were suitable for exploring the ways in which knowledge and ideas grow and operate in a particular cultural context, as they can expose how social exchange shapes people's views and opinions (Kitzinger, 1995). However, Krueger (1994) and Burrows and Kendall (1997) pointed out that a skilled group moderator plays a vital role in managing the focus group appropriately and keeping it on track (Krueger, 1998). A skilful moderator can create an atmosphere in which all participants feel able to enter into discussion and offer their opinions, whether they are complete strangers or already know each other (Rabiee, 2004). Therefore, during the data collection for this study, the researcher tried to undertake this role by creating a welcoming environment and building a trusting relationship with participants.

Another strength of focus groups is that only a limited number of participants need to be involved for these to be effective, and thus they are a much cheaper and faster way of generating useful information than individual interviews (Flick, 2009). However, according to Kitzinger (1995), in addition to the moderator, a notetaker should attend the focus group interviews to observe the participants' body language, note the effect of the group dynamic, and document interactions, exchanges of opinions among the group, and the discussion content, as this can supplement the transcripts and enable a complete analysis of the data. This would however increase the resources needed for such a study and the researcher felt that having an additional person involved would make scheduling these groups even more complex. Therefore, she carried out the data collection alone, but did use audio-recordings to support data collection, enabling her to facilitate the discussion and focus on the participants but still take notes during the discussion (Kidd and Parshall, 2000). It is known that during the subsequent analysis of the data from

focus groups it can be difficult to identify and differentiate between several individual speakers, especially if several participants speak at once (Flick, 2009). However, this was not an issue in this study as the researcher was more concerned with gaining in-depth understanding of mentorship experiences, and given the purpose of the study, identifying individual speakers was not required.

Focus group interviews produce a vast amount of data which can be overwhelming for experienced researchers, let alone novice ones (Rabiee, 2004; Wolcott, 1994). Thus, new skills had to be developed to analyse the data, as well as time, preparation and practice (Rabiee, 2004). However, the thematic analysis which the researcher used to analyse the data was a helpful, flexible and accessible approach (Braun and Clarke, 2006).

Whilst AI was the approach chosen by the researcher it is possible to use others to explore mentorship. Another possibility would have been to use a survey approach through a questionnaire for both mentors and mentees, with open questions to gain rich data (Mack et al., 2005), but it was felt that this would prevent probing for further details and the researcher was concerned about response rates (Bradburn et al., 1979). A survey approach could also have involved individual interviews with mentors and mentees. This may have made scheduling meetings easier, but the researcher wanted to gain group perspectives and hear where differences were aired and where groups had a shared view. A phenomenological approach could have been used where both mentors and mentees were asked to keep a diary to record their thoughts and experiences of mentorship during their clinical placements for a specific period of time and then be individually interviewed. However, the researcher felt that there may be issues around diary documentation, including quality of the data, confidentiality and response rate

(Verbrugge, 1980). The researcher is confident that for this study, at this time, using the AI approach has enabled the positive aspects of the mentoring process in Saudi Arabia to be identified as well as areas for future development.

7 Dissemination artefact and plan

7.1 Introduction

The findings of this doctoral research (sections 3.3 and 5.3) assisted in the design of an outline for a mentorship training programme for mentors (section 7.2.2), and a draft handbook for a programme (section 7.2.3), which will be a useful resource for mentors. A dissemination plan (section 7.3) supports this artefact, which describes the procedure for the roll out of the mentorship programme in Saudi Arabia. The draft outline of the handbook is a template for local use in Saudi Arabia; the template is customisable to the needs of the hospital and the nursing college concerned. Additions are suggested, and materials can be omitted. The template for the draft handbook is presented as a section in this thesis, as it is a component of it. However, it will be presented in a different format (as a separate document) to stakeholders in Saudi Arabia. The programme proposed in this artefact is short and limited. However, starting a mentorship training programme can be an intensive process. The proposed programme is therefore designed to act as a starting point for stakeholders, providing them with a set of ideas that they can use to prepare and deliver a mentorship training programme that will have a positive impact on the mentor-mentee relationship. The researcher believes that as the programme starts to roll out and institutions beyond the study start using it, its length may develop alongside the use of reference materials and frameworks that are likely to increase.

7.2 Artefact

The artefact contains the following elements: *a briefing for stakeholders*, containing a brief overview of the study and the key findings; *an outline of a mentorship training programme*; and, finally, *a template for draft handbook* for the programme.

7.2.1 Briefing for stakeholders: Overview of study and key findings

It is proposed that three major stakeholders be informed of the research findings: the MOH and the hospitals and the nursing colleges which work together to train nursing students and took part in this study. Senior MOH officials and staff, hospital directors, nursing directors and coordinators, deans of the nursing colleges and lecturers will be invited to the presentation of the study key findings. The research brief for stakeholders is presented in Figure 4.

Figure 4: Research brief for stakeholders

Research Brief

March 2016

Understanding Registered Nurses' and Student Nurses' Positive Mentorship Experiences in Jeddah (Saudi Arabia) Using Appreciative Inquiry

Ruba Alharazi

Introduction

Clinical experience is a vital part of nursing education as it exposes students to the reality of their future career and helps them to gain practical skills. Mentors play a key role in clinical placements to the extent that they sometimes determine how much students learn and the quality of their overall experience. Although there is considerable research on mentorship in nursing in the United Kingdom and other Western countries, a thorough search of the literature on the mentorship process in the specific context of Saudi Arabia revealed only one study.

Two research studies on mentorship have been undertaken in Saudi Arabia, producing major findings that, if acted upon, could enhance mentorship for all involved. The first was an exploratory case study that explored the perceptions of mentees (student nurses), mentors (registered nurses), clinical educators, nursing lecturers and head nurses at a government nursing college and its associated governmental hospital. The second was a main study emerged from the literature and builds on the case study. It aimed to investigate the factors contributing to positive mentorship experiences in nursing in Jeddah, Saudi Arabia, by exploring mentors' and mentees' positive experiences in mentorship. The qualitative study was conducted from the theoretical perspective of appreciative inquiry (AI) at three different settings in Jeddah, Saudi Arabia.

Key Findings

The major findings of the studies were as follows:

➢ The term 'mentorship' and the roles of stakeholders in the mentorship process were not clearly defined, lead to misunderstandings of its purpose, the process involved and the roles and responsibilities of the individual groups involved.

➢ No official requirement for nursing mentorship exists in Saudi Arabia, so there is no standardised nursing mentorship programme. Only an orientation programme for nurses and student nurses new to the hospital is provided. Nurses were obliged to be mentors, regardless of their skill levels and motivation. This, along with the lack of training and support for the role, led mentors and mentees to feel that the value of mentorship lacked recognition.

➢ The environment in which mentors fulfilled the role had serious shortcomings, particularly their professional commitment to patients, the availability of mentees for training and the planning for the number of mentees assigned to each mentor.

➢ In addition, mentees' expectations for the transition to clinical practice were often very different than the reality. Lecturers needed more insight into what clinical practice would involve for mentees.

➢ Assessment of mentees' clinical practice was conducted solely by lecturer, although it was mentors who worked with students.

➢ Miscommunication between all the parties sometimes led to mistaken attributions of competence and motivation and feelings of anxiety and frustration. Cultural differences exacerbated communication issues, as did language and national cultural norms.

➢ However, mentors and mentees generally supported the mentorship concept and were positive about continuing it and improving its quality and content.

Conclusions and Recommendations

A consensus definition of mentorship should be issued by the Saudi Ministry of Health to prevent conflicting roles and expectations. In addition, mentors and mentees need greater awareness of their own and others' roles and expectations. To improve mentoring practice, effective strategies need to be implemented. These include the development of a national mentoring policy that clarifies the nature of the mentorship and the role and expectations for mentors, mentees and others involved. Hospitals should also develop a clear job description detailing nurses' role as mentors, policies and guidelines regarding mentoring practice and a mentorship training workshop or programme.

This workshop or programme needs to be mandatory for all first-time mentors in order to educate them and increase their awareness of mentoring process, its importance and its impact on the nursing profession and on the quality of nursing education and care. The workshop/programme needs to highlight the aims and objectives of mentorship, strategies for effective mentorship and important issues in mentorship, such as the meaning and value of mentorship, the roles and responsibilities of individuals involved, mentees' learning needs, effective communication and performance assessment. Therefore, the researcher has designed an outline of a mentorship training programme and a draft handbook for local use in Saudi Arabia.

In addition, the college and the hospital should make arrangements to prepare mentors and mentees for their clinical placements. For example, mentors should be identified, clear learning objectives established, and meetings between mentees and mentors arranged before clinical placements. Moreover, the college and hospital should consider how to communicate and collaborate effectively to ensure that mentors and mentees are given support. In addition, frequent meetings between the mentors and nursing lecturers are needed for effective communication between the hospital and the college and to evaluate the progress of the mentees.

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7.2.2 Mentorship training programme: An outline

The core aspects of this outline of the mentorship training programme are:

- Organisation of the mentorship programme

- Objectives of the mentorship training programme (learning outcomes) for mentors

- Suggested training programme agenda template

7.2.2.1 *Organisation of the mentorship programme*

The start date of the mentorship programme will be set by the nursing director of the hospital. The programme sessions will require attendance by first-time mentors entering the mentorship programme. Ideally, these programme sessions should be held in the hospital so it will be convenient for mentors to attend it at their workplace.

Before commencing the programme, the nursing director, hospital coordinators, deans of the nursing college and nursing lecturers must meet to discuss the following issues:

- Structure and content of programme sessions

- Programme leader and presenters

- Content of the handbook that could be developed to support the programme

- Designation of person responsible for the preparation of programme materials and the deadline for completion

- Delegation of workload, outlining the role and responsibilities of each participant

At least one month before the date of the workshop, the mentors must be contacted and advised that they are obligated to attend the mentorship programme session. They must be provided with a programme schedule at least a fortnight before the event.

All parties (head nurses, nursing lecturers, nursing coordinators and clinical educators) also must attend these sessions so that all will have a comprehensive understanding of the mentorship programme and their role in the mentorship. This will ensure consistency throughout the process and avoid any confusion in policy, standards, roles, responsibilities or assessment procedures.

7.2.2.2   *Objectives of the mentorship programme*

7.2.2.2.1   Mentors' learning objectives

By the end of this programme, you will achieve the following objectives:

- You will be able to list the fundamental components of the mentorship programme.

- You will be able to define the different roles played by each participant in the programme.

- You will possess the professional and personal competencies necessary to adequately guide and inspire your mentee.

- You will be able to stay up-to-date with the mentee's progress and assess the mentee's level of motivation.

- You will be able to discuss the hospital's policy about mentee placement.

- You will be able to outline the mentee evaluation process and will have a defined role in assessing the mentee's development.

- You will set goals in collaboration with the mentee and take the mentee's needs into consideration.

- You will provide honest feedback about progress and be capable of answering all queries.

- You will learn how to interact professionally and to communicate with all programme participants, both academic and clinical.

- You will develop your learning capabilities by engaging in continuous professional development, using the resources available and taking advantage any opportunity to enhance your skill set.

- You will know who to contact if incidents occur or issues arise during the placement period.

- You will seek feedback on your role as a mentor, so you can identify areas for further development.

7.2.2.3 *Mentorship programme sample schedule*

<u>Sample Schedule</u>

9.00   Meet and greet with refreshments

9.10   Overview of the concept of mentorship

9.30   Programme objectives

9.45   Roles and responsibilities of mentor and mentees

10.45   Effective communication

11.45   Assessment framework and process

12.45   Lunch

1.45   Clinical placement objectives and checklist

2.00   Hospital policy and standards

2.15   Continuous learning and development resources

2.30-3.00 Conclusion—opportunity to ask questions

7.2.3   Template for draft handbook

A handbook for mentors, which discusses the key aspects of mentorship and provides information delivered through the programme, should be developed. The following sections present a template for that handbook which can be adapted locally and information added. The content of the handbook was shaped based on the research reported in this thesis and includes:

- An overview of the mentorship process, its purpose and its objectives

- Description of the roles and responsibilities of the main stakeholders

- Identification of key attributes of mentors and mentees

- Assessment guidelines and frameworks for mentors and on giving feedback to mentees

- Mentee skills and assessment checklist for clinical practice

- General practical information that mentors should ensure that mentees are familiar with, such as ward induction

- Hospital policy and standards which need to be completed by the hospital administration

- List of contacts and resources available for continuous learning and development, which the college nursing department and hospital administration need to complete

- List of references and useful websites

7.2.3.1 *Introduction*

This aims of the mentorship handbook are to guide mentors through the mentoring process and to outline the roles and responsibilities of all participants in the process. The handbook also outlines the policies and standards approved and implemented by the nursing college and hospital. This handbook will be provided as a resource for all mentors and other participants in the mentorship programme (head nurses, nursing lecturers, hospital coordinators and clinical educators).

7.2.3.2 *Overview of the mentorship process*

7.2.3.2.1 What is meant by the term 'mentorship'?

The word 'mentorship' is used in different ways, and misunderstandings can arise from the term being used interchangeably with 'preceptorship', 'coaching' and 'teaching'. In a general sense, mentorship can be defined as the relationship between those with more experience and specialist knowledge or abilities and those with less experience who

wish to acquire advanced knowledge and abilities (Darling 1984). In nursing, formal mentoring is a structured process, with defined objectives designed to help mentees develop their skills, acquire more knowledge and achieve their professional objectives. In essence, the mentorship process is designed to assist nurses develop both professionally and personally so that they can perform their duties competently and mindfully.

7.2.3.2.2 Purpose of mentorship

The primary aim of mentorship is to allow mentees (student nurses) the opportunity to practice the theoretical skills they have developed during at university in a real-life clinical context. This process can be rather difficult for many mentees as they work with patients for the first time. In such cases, the purpose of mentors (registered nurses) is to support and guide their mentees through this transition period.

According to Hodges (2009), the mentorship process successfully prepares mentees for their future careers by training them to apply theoretical knowledge to real-life circumstance. This is also a beneficial process for mentors, allowing them to share the knowledge and experience they have acquired over time and to contribute to the next generation of nursing practitioners.

7.2.3.2.3 Objectives of the mentorship process

- Assist mentees in applying theoretical knowledge in a clinical setting and practicing in a real-life clinical environment.
- Enhance mentees' skill base by assigning them an experienced mentor to ensure that patients are treated appropriately.

- Establish a rapport between mentee and mentor (a role model) so that they are supported and motivated to develop their skills and become competent professional practitioners.

- Implement a frequent appraisal process in which participants reflect upon their own performance and critically assess the performance of their mentorship partner.

7.2.3.3 *Roles and responsibilities*

7.2.3.3.1 Mentor

This individual must be a qualified, experienced nurse who can effectively guide and monitor the activities of mentees in a clinical context (Nursing and Midwifery Council, 2004). In addition, this individual must have undergone a mentorship training programme before serving as a mentee and must be a registered nurse for a minimum of one year before participating in the programme. The mentor is responsible for their mentees' professional development and must ensure that they improve their knowledge and skills and develop standard nursing competencies. The mentor's responsibilities can be classified in six distinct categories.

- **Patient safety**

The mentor is obligated to teach, supervise, guide and evaluate the work performed by the mentee in a clinical setting. To do this, the mentor must carefully plan all mentoring activities to suit the needs and challenges of their mentees and assist them in improving their professional competency. Most importantly, the mentor must provide honest feedback on mentees' performance so that patient health and safety remains a priority.

- **Role model**

The mentor should maintain professional standards all the time, demonstrate them in interactions with patients and the mentee and ensure that the mentee learns up-to-date best practices. By adhering to hospital policy and practice standards at all times, the mentor will demonstrate positive working practices and ensure that mentees are aware of the correct procedure in all situations.

- **Facilitating learning**

The mentor should encourage mentees to practice reflection and teach them how to perform evaluations of themselves and their experiences in clinical practice. In this way, mentees can determine what aspects of their learning require more attention, and the mentor can address these and modify teaching activities to suit the mentees' needs.

- **Supporting mentees**

The mentor is also responsible for counselling the mentee both personally and professionally. By discussing personal and professional issues, the mentor can assist the mentee overcome personal and professional barriers and achieve professional goals.

- **Assessing mentees and reviewing progress**

The mentor must critically appraise mentees and provide them with advice and guidance on what aspects of their progress require more attention. The parties should draw up an evaluation plan so that progress is regularly monitored, and feedback provided accordingly. Feedback sessions should be held halfway through and upon conclusion of mentees' clinical practice placement. Supplementary sessions can be organised, if deemed necessary by either the mentor or the mentee.

7.2.3.3.2   Mentee

This section outlines the key role and responsibilities of the mentee and delineates all aspects of clinical practice to which a nursing practitioner must adhere. The mentee's ultimate goal is to become a competent, qualified professional under the clinical guidance and support of an experienced mentor. By developing key skills and competencies during a mentorship with an experienced nurse, the mentee can learn how to work effectively and in accordance with hospital standards and policies.

Mentee responsibilities

- The mentee must respect patients' wishes at all times. These can be overruled only in cases where the patient's life is endangered.

- Patient confidentiality must be guaranteed, and the mentee must learn what information should and should not be passed onto colleagues or the patient's family.

- Patient details should never be discussed outside the clinical setting.

- Mentees need to consider confidentiality and the ethics policies of the clinical setting when writing an assignment about patient. Use of documents related to the patient requires the approval of the mentor.

- Mentees should not share personal information about themselves with the patient.

- As the mentor is ultimately held accountable for the activities of mentees, the mentee must not accompany any patient to a different area without first seeking consent from the mentor.

- When providing care for patients and administering medicine, mentees must follow clinical policy. A mentee must consult with the mentor before providing the patient with any medicine or performing any medical procedure.

- The mentee must maintain a professional relationship with the patient. All interaction with the patient must remain professional at all times.

- In the event of hostility or abuse from a patient (e.g. verbal comments, sexual harassment, or physical aggression), the mentee must discuss the event with the mentor and learn how to prevent such incidences in the future.

- If the mentee encounters evidence of inappropriate patient care or poor clinical practice by other nurses, the mentee must first raise the issue with their mentor. If the mentor cannot be contacted, the mentee may discuss the issue with the nursing college lecturer.

- When training a mentee, patients must be informed immediately if a mentee is present, and the mentee must collaborate with the mentor in outlining the mentees' role and responsibilities to the patient.

- The mentee must prepare effectively for each meeting with the mentor.

- Mentees must use all opportunities to develop their practice.

- Mentees must act in accordance with professional standards. If they are unsure of these standards at any stage in clinical practice, they must contact their mentor for clarification. If the mentee is discovered to have acted inappropriately, the mentor will address the matter and provide guidance on how to proceed. If inappropriate behaviour is reported regularly, the head nurse and the mentee's nursing college lecturer will be notified.

- Mentees must not participate in any medical procedures in which they have not been adequately trained. Mentee may not participate in any advanced procedure without the presence of their mentor or another more experienced nurse.

- In the case of injury, the mentee is obliged to immediately contact the mentor or nursing college lecturer.

- The hospital's professional standards must be adhered to by all mentees throughout their clinical practice.

- Any issues with the mentor should be discussed directly with the mentor. Miscommunications frequently occur in a busy clinical setting, and effective communication between both parties can usually resolve most issues or concerns that may arise. These situations also present a learning experience for mentee as they will work alongside many different people over the course of their careers and must know how to deal with conflict quickly and effectively. If issues with the mentor cannot be resolved internally, the mentee may then discuss the matter with the nursing college lecturer.

7.2.3.3.3 Nursing college lecturer

The nursing college lecturer is the mentee's core link between the nursing college and the clinical setting and is responsible for liaising with the mentee and the mentor. Lecturers must ensure that the mentee's transition from a largely theoretical educational setting to a clinical environment is smooth and successful. Lecturer's key roles in this process include:

- Teaching the mentee how to respond to the difficulties of transitioning into a clinical setting

- Collaborating with the mentor in evaluating the mentee's progress

- Monitoring mentees' progress in a clinical setting and providing personal guidance if they have any issues adjusting

- Supplying the mentor with a breakdown of the course structure and details of the curriculum to ensure that mentees apply the skills they acquired in class

- Periodically evaluate the progress of the mentorship against predetermined goals and mentees' progress against their objectives checklist

- Devise an evaluation agenda (scheduled feedback meetings) for both parties so that both the mentee and the mentor can monitor and assess development

7.2.3.3.4 Head nurse

The head nurse decides which experienced nurse will act as a mentor to each incoming mentee. The main duties of the head nurse are as follows:

- Assign appropriate mentors to mentees

- Oversee the mentorship process

- Regulate mentors' workload and responsibilities so that they have sufficient time to conduct their mentorship duties

- Arrange the initial meeting between the mentor and mentee

- Inform mentors of what mentees hope to achieve in placement, and discuss the importance of the mentees' objectives checklist for clinical placements

- Maintain regular communication with other participants in the mentorship programme

7.2.3.3.5 Hospital coordinator

This individual liaises between the academic institution and the clinical setting in order to facilitate the progress of the mentorship process. Hospital coordinators have two key roles in the process:

- Maintaining regular and effective communication among all programme participants.

- Becoming familiar with the primary aims, objectives and content of the programme

7.2.3.4 *Key mentor and mentee attributes*

It is important that mentors and mentees exhibit certain characteristics in order to establish effective mentor-mentee relationship. Table 10 presents these key characteristics as identified in this research on the positive mentorship experiences of registered nurses and student nurses in Jeddah.

Table 10: Key mentor and mentee attributes

Mentor Attributes	Common Attributes	Mentee Attributes
Qualified, competent and skilled	Mutual passion for nursing practice	Eager to learn from the experienced mentor; eager to develop similar professional competencies
Adopts the role of teaching, guiding, supervising and evaluating the mentee	Positive attitudes	Observes the mentor as a role model to acquire new skills and to develop personally and professionally
Supportive, approachable, helpful and motivational	Compassionate and accessible	Communicates goals and desires with ease
Positive role model	Effective observational and communication abilities	Prepared to push oneself and take risks when necessary
Supports independence and initiative	Ability to adapt	Eagerly accepts all challenges and learning opportunities
Effective decision-maker and problem solver (proficient in conflict resolution)	Professional commitment	Perceives critical evaluation and feedback as opportunities to develop skills
Supports and guides mentees both professionally and personally	Shared understanding	Is aware of workload and time constraints on mentors' availability
Eager to allocate sufficient time to mentorship	Good communicator and open minded	Open to others' opinions
Motivated by progress and development	Ambitious	Eager to meet targets and achieve objectives
Sets high standards for both parties	High standards and goal oriented	Eager to reach full potential and achieve primary goals

7.2.3.5 *Guidelines for the assessment of mentees in clinical practice*

The mentor is responsible for teaching and supporting mentees so that they can competently apply the theoretical procedures and activities they learnt in college in a practical context. Mentors must also ensure that the mentee continues to follow hospital standards. The ultimate responsibility of mentors is to protect patient safety. By regularly monitoring mentees progress, they can ensure that mentees are becoming skilled professional nursing practitioners.

7.2.3.5.1 Discussing mentees' learning needs

It is important that mentors plan meetings to discuss mentees' needs, set goals and objectives and formulate action plans accordingly. The mentor and mentee collaborate on setting goals and outlining expectations. At the first meeting, mentors should give their mentees a tour of the clinic/ward. This first meeting will allow all participants to become familiar with one another and help the mentor and mentee establish a rapport and define each other's expectations for the mentorship process.

7.2.3.5.2 Provide opportunities for learning and assessment

Along with patient safety and well-being, mentors are also accountable for the development of the mentee. Therefore, mentees must be giving a certain level of leeway to actively engage in challenging tasks and learn from their experiences and mistakes. If the mentor does not allow mentees to actively participate in procedures, they likely will become disillusioned with the placement.

The mentor should first show how a procedure is performed and explain any intricacies associated with the task. Next, the mentor should:

- Ask mentees questions about the procedure and knowledge retained.

- Question mentees on how and why they would choose to perform the procedure before letting them attempt it.

- Observe mentees performing the procedure, and provide constructive feedback on their performance.

- Allocate time later for mentees to actively evaluate their own performance and consider what they have learnt from the experience.

7.2.3.5.3   Encourage the mentee to self-assess and reflect on learning

Discussing of the mentee's performance immediately after the procedure will allow the mentee to conduct a self-evaluation. It is also important that the mentor reflects on the experience and provides praise for things done well and advice on how to perform better in future. When issuing feedback, the mentor should use terms with positive connotations, such as 'development potential' and 'room for improvement' instead of 'incompetent' or 'weak'.

The mentor should perform the following:

➢ Inform mentees if they performed a procedure incorrectly
➢ Ensure that mentees acknowledge what they did wrong and what they must do if they encounter a similar situation in future
➢ Provide consistent, accurate appraisals of performance which adhere to the hospital's standards policy

If mentors achieve these objectives, they can confidently allow the mentee to gain more hands-on experience whilst protecting the well-being of the patient.

7.2.3.5.4 Boosting confidence and morale through a continuous assessment strategy

It is important to view assessment procedures as a continuous process for regularly monitoring the development of mentees. Assessment procedures can be either formal or informal. Both types assist mentees in gaining knowledge, skills and confidence and evaluate their competency in professional nursing skills, such as bedside manner, personal conduct, eagerness and communication. Mentees beginning a placement establish a series of personal and professional goals, so their performance in these areas should be monitored. When mentees achieve any of their designated objectives, they should receive recognition in order to increase their confidence and motivation. This is imperative during the early stages of the placement as performance anxiety can often prevent mentees from reaching their full potential.

7.2.3.5.5 Complementary assessment methods

Clinical staff other than the mentor may evaluate the development of the mentee and convey any feedback that they feel might benefit the mentee or assist in developing skills. In the case of negative feedback, mentees should appreciate the advice and communicate with the staff member to determine how to improve their skills and avoid repeating the same mistake. This feedback can be recorded in writing and form part of the assessment for mentees' placement development report.

7.2.3.5.6 Validity and reliability of assessment

The feedback offered by the mentor can only be deemed valid if the mentee's performance was evaluated according to specific criteria. Therefore, mentees should have clear objectives. This approach to assessment will eliminate the risk of bias as mentees will be regularly assessed according to certain criteria and will know why and how they earned the assessment results.

For validity, a credible assessment should ensure that the performance measurement method used actually measures what it should (Stuart, 2007). It is important to consider what and how is assessed and whether the assessment method used is appropriate for what it evaluates.

To ensure reliability, the nursing college lecturer needs to be involved in the assessment process and to monitor the assessment procedures to ensure that they are consistently accurate. Having more than one assessor who uses similar evaluation criteria to evaluate mentees also reduces the risk of bias. The assessment method is considered reliable if it produces similar results when applied by multiple assessors. Feedback from various clinical staff members then can be beneficial.

Therefore, a comprehensive approach to mentee assessment must be adopted and utilise a series of different measures, which might include the following:

- Observation

- Feedback from clinical staff

- Self-governed performance appraisals (mentee self-assessment)

- Practical skills

- Retrospective self-evaluation

- Feedback from patients

- Feedback from peers

- Analysis of assessment documentation

7.2.3.5.7   Example of assessment in practice framework

Bondy's assessment framework was formulated by Kathleen Bondy in 1983 and is used as a framework for measuring performance by the achievement of objectives. This framework is especially suitable for clinical assessments as it enables accurately and

objectively measuring the mentee's competencies in different areas. In addition, this method increases the credibility of evaluation outcomes as all participants can determine the skills that they believe the mentee should possess upon concluding their placement. All mentees must be informed of this framework so that they are aware of how it affects the evaluation of their placement performance. Table 11 presents the scoring system used in the assessment framework.

Table 11: Scoring system for Bondy's Assessment Framework (Bondy, 1983)

Score	Level of assistance required
1	Requires constant supervision while doing routine tasks
2	Requires regular supervision but can manage some basic tasks independently
3	Requires minimal supervision and needs assistance only in more complex situations
4	Capable of working independently

Hospitals can use this assessment framework as a model as it is clear, concise and straightforward for both mentors and mentees. It also clearly distinguishes different levels of achievement.

7.2.3.5.8 Giving effective feedback to the mentee

This aspect has been addressed previously but is such an important part of the programme that a more comprehensive delineation of the fundamentals is needed.

Overall, the following measures should be taken to ensure that the feedback provided is relevant, valid and constructive.

- Regular feedback and performance evaluation should be offered during the performance of specific activities and immediately after their completion.

- The mentor must always be available to offer feedback and discuss the outcome with mentees.

- Feedback better be offered in private, where possible and when appropriate.

- Mentees should be asked to provide a self-evaluation before mentors offer their own evaluation of performance.

- In some cases, recording the feedback in writing could be useful, especially in cases when the mentee is anxious or upset and might not remember the specifics of the appraisal when attempting to learn from the experience.

- All feedback should be concise, specific and constructive. If negative feedback must be provided, it should be phrased as a development opportunity, not as failure.

- The mentor must avoid bias in evaluation and letting personal sentiments affect the objectivity and constructiveness of feedback. The mentor should always base views based on specific facts and explain the reasoning for the feedback.

- When providing feedback, it is recommended that the mentor ask mentees broad questions to ensure that they understand what they are told.

- The mentor should monitor mentees' body language and attitudes when giving feedback. Mentees might be too uncomfortable or anxious to ask for an explanation, state that they do not fully understand the situation or seek to clarify any points that appear to be unclear.

- The mentor should always ask mentees questions when providing feedback to ensure that mentees fully comprehend what will be required of them in future.

- Both the mentor and the mentee should collaborate in the formulation of an action plan based on the evaluation outcomes.

7.2.3.6 *Clinical placement objectives and checklist*

This section outlines what skills mentees are expected to have developed upon conclusion of their clinical placement. The college nursing department must complete this list, and the objectives may be updated during the placement if recommended by the nursing coordinator in consultation with the head nurse, nursing college lecturer and the student's mentor. The mentor will discuss these objectives with the mentee and outline a timeframe within which the mentee should achieve each objective. The mentee's performance will be assessed for each skill during the placement.

7.2.3.7 *Ward induction*

Mentors should ensure that all mentees complete induction training before starting work in an unfamiliar ward. This induction session will outline the standards and practices followed by the ward and provide mentees with the opportunity to clarify issues or ask questions before beginning their placement. Upon completion of the induction session, mentees are required to sign a document stating that they have received satisfactory induction training. See Appendix 19 (p. 487) for a sample of a ward induction template.

7.2.3.8 *Hospital policy and standards*

(This section must be completed by hospital administration.)

7.2.3.9 *List of contacts*

(This section should be completed by the college nursing department and hospital administration.)

7.2.3.10 *Continuous learning and development - resources available*

It is important that mentors discuss with mentees the importance of the learning opportunities in clinical practice, such as seminars, tutorials and networking with external organisations. Mentors also need to point to the available student support, such as mentors, nursing college lecturers, educational facilities and libraries, and encourage mentees to use these facilities and support.

(This section should be completed by the college nursing department and hospital administration.)

7.2.3.11 *Mentorship programme evaluation form*

An evaluation form for the mentorship programme will be developed locally to help develop the programme and address any issues for the mentor or mentee.

7.2.3.12 *References and useful websites*

This section contains a list of references used in this handbook and other useful websites.

7.2.3.12.1 References:

Bondy, K.N. (1983) 'Criterion-referenced definitions for rating scales in clinical evaluation', *Journal of Nursing Education*, 22(9), pp. 376–382.

Darling, L.A.W, (1984) 'What do nurses want in a mentor?' *The Journal of Nursing Administration*, 14(10), pp. 42–44.

Hodges, B. (2009) 'Factors that can influence mentorship relationships', *Paediatric Nursing*, 21(6), pp. 32–35.

Nursing and Midwifery Council (2004) *Consultation on a standard to support learning and assessment in practice*. Available at: http://www.nmc-uk.org/Documents/Consultations/NMC%20Consultation%20-%20learning%20and%20assesment%20in%20practice%20-%20consultation%20document.pdf (Accessed: 5 July 2011).

Stuart, C.C. (2007) *Assessment, supervision and support in clinical practice*. 2nd ed. Churchill Livingstone: Edinburgh.

7.2.3.12.2 Useful websites

Nursing and Midwifery Council (2008) *Standards to support learning and assessment in practice*. Available at: http://www.nmc-uk.org/Educators/Standards-for-education/Standards-to-support-learning-and-assessment-in-practice/

Royal College of Nursing (2007) *Guidance for mentors of nursing students and midwives: An RCN toolkit.* Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0008/78677/002797.pdf

7.2.4　Commentary

The researcher decided that the artefact arising from this study should be the mentorship training programme which could be implemented in practice to enhance mentoring for all as it would be an easier and less controversial outcome than following some of the other possible lines of enquiry. Other possible lines of enquiry were the issues that arise in the workplace, which are derived from differences between mentors and mentees (such as their ethnicity and culture), managing the diverse workforce through communication, and the control and power dynamics of the mentoring relationship, which were outlined and discussed in chapter 2. There are also issues associated with collaboration between nursing colleges and hospitals to ensure consistency within mentorship, the support provided by nursing colleges and hospitals for mentors and mentees, and evaluation of mentorship, which were mentioned in the findings from the case study (section 3.3) and main study (section 5.3). This does not mean these areas are less important but they are less tangible to tackle and would probably require a longer period of time to develop and approach. Having been outlined, the mentorship programme can now be implemented quickly once dissemination of this thesis begins.

7.3   Dissemination plan

7.3.1   Objectives

The dissemination plan outlines how key stakeholders in Saudi Arabia will be informed of the key findings of the completed research and provided with the outline of the mentorship training programme and draft handbook. The objectives of the dissemination plan are to:

- Identify the key stakeholders to who can benefit from the presentation of these findings, the outline of the mentorship training programme and the draft handbook.
- Define the rationale behind each choice made.
- Set the schedule of activities throughout knowledge will be disseminated.
- Specify the desired outcomes from these interventions.

The Saudi MOH has issued no standard guidelines or regulations for a nurse mentorship initiative. Therefore, these research findings have significant potential to shape a nationwide standard framework for nurse mentorship appropriate for the kingdom's cultural, religious and economic strategies that mirrors the rigour of such programs, in western nations. The researcher intends to share with the most senior MOH officials the findings, including the proposed outline of a mentorship training programme and the draft handbook. The researcher will share the findings with appropriate staff at the participating hospitals and nursing colleges, initially to discuss the findings and support implementation of the recommendations. Ultimately, the researcher seeks to link the institutions with the MOH, so that they collaborate and spread their efforts and disperse the learning to all hospitals and nursing colleges in Saudi Arabia in order to raise the standards of nursing mentorship.

7.3.2   Dissemination strategy and implementation timetable

It is proposed that three major stakeholders be informed of the research conclusions and invited to take part in increasing the quality of nursing mentorship in Saudi Arabia: the MOH and the hospitals and nursing colleges which work together to train student nurses. See Appendix 20 (p. 491) for the invitation letter for the presentation of the study findings.

1. Ministry of Health

In Saudi Arabia, the MOH has not introduced guidelines for nursing mentorship, which is a fundamental requirement for nursing qualifications. Among its key objectives, the Saudi government seeks to increase standards in healthcare and to attract more nationals into this sector, in which the majority of nurses are expatriates. Many developed countries have national standards and government regulatory bodies which maintain and improve nursing standards and support those involved in the nurse training process. Therefore, it is critical to apprise the MOH of the existing practices and the efforts made by the participating nursing colleges and hospitals to implement quality enhancement processes, further demonstrated by their involvement in this study. In addition, sharing the study findings and outputs with the MOH might encourage it to support the national rollout of the mentorship training programme.

2. Hospitals

The findings demonstrated the lack of a shared vision for current practices and outcomes, as along with the value that mentors and mentees perceived in this intervention. To improve the transition from student to qualified nurse and, consequently, standards of patient care, it is vital to provide the hospitals with constructive feedback. Sharing the outputs of the study (the outline training programme

and the draft handbook) could encourage the hospitals, along with the nursing colleges, to adopt a more structured approach to the mentoring of student nurses, supported by the mentorship training programme based on the research.

3. Nursing colleges

After beginning training in a safe, theory-oriented environment, nursing students expressed feelings of fear at moving into clinical practice. Although responsible for assessing students' clinical practice, lecturers had little practical knowledge of it. The nursing colleges' practical involvement in the study was extremely valuable and illustrated the more active role they could take in providing successful mentorship if given the tools to do so—a need which the outputs of this research meet.

A timetable for implementation and interventions is presented in Table 12.

Table 12: Implementation timetable and interventions

Audience/ stakeholder	Interventions	Target Date
Ministry of Health	1. Arrange meeting with senior MOH official to discuss the study findings, the proposed outline of a mentorship training programme and the draft handbook, and their value to government healthcare objectives *Desired outcome:* Gain an additional meeting to give a full presentation to senior MOH staff	1 March 2016
	2. Presentation to senior MOH staff, along with senior hospital managers (hospital directors, nursing directors, and nursing coordinators) and senior college officials (deans of the nursing colleges, lecturers) *Desired outcome:* Link the three key sources and initiate joint work on a national nurse mentorship regulatory programme	1 May 2016
Hospitals	1. Arrange meeting with the hospital directors to discuss the study findings and the proposed outline of a mentorship training programme and the draft handbook *Desired outcome*: Gain support for the mentor programme and commitment to arranging a meeting with the hospital director, nursing director and nursing coordinators	3 March 2016
	2. Present and elicit feedback on the study findings, proposed programme and draft handbook from the hospital director, nursing director and nursing coordinators *Desired outcome*: Gain commitment to allow development of the mentor programme for the next cohort of mentors	1 May 2016
	3. *Develop/amend* the draft programme and core content for the handbook in collaboration with the nursing director, hospital coordinators and the deans of the nursing colleges	May/June 2016

Audience/ stakeholder	Interventions	Target Date
Nursing Colleges	1. Arrange meetings with the deans of the nursing colleges to discuss the study findings, the proposed outline of a mentorship training programme and the draft handbook *Desired outcome*: Gain support for the mentor programme and commitment to arranging a meeting with the deans of the nursing colleges, lecturers and nursing coordinators	5 March 2016
	2. Present and elicit feedback on the study findings, proposed outline of a mentorship training programme and draft handbook from the deans of the nursing colleges and nursing lecturers *Desired outcome*: Initiate new links between hospitals and colleges and gain further commitment to allow development of the mentor programme for the next cohort of mentors.	1 May 2016
	3. *Develop/amend* the draft programme and core content for the handbook in collaboration with the nursing directors, hospital coordinators and the deans of the nursing colleges	May/June 2016
Nursing Colleges and the Hospitals	Launch pilot mentorship programme for mentors in the involved hospitals, with the presence of the nursing director, nursing coordinators, deans of the nursing college and lecturers.	Start of next cohort of mentors

7.3.3   Desired outcomes

1. Gain commitment from the MOH to support the nurse mentorship programme and officially endorse the mentorship programme

2. Build strong links among the three stakeholders and encourage them to lobby for a national standard, with the hospitals and the nursing colleges pioneering a new standardised approach to nurse mentoring that can be further developed

3. Influence the development of long-term, practical relationships between hospital and nursing college practitioners in which they work together closely and design the nurse mentorship programme to strengthen the positive aspects of mentorship and to create an environment that allows mentees and mentors to achieve the optimum outcomes in student retention and quality of nursing education and nursing care

8 Commentary three: Conclusion and recommendations

This section first summarises the findings and then discusses the study's limitations, contributions to knowledge, implications and recommendations for policy, practice and future research.

8.1 Summary

In clinical placements, mentoring plays a key role in student nurses' practical education and overall experience in that particular placement. However, there is a paucity of research on mentoring in the context of nursing education in KSA. To address this, the researcher undertook a case study, literature review and AI-based research study.

The case study, conducted in a clinical setting in Jeddah, Saudi Arabia, showed that neither mentors nor mentees were satisfied with the current mentorship practice and blamed each other for the mentorship's deficiencies. Student nurses felt that the mentorship was not useful, whereas the mentors did not want to give their time to students. Problems arose mainly because of a lack of coordination between the hospital and the nursing college. From this case study, the researcher concluded that the mentorship process could be improved by ensuring that concerns that often arise (such as who evaluates students' progress) are clarified early. Additionally, efforts should be made to encourage nurse mentors to express empathy for their mentees and to provide sufficient time to obtain constructive feedback from mentees that is used to increase the effectiveness of mentoring and its outcomes.

The literature review was intended to explore the current state of research in four issues: existing knowledge about the concept of mentorship from the point of view of mentors and mentees; what makes mentorship effective; what hinders successful mentoring in

nursing education; and the gaps in the literature on nursing mentorship and what research could fill these gaps. Students frequently stated that mentorship should include a high level of support and time spent with mentors, which was often not possible. As a result of this misunderstanding of what mentorship entailed, mentors often felt frustrated when mentees demanded too much from them. Therefore, the concept of mentorship and the roles of the mentors and mentees should be clarified in order to improve the mentor-mentee relationship.

The researcher found that effective mentoring empowered the student nurses and improved their capabilities. This occurred when mentorship made the students feel appreciated, increasing their self-esteem. Mentoring was powerful when the mentor showed high levels of nursing competence, patience and empathy, amongst other qualities perceived by the mentees as important. Mentoring was also powerful when mentors had sufficient contact with the academic institution, perhaps because this gave them more contact with academic staff and facilitated understanding of the mentoring process. However, the most important factor in improving the mentoring process that the researcher found in the literature review was continuity. Students who had more contact with their mentor perceived their mentoring as more effective.

In the literature review, the researcher found that the primary factor contributed to effective mentoring was time availability, specifically that students could not schedule regular meetings with their mentors. This situation could have been affected by recent staffing cuts which hospitals have not balanced by reducing the numbers of students. Another factor the researcher found was the realistic and clear expectations of both mentors and mentees, effective communication and administration. The introduction of

national standards could help facilitate these factors by clarifying the roles and responsibilities of all parties in the mentorship process.

Mentees should be aware of the problems that mentors face when providing mentoring to nursing students in clinical settings and therefore should be more thoughtful when requesting time from their mentors, who often felt that their students expect too much from them. Only a few studies have looked at mentoring from the perspective of the mentor; therefore, mentees might not have appreciated the pressures with which mentors have to cope while nursing. Therefore, more research on mentors' perceptions of the mentoring process could help solve these problems. Secondly, most studies were conducted in western countries.

A further issue arising from this study was the need for mentors and mentees to be aware of concepts of culture and power balance, particularly with regard to difference in contracts between Saudi and non-Saudi nurses as mentors which has been noted in this study, and which could present challenges for mentees who are mentored by non-Saudi mentors. The power which mentors exert over mentees with language difficulties and/or a poor understanding of Saudi patients' spiritual, cultural and physical needs, may make mentees feel disempowered. Mentorship difficulties are further exacerbated by cultural underpinnings, which lead to the perception of nursing being an unsuitable career for women in Saudi Arabia and thus complicates the mentoring process.

The main study approach was AI, which involved qualitative study of the positive aspects of mentoring to explore what mentors and mentees do best. This study adds knowledge from a non-western context to the literature.

Mentees emphasised the importance of communication, which, along with openness, builds a good relationship between mentor and mentee and allows the mentor to be

attentive to the mentee's needs. Without a good relationship, mentees might feel that they cannot ask their mentors questions, hindering their learning. In addition, language and fluency were important aspects of communication as both English and Arabic were spoken by mentors and mentees studied by AI. Ideally, both mentors and mentees should have a good grasp of the two languages, but some mentees did not speak English fluently, and some mentors did not speak Arabic. Other mentors spoke English with an accent the Saudi mentees found hard to understand.

Involvement, encouragement, reciprocity and mentors' preparation were also emphasised as important. Mentors involved with their mentees were the most highly thought of, as were those who encouraged their mentees to take on difficult tasks and helped them to succeed. Mutual respect, acceptance and enthusiasm were also seen to be highly important in a successful mentor-mentee relationship. Finally, mentees thought that the good mentors knew what they should do, were prepared for the mentoring process and were willing to teach their mentees, which goes hand-in-hand with involvement and enthusiasm for teaching.

Mentors gave very similar answers as mentees, focussing more on the need for mentees to appreciate the limits of mentoring (as found in the literature review) and the need for mentors to foster their students' self-esteem and self-confidence and help them overcome fear of performing new clinical procedures. Both mentors and mentees noted that it is important to carefully balance time between clinical care and mentoring, although they had differing opinions of how to do so.

The findings of this study, in conjunction with the literature review, including consideration of quality indicators of effective mentorship, can help inform policymakers in Saudi Arabia. From this study, it can be concluded that the Kingdom of

Saudi Arabia needs to invest further in its mentorship programmes if it is to produce Saudi national nurses of sufficient quality to replace the largely expatriate workforce. It is thus vital that organisations strive for high quality mentorship that adheres to the aforementioned qualities of a good mentor, whilst guarding against mentor disaffection, caused, for example, by work overload and a feeling of being undervalued, such as mentors having to stay after the end of their shift or miss meal breaks to mentor students or complete paperwork. This practice is untenable as excessive workload can burden mentors and have a negative impact on them causing them to feel stressed and thus have a detrimental effect on the quality of patient care and of mentors' work environments. It could also lead to mentors experiencing burnout, fatigue, low job satisfaction and intentions to leave. This situation can be overcome by organisations developing more suitable and sustainable economic models of practice education. Specifically, employers need to be seen to value the contribution that good mentorship makes in the development of high quality and effective nurses who, in turn, provide excellent, culturally sensitive patient care. Conceivably, this may sometimes mean the need to pay extra to mentors for their work, as is the practice in certain other professions. This, in turn, would ensure services are run according to a quality teaching model that rewards excellence in teaching through remuneration, rather than exploitation of the goodwill of those willing to or feeling obliged to mentor future nurses. These concepts are embraced by the recommendations for policy and practice development described below.

8.2 Discussion of limitations

The research undertaken for this thesis has produced valuable findings, however, there are some limitations that the researcher must acknowledge. The case study was conducted in only one clinical setting in Jeddah; therefore, its findings might not be relevant to all clinical settings in Saudi Arabia, or even in Jeddah. However, Lincoln

and Guba (1985) suggested that quantitative and qualitative studies cannot be judged by the same criteria and that qualitative studies (such as this case study) should be judged by their credibility, confirmability, dependability and transferability. The researcher paid careful attention to these criteria to increase the trustworthiness of the case study. Credibility was ensured as the researcher had experience in Saudi culture as both mentor and mentee. The researcher also made preliminary visits to the case study's settings, so she had adequate knowledge about the environment. However, to ensure that her experiences (discussed in section 1.2) did not influence the results, the researcher took a reflexive approach (section 3.2.8) throughout the study. In particular, she kept a reflective commentary and met regularly with her PhD supervisors in order to challenge her assumptions. Therefore, the findings of this study could be transferable to other settings with similar characteristics as those studied.

The case study conducted yielded few descriptions of mentorship which worked well as participants spent the most time elaborating on their negative mentorship experiences. This could simply reflect that participants simply had nothing positive to say about their mentorships. However, questions asked in focus groups and individual interviews might not have been structured in a way that encouraged participants to detail their positive mentorship experiences. This approach could have helped create a skewed perspective of mentorship experiences. Therefore, the researcher made changes to the methodological approach of the main study so that undue emphasis was not placed on negative experiences. Instead, participants were encouraged to explore their positive mentorship experiences by appreciating what works well. In the main study, the researcher used the AI approach to discover the strengths of mentorship in nursing experienced by a diverse team of nursing students and RNs, who were assisted in discovering their strengths and identifying key characteristics of successful mentorship.

The researcher realised that an exploration of the positive experiences of mentorship in Saudi Arabia was needed to develop mentoring among nurses in Saudi Arabia.

The literature review was designed to be as inclusive as possible and used a wide range of search terms. Research studies were not excluded based on their country of origin but had to be published between 1980 and 2014. Although dated, studies from the 1980s and 1990s still provided some significant findings and so were included.

The aforementioned criteria for judging a qualitative study (credibility, confirmability, dependability and transferability) were considered throughout the design and implementation of the AI main study. The AI technique has been widely used in social research and organisational development. Focusing on the positive, not the negative, aspects of mentoring enabled identifying and exploring the strengths of the mentoring process. The researcher made every effort to help participants identify and describe their peak experiences. However, one possible limitation of AI is that participants might not identify their peak experiences, preventing determining the most effective components of their mentorship experience.

The researcher independently collected and analysed the data and reported the findings. Not all interpretations of the data were checked by another party, such as a peer or expert, which could have negatively affected the study's findings. However, the researcher's supervisors performed some checks in this process. In addition, the researcher provided summaries for respondents to check the accuracy of their recorded responses in order to reduce the risk of misinterpretation.

The number of participants in some focus groups was less than the number the researcher had intended and invited to participate (see Table 2 and Table 6). However, the subjects were recruited by using convenience sampling in the first place. The sample

size is not a major issue in an exploratory study as the researcher's aim was to explore participant' insights into their mentoring experiences. The number of participants still enabled obtaining valuable findings as exploratory studies focus on the quality of data, not the quantity.

During focus group and individuals interviews, participants' reactions might have been affected by the presence of the researcher. The researcher took care not to influence the participants or share similar ideas and perceptions and did not agree or disagree with participants during the interview in order to avoid false perceptions (Bryman, 2001) expressed by participants trying to provide the answers they thought were desired. See section 1.2 for details on the preconceived ideas which the researcher monitored during analysis to ensure that they did not inappropriately influence the findings.

The researcher was aware that some participants, specifically, foreign nurses, might have feared that providing honest answers would give their clinical setting a bad reputation. (For example, one participant in the case study withdrew before the focus group when she knew that the discussion would be digitally recorded). To avoid this problem, the researcher assured participants that their data would be kept confidential and used only for research purposes only and no one except the researcher would have access to it. The researcher also stressed the importance of honest and genuine responses.

One site selected for the main study, a private hospital in Jeddah, refused to give the researcher ethical approval to collect data there. However, the researcher did receive ethical approval from the hospital's collaborative private college. The setting provided no specific reason for the refusal. However, it did request more information about some questions in the ethical application form. The researcher did her best to provide the

requested clarifications but still did not gain approval. However, in qualitative studies, this limitation is not a concern as there is no aim to generalise but, instead, to investigate the particularity, intrinsic uniqueness and complexity of the single case (Simons, 1996; Stake, 1995; Keeves, 1988).

Other limitations of this study were discussed in section 3.5.2.

8.3   Contributions of this research

Despite the limitations acknowledged in the preceding section, this thesis still has contributed original knowledge to this area. This thesis has explored the factors contributing to positive mentorship experiences in nursing in Jeddah, Saudi Arabia. Its original contributions to knowledge are outlined in this section.

The thesis introduces a new understanding of mentorship from a non-western context. Although there is considerable research on mentorship in nursing in the UK and other western countries, a thorough search of the literature on the nursing mentorship in the specific context of Saudi Arabia found only one study (section 4.4.2). Issues relating to nursing education in Saudi Arabia in general have received little attention in academia. The vast majority of the literature focuses on nursing mentorship in western countries, such as the UK and the USA. However, nursing in Saudi Arabia presents some different issues that might not be found in the western world. One such issue found by the researcher was the language barrier between nursing students and their mentors. A high proportion of RNs in Jeddah are from India or the Philippines (Tumulty, 2001) and are not native speakers of either English or Arabic, the two main languages spoken in hospitals in Jeddah. This problem would not be as significant in a country where most mentors and mentees are native speakers of the same language.

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The thesis presents key themes related to mentorship from different perspectives, including those of mentors, mentees, lecturers, head nurses, nurse educators and nursing coordinators. This wide range of viewpoints could fill the gap in the literature by exploring the perception of those who learn and those who educate, as well as other individuals directly or indirectly involved in the process. This study is one of a very few to focus not only on mentees' viewpoints but also on mentors' views. Some problems in nursing mentorship stem from mentees' unrealistic expectations or from a lack of understanding of what is required of mentors. Exploring mentorship from mentors' point of view exposed these problems and the differences between mentors' and mentees' expectations.

This research will benefit the education practice by increasing the understanding of issues related to mentoring and offering strategies to enhance the mentorship process and inform educational policy. Such strategies could include clarifying mentors' and mentee's roles and expectations. This could be achieved by offering a mentorship training programme to prepare mentors for their role and providing mentees some preparation for the mentorship process. Another feasible strategy is a reflection exercise based on themes that emerged in this research in order to give mentors constructive feedback from mentees about the process. Such feedback is needed, as evidenced by the need to increase recognition of mentees' emotions and self-esteem and to close the disparity between mentees' needs and the widely held concept of mentorship.

The findings of this research have significant implications for the development of a nationwide, standard framework for nurse mentorship. Specifically, the proposed outline of a mentorship training programme for mentors and the draft handbook

designed for local use in Saudi Arabia (see Chapter 7) will be of use to mentors to prepare them for the mentoring role.

This research will influence and enhance nursing mentorship practices in Saudi Arabia. The results and recommendations will be shared with the participating institutions and the Saudi MOH in order to gain their support in increasing the quality and status of nursing mentorship in the kingdom. Finally, the researcher hopes to encourage the MOH to publish appropriate national guidelines for nursing mentorship in Saudi Arabia, shaped by the national culture and setting and influenced by the standards of western countries.

This study will inform future research on mentorship in non-western countries and the wider population that has roles to play in this process.

8.4 Recommendations for policy and practice development

The findings of this study show that there is no clear understanding of mentorship in Saudi Arabia. This lack could reduce the effectiveness of the mentoring process and, therefore, is an area that needs to be improved. A national mentoring policy for Saudi Arabia could help decrease the ambiguity about the roles of mentors, mentees and those administering the programme. The literature review raised many of the same issues as the case study, particularly the ambiguity of the roles of participants in the mentorship process.

The following points are recommended as a result of this research:

1. A consensus definition of mentorship should be issued by the Saudi MOH in order to avoid conflict in role and expectations. In addition, mentors and mentees need greater awareness of their own and the other's role and

expectations. Improving mentoring practice requires implementation of effective strategies, including the development of a national mentoring policy in Saudi Arabia that clarifies the nature of the mentorship and the roles and expectations; clear job descriptions outlining the registered nurse's role as a mentor; hospital mentoring policies and guidelines; and a training workshop or programme for mentors. This training should be mandatory for all first-time mentors to educate them and increase their awareness of the mentoring process, its importance and its impact on the nursing profession and on the quality of nursing education and nursing care. The training needs to highlight the programme's aims and objectives, strategies for effective mentorship and important issues in mentorship, such as the meaning and value of mentorship, participants' roles and responsibilities, mentees' learning needs, effective communication and performance assessment. Based on the study findings, the researcher outlined a mentorship training programme and a draft handbook to improve mentoring across Saudi Arabia (Chapter 7).

2. Key Quality Indicators (KQIs) of good mentorship must be established through policy directives. KQIs include having clear goals, objectives and expectations of the relationship, as well as personal targets, the provision of training for both parties, and a system for evaluation of this process. These KQIs need to be in place, with data being collected through a variety of means, such as informal conversations with mentors, mentees and other qualified nurses, documentation of the mentorship process and questionnaires. Mentors must be shown to be providing high quality direct or indirect supervision to mentees during their practice time. Additionally, mentors must provide formal evidence that mentees

are achieving the learning outcomes and competencies according to regulatory body requirements, hence demonstrating they are fit for practice.

3. Who is responsible for mentoring, assessing and evaluating students in their clinical placements needs to be clearly defined. Appropriate people should be recruited and selected for these roles. Clinical staff in departments which mentees join could be recruited. This measure would give staff members, such as head nurses, a clear, concise developmental programme with instructions for each particular mentee.

4. The main study highlighted the important aspects that contribute to a successful mentor-mentee relationship. These included communication and openness between mentor and mentee, mutual respect, mentor's involvement in the student's professional development, and easing of students' fear during new procedures and situations. With these important aspects confirmed in a Saudi Arabian setting, assessment of mentorship relationships can be implemented to ensure that both parties work together as well as possible.

5. Effective relationships need to be built between mentors and mentees. Both parties must develop continuity during mentorship and effective communication skills to build such a relationship. Mentees should have the same mentor for the entire mentorship in each ward, instead of frequently changing mentors. In addition, the assignment of mentees to mentors needs to be established in advance.

6. Mentors need to be acutely aware of the challenges that their mentees face during the interpersonal clinical relationship, such as fear, lack of time and continuity with the mentor and language barriers. If these findings are appropriately disseminated, they will help mentors examine and improve their efforts.

7. Mentors need to consider individual students' learning needs in the practice setting and plan activities to meet these needs.

8. The college and hospital should prepare mentors and mentees before clinical placements, such as identifying mentors, designing clear learning objectives and arranging for mentees to meet their mentors before the start of the clinical placement. Additionally, effective communication and collaboration between the college and the hospital warrants consideration, especially among hospitals affiliated with colleges, in order to ensure support for placements, mentors and mentees. Frequent meetings between the mentors and college instructors are needed for effective communication between the hospital and the college in order to evaluate the progress of the mentees.

9. College instructors' role in students' clinical placements needs to be stated in their job descriptions. Doing so could place more emphasis on aiding the placement process, such as providing information about methods of securing placement at a particular clinical department in affiliated hospitals. College instructors need also to be given responsibility for ensuring that students learn

from their placements through such methods as feedback and evaluative case study seminars.

10. Support from the college and the hospital for mentors and mentees needs to be increased, along with mentors' and mentees' support for each other. Such support requires adequate resources and infrastructure to facilitate communication between mentors and mentees.

11. Organisations employing nurses, locally nationally and internationally must recognise the importance of protected time to teach and mentor nurses in practice if students are to be prepared and supported to become competent future practitioners. Mentors should therefore be provided with protected time by their employers, to enable them to spend sufficient time with their mentees, in addition to having time for reviewing practice documentation and ascertaining the success of mentees' progress in relation to practice based competencies. Mentors' workload needs to be considered, particularly reducing the number of mentees assigned to them to allow enough time for mentoring students.

12. In order to ensure sustainable, high quality mentoring and teaching in practice, additional measures should be taken by organisations to recognise and reward mentors for their work. This should involve suitable remuneration, for instance in the form of an increase in pay, paid training days, or a decreased workload for the duration of mentorship. In addition, recognition could also include certificates or thank you letters from senior management.

8.5   Recommendations for future research

Based on this study and the identification of an opportunity to improve what exists, the following research is recommended: (1) an evaluation of the mentorship training programme and (2) a comparative study of the results of this study in the Saudi Arabian context and those in western settings.

This study stands as an important addition to knowledge on nursing mentorship in Saudi Arabia, providing outline of a mentorship training programme and a draft handbook to establish a framework for nursing mentorship. More research is needed to evaluate this training programme and make it rigorous. The effects of the mentorship training programme, especially in redressing the shared concerns of mentors and mentees, should be assessed.

Although this study answers questions relating to both mentors' and mentees' nursing mentorship experiences, many more questions need to be answered to effect real change in nursing education in Saudi Arabia. For instance, a comparative study of the findings of this study in the Saudi context and those of others in western settings might be necessary to assess whether the issues raised are similar or different. This analysis could give insight into possible ways to improve nursing mentoring experiences and to design studies to test them. It could also maximise the outcomes for mentees whilst providing a satisfying experience for mentors. The factors contributing to positive mentorship experiences, such as language, culture and power balance, and their impact on the outcomes also need further exploration.

These recommendations could help to improve understanding of the mentorship process and to develop mentoring practice in nursing. In conclusion, nursing mentorship is important as it offers new learning experiences to mentees. This study has offered useful

findings which add to the existing body of knowledge and could improve the practice of

nursing education and mentorship in Saudi Arabia and other countries.

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Appendices

Appendix 1: Ethical Approval Letter (City University London)

CITY UNIVERSITY LONDON

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13 April 2010

Dear Ruba

Re: The perception of clinical nurses, student nurses and nurse academics, about mentorship in nursing in Jeddah, Saudi Arabia

Thank you for forwarding amendments and clarifications regarding your project. These have now been reviewed **and approved** by the Chair of the School Research Ethics Committee.

Please find attached, details of the full indemnity cover for your study.

Under the School Research Governance guidelines you are requested to contact myself once the project has been completed, and may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely

Carol Dossett

Carol Dossett
Research Administrator

c.dossett@city.ac.uk
0207 040 5763

Please note that City University has extensive insurance cover in place for the academic year 2009/2010, relevant details of which currently are:

1. Employers Liability

This is cover for legal liability to employees for death, injury or disease arising out of the business of the University. The limit of indemnity is £50,000,000 for any one claim.

2. Public and Products Liability

This is cover for legal liability to third parties for accidental loss of or damage to property or for death, injury, illness or disease arising out of our business and including liability arising from goods sold or supplied. The limit of indemnity is £50,000,000 for any one claim.

3. Professional Indemnity

This is cover for legal liability to third parties for breach of professional duty due to negligent act, error or omission in the course of our business. The limit of indemnity is £15,000,000 for any one claim.

Clinical trials cover is included within the above insurances in place.

Ken

Ken Cridland

Head of Finance

(Financial Accounting and Payables)

City University

Northampton Square

London EC1V 0HB

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Fax: 020 7040 8564

Email: k.s.cridland@city.ac.uk

Appendix 2: Ethical Approval Letter- The Hospital (Case Study)

المملكة العربية السعودية

Faculty of Medicine

كلية الطب

Ref.FM :

الـرقـم :

Date :

التاريخ :

Encl :

المرفقات :

Unit of
Biomedical Ethics
Research Committee

TO : Ms.Ruba Matoug Al harazi   From :

Date :Tuesday, March 9, 2010   CC : Dean /Vice-Dean, University /Hospital Director& File

RE : The perception of clinical nurses ,student nurses , and nurse academics about mentorship in nursing in Jeddah , Saudi Arabia . (Reference No   )

THIS IS TO CERTIFY THAT RESEARCH TITLED :

The perception of clinical nurses ,student nurses , and nurse academics about mentorship in nursing in Jeddah , Saudi Arabia .

Submitted by :

Ms. Ruba Matoug Al harazi   (Nursing Department.)(City University London)

Has been reviewed by the committee with respect to protecting the rights welfare of human subjects involved in the research project and / or experimental animals utilized. The methods employed are adequate for obtaining the information required and satisfy the required ethical principles and does not involve undue risk in the light of the medical benefits to derived there form .

Decision :

The committee approves the above mentioned proposal as fulfilling the ethical requirements .

(Reference No   )

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**Appendix 3: Ethical Approval Letter- The Nursing College
(Case Study)**

KINGDOM OF SAUDI ARABIA

████████████

████████████

Faculty of Applied Medical Sciences

Ref. ████████

Date ████████

████████

ETHICS AND RESEARCH
COMMITTEE

المملكة العربية السعودية

████████████

كلية العلوم الطبية التطبيقية

الرقـم : ████████

التاريخ : ████████

المرفقات :

To :   Ruba Matoug Alharazi, PhD candidate
From: ████████ Chiarman, Ethics and research Committee
Date: Sunday, 7 March 2010
Re: Research proposal (The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia).

Dear Mrs. Ruba Alharazi,

The above titled project, in fulfillment of your PhD degree in City University London, school of Community and Health Sciences, United Kingdom has been discussed in the ethical committee meeting held on, 7 March 2010.

The ethics and research committee has reviewed your research proposal which is a qualitative study that involves focus group interviews, and which will be carried out with mentees 2nd year, 3rd year, 4th year, and interns students of Bsc nursing programme and with nursing lecturer and teaching assistant in the nursing department at ████████ during the academic year 2010-2011. The following sections of your research proposal were reviewed in relation to ethical aspects:
1- Research objectives.
2- Methodology: including study design and data collection methods (focus group interviews).
3- Study components and outcomes: (the perception of the student nurses and nurse academics about mentorship in nursing, and the exploration of the current practice of mentorship in nursing in Jeddah).
4- Information letter and consent forms to be provided to recruited students.

I am pleased to say that the committee was satisfied in relation to its ethical aspects.

We wish you all the best in your project.

Yours Sincerely

████████

████████

Chairman, Ethics and Research Committee.

████████   ████████   ████████   ████████

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Appendix 4: Invitation Letter (Case Study)

Invitation Letter

(Focus Group Interview)

Date:

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about preceptorship and mentorship in nursing in Jeddah, Saudi Arabia.

My name is Ruba Alharazi, I am a PhD student in the School of Community and Health Sciences at City University London. I am conducting a research study as part of my PhD thesis as a requirement of my degree, and I would like to invite you to take part in this study and to participate in a group discussion which in fact is a focused group interview. Since the topic of discussion is important for the development of Nursing and Nursing Education in the Kingdom of Saudi Arabia, I hope you will want to participate in this study. Your opinions will be valuable and I will take care not to identify you individually when I write reports on the range of opinions gathered.

If you agree to take part in this study, you will be asked to participate in a group discussion lasting about one hour, we will discuss mentorship in nursing.

Thank you for your consideration. If you would like to participate, please read the attached explanatory statement sheet and sign the attached consent form.

I will be happy to answer any questions you have about the study.

Sincerely yours,

Ruba Alharazi
School of Community and Health Sciences
City University
West Smithfield Site
20 Bartholomew Close
London EC1A 7QN
Tel: + 44 (0)20 7040 8797
E-mail: Ruba.Alharazi.1@city.ac.uk

Invitation Letter

(Individual Interview)

Date:

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about preceptorship and mentorship in nursing in Jeddah, Saudi Arabia.

My name is Ruba Alharazi, I am a PhD student in the School of Community and Health Sciences at City University London. I am conducting a research study as part of my PhD thesis as a requirement of my degree, and I would like to invite you to take part in this study and to participate in a discussion which in fact is an individual interview. Since the topic of discussion is important for the development of Nursing and Nursing Education in the Kingdom of Saudi Arabia, I hope you will want to participate in this study.

If you agree to take part in this study, you will be asked to participate in an individual interview lasting about one hour, we will discuss mentorship in nursing.

Thank you for your consideration. If you would like to participate, please read the attached explanatory statement sheet and sign the attached consent form.

I will be happy to answer any questions you have about the study.

Sincerely yours,

Ruba Alharazi
School of Community and Health Sciences
City University
West Smithfield Site
20 Bartholomew Close
London EC1A 7QN
Tel: + 44 (0)20 7040 8797
E-mail: Ruba.Alharazi.1@city.ac.uk

Appendix 5: Explanatory Statement (Case Study)

Explanatory Statement

(Focus Group for Staff Nurses and Clinical Educators)

School of Community and Health Sciences, City University London

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

Name of lead researcher: Ruba Alharazi.

Before you decide if you would like to participate, it is important for you to know about the research and what you can expect if you join the study. This explanatory statement sheet will tell you everything you need to know about the project, but if there is anything that you do not understand, I will be happy to explain it to you. Take as much time as you need to read this sheet and think about whether or not you want to participate in the study.

What is the purpose of the project? And why have I been chosen?

The study aims to investigate and explore the current practice of mentorship in nursing in Jeddah's clinical settings (hospitals) as seen from the perception of clinical nurses, student nurses, and academics by asking the following research questions:

- What is mentorship?
- What is the current practice of mentorship in Jeddah?

You have been asked to join the study because I want to hear your thoughts and opinions on nursing mentorship in Jeddah. The focus group will be composed of clinical educators and mentors (staff nurses). The group is expected to be 12 people.

How is the study intended to benefit me?

There will be no direct benefits to you. However, the findings of this study will benefit the mentees, the mentors, nursing students, clinical supervisors, clinical educators, senior managers, clinical and academic organizations by raising their awareness to an important issue in nursing education that requires further and enhanced recognition. This is the reason which for the present session which would go into exploring your perceptions and views regarding the current practice of mentorship in nursing in Jeddah, Saudi Arabia.

What is the process of the individual interview? And how long would it last?

The Semi-structured focus group interview will take place in a conference meeting room at King Abdulaziz University Hospital. The interview will be composed of open ended questions and will last for approximately one hour. There will be a note taker and the interview will be audio taped to allow the researcher to facilitate the discussion and code responses. And at the end of the focus group interview, the researcher will provide the participants with a summary sheet to make sure that her perception was accurate. All participants will be equally treated with requisite dignity and respect.

Do I have to take part in this research? What if I change my mind during the study?

Participation in this study is voluntary. If you decide to take part, you are free to refuse to answer any or the entire set of questions and even to withdraw from the interview at any point of time without giving any reason and there will be no disadvantage to you of any kind.

What do you do with all of the information that is collected during the study? What happens at the end of the research?

Interview transcripts will be kept confidential with only the researcher and her supervisors having access to them. The tapes will only be reviewed by members of the research who will transcribe and analyze them. They will then be destroyed. All the study materials and data will also be kept secured in the researcher's work place. You will remain anonymous and will not be identified, as codes will be used. It

will be ensured that identifying information is not available to anybody who is not directly involved in this study. All records will be appropriately disposed off after the completion of this study.

What will happen to the Results of the Research Study?

The results of this study will be published in the form of a report as PhD thesis in nursing at City University, London. Research participants will not be identified in any part of the report. Interested persons can contact the researcher and receive a copy of the result.

How do I join the study?

This study has been authorized by the Research Ethics Committee of KAUH. You will be given a consent form enclosed to this information sheet, if you are willing to participate in this study, please sign the consent form and return it back to the head nurse of your department before the start of the study. Then I will contact you by phone or email to arrange the place of the interview. All of the study participants will be given a copy of this explanatory statement sheet and a signed copy of the consent forms to keep.

How do I make a complaint about the study?

If there is an aspect of the study which concerns you, you may make a complaint to:

Mr. Mohamed Alsearee
The Secretary of Unit of Biomedical Ethics
Tele: 02/6402000
Ext: 22131

In addition, City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 004420 7040 5763 or fax 0044207 040 5717. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

You could also write to the Secretary at:

Carol Dossett
Research Ethics Committee Administrator
City University
20 Bartholomew Close
West Smithfield
EC1A 7QN
London
Email: C.Dossett@city.ac.uk

Who should I talk to if I have questions or need more information about the study?

For further information please don't hesitate to contact me.

Contact details:

Ruba Matoug Alharazi

E-mail: Ruba.Alharazi.1@city.ac.uk

Thank you so much for your participation.

Explanatory Statement

(Individual Interview)

School of Community and Health Sciences, City University London

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

Name of lead researcher: Ruba Alharazi.

Before you decide if you would like to participate, it is important for you to know about the research and what you can expect if you join the study. This explanatory statement sheet will tell you everything you need to know about the project, but if there is anything that you do not understand, I will be happy to explain it to you. Take as much time as you need to read this sheet and think about whether or not you want to participate in the study.

What is the purpose of the project? And why have I been chosen?

The study aims to investigate and explore the current practice of mentorship in nursing in Jeddah's clinical settings (hospitals) as seen from the perception of clinical nurses, student nurses, and academics by asking the following research questions:

- What is mentorship?
- What is the current practice of mentorship in Jeddah?

You have been asked to join the study because I want to hear your thoughts and opinions on nursing mentorship in Jeddah.

How is the study intended to benefit me?

There will be no direct benefits to you. However, the findings of this study will benefit the mentees, the mentors, nursing students, clinical supervisors, clinical educators, senior managers, clinical and academic organizations by raising their awareness to an important issue in nursing education that requires further and enhanced recognition. This is the reason which for the present session which would go into exploring your perceptions and views regarding the current practice of mentorship in nursing in Jeddah, Saudi Arabia.

What is the process of the individual interview? How long would it last?

The interview will be composed of open ended questions and will last for approximately one hour. The interview will be audio taped to allow the researcher to facilitate the discussion and code responses. And at the end of the interview, the researcher will provide you with a summary sheet to make sure that her perception was accurate. You will be treated with requisite dignity and respect. The individual interview will be conducted where is more convenient for you either in your office or in a conference meeting room at your work place.

Do I have to take part in this research? What if I change my mind during the study?

Participation in this study is voluntary. If you decide to take part, you are free to refuse to answer any or the entire set of questions and even to withdraw from the interview at any point of time without giving any reason and there will be no disadvantage to you of any kind.

What do you do with all of the information that is collected during the study? What happens at the end of the research?

Interview transcripts will be kept confidential with only the researcher and her supervisors having access to them. The tapes will only be reviewed by members of the research who will transcribe and analyze them. They will then be destroyed. All the study materials and data will also be kept secured in the researcher's work place. You will remain anonymous and will not be identified, as codes will be used. It will be ensured that identifying information is not available to anybody who is not directly involved in this study. All records will be appropriately disposed off after the completion of this study.

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What will happen to the Results of the Research Study?

The results of this study will be published in the form of a report as PhD thesis in nursing at City University, London. Research participants will not be identified in any part of the report. Interested persons can contact the researcher and receive a copy of the result.

How do I join the study?

This study has been authorized by the Research Ethics Committee of KAUH. You will be given a consent form enclosed to this information sheet, if you are willing to participate in this study, please sign the consent form and it will be collected from you by me. I will then contact you by phone to arrange a convenient time and place for the interview. All of the study participants will be given a copy of this explanatory statement sheet and a signed copy of the consent forms to keep.

How do I make a complaint about the study?

If there is an aspect of the study which concerns you, you may make a complaint to:

Mr. Mohamed Alsearee
The Secretary of Unit of Biomedical Ethics
Tele: 02/6402000
 Ext: 22131

In addition, City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 004420 7040 5763 or fax 0044207 040 5717. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

You could also write to the Secretary at:

Carol Dossett
Research Ethics Committee Administrator
City University
20 Bartholomew Close
West Smithfield
EC1A 7QN
London
Email: C.Dossett@city.ac.uk

Who should I talk to if I have questions or need more information about the study?

For further information please don't hesitate to contact me.

Contact details:

Ruba Matoug Alharazi

E-mail: Ruba.Alharazi.1@city.ac.uk

Thank you so much for your participation.

Appendix 6: Interview Consent Form (Case Study)

Interview Consent Form

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the study, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organization.

☐

I confirm that I have had the project explained to me, and I have read and understood the Explanatory Statement. I understand that my participation is voluntary and that I am free to refuse to answer any question during the interview and to withdraw from the interview at any time without giving any reason and there will be no disadvantage to you of any kind.

☐

I agree to take part in this study. I understand that agreeing to take part means that I am willing to be interviewed by the researcher and to have the interview tape recorded.

☐

I agree to the use of anonymised quotes in publications.

☐

Name of participant:

Signature of participant: Date:

I believe that the above participant understands the project and gives her/his consent voluntarily.

Name of researcher:

Signature of researcher: Date:

Contact details:

Ruba Matoug Alharazi
School of Community and Health Sciences
City University
West Smithfield Site
20 Bartholomew Close
London EC1A 7QN
Tel: + 44 (0)20 7040 8797
E-mail: Ruba.Alharazi.1@city.ac.uk
Thank you so much for your participation.

NB. Copy will be given to the participant. Copy will be kept with the researcher.

Appendix 7: Initial focus groups' Guide

Initial focus groups' questions for mentors (registered nurses) and clinical educators

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

- What does mentorship mean to you?

- What do you feel about the time you spend with your mentees?

- What could you tell me about your relationship with mentees?

- Can you tell me what is it like working as a mentor in your area?

- What do you think about the support mentors receive?

- What are your suggestions for the improvement of mentoring?

- Would you like to add anything before we end our discussion?

Appendix 8: Focus Group's Guide (Case study)

Focus groups' questions for mentors (registered nurses) and clinical educators

Title of the Study: The perception of clinical nurses, student nurses, and nurse academics about mentorship in nursing in Jeddah, Saudi Arabia.

- What do you feel about the time you spend with your preceptees?

- What could you tell me about your relationship with preceptees?

- If you were mentoring the students, is the relationship would be different?

- Can you tell me what is it like working as a preceptor in your area?

- What do you think about the support preceptors receive?

- What are your suggestions for the improvement of mentoring?

- What does mentorship mean to you?

- Would you like to add anything before we end our discussion?

Appendix 9: Focus Group Transcript with Associated Coding and Analysis

I: what do you feel about the time you spend with your mentor?

R: it depends on the nurse and also depends if she have knowledge because if there is lack of knowledge, she will not be able to teach me anything. M-KN

R: the most important thing that she smiles at your face and to be cooperative. For example, if there is a medication or procedure she asks you to come and observe or participate. It is important that she is willing to teach. M-FR, M-WT

R: and those who are like this are few. NVM

R: if there are mentors like this of course we will be happy with time we spend with our mentors.

R: most of the time they are grouped together according to their nationality, you can see that Philippines nurses are grouped together; Indian nurses also are grouped together. The staff nurses who usually help us are the intern nurses, maybe because they are Saudis like us…they always teach us. AoN

R: of course because they felt what we are feeling now. AoN

R: it depend on the nurse, sometimes I feel that the clinical placement is boring and that the time is passing slowly…and sometimes when the nurse teaches me I don't feel the time, it passes so quickly and I feel that I want to stay and wish to spend more time. SF

R: also it depends in her performance, if she is doing a good job and doing it in a proper way. M-Pf

R: sometimes you feel that you are a heavy load on her and that you are not accepted because she has a lot of work which she wants to get done quickly. And you are making her feel board and I hate this feeling. SF, M-WL

I: You've said that "you are making her feel board", what made you think that you are making her feel board?

R: because she has lots of work. M-WL

R: and she got board from teaching every day. M-WT

R: she might feel that you are Saudi so why do you want to work and they might also feel that you don't need to work, she wants to keep her job and doesn't want someone to take her position. AoN

R: they seem that they don't like their working place, and sometimes they don't seem interested in the nursing profession or even that they like it….they are different than other staff nurses in other hospitals….in another hospital such as X hospital, staff are adorable, they are happy and willing to teach you. M-WT

I: and why do you think that nurses are different from one hospital to another?

R: maybe because this hospital accommodates too much students, and most of the time students keep asking them questions. TMS

R: also they don't allow us to participate in most of the procedures because they are afraid to get in trouble if the student made any mistake because they are the one who will be questionable and responsible for that. SE

R: each one of us is assigned to a mentor but there are other students in the unit, not only us....there are the interns and also other students from ministry of health...so some time one nurse is assigned to mentor a nursing student, an intern student and a nursing student from the ministry of health as well. So you can see a nurse who's mentoring 3 students from different sectors which makes them sometimes get confused with the students. TMS

R: some nurses are happy to teach you without asking that from her....but others even when you ask, they are not accepting you. M-WT

I: what could you tell me about your relationship with your mentor?

R: I am trying to be nice and friendly with her to encourage her to teach me more. I am always trying to smile on her face even if she seemed angry or upset. I also apology to her if I made a mistake or did something wrong...some mentors accept to me and some of them wouldn't accept me from the beginning... If I am with a mentor who doesn't accept me, I try to withdraw and teach myself and to spend time with other staff nurses to learn from them. Sometimes I change my preceptor by accompanying a different staff nurse who is willing to help. SA, RMM

First order coding:

M-KN: Mentor Knowledgeable

M-FR: Mentor Friendly

NVM: Negative View of Mentorship

AoN: Aspect of Nationality

M-Pf: Mentor Performance

SM: Support from Mentor

MMP: Male Mentor Preferred

FL: Feeling Lost

NSI: Need to Show Interest.

DoW: Depends on Ward

SFOS: Support from Other Sources

Sfl: suggestions For Improvement

DoM: Definition of Mentorship

SF : Students' Feelings

M-WL: Mentors' Workload

TMS: Too Many Students

M-WT: Mentors' Welling to Teach

SE: Students' Engagement

SA: Students' Attitude

RMM: Relationship between Mentor and Mentee

NEGATIVE FEELINGS ABOUT THE CLINICAL PLACEMENT

CULTURAL DIFFERENCES AND LANGUAGE BARRIERS

WORKLOAD OF NURSES HINDERING GOOD COMMUNICATION

SUGGESTIONS FOR IMPROVEMENTS

Second order coding with memos

NEGATIVE FEELINGS ABOUT THE CLINICAL PLACEMENT

- Students do not feel supported by nurses or college clinical instructors. Their source of support is themselves, friends, family and interestingly; patients.
- Students are very unhappy about the way their placement is evaluated. Their clinical instructor evaluates them although she does not observe them. Students think mentors who observe them should also have a say.
- Students feel dejected and useless when they are not allowed to carry out simple procedures such as giving medication to patients. They are stuck between their instructors who ask them to do procedures and nurses who refuse them (it is not clear whether students know the reason nurses refuse is because it is against the policy).
- Students exemplify certain clashes with nurses and voice some extreme dissatisfaction of their relationships with mentors saying they feel invisible, frustrated, abused etc...

CULTURAL DIFFERENCES AND LANGUAGE BARRIERS

- Saudi nurses more friendly and helpful. They have empathy as they too went through the same route.
- The language barrier with foreign nurses makes communication difficult.
- Students feel nurses of same nationalities group together.
- Students feel foreign nurses resent them thinking they don't need to work, they also see them as future rivals.

WORKLOAD OF NURSES HINDERING GOOD COMMUNICATION

- Students feel they are being a burden when nurses are busy and are 'bored' with teaching.
- Sometimes one nurse is responsible to mentor three students and this makes communication difficult.
- Students withdraw when nurses appear unfriendly and not interested in teaching (business of nurses may be interpreted as not being willing to teach).
- Some nurses seem like they don't enjoy their job (students might be feeling that way due to the idealisation of the profession when still a student and not being able to realistically evaluate the pressure nurses work under).

SUGGESTIONS FOR IMPROVEMENTS

- There should be better coordination between hospital and university; mentors should be provided with the course curriculum and objectives. There should be agreement on what students can and cannot do according to policy.
- Mentors should be given 1-2 students maximum and there should be more clinical instructors based at the hospital during student shifts.
- Mentors should be chosen from among those nurses who are suited to the task, they should be prepared, trained and given bonuses.
- Mentors should be evaluated by the hospital and students should give feedback about their mentorship experience to the head nurse.

Appendix 10: Search Strategy

<u>**Search Strategy**</u>

The studies forming the basis of this literature review were sourced by conducting searches on multiple databases. The search strategy employed for the Ovid database is reproduced below.

The combinations of words listed below were entered into the 'Title', 'Abstract' and 'Contents' fields of the database. Special characters were used at the end of the words which were searched in order to identify multiple endings. For example, 'nurs$' was used to identify 'nurse', 'nurses' and 'nursing'.

Mentorship AND nurses
Mentor AND nurses
Mentee AND nurses
Preceptorship AND nurses
Preceptorship OR students AND nurses
Coaching AND nurses
Mentorship OR support AND nurses
Mentor OR mentee OR relationship AND nurses
Mentorship OR factors AND nurses
Education AND clinical placements
Mentorship AND clinical placements
Mentor OR mentee AND clinical placements
Preceptorship AND clinical placements
Learning experience AND nurses
Learning environment AND clinical placements
Supervision AND nurses
Supervision OR mentorship AND clinical placements
Supervision OR mentorship AND nurses

The same combinations of search terms were used on Medline, Embase, CINAHL, Cochrane and Pub Med. databases. Not all databases enabled searching of title, content and abstract, but the search terms listed above were entered in all available fields.

Appendix 11: Reference Grid: Mentorship experiences from the perspectives of mentors and mentees

Reference Grid: Mentorship experiences from the perspectives of mentors and mentees.

The studies included in this grid incorporate all of the sixteen academic studies which are referenced in detail in the main body of the literature review. They are organised alphabetically by the name of the first author.

Details of study [Author/Year/Title/Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Author: Beecroft et al. (2006) Title: 'New graduate nurses' perceptions of mentoring: six year programme evaluation' Country: USA	To assess the situation of graduate nurses, namely: were they supported/offered guidance? Did they have an appropriate role model? Were they happy with the mentorship they received? Were they socialised to the job of nursing?	Survey (Quantitative & qualitative study)	Descriptive statistics, logistic regression and content analysis based on survey responses	New graduate nurses (n=318)	- Positive mentorship is achieved when abundant guidance and support are provided by mentors. - A positive mentor can improve a graduate's confidence making it more likely they will progress to being a qualified nurse. - Neither mentors nor nurses were aware of what mentorship would entail. - Obstacles to positive mentorship were primarily compromised by a paucity of time or dedication to the process.	- The use of both qualitative and quantitative methodologies has made the results of this study more reliable as a range of perspectives were included and studied. - Certain survey questions were inadequately phrased which may affect the findings (e.g. nurses were asked if they met with their mentor 'regularly'). This could have been resolved by making the wording of

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					- The educational level of nurses had a clear impact on the probability of frequent meetings with the mentor. - Frequent personal meetings between mentor and mentee are required to create a positive mentor-mentee relationship. - Mentorship programmes for newly-graduated nurses must consider any barriers to sufficient training for both mentors and mentees and must provide them with the required training and preparation for the role.	questions more precise. A subjective understanding of responses is now possible and could result in bias.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Author: Bradbury-Jones, Sambrook and Irvine (2007) Title: 'The meaning of empowerment for nursing students: a critical incident study' Country: UK	To explore the experiences that both empower and disempower nursing students regarding their clinical practice	Qualitative study.	Critical incident technique (CIT).	Nursing students (n=66)	- During clinical placements, students feel both empowered (enabled) and disempowered (hampered) at different times, and these experiences relate primarily to being a member of a team, authority and practical learning. - Empowering experiences for students were based on placement continuity, time and the attendance of a mentor while the non-attendance of a mentor disempowered the students. - The empowering experiences of nursing students resulted in improved self-esteem, high motivation-for-	- CIT is reliant on accurate portrayals of situations rather than descriptions of what should be occurring. In this approach the abstract is eschewed for the real and thus CIT is perfectly conceived for reconstructing a true-to-life practice situation. - CIT depends upon participants offering examples, and while the majority of students offered comprehensive descriptions, some explanations were imprecise and could not be elucidated as the responses were written anonymously.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					learning levels and a beneficial attitude towards the placement.	- The study results relied upon the capacity of the students to provide clear and specific accounts of empowering and disempowering experiences. However, in-depth portrayals of events were not provided by all students and thus the findings of the study are restricted in scope.
Bukhari E (2011) Title: Nature of preceptorship and its impact on clinical nursing care from the perspectives of relevant nursing staff.	To investigate the character and the role of preceptorship in Saudi Arabian clinical nursing practice.	Qualitative design	semi-structured focus groups and individual interviews	30 nurses (8 preceptees; 8 preceptors; 6 nurse managers; 6 clinical resource	The study findings revealed the central importance of preceptorship in introducing newly hired nurses to their clinical nursing positions. The key topics identified are: 1) how preceptorship is	- The importance of this research lies in the fact that the viewpoints of experienced newly-hired nurses as preceptees were collected, and not the opinions of students or

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Country: KSA				nurses and 2 nurse educators)	understood; 2) the impact preceptorship has on the provision of nursing care; 3) time requirements; 4) the level of support provided; 5) the issue of recruitment and how it impacts on the effectiveness of preceptorship; 6) choosing preceptors and how they are prepared for the role.	interns. Furthermore, an additional understanding of the research topic was gained by exploring the viewpoints of managers and preceptors. - A possible limitation of this study is the use of only one clinical setting in Saudi Arabia where a broad range of situations and viewpoints may exist among nurses in other Saudi Arabian clinical settings. - As only three Saudi nurses participated in this study, the Saudi-nurse sample size is deemed to be too insignificant to allow

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
						a comparison to be drawn with the non-Saudi Arabian nurses to determine whether nationality has an impact on preceptee experiences.
Duffy (2003) Title: Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice Country: UK	To explore the attitudes and experience of mentors and lecturers as regards why certain nursing students are allowed to graduate despite not displaying the required competencies.	Qualitative design	Unstructured and semi-structured individual interviews	14 nursing lecturers and 26 mentors.	- A mentor must be ready to offer a student truthful feedback about their performance and is ultimately accountable to that student. - It was general practice that mentors gave students the benefit of the doubt, meaning that students were shocked if they did not pass their final year placement evaluations. - A large number of students are eager for truthful comments from their mentors as they are	The use of unstructured and semi-structured individual interviews to explore individual perceptions regarding why some mentors fail to fail students enabled mentors' and lecturers' to freely express their thoughts, views and feelings and to communicate effectively with the researcher.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					frightened of failing their assessments. - In order to prepare for the role of mentor, mentors require training on how to deliver criticism in a way that is constructive and that will help students improve.	
Author: Elcigil and Sari (2008) Title: 'Students' opinions about and expectations of effective nursing clinical mentors' Country: Turkey	To discover the perceptions and expectations of nursing students regarding their mentors, particularly in relation to their effectiveness in the role.	Qualitative study.	Semi-structured focus group interviews.	Students after completion of their third year nursing (n=24)	- Communication was identified as the crucial factor regarding the effectiveness of a mentor. Furthermore, positive relationships between mentors and mentees were based on good, clear communication. - The characteristics of a good mentor are the ability to effectively communicate with students, be sympathetic,	- The use of focus group discussions aided in the examination of the thoughts and feelings of students.

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Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					help students to undertake their own research and offer constructive criticism.	
Author: Gray and Smith (2000)

Title: 'The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study'

Country: UK | To identify what impact mentorship has on nursing students after the implementation of the 1992 programme (which leads to a Diploma of Higher Education in Nursing followed by registration with the United Kingdom Central Council, known as the UKCC). | A longitudinal qualitative study using Grounded theory. | -Interviews on five occasions during the three years of their course.

-Voluntary participation by diary. | 10 students from a large Scottish College of Nursing & Midwifery participated in the interview and by diary.

- Another 7 students participated by diary only. | - Effective mentors are characterised by students as mentors who are friendly, welcoming, skilful communicators, empathetic, patient and passionate.

- Ineffective mentors are characterised by students as being less welcoming and friendly, frightening and typically distant.

- Typically, students are not fully informed about their course and do not have a realistic expectation about their mentors' availability. | - The use of a longitudinal technique that adopted grounded theory methodology helped the researchers to collect the variations over time in students' opinions regarding their mentors.

- The use of Face-to-face interviews allowed the researchers to obtain additional understanding regarding the diary entries of students. |

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					- Diploma students are quick to discard their idealised vision of their mentor and subsequently gradually gain an understanding of the features they regard as central to being a good mentor. - Students are quick to appreciate the value of choosing positive role models and the value of understanding the preferences of their mentors as these elements impact on their evaluation results. - It is clear that students become increasingly detached from their mentor when they begin their Branch programme. This detachment	

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					corresponds to an increase in the students' skills and self-confidence and the development of a view of care-giving as a whole.	
Author: Jones, Walters and Akehurst (2001) Title: 'The implications of contact with the mentor for preregistration nursing and midwifery students' Country: UK	To discover the amount of contact midwifery and nursing students have with their mentors and the effects of this level of contact.	Quantitative & Qualitative study	-Students and mentors kept an activity diary for one week - Focus group discussions were held separately with mentors and with students	-nursing and midwifery students and mentors (n=270) (46.3% response rate from students (n=125) and 45% response rate from mentors(n= 117))	- Mentors were often absent when students worked. - The sustained absence of mentors and poor continuity had a negative effect on the mentorship experience of the students.	Carrying out separate focus groups for mentors and mentees was found to be a valuable approach to examine and develop an understanding of the experiences of both mentors and mentees.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Country: Kaviani and Stillwell (2000) Title: 'An evaluative study of clinical preceptorship' Country: New Zealand	To investigate the elements that affect the role and effectiveness of a mentor from the point of view of mentors, nursing managers and nursing students.	An evaluative qualitative study	-Focus groups -individual Interviews with the nurse managers	-Preceptors (n=6) -3rd year nursing students (n=13) -nurse managers (n=2)	- The study revealed that structured preceptor preparation is of significant value as is the encouragement of effective partnerships between nurse practitioners and educators. - In practice, there is a need for the role of preceptors to be officially acknowledged especially regarding the time and resources that should be allocated to the role.	- The identification of the practical implications of the findings of the programme was facilitated by the utilisation of focus groups.
Author: Lis et al. (2009) Title: 'Mentoring in Psychiatric Residency Programs: A Survey of Chief Residents'	To examine the opinions of general psychiatry chief residents in relation to whether the mentorship given during training is sufficient.	Quantitative approach	Survey	Chief residents 'doctors' (n=229)	-The findings identified that almost half (49%) of mentees had no specific career development mentor. A total of 39% of mentees stated that they were not sufficiently equipped for a future nursing career and were	- The findings are more generalizable due to the substantial sample size. - Real outcomes and the feelings of mentees regarding how prepared they are

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Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Country: USA					not adequately mentored.	to deal with a nursing career may not correlate and thus it would have been worthwhile to examine the relationship between these two elements. - The exclusive focus on quantitative analysis prevented researchers from obtaining a deeper understanding of the mentees' experiences through interviews. It can be inferred that the methodology adopted was not able to provide a truly comprehensive view of the issues involved. A mixed methodology would have been more beneficial.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Author: Lofmark et al. (2009) Title: 'Supervising mentors' lived experience of supervision in teaching, nursing and social care education. A participation-oriented phenomenological study'.' Country: Sweden	To examine mentors' experiences in the context of social care, nursing and teaching.	A qualitative, phenomenological approach	Semi-structured interviews	Mentors in nursing and social care (n=19)	- Mentors believe they bridge the gap between practice and university education. - The continued motivation of mentors requires higher amounts of contact and communication between the university and the mentors.	- The results of this research are useful in terms of informing and progressing nursing practice, a valuable consideration in the context of phenomenological research methodology (Creswell, 2003).
Author: Myall, Levett-Jones and Lathlean (2008) Title: 'Mentorship in contemporary practice: the experiences of nursing students and practice mentors'	To discover the mentor role in current nursing practice in the United Kingdom	Quantitative & Qualitative research	Online survey for pre-qualifying students and postal questionnaire for mentors	-A total of 161 (10%) questionnaires from nursing students and 156 (21%) from mentors were	- Theoretical and practical mentoring considerations are continuing to move closer together. - National standards that clearly set out the mentorship role and the duties of the position would be helpful.	- Low response rates have raised the likelihood of the presence of bias. - Face-to-face interviews with both mentees and mentors would have provided additional information

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Country: UK				returned		regarding the mentor role.
Author: Nahas (2000) Title: 'A transcultural study of Jordanian nursing students' care encounters within the context of clinical education' Country: Jordan	The explore mentoring experiences among Jordanian and Australian nursing students in terms of level of care provided by their mentors	Qualitative research	Observation & Interviews	-2nd year nursing students (n=17) -3rd year nursing students (n=16) -4th year nursing students (n=14)	- Higher care levels from mentors were expected by Jordanian students. These students reported higher satisfaction levels when a mentor's behaviour included sustaining, negotiating, transforming, translating and mothering activities.	- Mentors' experiences were not explored in this study. It would thus have been beneficial for the outcomes of the study to have explored mentors' perceptions of their experiences with mentees as well.
Author: Neary (2000b) Title: Responsive assessment of clinical competence: part 2	To compare the supportive element of mentorship to the provision of 'scaffolding' to newly-qualified nurses.	Quantitative & Qualitative design	Survey and interviews	300 student nurses and 155 nurse practitioners, with interviews conducted	There are three types of support provided to mentees: 1) educational; 2) managerial; 3) emotional/psychological.	-As the study sought to describe experiences as well as to clarify phenomena, a mixed methodology was applied.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Country: UK				with 70 students and 80 mentors from three nursing colleges.		
Author: Papp, Markkanen and Bonsdorff (2003) Title: 'Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences' Country: Finland	To explore the perceptions of nursing students regarding clinical learning experiences in a clinical learning setting.	Qualitative study (phenomenol ogical approach)	Observation & Unstructure d interviews	2nd, 3rd and 4th year student nurses (n=16)	- The creation and maintenance of a positive learning environment requires that the university and clinical staff collaborate with each other. - In a clinical environment, it is important for students to feel they are supported and valued. - Students' clinical learning experiences are characterised by how supported and valued they felt, their own self-	- Conducting unstructured interviews allowed students to freely present their thought and feelings regarding clinical learning experiences within a clinical learning setting.

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Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
					directedness and the standard of patient care and mentoring.	
Author: Ronsten, Andersson and Gustafsson (2005) Title: 'Confirming mentorship' Country: Sweden	The explanation of newly-registered nurses' experiences of mentorship in terms of their competence level as nurses.	Quantitative & Qualitative design	Questionnaires, individual interviews, focus group interviews	Recently registered nurses (n=16)	- Nurses' self-confidence increases as do their competencies and motivation to provide nursing care when they have an effective mentor. - Nursing practices are also improved by an effective mentorship experience. - In terms of mentor-mentee interaction, male nurses appear to engage in this interaction more confidently than female nurses.	- A more accurate view of the effect of mentorship on nurses' professional development was given here as the study was conducted two years after mentorship. However, it is possible that this time lapse adversely affected the accuracy of nurses' recall of mentorship experiences. - The usefulness of this study is strengthened by the utilisation of a mixed methodology, i.e. triangulation.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
Author: Shannon et al. (2006) Title: 'Rural clinician opinion on being a preceptor' Country: Australia	To assess the experiences and motives of preceptors of professional healthcare students at the Spencer Gulf Rural Health School (South Australia).	Quantitative & Qualitative design	A questionnaire with Likert scales and open-ended responses. This was pilot tested twice	255 preceptors (with a response rate of 58%.) drawn from: -Medicine (n=70) -Nursing (n=37) -Allied health (n=24) -Other background (14) -Had generally preceptored	-It was stated by clinicians that they suffered from a lack of time and a more demanding workload as preceptors and that these factors are the main drawbacks to the role.	- The study would have benefited from the use of a wider range of methods which included interviews or focus groups. A more comprehensive view of the various opinions, problems and value differences would have resulted from taking this approach.

Details of study [Author/Year/Title/ Country]	Aim	Study Design	Methods	Sample size	Results	Critique of methods used
				previously (133)		

Appendix 12: Focus Group's Guide (Main Study)

Semi-Structured Focus Group Interview Questions

Participants' group:

Date of Interview:

Location:

Title of the Study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

Appreciative Inquiry Guide

Thank you so much for agreeing to take part in this study. In this study I will use an organizational development method called appreciative inquiry. It is an approach based on the belief that there is a valuable work happening in all organizations and that they all have something which works well. It is a positive way to create organizational change by appreciating what the organization does best (Cooperrider, Whitney and Stavros, 2008).I will be using this method to discover the strengths of mentorship in nursing among a divers team of nursing students and registered nurses by assisting them to discover their strengths and to identify key characteristics of successful mentorship. Mentors and mentees from different cultures, backgrounds, genders, and ages are invited to share their experiences. During the interview, you will be guided through the first three stages of appreciative inquiry which include discovery, dream, and design. According to Cooperrider, Whitney and Stavros (2008), appreciative inquiry involve 4 phases: discovery phase 'What gives life?', dream phase 'What might be?', design phase 'How can it be?', and destiny phase 'What will be?'. The fourth stage will not be involved in this study according to the aim of this study.

Do you have any question? If you do feel free to ask me.

Ground Rules:

- Take notes.
- Observe time frame.

Discovery Phase:

- Take some time to think what mentorship means to you. Could you tell me what mentorship means to you?

- Could you please describe a specific peak (powerful) experience in mentorship, a time when you felt most alive, most engaged and really proud of yourself and your work? What happened? What did you feel?

- What did you value most in yourself and then in your mentor/mentee?

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- What do you consider to be the core factors that give life to your positive mentorship experience?

Activity: *(10 min)*

- Would you please select one of the best stories shared by the group members? Then, create a list of the themes highlighted in the story and which you feel are important and contributed best to that story.

- From the list of themes, could you please select three to five themes you feel are important for positive experiences?

Dream Phase: *(10 min)*

- If you have three wishes that could come true to improve your mentoring experience, what would those wishes be?

- What specific activities and circumstances would make the best (ideal) peak mentorship's experiences possible?

Design Phase: *(10 min)*

- Draw a design map. In the middle, draw your dream of an ideal experience in mentorship…Remember all the themes and core factors, both internal and external, that will influence the achievement of your dream.

Destiny Phase: *(5 min)*

- 'What are we going to do to achieve that ideal experience in mentorship?'

Appendix 13: Invitation Letter (Main Study)

<u>Invitation Letter</u>

(Focus Group Interview)

Date:

Title of the Study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

My name is Ruba Alharazi, I am a PhD student in the School of Community and Health Sciences at City University London. I am conducting a research study as part of my PhD thesis as a requirement of my degree, and I would like to invite you to take part in this study and to participate in a group discussion which in fact is a focused group interview. Since the topic of discussion is important for the development of Nursing and Nursing Education in the Kingdom of Saudi Arabia, I hope you will want to participate in this study. Your opinions will be valuable and I will take care not to identify you individually when I write reports on the range of opinions gathered.

If you agree to take part in this study, you will be asked to participate in a group discussion lasting about one and a half hour, we will discuss mentorship in nursing.

Thank you for your consideration. If you would like to participate, please read the attached explanatory statement sheet and sign the attached consent form.

I will be happy to answer any questions you have about the study.

Sincerely yours,

Ruba Alharazi
School of Community and Health Sciences
City University
West Smithfield Site
20 Bartholomew Close
London EC1A 7QN
Tel: + 44 (0)20 7040 8797
E-mail: Ruba.Alharazi.1@city.ac.uk

Appendix 14: Explanatory Statement (Main Study)

Explanatory Statement

(Focus Group Interview for Mentees)

School of Community and Health Sciences, City University London

Title of the Study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

Name of lead researcher: Ruba Alharazi.

Before you decide if you would like to participate, it is important for you to know about the research and what you can expect if you join the study. This explanatory statement sheet will tell you everything you need to know about the project, but if there is anything that you do not understand, I will be happy to explain it to you. Take as much time as you need to read this sheet and think about whether or not you want to participate in the study.

What is the purpose of the project? And why have I been chosen?

The aim of this study is to investigate the factors contributed to positive mentorship experiences in nursing in Jeddah, Saudi Arabia by exploring the mentors (registered nurses) and mentees (student nurses) positive experiences in relation to mentorship by asking the following research questions:

- What is mentors' and mentees' understanding of mentorship in nursing in Jeddah, Saudi Arabia?
- What are mentors' and mentees' positive experiences of mentorship in nursing in Jeddah, Saudi Arabia?
- What factors contribute to mentors' and mentees' positive mentorship experiences in nursing in Jeddah, Saudi Arabia?

You have been asked to join the study because I want to hear your thoughts, opinions and best experiences in mentorship in Jeddah (Saudi Arabia). The focus group will be composed of mentees (3rd year, 4th year, and intern students of BSc nursing programme). The group is expected to be 12 people.

What is Appreciative Inquiry?

In this study I will use an organizational development method called appreciative inquiry. It is an approach based on the belief that there is a valuable work happening in all organizations and that they all have something which works well. It is a positive way to create organizational change by appreciating what the organization does best (Cooperrider, Whitney and Stavros, 2008). I will be using this method to discover the strengths of mentorship in nursing among a divers team of nursing students and registered nurses by assisting them to discover their strengths and to identify key characteristics of successful mentorship. Mentors and mentees from different cultures, backgrounds, genders, and ages are invited to share their experiences. During the interview, you will be guided through the first three stages of appreciative inquiry which include discovery, dream, and design. According to Cooperrider, Whitney and Stavros (2008), appreciative inquiry involve 4 phases: discovery phase 'What gives life?', dream phase 'What might be?', design phase 'How can it be?', and destiny phase 'What will be?'. The fourth stage will not be involved in this study according to the aim of this study.

How is the study intended to benefit me?

There will be no direct benefits to you. However, the findings of this study will benefit the mentees, the mentors, nursing students, clinical supervisors, clinical educators, senior managers, clinical and academic organizations by raising their awareness to an important issue in nursing education that requires further and enhanced recognition. This is the reason which for the present session which would go into exploring your positive experiences in relation to mentorship in Jeddah (Saudi Arabia).

What is the process of the focus group interview? How long would it last?

The semi-structured focus group interview will take place in a conference meeting room at your work place. The interview will be composed of open ended questions and will last for approximately one and a half hour. The interview will be audio taped to allow the researcher to facilitate the discussion and code responses. At the end of the focus group interview, the researcher will provide each participant with a

summary sheet to make sure that her perception was accurate. All participants will be equally treated with requisite dignity and respect.

Do I have to take part in this research? What if I change my mind during the study?

Participation in this study is voluntary. If you decide to take part, you are free to refuse to answer any or the entire set of questions and even to withdraw from the interview at any point of time without giving any reason and there will be no disadvantage to you of any kind.

What do you do with all of the information that is collected during the study? What happens at the end of the research?

Interview transcripts will be kept confidential with only the researcher and her supervisors having access to them. The tapes will only be reviewed by members of the research who will transcribe and analyze them. They will then be destroyed. All the study materials and data will also be kept secured in the researcher's work place. You will remain anonymous and will not be identified, as codes will be used. It will be ensured that identifying information is not available to anybody who is not directly involved in this study. All records will be appropriately disposed off after the completion of this study.

What will happen to the Results of the Research Study?

The results of this study will be published in the form of a report as PhD thesis in nursing at City University, London. Research participants will not be identified in any part of the report. Interested persons can contact the researcher and receive a copy of the result.

How do I join the study?

This study will be authorized by the Research Ethics Committee of City University London and of your organization. You will be given a consent form enclosed to this information sheet, if you are willing to participate in this study, please sign the consent form and it will be collected from you by me. I will then contact you by phone to arrange a convenient time and place for the interview. All of the study participants will be given a copy of this explanatory statement sheet and a signed copy of the consent forms to keep.

How do I make a complaint about the study?

City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 004420 7040 5763 or fax 0044207 040 5717. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: Factors contributing to registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Ethics Committee
CRIDO
City University
Northampton Square
London EC1V 0HB
Email: anna.ramberg.1@city.ac.uk

Who should I talk to if I have questions or need more information about the study?

For further information please don't hesitate to contact me.

Contact details:

Ruba Matoug Alharazi   E-mail: Ruba.Alharazi.1@city.ac.uk

Thank you so much for your participation.

Explanatory Statement

(Focus Group Interview for Mentors)

School of Community and Health Sciences, City University London

Title of the Study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

Name of lead researcher: Ruba Alharazi.

Before you decide if you would like to participate, it is important for you to know about the research and what you can expect if you join the study. This explanatory statement sheet will tell you everything you need to know about the project, but if there is anything that you do not understand, I will be happy to explain it to you. Take as much time as you need to read this sheet and think about whether or not you want to participate in the study.

What is the purpose of the project? And why have I been chosen?

The aim of this study is to investigate the factors contributed to positive mentorship experiences in nursing in Jeddah, Saudi Arabia by exploring the mentors (registered nurses) and mentees (student nurses) positive experiences in relation to mentorship by asking the following research questions:

- What is mentors' and mentees' understanding of mentorship in nursing in Jeddah, Saudi Arabia?
- What are mentors' and mentees' positive experiences of mentorship in nursing in Jeddah, Saudi Arabia?
- What factors contribute to the mentors' and mentees' positive mentorship experiences in nursing in Jeddah, Saudi Arabia?

You have been asked to join the study because I want to hear your thoughts, opinions and best experiences in mentorship in Jeddah (Saudi Arabia). The focus group will be composed of mentors (registered nurses). The group is expected to be 12 people.

What is Appreciative Inquiry?

In this study I will use an organizational development method called appreciative inquiry. It is an approach based on the belief that there is a valuable work happening in all organizations and that they all have something which works well. It is a positive way to create organizational change by appreciating what the organization does best (Cooperrider, Whitney and Stavros, 2008). I will be using this method to discover the strengths of mentorship in nursing among a divers team of nursing students and registered nurses by assisting them to discover their strengths and to identify key characteristics of successful mentorship. Mentors and mentees from different cultures, backgrounds, genders, and ages are invited to share their experiences. During the interview, you will be guided through the first three stages of appreciative inquiry which include discovery, dream, and design. According to Cooperrider, Whitney and Stavros (2008), appreciative inquiry involve 4 phases: discovery phase 'What gives life?', dream phase 'What might be?', design phase 'How can it be?', and destiny phase 'What will be?'. The fourth stage will not be involved in this study according to the aim of this study.

How is the study intended to benefit me?

There will be no direct benefits to you. However, the findings of this study will benefit the mentees, the mentors, nursing students, clinical supervisors, clinical educators, senior managers, clinical and academic organizations by raising their awareness to an important issue in nursing education that requires further and enhanced recognition. This is the reason which for the present session which would go into exploring your positive experiences in relation to mentorship in Jeddah (Saudi Arabia).

What is the process of the focus group interview? How long would it last?

The semi-structured focus group interview will take place in a conference meeting room at your work place. The interview will be composed of open ended questions and will last for approximately one and a half hour. The interview will be audio taped to allow the researcher to facilitate the discussion and code responses. At the end of the focus group interview, the researcher will provide each participant with a

summary sheet to make sure that her perception was accurate. All participants will be equally treated with requisite dignity and respect.

Do I have to take part in this research? What if I change my mind during the study?

Participation in this study is voluntary. If you decide to take part, you are free to refuse to answer any or the entire set of questions and even to withdraw from the interview at any point of time without giving any reason and there will be no disadvantage to you of any kind.

What do you do with all of the information that is collected during the study? What happens at the end of the research?

Interview transcripts will be kept confidential with only the researcher and her supervisors having access to them. The tapes will only be reviewed by members of the research who will transcribe and analyze them. They will then be destroyed. All the study materials and data will also be kept secured in the researcher's work place. You will remain anonymous and will not be identified, as codes will be used. It will be ensured that identifying information is not available to anybody who is not directly involved in this study. All records will be appropriately disposed off after the completion of this study.

What will happen to the Results of the Research Study?

The results of this study will be published in the form of a report as PhD thesis in nursing at City University, London. Research participants will not be identified in any part of the report. Interested persons can contact the researcher and receive a copy of the result.

How do I join the study?

This study will be authorized by the Research Ethics Committee of City University London and of your organization. You will be given a consent form enclosed to this information sheet, if you are willing to participate in this study, please sign the consent form and it will be collected from you by me. I will then contact you by phone to arrange a convenient time and place for the interview. All of the study participants will be given a copy of this explanatory statement sheet and a signed copy of the consent forms to keep.

How do I make a complaint about the study?

City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 004420 7040 5763 or fax 0044207 040 5717. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: Factors contributing to registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Ethics Committee
CRIDO
City University
Northampton Square
London EC1V 0HB
Email: anna.ramberg.1@city.ac.uk

Who should I talk to if I have questions or need more information about the study?

For further information please don't hesitate to contact me.

Contact details:

Ruba Matoug Alharazi   E-mail: Ruba.Alharazi.1@city.ac.uk

Thank you so much for your participation.

Appendix 15: Interview Consent Form (Main Study)

Interview Consent Form

Title of the Study: Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the study, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organization. ☐

I confirm that I have had the project explained to me, and I have read and understood the Explanatory Statement. I understand that my participation is voluntary and that I am free to refuse to answer any question during the interview and to withdraw from the interview at any time without giving any reason and there will be no disadvantage to you of any kind. ☐

I agree to take part in this study. I understand that agreeing to take part means that I am willing to be interviewed by the researcher and to have the interview tape recorded. ☐

I agree to the use of anonymised quotes in publications. ☐

Name of participant:

Signature of participant: Date:

I believe that the above participant understands the project and gives her/his consent voluntarily.

Name of researcher:

Signature of researcher: Date:

Contact details:

Ruba Matoug Alharazi
School of Community and Health Sciences
City University
West Smithfield Site
20 Bartholomew Close
London EC1A 7QN
Tel: + 44 (0)20 7040 8797
E-mail: Ruba.Alharazi.1@city.ac.uk

Thank you so much for your participation.

NB. Copy will be given to the participant. Copy will be kept with the researcher.

Appendix 16: Ethical Approval Letter- The Hospital
(Main Study)

Research Committee,

☎ :

MEMORANDUM

To	:	Ms. Ruba Alharazi PhD Student, School of Community & Health Sciences City University, West Smithfield Site 20 Bartholomew Close, London EC1A 7QN
Date	:	18th April 2011G / 14th J. Awal 1432H

Study title	:	**Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry.**
HRC ref. #	:	

Please be advised that your research study proposal entitled above submitted in this office on the 20th of February 2011 has received favorable opinion from the committee and thereby giving you approval to conduct your study.

Condition of approval:-
- This notice of acceptance is based on the approved application, protocol and supporting documentation. Any significant deviations or unanticipated developments within the research study should be brought to the attention of the Hospital Research Committee for subsequent approval.
- This approval is valid for "**1 year**" in which you have to apply for re-approval should you need further extension.

Kindly note that we may, for the purpose of audit, contact you from time to time to ascertain the status of your study and we do hope in due course to be informed of the progress and final outcome of the study once it is completed.

Best wishes for the successful completion of your study.

Kind regards,

Chairman, Research Committee
Section Head, Nephrology Unit

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Appendix 17: Ethical Approval Letter- The Nursing College 1 (Main Study)

OFFICE OF THE DEAN

Ms. Ruba Matouq Alharazi

Subject: **Research Proposal #** ▮▮▮▮▮▮▮▮▮
          "Understanding registered nurse's and student nurse's positive mentorship experience in Jeddah , Saudi Arabia

I am pleased inform you that the Research Committee has approved your proposal to collect data from Faculty, Teaching Assistants and students at the ▮▮▮▮▮▮▮ Jeddah.

We hope that in due course, we will be kept informed of the progress of the data collection and final outcome of the study.

Kind regards.

Dean, ▮▮▮▮▮▮▮ Jeddah

Cc: Research Committee, ▮▮▮▮▮

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Appendix 18: Ethical Approval Letter- The Nursing College 2 (Main Study)

Date: Jan, 10, 2010

Ms. Ruba Matouq Al Harazi
Ph.D. Candidate

Re: Research proposal "Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia)

Dear Ms. Ruba:

I am pleased to inform you that the College Research Committee headed by ▮▮▮▮▮ has approved your request to conduct your Ph.d. research study titled "*Understanding registered nurses' and student nurses' positive mentorship experiences in Jeddah (Saudi Arabia) using appreciative inquiry*" at ▮▮▮▮▮

To achieve the following objectives set by yourself for the study, the Director of the Nursing Program, ▮▮▮▮▮ has set a schedule for you to conduct interviews with the focus group:

Study Objectives:
- To explore the mentors' and mentees' understandings of mentorship in nursing in Jeddah, Saudi Arabia
- To describe mentors' and mentees' positive experiences of mentorship in nursing in Jeddah, Saudi Arabia
- To investigate the internal and external factors that contributes to the mentors' and mentees' positive mentorship experiences in nursing in Jeddah, Saudi Arabia

The following is the interview schedule set by the Nursing Program:

Participants	Day/Date	Time	Place	Frequency of interview
3rd and 4th year (11 students)	Tues. Jan.12th 2011	8:30-10:30	▮▮▮	One time
Internship students (6)	The program will arrange with students and keep candidate updated	Expected 2 hours	Either at ▮▮ or at the hospital	One time

Please do not hesitate to contact us if further information is needed. Kindly contact ▮▮▮▮▮ to commence your study interviews.

Wishing you all the best.

cc. Research Committee
    Nursing Program Director

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Appendix 19: Ward Induction Template

Ward Name:

Name of Head Nurse:

Building	Ward Layout	Area Layout Area Routine Introduction to Ward Employees
Emergency Procedures	FIRE	Emergency Number Location of Fire Exits Location of Fire Fighting Location of Equipment Evacuation Procedure
	CARDIAC ARREST	Emergency Number *Equipment Location:* ➢ Cardiac Arrest Trolley ➢ Suction ➢ Oxygen
	INCIDENT	Emergency Number
Policies and Procedures	Location of Manuals/General Policies	Uniform Policy Sickness/Absence Policy Smoking Policy
	Health and Safety Policies	Laundry Procedures Clinical Waste General Waste Reporting Injuries Reporting Faults/Incidents
Duty Timetables	Schedule of Mentor availability	On-Duty Schedule Off-Duty Schedule
Student Assessment Material	Placement Objectives	List of learning objectives discussed Action Plan formulated to achieve these objectives

Mentee's Signature: **Date:**

Mentor's Signature: **Date:**

Appendix 20: Invitation Letter for the Presentation of the Study Findings

SHARING RESEARCH FINDINGS

1 March 2016

You are invited to a presentation and a discussion of research findings from a recent PhD study entitled **'Understanding Registered Nurses' and Student Nurses' Positive Mentorship Experiences in Jeddah (Saudi Arabia) Using Appreciative Inquiry'**, which investigated the factors contributing to positive mentorship experiences in nursing in Jeddah by exploring the mentors' (registered nurses) and mentees' (student nurses) positive experiences in mentorship.

Presented by:

Ruba Alharazi

Time:

Location:

Contact Details:

Ruba Alharazi

Email: r_alharazi@hotmail.com

Appendix 21: Focus Group Transcript with Associated Coding + A list of codes

File   Edit   Documents   Quotations   Codes   Memos   Networks   Views   Tools   Extras   A-Docs   Windows   Help

P-Docs | | Quotes | 8:138 I remember or | Codes | Acceptance {9-0} | Memos

I   if you just remember a peak experience. Could you please describe a powerful experience in mentorship, a time when you felt most alive, most engage and really proud of yourself and your work. What happened? What did you feel?

R   yeah. I remember one time when I had my training in the maternity ward, my mentor was very supportive, she was encouraging me all the time. She made me feel that I am doing a very good job. Even if I was preforming simple procedure, she provides me with a positive feedback and encouraging me.
I remember she used to tell me very good and well done when I even perform simple procedures. She was very nice with me. Sometimes she was surprised that we as students got all that knowledge and skills. She used to make me feel that I am doing a big and brilliant job.

I   what did you value most about your mentor?

R   her behaviour.

I   and what did you value most about yourself?

R   that I was confident.

I   from your experience. What do you consider are the core factors that contributed to your positive mentorship experience?

R   the mentor's encouragement and facilitation as well as her support.

I   how about the others? Any other experience?

R   I was scared because it was my first time experience, my mentor made me feel more confident and relaxed and I really felt more independent at that time. It was my first time to do cannulation and I was very scared but my mentor said to me "you can do it". I didn't think that I

Appreciation of students   Mentor Support   Encouragement of Students   Mentor Feedback   Self Confidence   Mentor Attitude
Encouragement of Students
Mentor Support

Encouragement of Students
Mentor Support

student feelings   Trust   Empowerment   Student Fear
Mentor Attitude
Self Confidence
Trust

P 8: Coding KSBU [5] 4th students.rtf -> <HUPATH>\atlas trancripts\Coding KSBU [5] 4th students.rtf   Size: 75%   Rich Text   Default

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Code-Filter: All

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HU: main study atlas
File:] C:\Users\RabRubA\Desktop\PhD USB 15-5-11\main study\ATLAS.TI\main study atlas.hpr[6
Edited by: Super
Date/Time: 23:38:31 29-11-2014

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Acceptance
Adaptive to Clinical Environment
Appreciation of Mentors
Appreciation of students
Awards for Mentors
Caring
Challenges of Different First Languages
Clarifying Learning Needs and Objectives
Clear Expectations
Collaboration
Collaboration between the Hospital and the College
Collaborative mentor
Comfortable Work Place
Communication
Competence
Culture
Discuss Cases
Education
Empowerment
Encouragement of Students
Engagement and Involvement of Students
Enthusiasm
Environment
Evaluating Skills
Evaluation of Mentor
Factors Affecting Each-Others
Guidance for Mentorship
High Self-Esteem
Initiation
Meeting objectives
Meeting place
Mentor Attitude
Mentor Feedback
Mentor Guidance
Mentor Helpful
Mentor knowledgeable
Mentor Support
Mentor Willingness to Teach/Learn
Mentor with Fewer/No Patients
Mentorship training Programme
More diversity of mentee experience
Motivation
Nurse-Student Relationship
Patient
Planning

Preparation
Respect
Role
Role Model
Selecting nurses to mentor students
Self Confidence
Setting goals
Sharing Knowledge
Student Fear
Student feelings
Student Helpful
Student Initiative
Student Knowledge
Student Motivation
Student Professionalism
Student Willing to Learn
Students Attitude
Suggestions for improvement
Support
Support from other sources
System
Teach Students at their Level of Understanding
Teaching Skills
Time Availability
Trust
Understanding
Work Load