The Impact of Nurse to Nurse Mentoring in Leadership Skills Development - RNMentor2Mentor

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Abstract

The Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010), recommended an increase nursing presence in board service to address healthcare issues and influence change within the healthcare system. Thus, the purpose of the project was to create, design, implement, and evaluate a nurse-to-nurse mentoring program (RNmentor2mentor) for nurses in the state of Michigan aimed at increasing the number of nurses serving on boards. Project results indicated the increase in the Leadership Practices Inventory (LPI) pre- and post- were not statistically significant, except in the practice of *Inspire a Shared Vision*. However, all the mean post values in all the five practices of exemplary leadership increased in the post- LPI for the respondents. Results further suggested there was no significant difference in mentor/mentee scores for those participating in between pre- and post- leadership survey at the end of the program. Evaluation of overall program satisfaction indicated the most frequently observed categories were Positive Experience and Good Match. Recommendations include an extended mentoring period of at least 12 months to allow for relationship building and online modules spread over a longer duration of time. The mentoring training process needs to be expanded from a partial day to a full day. The expanded training would provide more in-depth training on use of the modules. The training day should also discuss format, commitment, and exit strategies. The daylong event would provide more opportunity for the mentor and mentee to become more acquainted and promote the building of trust.

Keywords: mentoring, mentoring and leadership, mentoring in nursing, mentoring practices, nursing and e-mentoring, and barriers to board service

The Impact of Nurse to Nurse Mentoring in Leadership Skills Development

Introduction

The Future of Nursing: Leading Change, Advancing Health, (IOM, 2010) report recognized nurses as key stakeholders in healthcare. Nurses have always been uniquely qualified in navigating the complexity of access to care and patient advocacy. The eight recommendations in the report included allowing nurses to practice to the full extent of their training. The recommendations included a call for an increase in opportunities for nurses to lead and manage change by collaboration, creating nurse residency programs and doubling the number of doctoral prepared nurses by 2020; thus, ensuring that nurses continue with life-long learning. As these recommendations begin to take shape, nurses need to be prepared for positions on leadership boards and executive teams to affect positive healthcare change, and improving research and data collection (Capella University, 2016).

The IOM recommendations commanded a new coalition to integrate two key recommendations on leadership. Recommendation number two expanded opportunities for nurse led initiatives and collaborative improvement efforts. Recommendation number seven prepared and enabled nurses to lead change and advance health (IOM, 2010). In every state action and the District of Columbia coalitions (ACs) were developed to build an agenda that will nurture nurse leaders and build a coalition of nurses to lead change (Polansky, Gorski, Green, Perez & Wise, 2017). The creation of Nurses on Boards Coalition (2016) was to ensure that at least 10,000 nurses are in the boardrooms by 2020. The Michigan Health Council (MHC) and the Michigan Center for Nursing (MCN) collaborated to meet the state goal of 350 nurses serving on boards by 2020 in the state (MHC, 2017).

As stated in the IOM report, leadership is an important role for today's nurse. Potential nurse leaders must learn how to lead. Bellack and Morijikian (2005) discussed the executive-level mentor for formal leadership was lacking in nursing. The Robert Woods Johnson (RWJ) Nurse Fellows program initiated a formal three-year mentoring program to broaden leadership roles by mentoring with senior-level executives. Business has used mentoring to engage in career development, develop a positive organizational culture and provide new ways of doing business to engage the millennial generation. In business, the topic of mentoring has been robust with developed programs and consultants that assist in helping individuals and organizations make positive culture changes to stay competitive.

The mentoring process assists with professional growth and development. In nursing, different approaches, divided in the areas of academia, nursing faculty, leadership, and clinical, have fragmented mentoring. To solve complex issues in nursing, mentoring programs have begun to take shape in education and clinical residency programs. However, in a nurse-to-nurse relationship there has been little data regarding mentoring programs. The aim of this project was to create, design, and implement a nurse-to-nurse mentoring program, RNmentor2mentor, for professional nurses available through the MHC/MCN website (MHC, 2017).

Background of Problem

The Future of Nursing report (IOM, 2010) outlined eight recommendations for the nursing profession to lead change and advance health. Recommendation 2 addressed increasing opportunities for nurses to lead and manage collaboratively and seven addressed transformational leadership to prepare and enable nurses to lead on boards and executive teams to advance health. An action step to meet this recommendation included active nurse participation as members on executive boards, management teams, and key leadership positions

in the public, private and government health care organizations. While the goal of the IOM recommendation is increased leadership skills in nursing so that nurses can lead in the community, there is not agreement on any one-implementation process.

Traditionally, a hospital governance structure addresses fiscal and moral responsibilities through a voting Board of Directors (Prybil, Dreher, & Curren, 2014). In a traditional structure, most hospital boards have 26% physicians as voting members and only 2.4% nurses with voting privileges have comprised boards (Prybil, Dreher, & Curren). This disparity can be problematic for patients and communities. An increase in highly qualified nurses serving on boards is a way to provide communities with high-quality care delivery and patient advocacy that only nurses bring to the table. McBride (2017) supported the need for nurses to serve on boards was by a case study on the impact of nursing on hospital boards. The voice of the professional nurse was essential to addressing issues related to patient safety and quality of patient care. The decision makers for healthcare institutions included champions of quality for patient care, nurses, on the boards (McBride).

Nelsey and Brownie (2012) discussed the crisis facing the nursing profession, including an aging workforce, high staff turnover, generational conflicts, and nurse retention. These factors have led to dissatisfaction in nursing and resulted in nurses leaving the profession. The impact of nurse retention to the healthcare delivery system was costly to organizations and patients. Frost and Nickolai (2013) noted that the average cost of nursing turnover for bedside nursing is $37,00 to $58,400 resulting in average hospital losses between five and eight million dollars. Lack of opportunities for professional development and career movement into nursing leadership positions has magnified these factors.

In nursing, mentoring was a key thread in the development of nurses. The implementation of mentoring utilized in the development of novice nurses in the clinical setting to refine skills and expertise in patient care. Midwifery has a long history of using mentoring to prepare nurse midwives. Jakubik, Eliades, and Weese (2016) stated that in the 1990s nursing traditionally viewed mentoring as a relationship dyad between the mentor and mentee. Business models, such as Zey's 1991 Mutual Benefits Model, viewed the mentoring relationship as a triad that included the mentor, mentee and organization. Various studies demonstrated the benefit of mentoring to all parties, using the triad approach of mentor, mentee, and organization (Jukubik, Eliades, & Weese). Leadership skill development was important if nurses were to make an impact in the boardroom. Mentoring was the tool that facilitates an increase in leadership skills.

Purpose of Project

The purpose of the project was to create, design, implement, and evaluate a pilot project to establish a baseline for a nurse-to-nurse mentoring program for nurses in the state of Michigan. The pilot project, RNmentor2mentor, provided data to enhance nursing leadership competencies aimed at increasing the number of nurses serving on boards. The project established a baseline for a mentoring program and provided data to expand the nurse-to-nurse mentoring program beyond conference participants into a statewide network. The project aim was twofold. To answer: (1) What is the impact of nurse to nurse mentoring, RNmentor2mentor, in leadership skills development? (2) Is there an increase in one or more of the five practices of exemplary leadership, as reported by the Leadership Practice Inventory (LPI), after nurse-to-nurse mentoring?

The pilot project, RNmentor2mentor, established a baseline of data that enabled the expansion of a nurse-to-nurse mentoring program beyond initial participants in a statewide

conference pilot project. This project was a collaborated effort with the MHC/MCN. The MHC/MCN is a solutions-oriented nonprofit organization on a mission to develop a premier health care workforce in every Michigan community. The MHC (2017) proactively addresses the needs of healthcare leaders, professionals, employers, educators, and students through various programs such as education and practice. The MHC/MCN is a statewide, nonprofit dedicated to creating a Culture of Health with health professionals at the heart of the delivery system. The MHC/MCN effects change in Michigan by leading through relationships, technology and an innovative spirit**.** The Letter of Collaboration for this project is in Appendix A.

Significance of Project

In 2014 the American Nurses Association (ANA), the American Academy of Nursing, and the American Nurses Foundation announced the initiative of 10,000 nurses on governing boards by 2020. Each state has an assigned goal to reach. In order to be counted nurses register on the Nurses on Boards Coalition website. A goal set for Michigan was 350 nurses registered on the site by 2020. The national Nurses on Boards Coalition were an initiative that took shape through a national coalition strategy forming state ACs. The RWJ foundation as a collaborative effort, in response through the Institute of Medicine's (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (2010), supported the initiative to increase nurses on boards. The initiative provided a nursing voice that increased authority on patient experience, quality and safety, and included the largest part of a healthcare workforce (ANA, 2014).

Montalvo and Byrne (2016) predicted that pending vacancies in senior leadership roles would create a leadership gap in nursing. An American Organization of Nurse Executives (AONE, 2014) report described outcomes from a 2013 study that indicated an alarming turnover

of chief nursing officers within the next three-to-five years at a rate of 41%-67% nationally. Furthermore, Nelsey and Brownie (2012) stated that due to the predicted decrease in the number of nurses due to dissatisfaction and turnover, it was imperative to improve nurse retention rates through effective nursing leadership. In Michigan, 38% of RNs are aged 55+ and 43% have indicated their plan to stop practicing within 10 years (MCN, 2016).

The nursing license renewal survey for 2016 with the MHC/MCN has indicated 53.6% (n=5,381) of registered nurses aged 55 years and over planned to stop working as a nurse within the next five years. In addition, 49% (n=705) of the Licensed Practical Nurses aged 55 years and over planned to stop working within the next five years (MCN, 2016) . These gaps left an imminent need for nursing leadership within the healthcare system. Mentoring provided a supportive system that is positive, builds relationships, increased nurse retention, and improved job satisfaction (NSI, 2016).

The MHC/MCN in December 2016 identified a Leadership sub-committee to develop and action plan to enable nurses to lead change. The objective identified in the leadership plan is to increase the number of nurses serving on boards in Michigan. The action steps included (1) development of a mentorship program; (2) created a structure to link mentors and mentees; (3) identified a format to remove geographical barriers in order to make the program viable to all nurses in Michigan; and (4) identified and provided supportive resources. This pilot project addressed all four of the action steps and collected initial data to support a possible annual online mentoring program.

Problem Statement

The general problem addressed by this project was the lack of nurses on board of directors, nationally and in the State of Michigan. In response to the IOM report of 2010, The

Nurses on Boards Coalition was formed to ensure the goal that at least 10,000 nurses are on boards by 2020. The benefit of this, from a community perspective, would be to achieve the goals of improved health along with efficient and effective healthcare systems at the local, state, and national level (Jones & Murray, 2016). A Gallup, Inc. (2008) survey indicated that nurses had the lowest engagement level in any level of worker category. The same survey found that one-quarter of nurses surveyed were actively disengaged compared to only 16% of all other workers in the United States. A Press Ganey Associates, Inc. (2008) report stated that organizations would improve nurse-employee perspectives by creating nurse partnerships. A mentoring partnership program would produce an engaged nursing workforce. The MHC/MCN in response to the IOM report of 2010 identified a nurse-to-nurse mentoring program as a way to meet the Michigan Nurses in the Boardroom 2020 objective. Therefore, in partnership with the MHC/MCN, and responding to the IOM report of 2010, the specific problems addressed in this project were leadership competencies, lack of mentorship for leadership roles in nursing, and increased nurse participation on boards for the state of Michigan to achieve the Nurses on Boards Coalition goal of 350 nurses by 2020 (NOBC, 2016).

Theoretical Frameworks

The leadership practice inventory. Through a triangulation, approach of qualitative and quantitative research methods and studies the LPI theoretical framework was developed Kouzes & Posner (The Leadership Challenge, 2000-2017). Kouzes and Posner's conceptual framework included in-depth interviews and written case studies from personal-best leadership experiences. This research developed the themes of five practices of exemplary leadership: (1) Modeling the Way, (2) Inspiring a Shared Vision, (3) Challenging the Process, (4) Enabling Other to Act, and (5) Encouraging the hearts (The Leadership Challenge, 2000-2017). This standardized

assessment tool measured individual reflection regarding leadership (Appendices B1-B4). Behavioral statements were translated into actions that make up these practices. The LPI instrument followed iterative psychometric processes. Academicians, scholars, and graduate students in many various settings have used the instrument (Kouzes & Posner, 2002). Appendix B1 represented the description of the five practices of exemplary leadership as measured by the LPI instrument.

The LPI has been administered to more than one million managers and non-managers in various organizational settings such as business, health care, acute care nursing, religious organizations, project management, online distance learning, the United States Navy, community health systems, and more (Kouzes & Posner, 2002). A student version of the LPI was developed to capture leadership skills in the high school and college settings. The LPI has been reviewed and validated by studies from not only the authors, but other researchers over a period of 15 years. The LPI has been extensively applied in many organizational settings and was deemed reliable and valid (Kouzes & Posner, 2002).

Conceptually, the evolvement of the Five Practices of Exemplary Leadership began as a collection of case study experiences that were analyzed. These experiences developed into a questionnaire, 12-pages long. Each respondent completed 38 open-ended questions. This Personal-Best questionnaire turned into a collection for more than 4,000 surveys and additional 7,500 respondents completed the short form. In-depth interviews complemented the surveys and were conducted from a variety of public and private companies. The data collected from these case studies and interviews spans over two decades. The data collected through these processes has been consistent (Kouzes & Posner, 2002).

Kouzes and Posner (Kouzes & Posner, 2002) stated that thedevelopment of the early LPI was measured using a five point Likert scale measuring leadership and behavior statements. In 1999 it was reformulated into a robust and sensitive ten point Likert scale. The process of development of the tool using feedback from respondents, content experts, and continued empirical analyses of the statements, led to revisions, modifications, or discarding statements. This refinement of the instrument yielded over 100,000 responses (Kouzes & Posner, 2002).

The five themes: (1) Model the Way, (2) Inspiring a shared vision, (3) Challenging the Process, (4) Enabling Others to Act, and (5) Encouraging the Heart (The Leadership Challenge, 2000-2017) contained thirty statements measuring the practices of exemplary leaders. The LPI included Self and Observer versions. In theObserver version, participants completed the LPI-Self first, and then requested that five to ten people that are familiar with the individual's behavior completed the Observer. The LPI/Observer completion was voluntary and anonymous. The LPI took a very short time to complete, about 10 minutes, and can be hand or computer scored (The Leadership Challenge, 2000-2017). Permission for LPI use is granted to Co-Lead One (Appendix B5) and Co-Lead Two (Appendix B6).

Theory of interpersonal relationship. Hildegard Peplau's (1991) Theory of Interpersonal Relationship identified the theory of the nurse-patient relationship. Peplau's nurse-client relationship is a developmental vertical relationship that descends to meet a common goal (Neese, 2015). Neese discussed four of the developmental phases that included orientation phase where engagement occurs; identification phase where both parties work together; exploitation phase where the patient takes advantages of the nurse's services; resolution phase where the effective communication concludes and the relationship is over. McCarthy and Aquino-Russell (2009) discussed Peplau's theory as a process relationship. McCarthy and Aquino-Russell

included the following developmental phases of (1) orientation phase; (2) working phase; (3) identification phase; (4) exploitative phase; and (5) termination phase. There was a starting point and an ending point in a formal mentoring relationship. Peplau's relationship theory was a guide in the mentoring process. Peplau's theory was timeless and well established in education and practice (Green & Jackson, 2014). D'Antonio, Beeber, Sills, and Naegle (2014) stated that there were three phases in the mentoring relationship, an initial phase, a working phase, and a terminal phase. These three phases that were the guiding principles that mirrored Peplau's relationship theory and guided the implementation of the RNmentor2mentor project were the orientation phase, working/identification phase, exploitive phase, and termination phase.

- Pre-implementation (September 2017): Nurses that responded with interest in the project were contacted via email (Appendix C) prior to the conference in the pre-intervention/pre-mentoring commitment phase (Phase 1).
- Month 1 (October 2017): Phase 2-Intervention/Onsite-Orientation Phase/Novice began during the Nursing Summit conference in October. Through a speed-meeting concept, the mentees were asked a series of self-determined questions in an allotted five minutes to a predetermined number of mentors, and then preferences were ranked with 1 for the highest preference and 5 for the lowest preference. A speed-meeting tally is in Appendix D. The Project Leads matched the top preferences from the tally and introduced each pair of mentors and mentees for introduction and orientation.
- Other tasks: Matched the mentor/mentee dyad, the signed Institutional Review Board (IRB) information, consents, contracts, and confidentiality paperwork.

- Dyads were introduced to the content modules online and Co-Leads included orientation to module use, expectations of the project, exiting the project, and completing all the needed paperwork pre-meeting, monthly, and at project end.
- Completion of pre- (baseline) LPI prior to exiting the conference; or if that was not possible due to time limitations, the deadline was in October.
- A face-to-face meeting between mentor and mentee-built trust, determined clear expectations of the project and relationship, and established a clear expectation for future meetings.
- Peplau's (1991) model for interpersonal relationship was the theory that guided the mentor and mentee as the dyad progressed through the module content. The mentors and mentees reviewed the self-directed modules online completing the required two modules monthly.
- Month 2 (November 2017): Phase 3-Intervention/Online Working/Identification/Novice period requires that modules, Section 4: Current Role-Power and Section 5: Understanding Self and Others, are the modules completed. A follow-up monthly email was sent prior to the end, or at the end, of the monthly phases that retrieved data such as module completion, and encounter preference (Face-to face, email, etc.) (Appendix E).
- Month 3 (December 2017): Phase 4-Intervention/Online-Identification/Exploitive Phase/Advanced Beginner required the completion of modules Section 6: Communication Crucial Conversations/Bullying and Section 7: Problem Solving. Follow up email as described in Month 2.
- Month 4 (January 2018): Phase 5-Intervention/Online-Termination Phase/Competent required the completed of online modules Section 9: Leadership and Section 10:

Leadership Development. An optional module was available this month. Module Section 8: Time Management. Follow up email as described in Month 2.

- Month 4 (January 2018): Phase 6- Termination Phase/Competent completed the program in January 2018, with program evaluations, LPI Self and Observer (mentors complete Observer mentee), leadership survey, and final discussion of scores.

Novice to expert practice. Patricia Benner (1984), (Appendix F) theorized the movement from a novice clinician to expert clinician. According to Benner (1984) there are five stages that include: (1) Novice; (2) Advanced Beginner; (3) Competent; (4) Proficient; and (5) The Expert (Appendix D). The novice nurse had no experience, needed verbal and physical cues to practice. The advanced beginner had some experience and provided a marginal performance with supportive cues. The competent nurse was practicing for two-to-three years and had confidence in actions without the need for supportive cues. The proficient nurse had a broad view of the situation and recognized the normal when exhibited. Finally, the expert had an intuitive understanding of the situation with a broad contextual perspective. The movement from novice to expert was defined in this project as a nurse learning a new skill of which the nurse is unfamiliar. For example, an expert nurse in the clinical area, would begin again as a novice once a career transition was made by accepting a faculty position at a university.

Patricia Benner's novice to expert relationship defined a mentoring relationship. Blum (2010) discussed the importance of Benner's intuitive-humanistic decision model. Blum incorporated Benner's model with the movement from novice to expert at multiple points in a nursing career. Gardner (2012) discussed the value of Benner's theory as understanding a mystery about expert practice and the respect that this mastery holds. Benner's research found that experienced practitioners display intuition or a gut feeling that is noted in expert practice and

cannot be theorized (Gardner).

Blum (2010) discussed the importance of Benner's intuitive-humanistic decision model. Blum's weave of Benner's model into the movement from novice to expert occurs at many points in a nursing career and is not limited to the novice to expert role of a newly graduate nurse. The results of this four-month project do not expect a proficient or expert equivalent in the increase of leadership skills. However, after completion of Month 4 (January): Phase 5-Intervention/Online-Termination Phase/Competent the results provided insight on increased leadership skills as the modules were specific to board leadership.

Program-action-logic model. The W. K. Kellogg Foundation (2004) defined a logic model to systematically and visually present and share relationships among the integrated parts of a program. These relationships included the operation of the program, any activities that are planned, and the changes or results that the program hopes to achieve. Logic model templates were retrieved from The Pell Institute and Pathways to College Network (2017). The template used for this project is Appendix G.

According to Ellermann, Kataoka-Yahiro and Wong (2006) logic models are used to enhance critical thinking. In the research, the authors used logic models to support critical thinking and reasoning in nursing curricula, by concept mapping, concept papers, concept linking, and framework. Using logic models assisted conceptualization through the four elements of dialogue, context, time and reflection; the core elements necessary for critical thinking that and the practice of nursing (Ellermann, Kataoka-Yahiro and Wong). The use of logic progressed as novices, in the continuum of novice to expert, are to become expert critical thinkers by opening broad thinking and becoming flexible in order to integrate experiences. When expert nurses move to new knowledge areas, the return is to the novice phase; starting the novice to

expert continuum over again. The updated definition of mentoring in model of the career continuum of a nurse, by Jakubik, Weese, Eliades, and Huth (2017) was one-year experience to retirement.

Logic models were used in nursing to evaluate practice. Miller (2013) used a logic model for the evaluation of theories in papers. Miller stated that logic models presented a way to divulge patterns an evaluator can use to build skills, develop knowledge, and develop change behavior that improved an organization. Logic models were used by evaluators to visualize patterns. This enhanced pattern visualization assisted the evaluator in comparing and contrasting practice areas, examine questions for further study, and pinpoint needs for future training.

Butler, et al**.** (2014) in a study that evaluated midwives leading in antenatal care, used the logic model. The authors identified seven categories of relevant outcomes. The use of the logic model in the midwifery program visualized a flow chart that displayed a logical sequence in steps on how the key elements of the model yielded the outcomes. The logic model exercised in this project provided guidance in achieving the goal, priorities, inputs, outputs, and outcomes that impacted the nurse-to-nurse, RNmentor2mentor, project and leadership skills. The rationale for doing this project included evidence in the nursing literature that demonstrated a lack of mentoring among professional nurses for leadership development.

The logic model used in this project, RNmentor2mentor:

Inputs: Interpersonal resources for the mentors and mentees

- relationship building
- networking

Inputs: Organizational resources

- leadership committee support

    - informational technology support
    - funding for the purchase of the online modules
- Output -Activity: Phase 1 - Pre-Intervention/Mentoring Commitment
    - Determined commitment
    - Determined mentor/mentee ratio
    - Emailed participants with information on study, what to bring, time regarding face-to-face meeting and orientation.
    - Co-Lead emailed follow-up
- Output - Activity: Month 1 (October): Phase 2: Intervention/Onsite-Orientation Phase/Novice
    - Speed Meeting – mentees chose mentors
    - Mentor and mentees met
    - Introduction
    - Consents and contracts signed
    - Exit strategy reviewed
    - Mentors/Mentees separated
    - Reviewed online modules Sections 1, 2, and 3
    - Online LPI pre-assessment completed
    - Co-Lead emailed follow-up
- Output-Activity: Month 2 (November): Phase 3: Intervention/Online-Working/Identification Phase/Novice
    - Developed nursing knowledge and relationships
    - Online modules required Sections 4 and 5

    - Co-Lead emailed follow-up
- Output-Activity: Month 3 (December): Phase 4: Intervention/Online-Identification/Exploitive Phase/Advanced Beginner
    - Developed nursing knowledge and relationships
    - Online modules required Sections 6 and 7
    - Co-Lead emailed follow-up
- Output-Activity: Month 4 (January): Phase 5: Intervention/Online-Termination Phase/Competent
    - Developed nursing knowledge and relationships
    - Online modules required Sections 9 and 10
    - Online module optional Section 8
    - Co-Lead emailed follow-up
- Output-Activity: Month 4 (January): Phase 6: Termination Phase/Competent
    - Mentor/Mentee – End of program evaluations
    - Post-Assessment LPI and Observer LPI completed
    - Leadership Survey completed
    - Discussed Scores
    - Thank you notes completed
- Output-Participant: Mentors: Any RN with minimum of five years nursing experience and a minimum Bachelor of Science degree in nursing (BSN).
- Output-Participant: Mentees: Any RN that self-determines the need for a mentor.
- Pre- and Post-Evaluation Metrics – Interpersonal barriers included time, use of technology, and relationship issues. The pre-evaluation metrics included the LPI and

initial demographic information. The post evaluation metrics included the LPI Self and Observer, the Leadership survey as a process measure, and mentor and mentee program evaluations.

- Outcomes
    - Short-Term:
        - RNs participating in MCN Summit and mentoring program will have an increase in leadership skills as measured by leadership survey and LPI.
    - Intermediate-Term:
        - RNs participating in the mentoring program will act to review the nurses on board coalition website and register. RNs may act to be a board member in community.
    - Long-Term:
        - RNs participating in the mentoring program will act to find a board position, register, and then will be counted for the State of Michigan and make an improvement in patient advocacy.

The outcomes of the RNmentor2mentor project in the short-term was to gather baseline data to discover if there was an increase in leadership skills development. Sustainability for the program may continue to grow with a positive short-term outcome. The mentor and mentee feedback was essential for quality improvements with the program. The MCN has identified technology support for an online mentor and mentee matching process in this platform for the nurses in Michigan.

Project Objectives

Jakubik, Eliades, Weese, and Huth (2016) in Nursing and Midwifery Council in Scotland found that mapping using Specific, Measurable, Action Oriented, Realistic, and Time-Bound (SMART) goals is important in career optimism and engagement in the workplace. The short-term objective identified above and in the logic model discussion for the RNmentor2mentor project are:

Short-Term Project Objectives.

- Primary Project Program Objective:
    - RNs participating in the evidence based RNmentor2mentor mentoring program increased leadership skills as measured by the LPI at the end of the program.
    - Tool: LPI Instrument: Validity and Reliability
        - Cronbach's alpha (ǎ) was used to measure internal consistency and reliability of items in the instrument
        - Consistently reliable between .75 and .87 with the LPI-Observer ranging between .88 and .92 (Kouzes & Posner, 2002). Reliability using Cronbach Alpha (ǎ) coefficients for the LPI and LPI-Observer respectively (Kouzes & Posner, 2002).
- Secondary Project Program Objectives:
    - Objective 1: RNs participating in the evidence based Rnmentor2mentor mentoring program increased leadership skills as measured by the LPI Observer at the end of the program. LPI/Observer as secondary scoring to identify blind spots for mentee.

- Objective 2: RNs participating in the evidence-based RNmentor2mentor mentoring program increased mentor/mentee scores pre- and post- LPI at the end of the program.
- Tool: LPI and LPI /Observer Instrument: Validity and Reliability
  - Consistently reliable between .75 and .87 with the LPI-Observer ranging between .88 and .92 (Kouzes & Posner, 2002). Reliability using Cronbach Alpha (ǎ) coefficients for the LPI and LPI-Observer respectively
  - Cronbach's alpha (ǎ) was used to measure internal consistency and reliability of items in the instrument
- Objective 3: RNs participating in the evidence-based RNmentor2mentor mentoring program demonstrated action in leadership skills by stating 4 (Agree) or 5 (Strongly Agree) to questions in the Leadership Survey. Question number 25 "I am involved in Shared Governance in my organization," and question number 26, "I have an intention on serving on a Board of Directors." These questions were identified as expert questions. These leadership questions were asked in the beginning of the program (pre) and again at the end of the program (post).
- Tool: Leadership Survey: Validity and Reliability
  - Face Validity - superficial and subjective assessment, no previous published results with this survey tool
  - Exploratory descriptive themes

        - Likert Scare: Strongly disagree (1); Strongly agree (5)
        - Total possible score 1-130

- Tertiary Project Program Objectives:
    - Objective 1: RNs participating in the evidence based Rnmentor2mentor mentoring program self-reported program satisfaction of 4 (Agree) or 5 (Strongly Agree) to question 12, "I would recommend this program" in the Mentor Exit Survey, and will reported satisfaction of 4 (Agree) or 5 (Strongly Agree) to question 7, "I would recommend this program" in the Mentee Exit Survey at the end of the program. Other general satisfaction responses in the mentor exit survey were 4 (Agree) or 5 (Strongly Agree) to question 7, "The mentoring relationship was a positive experience for me;" and question 9 "I felt my mentee and I were a good match;" in the mentor exit survey. In the mentee exit satisfaction of 4 (Agree) or 5 (Strongly Agree) to question 5, "My mentor/mentee relationship experience was positive;" and question 6, "My mentor and I were a good match;" and question 9, "I felt supported by my mentor" at the end of the program.
    - Tool: Mentor and Mentee Exit Survey
        - Exploratory descriptive and themes – 3 short answer questions in each survey
        - Likert Scale: Strongly disagree (1); Strongly agree (5)
        - Total possible score 1-50

- Objective 2: RNs participating in the evidence based RNmentor2mentor mentoring program self-reported short answers to questions from Mentor and Mentee Exit Survey "List three challenges you have encountered in the mentoring program" and "List three successes you have experienced with the mentoring program" at the end of the program.
- Answers we reviewed for themes
- Tool: Mentor and Mentee Exit Survey
    - Face Validity - superficial and subjective assessment, no previous published results with this survey tool
    - Exploratory descriptive and themes – 3 questions in each survey
    - Likert Scale: Strongly disagree (1); Strongly agree (5)
    - Total possible score 1-50
- RNs participating in the evidence based Rnmentor2mentor mentoring program self-reported on monthly meetings; number of meetings; meeting format; and use of meeting modules at the end of the program.
- Tool: Monthly Feedback Forms
    - Face Validity-superficial and subjective assessment, no previous published results with this survey tool
    - Exploratory descriptive and themes from how many times dyads met, meeting format, and what modules (if any) were reviewed
    - Multiple Choice

- Number of interactions
- Meeting Format
- Names of online modules completed for the month

Intermediate –Term Objective.

- RNs participating in the evidence based RNmentor2mentor mentoring program will review the nurses on board coalition website. RNs may act to be a board member in community.

Long-Term Objective.

- RNs participating in the evidence based RNmentor2mentor mentoring program will act to find a board position, register, and make an improvement in nursing leadership.
    - The intermediate and long-term objectives are beyond the scope of this study and will not be measured. However, the MHC/MCN may monitor key intermediate and long-term objectives and include tabulation of the number of nurses on board in the state of Michigan.

Definition of Terms

Board of director. The Nurses on Boards Coalition (2016) defined board of director or board as leadership and governance roles in healthcare, or any community role that influences health.

Leadership. A nurse that displayed the five practices of exemplary leadership: (1) Modeling the Way; (2) Inspiring a Shared Vision; (3) Challenging the Process; (4) Enabling Other to Act; and (5) Encouraging the Heart (The Leadership Challenge, 2000-2017).

Mentoring. A relationship in which a mentor shares knowledge and guidance for professional development of nurses.

Mentor. An experienced nurse that is willing to share knowledge and guidance for a nurse with less experience.

Mentee. A voluntary relationship to work with a mentor to gain knowledge, insight and guidance for nursing leadership development.

Formal mentoring. A relationship that has an interpersonal component that parallels an educational structure.

Review of Literature

Presentation of Related Literature to Project

The researchers completed a review of peer-reviewed literature and noted the terms "mentoring," "mentoring and leadership," "mentoring in nursing," "mentoring practices," "nursing and e-mentoring," "cyber mentoring," "nurse leadership mentor," "online mentoring," and "barriers to board service." The search engines used were Cumulative Index to Nursing and Allied Health Literature (CINHAL), Science Direct, PUBMED, and ProQuest's Nursing and Allied Health. The years searched were 2012 through February 2018 with a greater emphasis between the years 2014 and February 2018 for a more current review of the literature. The search indicated early articles on the topic of mentoring in nursing around the year 2005. Recently, 2015-2017, there was a resurgence of the topic and articles in 2016 were robust. Many mentoring studies used a qualitative design. Longitudinal studies with a pre- and post- questionnaire after a mentoring intervention were cited. Other articles used a qualitative and quantitative triangulated approach with baseline data. However, none of the articles discussed nurse-to-nurse mentorship and the development of leadership skills through mentorship. There is a gap in the literature

regarding nurse-to-nurse mentoring, for vertical or horizontal career development and the development of leadership skills.

The literature review found the emergence of the following themes: (1) mentoring was a relational experience; (2) mentor and mentees had separate roles in the relationship, (3) common mentorship concepts were psychosocial support and career development, (4) formal mentoring was preferred versus informal mentoring, (5) challenges occurred in the mentor-mentee relationship; (6) e-mentoring removed some mentoring challenges; (7) Leadership Practice Inventory(LPI) supported e-mentoring by using an online instrument, (8) there were barriers to board service, (9) mentoring did reduce barriers to board service.

The mentoring relationship. The connection with mentoring and nursing had evidence citing the history of mentoring nursing students. The role of the clinical faculty aligned with the mentoring role to support nursing students in the formation of novice to professional role. The student's clinical development was supported by the expertise of the clinical faculty (Ali & Panther, 2008). The role of a mentor was instrumental in the development of nursing practice. The relationship between the mentor and mentee was a process that melds together the concepts of learning, mutual sharing and evolving as a professional nurse (McCloughen, O'Brien & Jackson, 2013). This study conducted in Australia explored the process of nurse leaders with significant influences in their professional development as a leader. The hermeneutic phenomenological approach to in-depth interviewing encompassed a historical life approach to find themes and influences with leadership development. The study identified thirteen participants that had experienced the mentoring process as both a mentee and a mentor. The focus of the study was primarily evaluating the impact of a mentor upon leadership development and empowerment. The contribution of this study included the journey that was impacted by the

perception of the mentor and mentee role in the world. The study recognized the importance of encouragement and active support of nurses within the profession. The findings aligned with the academic research conducted by Straus, Johnson, Marquez and Feldman (2013) and Eller, Lev and Feurer (2014) which identified positive mentoring shared characteristics including mutual respect, common values, defined expectations and a personal connection offering support emotionally.

Duffy, McCallum and McGuinness (2016) contemplated the pros and cons of all nurses becoming mentors. A con discussed was that mentors may want personal self-benefits that occur with mentoring rather than supporting the mentee. The advantages identified for mentoring include fostering professional growth in knowledge, skills, attributes, and practice; and encouraging maintaining competencies. Florczak, Collins, and Schmidt (2014) indicated that role modeling was very important in the mentoring relationship.

This review of the literature closely examined the strengths and weaknesses of the progression towards mentoring within the nursing profession. Mentoring has evolved to meet the needs of nurses in the clinical setting, develop skills of novice nurses, and the development of the advanced practice nurse's role (Montavlo & Veenema, 2015). The process of mentoring in these roles has met the needs of organizations and professional growth. However, the nursing profession has lacked the achievement of creating a mentoring culture promoting leadership development and influencing policy change within the healthcare systems through boardroom service (Montavlo & Veenema, 2015).

A key component in the development of nursing leaders requires retention of nurses within the profession. The mentoring process for novice to experienced nurses has become essential within the clinical setting to maintain adequate levels of staffing for an organization.

Mariani (2012) researched career satisfaction of nurses and intent to stay in the career. The research explored implementation of a mentoring program. A nationwide issue was the aging nursing workforce, retention, and career satisfaction. Despite the multiple nationwide mailings of survey instruments, the random sampling process used the modified Total Dillman Method (TDM) failed to collect adequate number of responses for the non-mentoring group creating some unbalanced groups of mentors and mentees. The research has failed to demonstrate a significant link between career satisfaction, intent to remain within the field and mentoring (Mariani). A significant relationship positively linked career satisfaction with intent to remain in the nursing profession. Sanfey, Hollands, and Gantt (2013) challenged that even without randomized control trials, the literature supports that mentored individuals were more likely to stay on track with career goals and experience increased career satisfaction compared to those without mentors. The authors concluded that lacking a mentor was cited as a deficiency for women in career development. Despite the lack of significance with the results, the outcomes positively supported the prevalence of mentoring with the recommendation for additional research to examine how mentoring relationships are positively affecting the nursing profession.

Essential factors for successful mentoring relationships included building mutual respect and trust. Practical components of positive mentoring qualities included honesty, active listening, flexibility, respect, a personal connection, and shared values (Sanfey, Hollands, & Gantt, 2013). These qualities were divided among more than one mentor throughout the lifetime career of a mentee. Sanfey, Hollands, and Gantt (2013) stated that a mentee that has developed a relationship with a mentor that has had career experience and a sustained professional network made for a successful mentoring relationship.

An essential factor for successful mentoring relationship included building mutual respect and trust. The personal-professional aspects of the relationship influenced the success of the process. The professional relationship is influenced by mentor's enthusiasm for mentoring, ongoing support and positive actions that contributed to building trust in the relationship. The mentee's role included forming and sustaining the relationship as a two-way relationship. Clearly defined expectations for the learning process between mentor and mentee positively affected the formative factors for the relationship (Hudson, 2016). The effective mentoring process challenged a mentee's professional growth by moving beyond the comfort zone, mastery of problem solving, and increased communication. The mentor was pivotal and provided transformational change that supported the mentee by building confidence (Jakubik, Eliades, Weese & Huth, 2016, September-October).

Wilbanks (2014) discussed the essential factor of time in the mentoring relationship. Drawing on the work of Kram (1985) there was a definite time for the mentoring relationship before the mentor or mentee decided to separate by ending the relationship. Kram's four phases of the mentoring relationship: (1) initiation is a period of six months to one year where the relationship is started and begins to have importance to the matched pair, (2) cultivation is a period of two to five years in which the goals created by the matched pair begin to take form in both the areas of psychosocial and career mentoring and the matched pair achieves stated goals, (3) separation is the third phase that lasts a period of six months to two years where the individuals by either psychosocial or structural changes decide to alter the relationship, (4) redefinition is the fourth stage that is an indefinite period separating the individuals by the relationship ending badly, taking on new roles, or ending in a peer friendship relationship.

The personal-professional aspects of the relationship affected the success of the process. Mentors' enthusiasm for mentoring, ongoing support, and positive actions contributed to building trust in the relationship. The mentees' role included forming and sustaining the relationship as a two-way relationship. Clearly defined expectations for the learning process between mentor and mentee positively affected the formative factors for the relationship (Hudson, 2016). The effective mentoring process challenged professional growth with the mentee to move beyond the comfort zone and master problem solving and communication. The mentor was pivotal with the transformational change with the mentee by building confidence and providing support (Jakubik, Eliades, Weese & Huth, 2016, September-October).

Mentor and mentee roles. Cheek, Dotson, and Ogilvie (2016) in a qualitative study on voluntary distance mentoring with an RN-to-BSN program, stated that the mentor had to accept a two-year obligation with the student, provide an online profile, and complete program evaluations. The mentee would then review the profile and choose a mentor to pair. Lantham, Singh, and Ringl (2016) used a Web-based portal for mentor/mentee recruitment, selection, and matching. The profiles of the volunteer mentors were available for mentees to read and choose a mentor. The mentee could make three selections. The matching process was completed once the mentee emailed the mentor and the mentor agreed to the relationship. By allowing mentees to select a mentor, the researchers found an increase in partnership confidence, engagement and comfort level. Lantham, Singh, and Ringl found that a designated facilitator role provided mentor and mentee support for education and training. The role of the facilitator included mentor support group meetings, emails and telephone feedback. The facilitator posted educational materials on the Web site that included tips and strategies on relationship building, roles and responsibilities for both parties and other quick facts and tips. Support provided to the mentor

was important. Douglas, Garrity, Shephard, and Brown (2016) found, in their analysis of mentor practices, that the most reported theme in the literature was support for mentors in mentoring programs. Mentor support throughout an organization provided a clear and consistent approach to mentoring. With mentorship support, the relationship between the mentor/mentee became a partnership and created a trusting relationship. Eller, Lev, and Feurer (2014) in an investigation of the mentor/ mentee relationship at academic institutions found that mentoring pairs that were evaluated and modified (reassigned) by a nurse manager strengthened the paired relationship for a more positive outcome. Leggat, Balding, and Schiftan (2015) paired Nurse Practitioners (NPs) to senior leadership through learning styles. There is not yet consensus on mentor and mentee pairing. However, most of the literature suggested that mentees should seek out mentors and make an initial decision based on a mentors' online biographical profile.

Mentorship concepts (psychosocial support and career development). In earlier studies, Eller, Lev, and Feurer (2014) identified two functions of the mentoring relationship, psychosocial and career development. The earlier studies discussed the psychological components of mentoring that included role modeling, acceptance and confirmation, counseling, and friendship. The career development components, in earlier studies included sponsorship, exposure and visibility; coaching, protection, and challenging assignments. More recently, Eller, Lev, and Feurer (2014) stated career development fosters the mentees' professional development while the psychosocial functions foster mentees' self-efficacy, self-worth and professional identity. These components identified eight outcomes. Eller, Lev, and Feurer (2014) identified, key components for an effective mentoring relationship: (1) open communication and accessibility, (2) goals and challenges, (3) passion and inspiration, (4) caring personal

relationship, (5) mutual respect and trust, (6) exchange of knowledge, (7) independence and collaboration, and (8) role modeling.

Wilbanks (2014) discussed two broad areas of mentoring, psychosocial support and career development. Career mentoring components included sponsorship, exposure and visibility, protection, coaching, and challenging work assignments. Psychosocial mentoring included role modeling, acceptance and confirmation, counseling, and friendship (Wilbanks). The combination of both psychosocial support and career development components were important in a successful mentoring relationship.

Chen, Watson, and Hilton (2016) reviewed measurement tools, eleven in education and seven in business. The authors found that business has a universally accepted framework for mentoring. Chen, Watson, and Hilton identified five functions of mentoring in education under the domains of psychosocial and career development. The functions included teaching, sponsoring, encouraging, counseling, and befriending. In nursing, Chen, Watson, and Hilton adopted a different framework. The authors discussed challenges in nursing especially in developing measurement tools. Due to specialized functions in nursing such as clinical, education, or students, accurate measurement tools are needed. The literature supported the domains of psychosocial and career development as the primary reasons individuals were involved in mentoring relationships.

Formal mentoring versus informal mentoring programs. In the literature the terms formal and informal mentoring were mentioned, but there is no consensus to the individual definition of each term. Formal mentoring was defined as providing mentoring experiences after some sort of training and support based on a formalized approach (Cheek, Dotson, & Ogilvie, 2016). Leggat, Balding, and Schiftan (2015) found that paired mentors/mentees matched through

learning styles in a formal mentoring program, using the LPI, was successful and developed clinical leadership competence. The LPI assisted nurse mentors and nurse mentees in transitioning to new roles by developing knowledge and skills in clinical leadership that were essential for advanced practice roles. The LPI measured the five practices of exemplary leadership. Lantham, Singh, and Ringl (2016) found a formal structured peer mentoring program to help diverse students adjust to rigorous nursing curriculum increased personal development and empowered students to problem. The literature supported a structured formal mentoring program versus an unstructured and social informal mentoring.

Professional organizational associations for nurse practitioners offering a mentoring program were emerging. Most notably, the American Association of Nurse Practitioners established a Fellows Mentoring program for a year long process. The program matched a junior nurse practitioner and a nurse practitioner leader to guide the new nurse practitioner during the transition to practice (Goolsby & DuBois, 2017). Midwifery tradition incorporated mentoring for midwifery students.

Informal and formal mentoring was beneficial to the mentor and mentee experience. A unique approach included reverse mentoring with newly hired nurses mentor senior nurses with the implementation of technology in the workplace. The approach utilized skills and expertise of emerging leaders to teach established leader nurses regarding technology. The reverse mentoring has provided learning opportunities for nurses. The article supported benefits of knowledge sharing from professional nurse to professional nurse to be beneficial. The mentoring approach supported mutual learning process to influence change and develop leadership skills (Stevenson & Vaulkhard, 2017). The value of the mentoring process has expanded the approach to utilize strengths to mentor others.

Mentoring challenges. Green and Jackson (2014) explored negative issues associated with mentoring relationships. Through exploration of the literature, the authors defined the phases of mentoring that included initiation, cultivation, separation and redefinition. The authors indicated that successful mentoring was a mutual pairing versus a blind pairing. Using technology to confirm pairing of mentor and mentee such as text and Skype® eliminated the burden of arranging face-to-face meetings. Healthy relationships were the responsibility of both parties. Toxic relationships needed to be guarded as jealousy, opportunism, bullying, and a mentee that is a bad reflection on the mentor can exist. Mentoring was a relationship that existed for a purpose. If there was mutuality in the relationship and the mentor and mentee pair found gain, then progress and growth should be tracked to ensure that the relationship was positive for both parties (Wenzel & Bekemeier, 2017). The greatest challenge to mentoring was time and support. The pitfalls of mentoring provided valuable insight. The characteristics with failed relationships included poor communication, conflicts of interest, perceived competition, lack of experience among the mentors and personality differences (Straus, Johnson, Marquez & Feldman, 2013). Sanfey, Hollands, and Gantt (2013) cited the challenges of generational differences in altering the mentoring relationship. These mentoring challenges supported the development of programs, training and structured mentoring to divert from the barriers to build a supportive foundation for mentoring. In addition, the relationship between the mentor and mentee should be reviewed over time. As relationships evolved, disagreements, misunderstandings, changes in goals, and overall tensions can occur (Wenzel & Bekemeier, 2017). Reviewing the relationship periodically supported a positive outcome.

E-mentoring. E-mentoring was defined as a relationship between a mentor and mentee that uses electronic means to support learning, guidance, and emotional support (Harris, Birk &

Sherman, 2016). A variety of terms were used including cyber mentoring, tele-mentoring, e-mentoring, virtual mentoring and online mentoring (Clement & Welch, 2018). Electronic means were used for mentoring include educational platforms, Skype®, Facebook®, Facetime®, chat rooms, instant messaging, and even telephone conversations.

Practice traditions in nursing included mentoring as part of training for nurses. The traditional mentoring practice was limited to location, time and accessibility to the mentor. A younger generation immersed in the use of technology, created new options for mentoring. These options have emerged through application software and social media. Pietsch (2012) used surveys specifically designed for the study and researched the perceptions and attitudes of nurses. The instruments included nurse's attitudes toward e-mentoring; e-mentoring facilitators and constraints and demographic data collection. The attitudes instrument included a seven-point Likert scale using opposite adjective pairs to measure attitudes. The e-mentoring facilitators and constraints instrument was a 15-item survey, which measured nominal responses and included open-ended questions to identify barriers and support for e-mentoring. E-mentoring was supported by the study findings as a positively perceived and viable means of mentoring for the nursing profession. The e-mentoring format was an avenue for mentors and mentees to engage in the mentoring process of the experienced nurses and the younger nurse professionals. The outcome of the research added value to the literature regarding e-mentoring.

The integration of technology provided an avenue for the e-mentoring process. In order to facilitate mentoring benefits without the geographical and time restraints, the use of the internet is important. The internet is a deviation from the traditional face-to-face model of mentoring. The use of internet has provided access to experienced nurses to implement mentoring activities (Pietsch, 2012). The experienced mentors reported more favorable attitudes with e-mentoring.

Mentors with low favor ability also scored lower on attitudes scale towards mentoring.

Technology rapidly expanded access to internet services. E-mentoring was discussed in the literature as a means provided to support students. A research study aimed to increase the number of ethnically diverse student nurse midwives by e-mentoring. Valentin-Welch (2016) conducted a descriptive study that analyzed online surveys to collect data from mentors and mentees participating in a diversity-mentoring program. The participants identified ethnicity as African American, Biracial, Hispanic, Portuguese and White. Areas for improvement with the process included the need for timely assignment of mentees to a mentor and more communication required for the participants. The mentees indicated with an 80% response rate in support of the e-mentoring as beneficial for their emotional support. The mentees indicated a deeper level of understanding with the clinical aspects of the midwifery program.

Harris, Birk, and Sherman (2016) in a longitudinal pilot program to support students in a DNP Leadership and Innovations degree program used a formal e-mentoring program to support students (mentees) with professional mentors in the first year of study. The materials were placed online using an educational platform that supported discussion boards. Mentees chose mentors by reviewing biographical information including name, photograph, professional backgrounds, career objectives and goals, and personal information important to the match. Mentees' prioritized and listed choices. Program coordinators reviewed and paired mentors and mentees. Students completed the modified Ideal Mentor Scale (IMS) before, midpoint, and after the program. Mentors did not complete the assessment. Mentees were contacted to indicate the preferred method of contact and the frequency of the interaction. A suggested contact point was monthly or bimonthly. The program time was nine months, from September to May. The results after the program included a positive response that the program was beneficial to both the

mentors (92%) and mentees (89%) (Harris, Birk, & Sherman, 2016).

E-mentoring provided an opportunity for global mentoring of nurses. The use of the internet has facilitated global mentoring to promote the profession of nursing. The National League for Nursing and Johnson & Johnson formed a partnership from 2007 to 2011 to sponsor mentoring program for nursing educators. The process matched five mentors and mentees to work on designated modules for a minimum of one year. Each year the focus was a differing topic and new mentors and mentees were identified for participation. After the e-mentoring process, the researchers sent email invitations to each of the 40 participants. The experiences of the distance-mentoring program were assessed with an interpretive phenomenological study that consisted of semi-structured interview questions. The research findings analyzed by Lasater, et al. (2014) provided support for e-mentoring as effective in developing meaningful mentoring relationships. An essential contribution to the literature was the findings for support of telepresence, which offered the face-to-face connection with technology, such as Skype®. The research study supported the value for under-resource countries to provide mentorship for nurses with limited professional development opportunities.

Additional research supported the viable option of e-mentoring for nurses. A study focused on identifying challenges and benefits of distance mentoring. The study conducted by Lach, Hertz, Pomeroy, Resnick and Buckwalter (2013), identified challenges with on-site mentoring as being limited with planning time, limited communication and competing demands within the institution. The benefits of online distance mentoring were the removal of the challenges listed. E-mentoring offered flexibility with meeting times, supportive interactions, and accessible resources for the mentoring project with more availability options for the mentor. The qualitative study analyzed open-ended questions to identify the common themes, the

overwhelming responses from the mentees supported e-mentoring as effective for professional development in research, clinical practice and leadership.

Batara and Woolgar (2017) initiated a research study in 2015-2016 to gather data regarding mentoring programs among eight healthcare and ten non- health organizations. Common factors supporting benefits of mentoring included 38.9% mentoring affected program change, 50% supported inter-professional development competencies and 38% supported the connection as positive among mentee and mentor. Strengths were identified among the 18 agencies programs. Strengths included the use of virtual platform for connecting, facilitating the matching process, self-initiated matching, clear expectations, focused targets for mentoring, and flexibility with implementation. Weaknesses among the participating organizations included no progression among pilot project, no formal training or tools (Batara & Woolgar, 2017).

The literature supported the implantation of e-mentoring as an avenue to facilitate mentoring in the nursing profession. The lessons learned from various studies supported interventions for effective mentoring programs including timely assignment of mentors and mentees (Valentin-Welch,2016). The use of telepresence was an option for enhancing the mentoring process with virtual face-to-face interactions with the mentors and mentees (Lasater, et al., 2014). The perceptions of nurses supported the use of technology to use as an effective means of mentoring (Pietsch, 2012) The evolution of technology has the capacity to become a conduit for professional development among nurses through a mentorship model (Lach et al., 2013).

Advantages to e-mentoring have begun to emerge in the literature. Clemente and Welch (2018) cited the cost-effective approach of technology for mentoring and the removal of geographic barriers as opportunities to network with a greater number of mentors. The increase

in technology for social media use and the development of software applications to foster mentoring relationships such as SCORE or MentorNet were growing (Wilbanks, 2014). The advantages of e-mentoring, its ease of use, and its global approach may change the future of mentoring.

The LPI in nursing. The International Confederation of Midwives (ICM) developed a leadership-mentoring program with global partnerships to the promotion of leadership development to strengthen the professional midwife role and to influence the promotion of women and family's health. The ICM supported the need for action with the identified needs of health promotion for women and families among the various global reports from the United Nations, 2000, the World Health Organization (WHO, 2016) and the United Nations (2016). Midwifery leadership was challenged with development of nursing leaders for engagement in policy deliberations to promote the health of women with three objectives from the WHO strategy to Survive, Thrive and Transform. The creation of the young midwifery leaders (YML) was implemented internationally to develop global leaders to influence change (Thompson, Moyo, & Fullerton, 2016).

The role of the midwife was specifically direct care of women and families. However, with the emerging need for policy development to promote the needs of families, the midwife's role will need to include advocacy to promote the health and wellness of the families in which they serve. The ICM embraced the challenge and expanded the role of the midwives to incorporate leadership development within the role of the midwife. The primary focus for the expanded role was to develop leaders that will be change agents to influence policy change among health care institutions and organizations that govern the maternal and child health care systems (Thompson, Moyo, & Fullerton, 2016). The leadership program was designed from the

published work of Kouzes and Posner's Five Practices of Exemplary Leadership. The midwives' leadership model was launched internationally in Port of Spain, Trinidad, Tobago in 2004 and then in Malawi in 2007.

The second implementation of the program included collaborations with the Latin American and Caribbean regions was in 2013 (Thompson, Moyo, & Fullerton, 2016). The young midwife's leadership development program focused on key areas including; individual professional development, scholarly achievements and the progression of the mentees career. The mentors and mentees voluntarily enrolled in the project. The selection of mentors by the mentees included a mix of self-selected mentors and mentors identified by the ICM. The participants were provided expectations including mutual sharing and investment with the project. The expectation with the roles and responsibilities was clearly defined among all participants with the expectation of sustainability with the project timeline. The option to continue beyond the defined period was allowed with agreement for participation (Thompson, Moyo, & Fullerton, 2016).

The implementation of the international mentoring program included distance learning, assignments, mentoring and participation in on-site workshop meetings. To participate actively, the participants were expected to attend ICM meetings and to be involved in their regional and country meetings. The workshop meetings included presentations by the mentees with their assigned work. The global workshops included educational presentations on maternal child health issues to increase knowledge and practices to promote health and wellness. At the completion of the mentoring program, certificates of completion were awarded at the ICM meetings. The ICM continued with the self-study module programs in specific languages and continued the workshops for mentors and mentees. The mentees completed modules then

discussed them with the mentor. Most participants successfully completed the mentoring program. A few were unable to continue participation and withdrew from the program. The program evaluation assessed the relationship between the designated activities and the development of leadership skills of the mentees. The modules were positive tools. However, the required attendance at workshops was a financial barrier for many participants.

The decade long study provided strengths and weaknesses of the program through the evaluation process. Challenges included the global arena, which presented with financial barriers for the participants to attend all the required meetings. The program challenges were with self-directed learning by the mentee and then reviewed with a mentor. The mentees indicated the desire for more interaction with the mentor. The evaluation resulted in initiated changes with the program and implemented a revised leadership-mentoring program in 2015. The objectives included extending the length of time for the mentor and mentee process. Specific qualifications for the participants were developed, and resources provided for professional organizations (Thompson, Moyo, & Fullerton, 2016).

Marath and Ramachandra (2015) studied the impact of leadership on undergraduate nursing students measured by the LPI. Using a quasi-experimental pretest and multiple posttest control group, the authors found a significant increase in the mean leadership scores for all the five leadership practices from pretest to posttest. Marath and Ramachandra's objectives were four-fold; to prepare a leadership package, assess and evaluate the self-reports of undergraduate leadership practices of nursing students, assess and evaluate the observer reports of the undergraduate nursing students, and to find the differences between the reports in the five leadership practices pre- and posttest. Participants completed both the LPI Self and Observer including a separate demographic information tool. The findings revealed that the undergraduate

nursing students had not participated in any formal leadership-training program. The practices from the LPI that were most common included Encourage the Heart and Model the Way; the lowest ranking practices included Inspire a Shared Vision and Challenge the Process. The study posited that the findings supported in other studies where the most frequent practice was Model the Way and the most infrequent practice was Inspire a Shared Vision and Challenge the Way. The findings question the culture of nursing and educational programs that may be directed to cohorts of nurses that are passive, compliant, dedicated only to the hospital, and work inexpensively (Marath & Ramachandra, 2015).

Marath and Ramachandra (2015) urgently identified the need to prepare nurses in leadership roles as almost one-third of nurse executives will retire within the next 10 years. Leadership development was a complex issue. However, mentoring through an organization at every state level can create a leadership development strategy that can support 10,000 nurses in the boardroom by 2020. Mentoring programs that were technology-based reached nurses anywhere and at any time, thus providing a flexible forum of relationship building that can promote positive leadership skills in a busy society.

The Leadership Practice Inventory (LPI) was used in multiple studies with nursing research. The LPI tool was evaluated for reliability and validity. The review of the database included close to 2.8 million responses over an eight-year period. The respondents included managers, direct reporters, observers, co-workers and peers. The participants included 130,515 men and 100,830 women. Less than one percent was below the age of 24 years of age. The majority of those that responded to the surveys had completed college. Internal reliability testing evaluated multiple aspects including individual and contextual factors; self and observers; gender; type of employer; ethic and cultural comparisons. The results of the study revealed

sound psychometric properties with strong internal reliabilities among the various groups tested. The testing demonstrated construct and predictive validity with the findings. The research findings by Posner (2016) established the LPI tool as reliable and valid for measuring leadership practice.

The barriers to board service. The financial impact of nurses on boards was important to note as nurses provide a diverse viewpoint in fiscal strategy. Nurses, particularly nurse managers, have significant budgeting background and can understand multi-million-dollar budgets (Capella, 2016). The expertise in fiscal responsibility, improved outcomes and improved caring for patients and families. This unique skill set made nurses uniquely qualified for board service.

Quality and safety was another area where nurses' impact was great. Expert navigating of safety indicators, such as quality improvement models, benchmarks for nurse-sensitive quality data, such as catheter-associated urinary tract infection rates, fall rates, pressure ulcer rates, and central line associated blood stream infection rates (Capella, 2016). In understanding these benchmarks, critical thinking using analysis and evaluation were important. Nurses knew how to navigate organizational culture including, collaborate inter- and intra- professionally, and organize successful teams (Capella, 2016).

The patient and family experience was integral to nursing education. Nurses understood that in relationship based care, patients and families came first. Nurses' first experiences were at the bedside. Nurses staffed hospitals and acute care settings twenty-four hours in a day. They were committed to a positive patient experience. In the boardroom, this attitude was invaluable, as nurses could know how healthcare decisions can affect the patient and family experience.

In previous sections, discussion regarding nursing turnover cannot be underestimated.

Capella University (2016) stated that turnover costs could be up to $6.4 million per year for a large hospital center. What was equally alarming was that 30% of newly licensed nurses leave positions in the hospital or change units within the first year (Capella, 2016). This cost directly affected quality, safety, and the patient experience. These statistics supported the need for nurses on boards. Nurses provided industry knowledge for board members. Mentorship for nursing leaders with the development of board competencies was identified as valuable (Rose & Nies, 2016). There were reasons why nurses are not on boards. The low number of nurses in board positions included the perception that nurses cannot contribute to healthcare policy equally as doctors do; advancement for nurses is difficult as there was a gender gap; and nurses have been silent to executives and others about their strategic view and training (Capella, 2016). Prybil, Dreher, and Curran (2014) indicated four relevant factors that contribute to the limited engagement of nurses on boards. The factors were the board selection process, gender disparities, board policies and procedures, and a lack of nurse advocacy efforts.

The board selection process was more amiable to physicians than nurses were. This attitude shuts nursing out of the selection process, as the bias was that nurses do not have qualities to bring to the table. Nurses had a symbiotic relationship with physicians and did complement the sharing of ideas for healthcare issues. The issue of gender disparities as a barrier to nurses on boards was evident in business as well as healthcare. According to Prybil, Dreher, and Curran (2014) more than 10% of Fortune 500 boards did not include women. This gender imbalance continued in healthcare boards. Board policies and practices inhibited the appointment of an organizational employee other than a voting Chief Executive Officer. Boards were intended to be independent bodies; direct voting privileges were not available to employees of the organization (Prybil, Dreher, &Curran). Nurses sought outside boards, such as other

healthcare institutions, consulting firms or universities where the nurse was an independent board member. The lack of advocacy efforts in nursing was another barrier to engaging nurses to be on boards. Organizations, such as the Robert Wood Johnson Foundation, have supported the nurses on boards' coalition. However, other organizations remained silent such as the American Nurses Credentialing Center, and the Joint Commission. This silence did contribute to the low level of nurse engagement (Prybil, Dreher, &Curran).

Mentoring to reduce barriers to board service. The healthcare system has historically made decisions regarding healthcare without the voice of nurses as voting members on boards. According to the American Hospital Association (2014), the representation of nurses on boards in the United States was reported at a mere 5%. As a result, to this alarming rate of ill representation of nurses, an initiative was launched as the Nurses on Boards Coalition in 2014 (Nurses on Boards Coalition, 2016). A study conducted by Szekendi et al. (2015) surveyed 58 academic medical practices regarding organization performance and practices. The high performing boards were identified and only 44% reported a nurse serving on the board, whereas the low performing boards only 11% reported a nurse serving on the board. The data also revealed the 69% of all the medical centers in the study reported that there was no nurse serving on the board. The significance of the study linked the value and power of nurses on boards to organizational effectiveness.

The power of boards has predominately operated as a patriarchal board. The uneven power in the operation of the board required the women on the board to be prepared and knowledgeable to have a voice to influence policy (Sundean, & McGrath, 2016). Because of an integrative review regarding nurses on health care governing boards, the focus of research shifted from passive observation to action towards social change. The value of nurses serving on boards

was established. Call to action by recommendations ask nurses to prepare for board service (Sundean, Polifroni, Libal, & McGrath, 2017).

The nursing profession must develop mentoring relationships among nurse executives in the academic and organizational environments to become active leaders in the role of mentoring for emerging leaders. The development of leadership skills in nursing was essential to influence change in the healthcare systems with social and political change (Montavlo & Veenema, 2015).

The state of New Jersey has responded to the Institutive of Medicine (2010) call to action and has implemented a statewide nurse leader's mentorship program. The program aligned with the American Organization of Nurse Executives goals to prepare the nursing professionals for leadership positions. The efforts began with a pilot study with 30 mentors and mentees participating to test the program components. The program has evolved to a formal mentorship program with participants committing to the process for a period of one year with defined phases. The program's toolkit included a relationship phase, role responsibilities, agreements, and a wealth of resources for the mentor and mentee. The mentors and mentees participated in a workshop prior to the launch of their mentoring experience. The collection of data included a qualitative research approach to analyze common themes for the mentoring program. The data collected from participants provided valuable insight into the challenges to address prior to the statewide launch of the mentoring program. The New Jersey model has become a model for development of nursing leaders with mentoring (Rich et al., 2015).

The nurse mentoring pilot project in New Jersey resulted in improvements with the mentoring project, as it was launched statewide encompassing 90% of the hospitals including 116,000 nurses in the healthcare system. The statewide mentoring program incorporated recommendations from the pilot study to include formalized one-day training for the mentors and

mentees. The qualitative results from the first two cohorts of participants included common themes among the successful mentoring matches. The areas identified as mentoring relationship themes included: making a connection; mutual relationship, range of emotions regarding the process; logistics of meeting and choosing a mentor (Vitale, 2018). The year- long relationship with the mentoring project resulted in structured educational sessions, focused networking and toolkit resources and check in points for promotion of success for both parties.

The vision for nursing leaders was to expand the role of the profession to affect change within the healthcare system and globally. The IOM report (2010) has challenged nursing to equip leaders with skills to participate on boards to influence change that will ultimately affect healthcare. The leadership development offered a prime opportunity to implement a mentoring program that will utilize the benefits of technology to remove the geographical barriers. The proposed project to implement a nurse-to-nurse mentoring program will promote leadership skills while adding to the research the sustainable value of mentoring.

Summary of Literature Review Findings

There was change in nursing. Nurses were highly qualified in terms of experience and education. Nurses need to be counted and invited to share their experience with communities in navigating the complexity of healthcare. The IOM (2010) reported *The Future of Nursing: Leading Change, Advancing Health* signals this change. Today, through state coalitions such as the MHC/MCN nurses have an opportunity to be formally educated through a mentoring program to gain in leadership skill development. The literature supported a formal mentoring program where mentees choose mentors through an online format. Mentoring research history was more available through the business discipline. Historically, business supported mentoring as increasing psychosocial behaviors and career development. The literature supported making

greater use of mentoring in nursing to support nurses' role transition (Leggat, Balding, and Schiftan, 2015). Nurses were underrepresented in leadership positions and would benefit from business in creating a unique mentoring program that would increase nurse's role in the boardroom.

The review of literature has identified the value of mentoring. The research has evolved over time and has built upon a successful model of developing nurses through the mentoring process. As student nurses in an undergraduate nursing program, the clinical area is where a nurse's early exposure to mentoring begins. In the clinical environment nurses learned hands on skills and bedside patient care by experienced nurses. The knowledge and skills that were developed in the clinical area with a pairing of an experience nurse, was essential to the student nurse's professional development. Nurses have utilized mentoring for decades. The development of the novice to expert skills in the profession, the clinical model still offered value in the nursing profession beyond the bedside patient care role.

The IOM (2010) report was clear; nurses made a commitment to patient care, improved outcomes, and safety and quality. These commitments made nurses impactful at the board level. Nurses have demonstrated unique qualifications with specific knowledge, skills, and competencies that affect healthcare in three important areas: financial, quality and safety, and patient and family experiences (Capella University, 2016). However, the most trusted profession was not regarded as influential (Gallup, 2008). Nurses were underrepresented on boards as a 2005 study of nonprofit hospitals found that 26% of physicians held voting positions on boards where only 2.5% of nurses held voting board positions (Walton, Lake, Mullinix, Allen, & Mooney, 2015). A mentoring program is an evidence-based option to assist nurses to excel in leadership roles.

Douglas, Garrity, Shephard, and Brown (2016) discussed the theme of support as the most consistent theme that mentors requested. Access and availability of support throughout an organization was imperative. Cheek, Dotson, and Ogilvie (2016) concluded that mentoring success was incumbent on relationships that require good training and support. Formal mentoring was an avenue to obtain training and support. Lantham, Singh, and Ringl (2016) discussed education and training completed by posting educational materials on the website included tips on strategies, relationships, and quick facts and tips. Group meetings, emails and telephone feedback provided support for both mentors and mentees. Roles and responsibilities for both parties must be clear and can be provided through video technology. Minimum monthly meetings were encouraged to help with a trust relationship that can move through the mentoring phases of the relationship.

The review of the literature has identified mentoring as a viable means to enhance nursing knowledge and develop leaders. The research studies evaluated, have explored the role of mentoring in the academic and clinical practice. The studies have identified desirable characteristics of mentors, the influence of positive reaffirmation, and the process of professional development. The data collection methods have included a variety of methods including quantitative and qualitative data for analysis. The overall outcomes have supported mentoring as a process to bring nursing from novice to expert in a variety of work environments. Jakubik, Weese, Eliades, and Huth (2017) identified mentoring as a career continuum moving from onboarding, orientation, residency, to mentoring. Onboarding was completed as an organizational and socialization introduction to nursing lasting for weeks to months. Orientation was the more purposeful transfer of specific skills and knowledge to the role of nurse lasting from weeks to months. Residency was a transitional perspective. The transition in residency

included organizational culture, specificity of role identification, and retention lasting from 12-18 months. Finally mentoring is a final phase of the career continuum of a nurse where the purpose is lifelong learning, advancement, engagement and succession planning lasting from the first year through retirement (2015-2017 Nurse Mentoring Institute). Mentoring can occur anytime from the first-year experience to retirement; horizontally within a role or vertically across roles; and in succession planning (Jakubik, Weese, Eliades & Huth). The use of mentoring in a variety of settings has reinforced the approach to be tailored for the needs of the mentee. An area that research was lacking includes the perspectives of mentees and how mentoring influenced leadership development from the mentee perspective. The literature focused on the mentors. However, gap in the literature suggested measurable benefits for the mentee. Mentoring was recommended in the IOM (2012) report to develop leadership skills and propel nurses to the boardroom.

Project Design/Implementation

Goal of Project

The MCN has embraced the recommendations of the IOM and Nurses on Boards Coalition to create a mentoring program for nurses in the state of Michigan. The goal of the project is to develop nursing leadership skills and increase the number of nurses serving on boards. The purpose of the proposed project is to design and implement a nurse-to-nurse mentoring program. The pilot project, RNmentor2mentor, will establish a baseline for the mentoring program and provide data to expand the nurse-to-nurse mentoring program beyond conference participants to a statewide network.

Setting

The nurse-to-nurse mentoring pilot project, RNmentor2mentor, was launched at the MHC/MCN annual conference in October 2017. The initial implementation of the project was during the conference. The post-conference meetings, November 2017-January 2018, (encounters) took place utilizing a format of choice for the mentoring dyad.

Population

The mentors and mentees included a convenience sample of 40 conference participants who indicated an interest in being a mentor or a mentee. The mentor requirements included a minimum of a Bachelor of Science (BSN) degree in nursing and five years' experience as a Registered Nurse. A mentee is an RN that self-determines the need for a mentor. The pilot study did not encompass the student or newly graduate nurse. The mentors and mentees were matched at the conference. Only pairs of mentors and mentees were included in the study.

Timeline

The Module Timeline (Appendix H) for the RNmentor2mentor program design is:

- Phase 1 (September, 2017) – Pre-Intervention/Pre-Mentoring Commitment. This phase included preparing an email sent to participants indicating they are interested in making a commitment to the mentoring program. The email contained project information such as the Speed Meeting pairing of mentees to mentors, orientation, supplies needed such as pencil, pen, and laptop or computer.
- The participants were confirmed (October 2017) by email identifying mentor or mentee.
- Month 1 (October 2017): Phase 2 – Intervention/Onsite - Orientation Phase/Novice. In this phase, the Speed Meeting, mentor and mentee orientation took place during the conference.

- Orientation included *Section 1: Introduction* — basic intent and overview of the toolkit; Sections 3 through 10 were designed for the mentors to use with the mentees. Each of these sections include the introduction page (which states the purpose, perspective, how to prepare for this topic, tools and pointers), discussion starters, tools, handouts and resources reviewed by the mentors online. The mentee had separate orientation material to review in the mentee section of the program. Handouts and tools that were intended for the mentee are designated by this star (✸) in the top right corner.
- Mentor: *Section 2: Keys to a Successful Mentoring Relationship* were part of the mentor orientation. Unlike the other sections in this toolkit, Section 2 was written for the mentor and was not to be used with the mentees. The goal of this section was to prepare mentors for their journey with the mentees.
- Review *Section 3: Overview/Getting Started* for face-to-face discussion prior to leaving conference: Getting Started: First Meeting Guide and Setting Goals* — The intent of the first two meetings was to start building trust between the mentors and mentees, to determine clear expectations and to establish a plan for future meetings based on the mentees' goals. Ideally, the mentees started to develop general goals by the end of the second meeting.
- Institutional Review Board (IRB) consents, other consents, mentoring contract, confidentiality and accountability, monthly data collection, exit strategy and other housekeeping items. Email information along with text numbers were collected to send out reminders and prompts for support in continuing to meet and work on the modules. The pre-evaluation Leadership Survey was completed along with the

pre-evaluation online LPI, if computers are available. If computers were not available, the participants had a deadline of Wednesday, October 28, 2017 at 8 a.m. to complete the pre-evaluation LPI. If the LPI is not completed the participant will be excluded from the study. This will affect the mentor and mentee relationship and study sample numbers.

  - An email follow-up using a link to Google Forms was sent to the participants.

- Month 2 (November 2017): Phase 3 – Intervention/Online- Working/Identification Phase/Novice. *Challenge the Process:*
  - *Required: Section 4: Current Role*. The mentors/mentees used this section to explore the mentees' current position and focus on their job satisfaction, workplace engagement and empowerment. The goal for the mentees was an increased understanding of their current position that results in increased effectiveness. The mentors/mentee discussed the mentor focused section on Power Content 4.7; 4.8; 4.9; mentee homework in the supplemental material in Power Content. The LPI scores were reviewed and tied to module content.
  - *Inspire a Shared Vision: Required: Section 5: Understanding Self and Others* — This section provided a knowledge base for the mentees to better understand themselves and others as they grow in their role as a nurse.
  - An email follow-up using a link to Google Forms was sent to the participants.
- Month 3 (December 2017): Phase 4 – Intervention/Online- Identification/Exploitive Phase/Advanced Beginner.
  - *Enable Others to Act: Required: Section 6: Communication* had a focus on effective communication skills; this section had a dual purpose: (1) to support the

mentors' ability to work with mentees; and (2) to strengthen the mentees' communication skills. This section included tips and concrete examples to assist in effective communication. The mentor focused on Crucial Conversations/Bullying and the mentee will use the supplemental material in *Crucial Conversations* content.

  - *Challenge the Process: Required: Section 7: Problem Solving* was designed to help mentees learn to problem solve and practice conflict management in the daily work environment.
  - An email follow-up using a link to Google Forms was sent to the participants.

- Month 4 (January 2018): Phase 5 – Intervention/Online- Termination Phase/Competent.
  - *Enable Others to Act: Optional: Section 8: Time Management*. This was an optional module based on the decision between the mentor/mentee dyad. It was a positive experience when mentees felt they had completed items during their shift. The purpose of this section was to assist mentees in learning how to manage their time.
  - *Model the Way: Required: Section 9: Leadership* was the module that increased awareness of leadership skills and included content to become aware of those skills. This required section helped mentees gain a better understanding of leadership and workplace dynamics. With knowledge and awareness based on realistic expectations, mentees were able to build optimal work relationships. Mentees also used the tools to assess their ability and desire to be a leader. The final module in this program is Encourage the Heart.

  - *Encourage the Heart: Required: Section 10: Leadership Development*. This section assisted mentees in developing a better understanding of the meaning of leadership in nursing. There were activities to reflect on leadership skills and an introduction to the Nurses on Boards Coalition website with information on reviewing the website. Recommended reading was a journal article to introduce the idea of a place at the board table. An email follow-up using a link to Google Forms were sent to the participants.

- Month 4 (January 2018): Phase 6 – Termination Phase/Competent is the final phase and termination of the project.
  - The mentor and mentee completed program evaluations, post-evaluation leadership survey, post-evaluation LPI and Observer LPI of each other. A discussion of final scores and thank you notes were sent to the participants.

Selection of the Measurement Method

Primary outcome: Comparison of LPI scoring. To compare the pre/post change, a paired t-test was used to test the difference for statistical significance. All significance testing was at an $\alpha = 0.05$. This may be adjusted if a larger sample than expected is enrolled in the study.

Secondary outcome: Comparison of mentee/mentor LPI scoring. To compare the self-assessment LPI to a secondary Observer LPI scoring of the individual as an assessment for identifying possible blind spots within the mentee. This comparison was not done due to the low response rate of the Observer LPI (n=0).

Tertiary Outcome(s): Description of Leadership questions related to modules. Surveys were summarized by pre-post and the findings were reported descriptively in the traditional manner. All testing for the tertiary outcomes were exploratory only.

Sample size. The sample size included a convenience sample of conference participants who self-selected to participate. The participants enrolled were six mentors and six mentees. The target sample size was twelve mentors with twelve mentees.

Primary Instrument. The LPI is the primary instrument for the project. A t-test measured any increase in leadership skills development pre- and post. A Cohen's Kappa measured the Observer LPI to determine if there was agreement between the mentor and mentee dyad. High Cohen's Kappa suggests a high level of agreement; low Cohen's Kappa suggests a low level of agreement.

Additional Instruments. The other instruments used to gather exploratory information. The Leadership Survey (Appendix I1) explored pre-baseline leadership data and post-module effectiveness by a score of 125 as the highest. An exit mentor (Appendix I2) and mentee (Appendix I3) evaluation explored descriptive data such as the relationship between the dyad, themes, and development of leadership skills.

Validity and Reliability

The valid and reliable tool used in this project was the LPI and LPI/Observer. Cronbach's alpha (ǎ) measured internal consistency and reliability of items in the instrument. These were reported to be consistently reliable between .75 and .87 with the LPI-Observer ranging between .88 and .92 (Kouzes & Posner, 2002). Reliability using Cronbach Alpha (ǎ) coefficients for the LPI and LPI-Observer respectively, by categories, indicates Model the Way reliability .77 and .88, Inspiring a shared vision reliability .87 and .92, Challenging the Process reliability .80 and .89, Enabling Others to Act reliability .75 and .88, and Encouraging the Heart reliability .87 and .92. The LPI in other researcher studies is reliable using Cronbach alpha (ǎ) between 0.71 and 0.94 (Kouzes & Posner, 2002).

The LPI had excellent face validity and the validity was determined by analysis that the five factors of items in the LPI correspond among themselves than with other factors (Kouzes & Posner, 2002). The stability of the five factors was tested and analyzed from difference subsamples and factor structure was using the five factors as in relation to the entire sample. (Kouzes & Posner, 2002). Other researches validated the LPI in a variety of settings using LISREL VII and PRELIS concluding that the LPI intercorrelations exceeded .50 resulting in a Chi-Square=399.9, df=363, p<.09. The t-values exceeded 7.0. LISREL confirms the LPI model.

The pre- and post-Leadership Survey, post Mentor Evaluation, and post Mentee evaluation was used as exploratory measurements using the convenience sample of mentors and mentees to offer insight into the sustainability of the project if the MCH/MCN chooses to continue the program.

Procedures

During the conference, time was designated for the interested participants to be involved in a speed meeting process. The purpose was to have the mentors and mentees meet in a coordinated manner. The mentors were at individual tables and the mentees moved from table to table to meet each mentor in an orderly fashion. The meeting time was equally divided between all participants. There was a bell to signal the move in the circuit to meet the next mentor. The mentee provided the co-project leads with a list indicating their top choices for a mentor, ranking 1 as highest and 5 as lowest. The co- project leads used this information to match the mentors and mentees prior to the afternoon session. The matching process included the collection of cards and tabulation by co-leaders. The mentors were arranged by name and the requests were aligned with mentees. With the overlap in requests, the additional preferences were matched as available.

At the orientation session, the co-project leads provided a presentation for the pilot

project. At that time, initial surveys and consent forms Jacksonville IRB (Appendix J1), Mentoring Agreement (Appendix J2), Mentoring Contract (Appendix J3), and Mentor/Mentee Confidentiality Agreement (Appendix J4) were distributed and signed. The initial Coding for Demographic Information (Appendix K), and the pre- intervention Leadership Development Survey was completed. The expectations for project participation and exit strategy were reviewed. The initial survey collection included demographic data including the initial question "Do you currently serve on a board?" to gather baseline results of RNs that currently may serve on a board. Additional information provided included how to access to modules, meeting format, and detailed instructions to access the online assessment tools through LPI. The Leadership Development Survey was completed online as a Google Form for the pre-intervention data collection. The pretest Leadership Development Survey was a 25-item survey with a 5-point Likert scale response. The completion time was approximately 10 minutes. The project leaders did not provide separate orientations for mentors and mentees after the initial data collection, due to conference time constraints. The mentors and mentees filled out separate confidentiality agreements after a brief orientation to the role of mentor and mentee. The co-project leads shared the orientation session. By the end of the conference, an introductory period was provided where the mentors and mentees were introduced to each other and given opportunity to schedule their first meeting.

Fiscal Consideration

The co-project leads shared the costs for implementation of the RNmentor2mentor pilot project. The LPI survey instruments were based upon the number of participants. The LPI survey was purchased for the pre/post testing and the observer test for a discounted cost of $180. The printing costs for the mentoring training packets was $100, as we were prepared to enroll up to

40 participants. The launch of the pilot project at the conference included expenses for the conference registration fees and lodging for two nights totaling $540. The total costs were shared by the co-project leads. The implementation costs were $820, divided by two resulted in a cost of $410 per project lead.

The online modules were paid for by the MHC/MCN for Nursing. The MHC/MCN facilitated module upload on the website at no cost to the co-project leads. The modules were password protected and used only for the pilot project. The mentor and mentee cost for the participation (e.g. conference attendance, medium used for their meetings, etc.) was self-paid. The use of the online modules removed the geographical barriers for the participants. The paired participants had the option to meet face to face, Skype®, internet email or phone. The participants were asked to commit to monthly meetings with their mentor or mentee.

Ethical Considerations

The proposed project was submitted to the Jacksonville University Institutional Review Board (IRB) committee through the online application process for project approval. The voluntary participants were drawn from the pool of registrants from the annual conference with the MHC/MCN. After reviewing the feedback from the mentees, the co-project leaders paired mentors with mentees using a speed matching process where mentees chose mentors. If mentors did not have matches, the co-project leads assigned mentors and mentees to maintain a one-to-one matching for mentors and mentees. The mentors and mentees were given information on how to opt out confidentially and how to contact the co-project leads if an exit strategy was needed.

Project Outcomes

Data Analysis and Descriptive Data

The project analysis plan outlined the collection and analysis of the data. The pilot project, RNmentor2mentor, researched the effects of a mentoring program on nurse's engagement with leadership activities/actions. The data collection included formative and summative data. The coding for demographic data items were collected from mentors and mentees and included demographic data. The data included demographics regarding age, gender, race, years of nursing experience, and level of nursing education. The role of mentor and mentee was defined by parameters, such as years as a nurse and nursing experience. The demographic data collected was utilized for descriptive statistical analysis. In addition to the demographic data, additional survey instruments were used as described. The pre- and post-testing was completed with matched pairing of participants completing the LPI tool. The LPI pre- and post-testing provided summative data for analysis. The Leadership Survey was a pre- and post-exploratory tool. Descriptive tools used to gather data on the exit of the program were the mentor and mentee exit surveys. The Leadership Survey, Mentor Exit Survey, and Mentee Exit Survey were tools found in the Nurse Mentoring Toolkit designed by The Health Alliance of MidAmerica (2017). The program was purchased by the MHC/MCN from The Health Alliance of Mid-America as a toolkit for the mentoring program. The Health Alliance of Mid-America granted approval to the MHC/MCN and the co-project leads to alter the product as needed. The co-project leads completed the data collection and analysis. See Divided Work Template (Appendix L).

Demographic Factors

The pre- project implementation demographic survey was completed by all *n*=12 of the participants. The age range of the participants was 40-69 years. The factor for ethnicity was predominately white for both mentee (*n* = 5, 83%) and mentors (*n* = 4, 67%). The participants were all female. The number of years as a nurse ranged from 16-30 years. All participants completed either a Masters (MSN) or Doctoral (DNP, PhD) degree. The question "Do you currently serve on a board?" was answered as Yes (53.8%) more than No (46.2%). The demographic factors are illustrated in Table 1. Due to rounding errors, column wise percentages may not equal 100%.

Table 1

Frequency Table for Nominal Variables

Variable	Mentee	Mentor
What is your age		
40-49 years	3 (50%)	2 (33%)
50-59 years	3 (50%)	2 (33%)
60-69 years	0 (0%)	2 (33%)
What is your gender		
Female	6 (100%)	6 (100%)
What is your ethnicity		
Asian Pacific Islander	0 (0%)	1 (17%)
Black African American	1 (17%)	1 (17%)
White	5 (83%)	4 (67%)
How many years have you been a nurse		
16-20 years	3 (50%)	0 (0%)
21-25 years	1 (17%)	2 (33%)
>30 years	2 (33%)	4 (67%)
What is your highest level of previous education certification or degree completion		
completed doctoral degree	3 (50%)	6 (100%)
completed master's degree	3 (50%)	0 (0%)

Results

IntellectusStatistics ™, 2017, software package summarized results of the project objectives. Prior to all the analyses, assumptions assessed included the assumptions of normality and homogeneity of variance. For normality, a Paired Samples *t*-Test statistic assessed for significant differences between two scale variables, as matched by pre- and post- (Razali & Wah, 2011). All variables varied from a normal distribution. As expected, the data was underpowered, the sample size small, and attrition occurred between the pre- and post- responses. These factors led to the non-parametric test, Wilcoxon Signed Rank, to assess variables of matched pre- and post- (Conover & Iman, 1981). This test ranks the pairs of scores by the magnitude of the differences between each matched pair, then sums the signed ranks to compute the *V* statistic. The *V* statistic is then used to compute *z*, which in turn is used to compute the *p*-value (i.e., significance level). A significant result in this test suggested that the matched variables are significantly different form each other, such as pretest scores that are statistically different from posttest scores (IntellectusStatistics ™, 2017).

Project Objectives

Short-term primary project objectives - LPI. The total number of participants recruited were (*n*=12) divided equally between mentors and mentees (*n*=6) for each group. The pretest LPI was completed by all participants (*n*=12) and the posttest was completed by ten participants (*n*=10). The short-term primary objectives were to determine if there was an increase in total leadership skills and/or an increase in one or more of the five practices of exemplary leadership in the pre- and post- LPI at the end of the RNmentor2mentor intervention. Summary statistics calculated for each of the LPI Survey Sections: Model the Way, Inspire a Shared

Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart split by pre- or post-.

Descriptive statistics. Table 2 illustrates the summary statistics for Pre-Model the Way, Pre-Inspire a Shared Vision, Pre-Challenge the Process, Pre-Enable Others to Act, and Pre-Encourage the Heart. The summary statistics indicate the observations for Pre-Model Way had an average of 51.33 (*SD* = 7.05, SE_M = 2.04, Min = 35.00, Max = 58.00). The observations for Pre-Inspire Vision had an average of 48.92 (*SD* = 11.50, SE_M = 3.32, Min = 18.00, Max = 57.00). The observations for Pre-Challenge had an average of 52.00 (*SD* = 6.70, SE_M = 1.93, Min = 34.00, Max = 60.00). The observations for Pre-Enable had an average of 53.50 (*SD* = 5.78, SE_M = 1.67, Min = 41.00, Max = 60.00). The observations for Pre-Encourage heart had an average of 50.25 (*SD* = 8.53, SE_M = 2.46, Min = 37.00, Max = 60.00). Skewness and kurtosis were also calculated in Table 2. When the skewness is greater than 2 in absolute value, the variable is considered to be asymmetrical about its mean. When the kurtosis is greater than or equal to 3, then the variable's distribution is markedly different than a normal distribution in its tendency to produce outliers (Westfall & Henning, 2013).

Table 2

Summary Statistics Table for Interval and Ratio Variables – Pre LPI Self-Reported

Variable	*M*	*SD*	*n*	SE_M	Skewness	Kurtosis
Pre Model the Way	51.33	7.05	12	2.04	-1.18	0.44
Pre Inspire a Shared Vision	48.92	11.50	12	3.32	-1.89	2.48
Pre Challenge the Process	52.00	6.70	12	1.93	-1.54	2.52
Pre Enable Other to Act	53.50	5.78	12	1.67	-0.82	-0.21
Pre Encourage the Heart	50.25	8.53	12	2.46	-0.31	-1.36

Note. '-' denotes the sample size is too small to calculate statistic.

Table 3 illustrates the Post-Model the Way, Post-Inspire a Shared Vision, Post-Challenge the Process, Post-Enable Others to Act, and Post-Encourage the Heart summary statistics. The summary statistics indicate the observations for Post-Model Way had an average of 53.80 (*SD* = 4.64, SE_M = 1.47, Min = 46.00, Max = 58.00). The observations for Post-Inspire Vision had an average of 51.80 (*SD* = 9.17, SE_M = 2.90, Min = 29.00, Max = 60.00). The observations for Post-Challenge had an average of 53.60 (*SD* = 4.38, SE_M = 1.38, Min = 46.00, Max = 60.00). The observations for Post-Enable had an average of 55.50 (*SD* = 4.06, SE_M = 1.28, Min = 46.00, Max = 60.00). The observations for Post-Encourage Heart had an average of 53.70 (*SD* = 4.88, SE_M = 1.54, Min = 46.00, Max = 60.00). Skewness and kurtosis were also calculated in Table 3. When the skewness is greater than 2 in absolute value, the variable is considered to be asymmetrical about its mean. When the kurtosis is greater than or equal to 3, then the variable's distribution is markedly different than a normal distribution in its tendency to produce outliers (Westfall & Henning, 2013).

Table 3

Summary Statistics Table for Interval and Ratio Variables – Post LPI Self-Reported

Variable	*M*	*SD*	*n*	SE_M	Skewness	Kurtosis
Post Model Way	53.80	4.64	10	1.47	-0.85	-0.78
Post Inspire a Shared Vision	51.80	9.17	10	2.90	-1.62	1.89
Post Challenge the Process	53.60	4.38	10	1.38	-0.13	-0.81
Post Enable Other to Act	55.50	4.06	10	1.28	-1.18	1.04
Post Encourage the Heart	53.70	4.88	10	1.54	-0.14	-1.42

Note. '-' denotes the sample size is too small to calculate statistic

Parametric (paired samples *t*-test) and non-parametric statistical analysis. Because of the small sample size and risk of type-II, or ß, error in the paired samples *t*-test, Cohen's *d* was evaluated for effect size. According to Cohen (1988), this means that if a *d* of 1 is reported, the two groups' means differ by one standard deviation; a *d* of .5 the two groups' means differ by half a standard deviation; and so on. Cohen noted that the probability of avoiding a type-II error (i.e., obtaining a statistically non-significant result when a predicted effect exists) is called statistical power (Power = 1 – Type-II-Error). Cohen suggested that *d*=0.2 be considered a 'small' effect size, 0.5 represents a 'medium' effect size, and 0.8 a 'large' effect size. This means that if two groups' means do not differ by 0.2 standard deviations or more, the difference is trivial, even if it is statistically significant. Cohen noted that the type-II error is inversely related to sample size. As sample sizes increase, sampling error decreases, and it becomes easier to demonstrate that an observed effect is a real effect rather than just a random event due to sampling error. In other words, one must determine what number of subjects in the study will be sufficient to ensure (to a particular degree of certainty) that the study has acceptable power to support the null hypothesis. Thus, one must control the probability of a type-II error by conducting projects with reasonable sample sizes. As this was a convenience sample of nurses attending a professional conference, sample size was not controllable. As noted in Table 4, the Cohen's d ranges from a low of 0.03 (e.g. below small effect size threshold) to a high of 0.44 (e.g. small to medium effect size). Due to the low sample size and small effect size, the project findings and differences or lack of differences found, should be interpreted with caution as findings may have been limited by the low sample size and the low number of observers (mentors) who returned completed surveys.

Table 4

Sample size and Cohen's d

Variable	Cohen's *d*
Pre and Post Self-Report Model the Way	0.42
Pre and Post Self-Report Inspire Vision	0.34
Pre and Post Self-Report Challenge the Process	0.22
Pre and Post Self-Report Enable Other to Act	0.37
Pre and Post Self-Report Encourage the Heart	0.33

Model the way: Self-report pre- and post- analysis. Prior to the analysis, the assumptions of normality and homogeneity of variance were assessed. A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were not significant, $W = 0.94$, $p = .578$. This suggests that the deviations from normality are explainable by random chance; thus, normality can be assumed. Levene's test for equality of variance was used to assess whether the homogeneity of variance assumption was met (Levene, 1960). The homogeneity of variance assumption requires the variance of the dependent variable be approximately equal in each group. The result of Levene's test was not significant, $F(1, 18) = 1.25$, $p = .278$, indicating that the assumption of homogeneity of variance was met. Therefore, the paired samples t-test was used to evaluate the difference between pre and post intervention Model the Way mean scores. The result of the paired samples *t*-test was not significant, $t(9) = -1.73$, $p = .118$, suggesting that the true difference in the means of Pre-Model Way and Post-Model Way was not significantly different from zero. Table 5 presents the results of the paired samples *t*-test.

Table 5

Paired Samples t-Test for the Difference between Pre-Model Way and Post-Model Way

Pre-Model Way		Post-Model Way				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
51.10	7.77	53.80	4.64	-1.73	.118	0.42

Note. Degrees of Freedom for the *t*-statistic = 9. *d* represents Cohen's *d*.

Inspire a shared vision: Self-report pre- and post- analysis. Prior to the analysis of the pre- and post- self-report mean scores of Inspire a Shared Vision; the assumptions of normality and homogeneity of variance were assessed**.**

A paired samples *t*-test was conducted to examine whether the difference between Pre-Inspire Vision and Post-Inspire Vision was significantly different from zero. Prior to the analysis, the assumptions of normality and homogeneity of variance were assessed**.** A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were significant, $W = 0.81$, $p = .017$. This suggests that difference is unlikely to have been produced by a normal distribution; thus normality cannot be assumed. However, the mean of any random variable will be approximately normally distributed as sample size increases according to the Central Limit Theorem (CLT). Therefore, with a sufficiently large sample size ($n > 50$), deviations from normality will have little effect on the results (Stevens, 2009). An alternative way to test the assumption of normality was utilized by plotting the quantiles of the model residuals against the quantiles of a Chi-square distribution, also called a Q-Q scatterplot (DeCarlo, 1997). For the assumption of normality to be met, the quantiles of the residuals must not strongly deviate from the theoretical quantiles. Strong deviations could indicate that the parameter estimates are unreliable. The result of the paired samples *t*-test was significant, $t(9) = -2.51$, $p = .033$,

suggesting that the true difference in the means of Pre-Inspire Vision and Post- Inspire-Vision was significantly different from zero. The mean of Pre-Inspire Vision (*M* = 48.10) was significantly lower than the mean of Post-Inspire Vision (*M* = 51.80). Table 6 presents the results of the paired samples *t*-test.

Table 6

Paired Samples t-Test for the Difference between Pre-Inspire Vision and Post- Inspire Vision

Pre-Inspire Vision		Post-Inspire Vision				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
48.10	12.53	51.80	9.17	-2.51	.033	0.34

Note. Degrees of Freedom for the *t*-statistic = 9. *d* represents Cohen's *d*.

A Wilcoxon signed rank test was conducted to examine whether there was a significant difference between Pre-Inspire Vision and Post-Inspire Vision. The Wilcoxon signed rank test is a non-parametric alternative to the paired samples *t*-test and does not share its distributional assumptions (Conover & Iman, 1981). The results of the Wilcoxon signed rank test (see Figure 1) were significant, $V = 4.00$, $z = -2.42$, $p = .016$. This indicates that the differences between Pre-Inspire Vision and Post-Inspire Vision are not likely due to random variation.

Figure 1. Ranked values of Pre-Inspire Vision and Post-Inspire Vision.

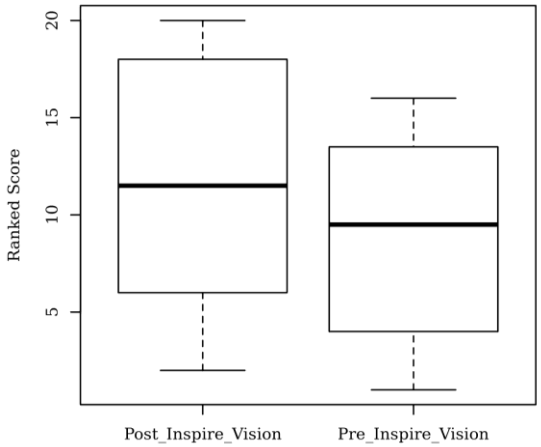

Figure 1. Differences between the Pre-Inspire a Shared Vision and Post-Inspire a Shared Vision

Challenge the process: Self-report pre- and post- analysis. Prior to the analysis of the self-report pre and post scores for challenge the process, the assumptions of normality and homogeneity of variance were assessed**.** A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were significant, $W = 0.76$, $p = .004$. This suggests that difference is unlikely to have been produced by a normal distribution; thus, normality cannot be assumed.

A Wilcoxon signed rank test (see Figure 2) was conducted to examine whether there was a significant difference between Pre-Challenge and Post-Challenge. The Wilcoxon signed rank test is a non-parametric alternative to the paired samples *t*-test and does not share its distributional assumptions (Conover & Iman, 1981). The results of the Wilcoxon signed rank test were not significant, $V = 16.50$, $z = -0.72$, $p = .469$. This indicates that the differences between Pre-Challenge and Post-Challenge are explainable by random variation.

Figure 2. Ranked values of Pre-Challenge and Post-Challenge.

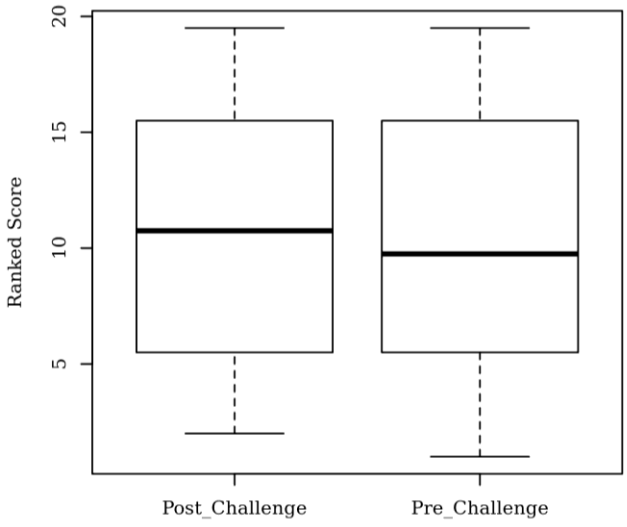

Figure 2. Differences between Pre-Challenge the Process and Post-Challenge the Process.

Enable others to act: Self-report pre- and post- analysis. Prior to the analysis of the self-report pre and post scores for enable others to act, the assumptions of normality and homogeneity of variance were assessed**.** A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were significant, $W = 0.80$, $p = .015$. This suggests that difference is unlikely to have been produced by a normal distribution; thus, normality cannot be assumed.

A Wilcoxon signed rank test was conducted to examine whether there was a significant difference between Pre-Enable the Process and Post-Enable the Process. The Wilcoxon signed rank test is a non-parametric alternative to the paired samples *t*-test and does not share its distributional assumptions (Conover & Iman, 1981). The results of the Wilcoxon signed rank test were not significant, $V = 8.00$, $z = -1.02$, $p = .309$. This indicates that the differences between Pre-Enable Others to Act and Post-Enable Others to Act are explainable by random variation. Figure 3 presents a boxplot of the ranked values of Pre-Enable the Process and Post-Enable the Process.

Figure 3. Ranked values of Pre-Enable and Post-Enable

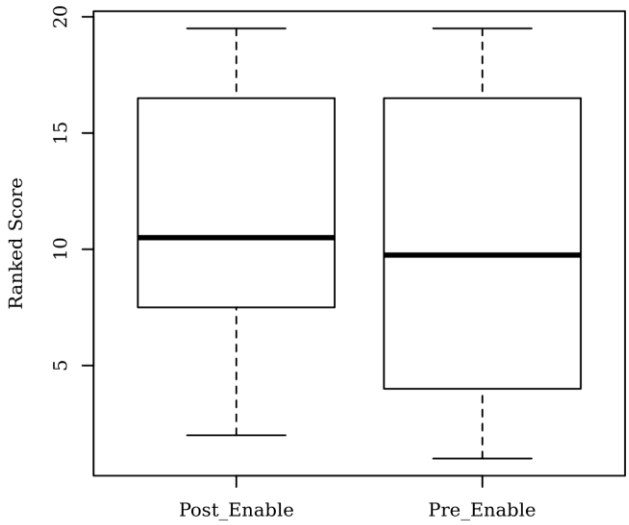

Figure 3. Ranked values of Pre-Enable and Post-Enable. A boxplot of the ranked values of Pre-Enable the Process and Post-Enable the Process.

Encourage the heart: Self-report pre- and post- analysis. A paired samples *t*-test was conducted to examine whether the difference between Pre-Encourage the Heart and Post-Encourage the Heart was significantly different from zero. Prior to the analysis, the assumptions of normality and homogeneity of variance were assessed. A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were not significant, $W = 0.86$, $p = .086$. This suggests that the deviations from normality are explainable by random chance; thus, normality can be assumed. Levene's test for equality of variance was used to assess whether the homogeneity of variance assumption was met (Levene, 1960). The homogeneity of variance assumption requires the variance of the dependent variable be approximately equal in each group. The result of Levene's test was not significant, $F(1, 18) = 2.26$, $p = .150$, indicating that the assumption of homogeneity of variance was met. The result of the paired samples *t*test was not significant, $t(9) = -1.47$, $p = .176$, suggesting that the true difference in the means of Pre-Encourage the heart and Post-Encourage the Heart was not significantly different from zero. Table 7 presents the results of the paired samples *t*-test.

Table 7

Paired Samples t-Test for the Difference between Pre-Encourage the Heart and Post-Encourage the Heart

Pre-Encourage the Heart		Post-Encourage the Heart				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
51.50	8.22	53.70	4.88	-1.47	.176	0.33

Note. Degrees of Freedom for the *t*-statistic = 9. *d* represents Cohen's *d*.

Short-term secondary project objectives.

Objective 1: LPI observer. The short-term secondary project objectives wanted to measure an increase in leadership skills using the LPI Observer, where mentors and mentees would score each other in the five exemplary practices of leadership. This yielded a response rate of three (*n*=3) participants. The responses were reported incorrectly by a mentor (*n*=1). The mentor evaluated three observers instead of the one observer – the mentee. The other observers (*n*=2) were responses from two mentees without mentor responses. Mentors did not take the time to complete the evaluation of the mentees even after reminder emails with screen shots of how to complete the Observer survey. Due to the poor response rate from participants the co-project leads excluded the data.

Objective 2: Mentor and mentee. The mentor and mentee paired responses illustrated that the summary statistics had a significant difference in the exemplary leadership practice of Inspire a Shared Vision in the LPI at the end of the program. The other four exemplary leadership practices of Model the Way, Challenge the Process, Enable Others to Act, and Encourage the Heart did not have statistically significant difference.

Objective 3: Leadership skills. The participants demonstrated action in leadership skills by stating 4 (Agree) or 5 (Strongly Agree) to questions in the Leadership Survey. Question number 25 “I am involved in Shared Governance in my organization,” and question number 26, “I have an intention on serving on a Board of Directors.” These questions were identified as expert questions. These leadership questions were asked in the beginning of the program (pre-) and again at the end of the program (post-). The results show no significant differences in the pre- or post- leadership survey measures for involvement shared governance or intention to serve on a board of directors.

Table 8 presents the summary statistics for both variables pre- and post-. For the shared governance item, means decreased between pre- and post- measures. For the intention to serve on a board directors item, means increased between pre- and post- measures. The data are not symmetrically distributed and were all negatively skewed. Concern arises when the skewness standard score is greater than ± 2. This is noted for both pre-involved in shared governance and post intention to serve on a board of director variables. The kurtosis standard scores are greater than ± 2, which indicates leptokurtic distribution for the same variables. This was confirmed by visual inspection of the histogram of the same data (see Figures 4 - 7).

Table 8

Summary Statistics for Pre and Post Shared Governance & Intention to Serve on Board

Variable		Pre-involved shared governance	Pre-intention serving Board Directors	Post-involved shared governance	Post-intention serving Board Directors
N	Valid	12	12	9	9
	Missing	0	0	3	3
Mean		4.17	4.50	3.89	4.89
Std. Error of Mean		.386	.195	.455	.111
Median		5.00	5.00	4.00	5.00
Mode		5	5	5	5
Std. Deviation		1.337	.674	1.364	.333
Variance		1.788	.455	1.861	.111
Skewness		-1.729	-1.068	-1.268	-3.000
Std. Error of Skewness		.637	.637	.717	.717
Skewness Standard Score		-2.714	-1.677	-1.768	-4.184
Kurtosis		2.177	.352	1.383	9.000
Std. Error of Kurtosis		1.232	1.232	1.400	1.400
Kurtosis Standard Score		1.767	0.256	0.988	6.428
Range		4	2	4	1
Minimum		1	3	1	4
Maximum		5	5	5	5

Figure 4. Bar Chart for Pre-Involved Shared Governance.

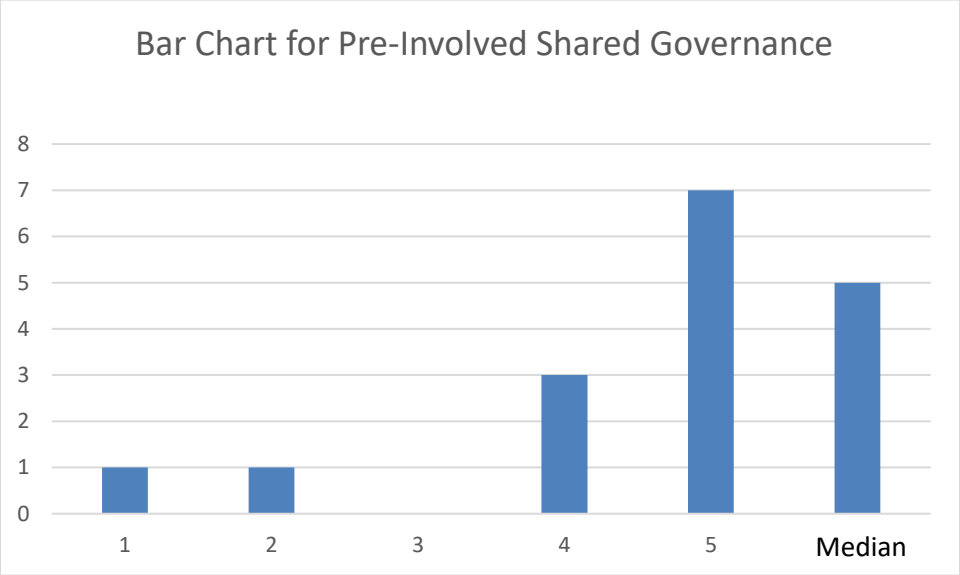

Figure 4. The Leadership pre-survey median score was five

Figure 5. Bar Chart for Post-Involved Shared Governance.

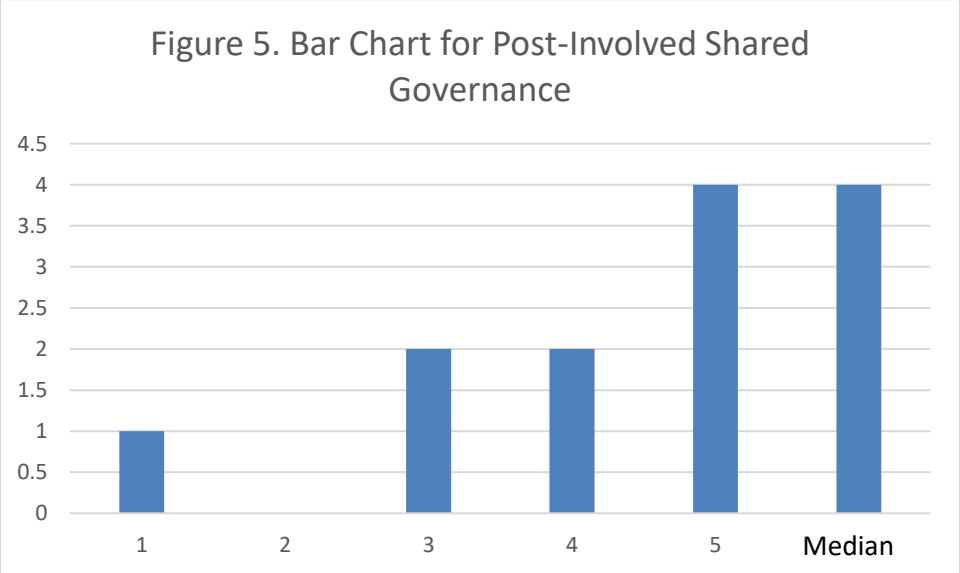

Figure 5. The Leadership post-survey median score was four.

Figure 6. Bar Chart for Pre-Intention of Serving on a Board of Directors.

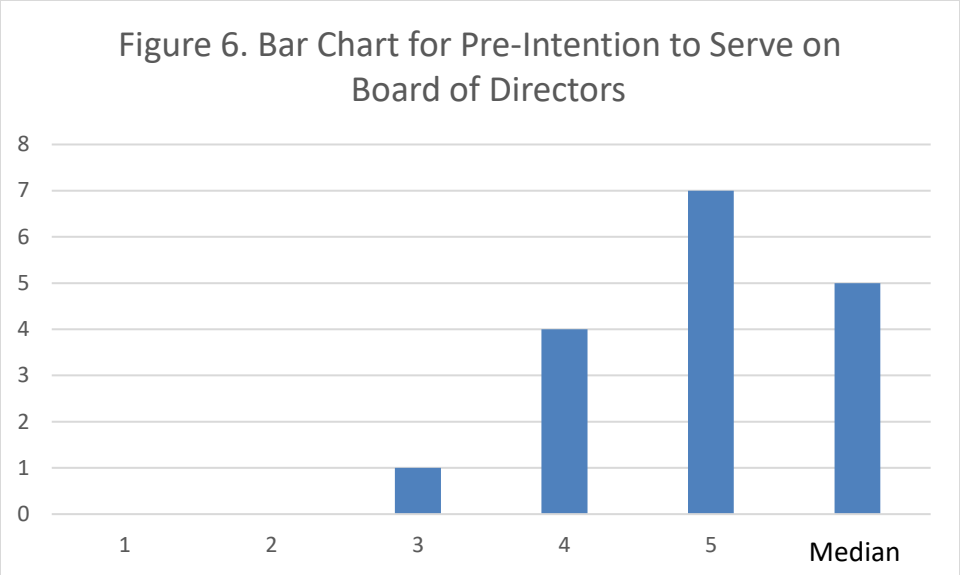

Figure 6. The Leadership pre-survey median score was five.

Figure 7. Bar Chart for Post-Intention to Serve on Board of Directors.

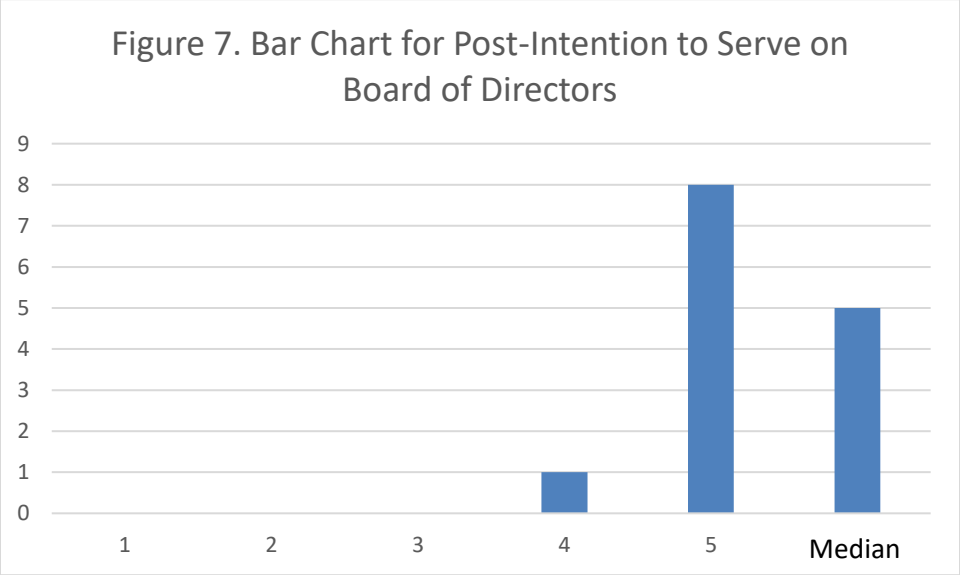

Figure 7. The Leadership post-survey median score was five.

Shared governance: Pre- and post- evaluation. Prior to the analysis of the pre and post Leadership Survey measure "I am involved in Shared Governance in my organization," the assumptions of normality and homogeneity of variance were assessed for Pre-Involved Shared Governance and Post-Involved Shared Governance. A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah,

2011). The results of the Shapiro-Wilk test were significant, $W = 0.78$, $p = .012$. This suggests that difference is unlikely to have been produced by a normal distribution; thus, normality cannot be assumed.

A Wilcoxon signed rank test was conducted to examine whether there was a significant difference between Pre-Involved Shared Governance and Post-Involved Shared Governance. The Wilcoxon signed rank test is a non-parametric alternative to the paired samples t-test and does not share its distributional assumptions (Conover & Iman, 1981). The results of the Wilcoxon signed rank test were not significant, $V = 4.00$, $z = -0.58$, $p = .564$. This indicates that the differences between Pre-Involved Shared Governance and Post-Involved Shared Governance are explainable by random variation. Figure 8 presents a boxplot of the ranked values of Pre-Involved Shared Governance and Post Involved Shared Governance.

Figure 8. Ranked Values of Pre-Involved Shared Governance and Post-Involved Shared Governance.

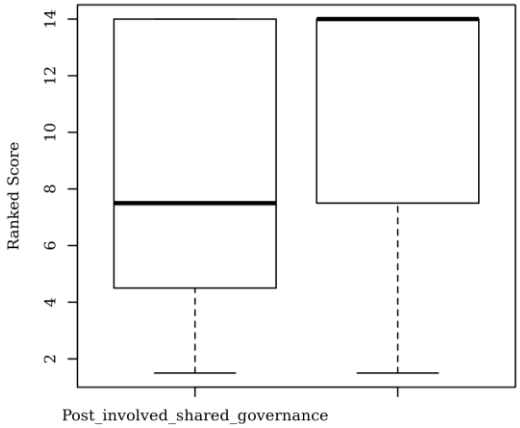

Figure 8. No statistical significance between pre- and post-.

Intention to serve on board of directors: Pre- and post- evaluation. Prior to the analysis of the pre- and post-Leadership Survey measure "I have an intention on serving on a Board of Directors," the assumptions of normality and homogeneity of variance were assessed. A Shapiro-Wilk test was conducted to determine whether difference could have been produced by a normal distribution (Razali & Wah, 2011). The results of the Shapiro-Wilk test were significant, $W =$

0.62, $p < .001$. This suggests that difference is unlikely to have been produced by a normal distribution; thus, normality cannot be assumed.

A Wilcoxon signed rank test was conducted to examine whether there was a significant difference between Pre-Intention Serving on Board of Directors and Post-Intention Serving on Board of Directors. The Wilcoxon signed rank test is a non-parametric alternative to the paired samples *t*-test and does not share its distributional assumptions (Conover & Iman, 1981). The results of the Wilcoxon signed rank test were not significant, $V = 0.00$, $z = -1.73$, $p = .083$. This indicates that the differences between Pre-Intention Serving on Board of Directors and Post Intention of Serving on Board of Directors are explainable by random variation. Figure 9 presents a boxplot of the ranked values of Pre-Intention Serving on Board of Directors and Post-Intention of Serving on Board of Directors.

Figure 9. Ranked values of Pre-Intention of Serving on Board of Directors and Post-Intention of Serving on Board of Directors.

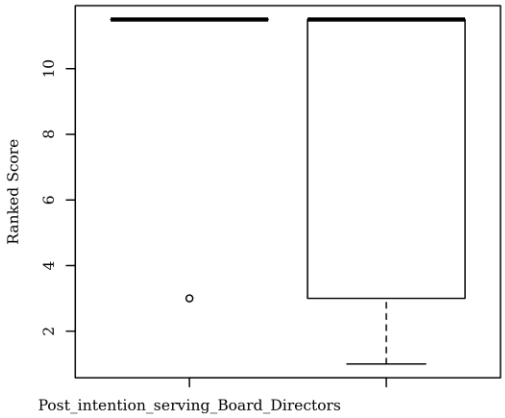

Figure 9. No statistical difference between pre- and post-.

Short-term tertiary project objectives.

Objective 1: Program satisfaction. The respondents discussed program recommendation, satisfaction, and an overall positive experience with the RNmentor2mentor program. In the Mentor Exit Survey, the program respondents self-reported program satisfaction with a response of 4 (Agree) or 5 (Strongly Agree) to question 12, "I would recommend this program." In the

Mentee Exit Survey, the program respondents self-reported satisfaction among the mentees with a response of 4 (Agree) or 5 (Strongly Agree) to question 7, “I would recommend this program.”

Table 9 represents frequencies and percentages that were calculated for “I would recommend this program.” The analysis also included participant’s responses in the areas of Satisfaction, Positive Experience, and Good Match split by Mentor or Mentee. The most frequently observed category of “I would recommend this program” was Yes, 100% (*n* = 7). For Mentor, the most frequently observed category of” I would recommend this program” was Yes, 100% (*n* = 4). For Mentee, the most frequently observed category of Satisfaction was No, 57% (n = 4). For Mentor, the most frequently observed category of Satisfaction was Yes, 100% (*n* = 4). For Mentee, the most frequently observed category of Positive Experience was Yes, 86% (*n* = 6). For Mentor, the most frequently observed category of Positive Experience was Yes, 100% (*n* = 4). For Mentee, the most frequently observed category of Good Match was Yes, 86% (*n* = 6). For Mentor, the most frequently observed category of Good Match was Yes, 100% (*n* = 4).

Table 9

Frequency Table for Nominal Variables

Variable	Mentee	Mentor
I_would_recommend_this_program		
Yes	7 (100%)	4 (100%)
Satisfaction		
No	4 (57%)	0 (0%)
Yes	3 (43%)	4 (100%)
Positive_Experience		
No	1 (14%)	0 (0%)
Yes	6 (86%)	4 (100%)
Good_Match		
No	1 (14%)	0 (0%)
Yes	6 (86%)	4 (100%)

Note. Due to rounding errors, column wise percentages may not equal 100%.

Objective 2: Success and challenges in program. The mentors' and mentees responded to the question "List three challenges you have encountered in the mentoring program." The most common responses were the themes of time, time constraints, busy schedules, and distance. Utilization of alternate ways to meet did not decrease the barrier of time. This response may indicate future implications of discussing barriers to an alternate format of meetings. Some participants may not have been comfortable using technology as a way to form a relationship. The literature finds time as the greatest challenge and barrier. Time was a barrier in this project. The use of face-to-face meetings (n=9); virtual meetings (n=5); written meetings (n=18); and phone meetings (n=4) supported that a variety of meeting options were used to eliminate the face-to-face barrier that demands the most time. The responses discussed that while distance was the most commonly reported challenge, the program participants were not all comfortable with a virtual or phone mentoring option.

Other results gathered through the program exit survey included "List three challenges you have encountered in the mentoring program." The most common response from mentors

(*n*=4) and mentees (*n*=6) were time, distance, and the holiday season. The mentors and mentees responded to the impossibility of meeting in the months of December 2017 and January 2018, due to the holiday season. The mentor survey asked, "List three successes you see with the mentoring program," the only response (*n*=1) was, "New colleague, coaching for job success, refresh on learning materials." However, the mentee exit survey (*n*=6) listed many successes to the RNmentor2mentor program. Mentee A: "I was able to do some self-reflection; I was able to narrow down goals for a vision I am working on; this program, and the thought of working with another nurse that had the same vision as me and helped motivate me to work on areas on my own since the mentor was not engaging with me." Mentee B: "It was great meeting my mentor at the conference and we seemed to connect, and both seem excited about our future meetings; I enjoyed reading through the modules and filling out the worksheets for my personal growth. I like being a part of this pilot to help determine the challenges of successful mentoring program." Mentee C: "Development of a friendship with my mentor. Growth in my current role specifically related to communication. Information that will be useful for my students." Mentee D: "networking, growth, professional development." Mentee E: "I was able to review my vision and help narrow down the vision that I shared with the Mentor. She never fully shared her vision with me: but we both actually seemed to have the same vision." Mentee F: "Modules were informative, organized framework to follow through the website and gained insight regarding leadership from the modules."

Discussion Project Outcomes

Primary Project Outcome

The short-term primary project objective (LPI) was to increase leadership skills after participating in an evidence based RNmentor2mentor mentoring program as measured by the LPI at the end of the program. Pre- and post- LPI survey results indicated that there was a significant difference between pre- and post- scores of Inspire a Shared Vision. Explained by the LPI Post Assessment Group Report were key points for discussion. The report discussed the group's top five most frequent practices and the bottom five most frequent practices. The top five most frequent practices supported by this group were the practices of Enable Others to Act in questions "14. Treats people with dignity and respect" and "9. Actively listens to diverse points of view." Challenge the Process in question "13. Actively searches for innovative ways to improve what we do." Model the Way in questions "11. Follows through on promises and commitments he/she/makes" and "1. Set a personal example of what he/she expects of others."

In comparison, the least five frequent practices that were not supported were to Inspire a Shared Vision questions "17. Shows others how their long-term interests can be realized by enlisting in a common vision;" "7. Describes a compelling image of what our future could be like;" and "2. Talks about future trends that will influence how our work gets done." Model the Way in question "21. Builds consensus around a common set of values for running our organization." Encourage the Heart in question "10. Makes it a point to let people know about his/her confidence in their abilities." The least frequent practices attributed to the support in the project that Inspire a Shared Vision is an important and least frequent practice needed in nursing to allow nurses to act on developing leadership skills that will lead volunteering for board

positions. There were no significant differences between the pre-and post-scores of the practices of Model the Way, Challenge the Process, Enable Others to Act, and Encourage the Heart.

Secondary Project Outcome

There were three secondary project objectives in this project. The first, secondary project objective was to measure LPI Observer as a secondary score. The participants did not complete the LPI Observer survey on each other. Due to the poor response (n=3) where a mentor responded to three different mentees and only two mentees responded, the data was excluded by the co-project leads. Directions to participants included screen shots of how to complete the LPI Observer. Mentors did not take the time to evaluate the mentees. The LPI/Observer was cumbersome to use. The mentor or mentee had to email the participant in order for the instrument to be completed. This additional step of emailing the mentor and mentee was not completed. By the end of the project, interest was lost and survey fatigue may be an issue that led to the low response rate.

The second, secondary project objective was to summarize any significance between the mentor or mentee scores for those participating in the pre- and post- LPI. There was no significant difference in mentor/mentee scores for those participating in between pre- and post-LPI at the end of the program. These results may be due to the time constraints for relationship building at the onset of the project.

The final secondary project objective summarized participants demonstrated action in leadership skills by stating 4 (Agree) or 5 (Strongly Agree) to questions in leadership survey question 25, “I am involved in Shared Governance in my organization” and questions 26, “I have an intention on serving on a Board of Directors” in either pre- or post- leadership survey at the end of the program. There was no significant difference in the pre- or post- leadership survey for

involvement in shared governance or intention to serve on a board of directors at the end of the program. The means for Post-Involved Shared Governance decreased as compared to the pre-. The Post-Intention Serving on Board of Directors increased as compared to the post- (Table 7).

Tertiary Project Outcome

The tertiary project objective summarized the RNmentor2mentor program. The program satisfaction ranking 4 (Agree) or 5 (Strongly Agree) to question 12, "I would recommend this program" in the Mentor Exit Survey and self-reported satisfaction 4 (Agree) or 5 (Strongly Agree) to question 7, "I would recommend this program" in the Mentee Exit Survey at the end of the program; a total (*n*=11), mentee (*n*=7) and mentor (*n*=4), or Yes, 100% to recommending the program. Program satisfaction was summarized by the mentor and mentee exit questions or mentee, the most frequently observed category of Positive Experience was Yes, 86% (*n* = 6). For mentor, the most frequently observed category of Positive Experience was Yes, 100% (*n* = 4). For mentee, the most frequently observed category of Good Match was Yes, 86% (*n* = 6). For mentor, the most frequently observed category of Good Match was Yes, 100% (*n* = 4). One respondent in Positive Experience and Good Match was No 14% (*n*=1) as there was one mentor that "lost interest" described as a challenge in the written part of the mentee exit survey. Responses included that the "course materials were elementary and not clear when to use them;" and "landing on specifics for mentee's focus" supported the limitation that the orientation period must be longer and more in-depth. The mentees' responded to the questions regarding time as the major barrier to the relationship. "Never could connect;" "Busy schedules." The modules were completed by the participants as directed in the orientation period of the implementation.

Discussion of Findings

The results indicated that the summary statistics for an increase in the LPI pre- and post- were statistically significant for the practice of Inspire a Shared Vision. The LPI pre- and post- was not statistically significant in the practices of Model the Way, Challenge the Process, Enable Others to Act, and Encourage the Heart. This supports the Group Assessment Report where the three of the five least frequent practices are Inspire a Shared Vision. The statistical implications of the low sample size may have been a factor in the results. The increase in the exemplary leadership practices aligns with the published validity and reliability of the LPI instrument (Posner, 2016). Other key elements for discussion include mitigating time commitment through refinement of an online virtual format, addressing the diversity of participants, and addressing supporting a trust relationship.

Additional time needs to be added for the development of a trust relationship. Additional conference time to network and review of goals prior to leaving the conference may add trust. The initial face-to-face meeting at orientation, built trust, but the period was too short. Participants wanted more time to set goals and get to know one another. Hudson (2016) in a grounded-theory design study of over 200 teachers involved in a mentoring program found that mentoring relationships are complex interactions and a guided approach is imperative. The forming of productive, positive relationships in the pilot study identified that mentors and mentees had increased leadership skills at the end of the intervention. Therefore, using Hudson's (2016) model, (Figure 1, used with permission from the author) for forming the mentor-mentee relationship, and focusing on the respect and trust elements of the close relationship, recommendations include spending more time on the Orientation Modules Section 2: Keys to a Successful Mentoring Relationship and Section 3: Overview/Getting Started. This virtual

program would replace the “speed meeting” portion of the face-to-face orientation and increase the success of a mentoring program that is not hindered by geographical location.

The module Section 5: Understanding Self and Others focus is to help mentees understand themselves and to grow in their role as a nurse. The Inspire a Shared Vision content focus increases self-awareness for the mentees. The content discussed to improve self-awareness and become engaged in understanding of self and others in order to prepare nurses to lead in a positive manner. The data analysis demonstrated significance with this module, recommendation to further develop the module for future implementation

Figure 10. Model for forming the mentor-mentee relationship (Hudson, 2016).

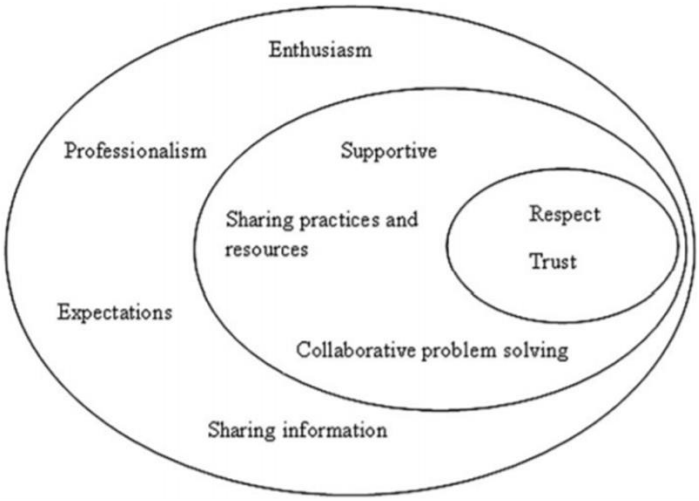

Figure 10. Model for forming the mentor-mentee relationship (Hudson, 2016). Respect and trust as important elements of a relationship.

This virtual meeting place can not only provide orientation information but can also be a location where the mentee can locate an alternate mentor if the relationship is not positive or time elements are becoming a barrier. In addition, a program coordinator should review feedback monthly that includes a question such as “How would you improve the program for this month?” so that real time quality improvement can occur and resolve issues on a continuous basis.

The quality of the participants was very educated individuals. Six mentors with DNP degrees. Mentees were divided with three MSN and three DNP degrees. The pilot may have yielded better results from a more diverse representation. Capturing BSN nurses through an emerging nurse program would add diversity to the program. The pilot project did not limit the BSN nurse from participation. The responses of interest in the leadership-mentoring project did not include interest responses from BSN nurses. The least number of years as an RN was 16 years of practice. The pilot project did not include representation from nurses moving from the 12 to 18 months of residency practice to the mentoring phase of the career continuum of a nurse (Jakubik, Weese, Eliades, & Huth, 2017). The possibility of an emerging nurse focus for the program may encourage a more diverse participation.

The use of face-to-face meeting (*n*=9); virtual meetings (*n*=5); written meetings (*n*=18); and phone meetings (*n*=4) supported that a variety of meeting options were used to eliminate the face-to-face barrier that demands the most time. The mentors and mentees responded to the impossibility of meeting in the months of December and January due to the holiday season was another common theme. Therefore, increasing the participation in the program to 9 or 12 months would support the literature regarding optimal length of time to foster a trusting mentoring relationship.

Table 10 illustrated the average number of meeting per month. The respondents met, on average, once per month. Monthly responses were the lowest for November (*n*=3) with an average of 1.14 meetings. December (*n*=9) responses averaged 1.62 meetings. January (*n*=9) responses averaged 1.62 meetings. All participants (*n*=12) met in October at orientation. However (*n*=8) responded to the monthly October survey.

Table 10

Summary Statistics Table for Interval and Ratio Variables Split by Month

Variable	M	SD	n	SE_M	Skewness	Kurtosis
Number of Meetings						
December	1.62	0.74	8	0.26	0.66	-0.74
January	1.62	1.06	8	0.37	1.57	1.21
November	1.14	0.69	7	0.26	-0.13	-0.61
October	1.17	0.41	6	0.17	1.79	1.20

Note. '-' denotes the sample size is too small to calculate statistic.

There were key points for discussion in the Post Assessment Group Report. This LPI report discussed the group's top five most frequent practices and the bottom five most frequent practices. The top five most frequent practices supported by this group were the practices of Enable Others to Act in questions "14. Treats people with dignity and respect" and "9. Actively listens to diverse points of view." Challenge the Process in question "13. Actively searches for innovative ways to improve what we do." Model the Way in questions "11. Follows through on promises and commitments he/she/makes" and "1. Set a personal example of what he/she expects of others."

In comparison, the least five frequent practices that were not supported were to Inspire a Shared Vision questions "17. Shows others how their long-term interests can be realized by enlisting in a common vision;" "7. Describes a compelling image of what our future could be like;" and "2. Talks about future trends that will influence how our work gets done." Model the Way in question "21. Builds consensus around a common set of values for running our organization." Encourage the Heart in question "10. Makes it a point to let people know about

his/her confidence in their abilities." The least frequent practices attributed to the support in the project that Inspire a Shared Vision is an important and least frequent practice needed in nursing to allow nurses to act on developing leadership skills that will lead volunteering for board positions.

Identification of Limitation

The conference registrants that expressed interest in participation in the mentoring project received details regarding the time commitment of the project and the scheduled times for the training while at the conference. The pilot project sessions were conducted during conference breaks, when there were no continuing education sessions. The scheduled training sessions were not conductive to inclusion of all the interested participants. The limited training times contributed to the small sample size of the pilot project. The pilot project was initiated at the annual conference in October and completed the end of January. The four-month implementation process was challenging to develop relationships. The time constraint of the pilot project presented with limitations with the number of required modules to complete during the holiday season. Mentor and mentee determined the meeting format. With geographical challenges the online resources and format was encouraged. Despite the access to technology as a format, the participants expressed challenges with time commitment for meetings to complete the modules.

The small sample size of twelve (n=12) was a limitation to the project. The highly educated professionals in the study, all Master and doctoral professionals, without representation from BSN nurses, was not representative of nursing. In Benner's theory of novice to expert, most of the sample was expert nurses with intuitive understanding of a situation and broad perspectives for learning something new. The range of nursing experience was 16-30 years as an RN. The participants were between the ages of 40-69 years old, there was no participant under

the age of 40 years. Another limitation was that the sample was female. Only female nurses were represented in the project. The limitation of mentors taking disinterest in the program as the months progressed left the mentee feeling unsupported and disappointed in the relationship.

Recommendations

The nurse-to-nurse mentoring project was a convenience sample drawn from the statewide Michigan Center for Nursing annual conference the Nursing Summit. The limited pilot project was successful in identifying areas for improvement. The expansion of the pilot project to a mentoring program will need to include several changes for successful implementation. The pilot project had limits including the participant's educational level. The mentors all had terminal degrees of the DNP. The mentees had MSN degrees. The recommendation is to expand the participants to include BSN nurses as participants for mentees; MSN nurses could participate as mentors. Module development would be progressive. Three separate modules for each level of degree, BSN, MSN, and DNP. The mentee selection was completed in a speed matching system, which provided a brief introduction by the mentor to share their expertise. Research conducted by Lantham, Singh, and Ringl (2016), supported the mentee selection process with an online profile format of the mentor displayed on the webpage. The online format would provide time for the mentee to review more in-depth the profile of the mentor and availability to contact the mentor to discuss specific areas of interest and discuss the availability of the mentor to commit to the desired period. In this era of technology, the development of an RNmentor2mentor application to connect nurses with messaging, friends, and profiles could be beneficial. Social media connection is natural to novice nurses. The application could be a gateway to mentoring for novice nurses beginning a nursing career.

The length of the pilot project was challenging with two modules per month to complete

coupled with the limited four-month process with two months with holidays (Thanksgiving and Christmas breaks). The quantity of modules per month can affect the participants follow through. The recommendation to recommend a 12-month mentoring period with up to 10 modules to be completed, which would provide flexibility for participants schedules. The pilot project monthly feedback clearly had more responses from the mentees than the mentors did. The recommendation for the expansion of the pilot project would include a commitment by the mentors and mentees for the designated period for the mentoring process to be beneficial for the mentee. If the mentor is unable to fulfill the responsibility, then the online profile to choose another mentor would be an alternative for the mentee rather than not continuing in the program.

The time constraints with the pilot project launch limited relationship building opportunities. Expanding the training process for the mentoring project from a partial day to the dedication of a full day of training for both the mentor and mentees to build trust is important. The expanded training would provide more in-depth training on use of the modules. The training day would also discuss format, commitment and exit strategies if needed. The daylong event would provide more opportunity for the mentor and mentee to become more acquainted and promote the building of trust.

The finding included that participants developed friendships with the mentoring dyad. These findings support future research to be conducted with inclusion of a social support theory as a component within this framework. The addition of a social support theory, relationship, or self-efficacy theory that complements the trust model should be considered.

The focus of Section 5: Understanding Self and Others to promote the exemplary practice of Inspire a Shared Vision is important. The three least frequent responses in the LPI Group Report for Inspire a Shared Vision were “17. Shows others how their long-term interest can be

realized by enlisting in a common vision;" "7. Describes a compelling image of what our future could be like;" and "2. Talks about future trends that will influence how our work gets done." The focus on these areas of the modules are important to promote a vision in the future of nursing and the development of leadership skills.

Revising the Leadership Survey question "I am involved in shared governance in my organization" to a more general question exploring leadership involvement should be considered. Shared governance is specific to clinical areas. Nursing leadership is displayed in a variety of forms throughout the continuum of a nurse. A broad term to identify types of leadership is important if using this instrument in future applications.

The data from the LPI/Observer would be recommended to review as the Observer analyzes the responses reciprocally of the mentoring dyad. The dyad requests that each other's behavior is scored by the LPI/Observer. In this project, due to poor response, the results were excluded. The individual mentors did not take the time to complete the evaluation of the mentees even after reminder emails with screen shots of how to complete the LPI/Observer survey. The recommendation would be to use a follow-up phone call with this online survey in order to remind the participants to fill out the survey or take the responses over the phone. This would ensure proper collection of the survey response.

Implications for Practice

The aging workforce has pressed the need for leadership development among our nurses. The baby boomer generation brings healthcare challenges with increasing number of long-term care needs coupled with the retirement of nurses. The need for nurses to provide bedside care was one facet to the pressing need, and the need for leadership development to be a leader in the direction for healthcare services continues to be imperative. Nurses serving on boards were a

means to provide necessary information for decision makers. The development of nursing mentoring programs was vital to the leadership development of the nursing profession.

The pilot project identified that even though the participants were highly qualified, the lack of time remains a barrier to successful completion of a mentoring program. The need for implementation of a mentoring program was essential. The professional development of our future leaders will need dedicated time allowances in the workplace for mentoring.

Dissemination of Results

The MCN/MHC collaborated with the Co-Leads in the completion of the mentoring project. The project leads have met with the agency representatives for dissemination of results and review of the recommendations for expansion of the pilot project into a program resource for the Michigan Center for Nursing. The dissemination of results included the pilot project outcomes at the annual statewide nursing summit conference in the Fall, 2018. The co-project leads will be presenting the pilot project, outcomes and recommendations for expansion of the project during the conference session. A poster presentation will also be available for the attendees to observe at the conference during the scheduled breaks.

The project paper will be submitted to the Virginia Henderson Global Nursing e-repository (2017). The Henderson Repository was designed as a free online resource of the International Honor Society of Nursing, Sigma Theta Tau International (STTI). The submission of publications has not been limited to STTI members. The repository has been designed to share the work of unpublished and published items from nurses. The authors retain the copyright to their work. The authors are required to submit publication for the peer-reviewed process. The free online resource has created a platform for sharing of information from conference presentations to scholarly final projects at the graduate levels in nursing. The primary author

must be a nurse from an accredited school of nursing program with the accreditation from either the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). The Virginia Henderson Global Nursing e-Repository access point (http://www.nursinglibrary.org/) has provided a broad base of nursing knowledge that is accessible without membership and fees to promote global education for the nursing profession.

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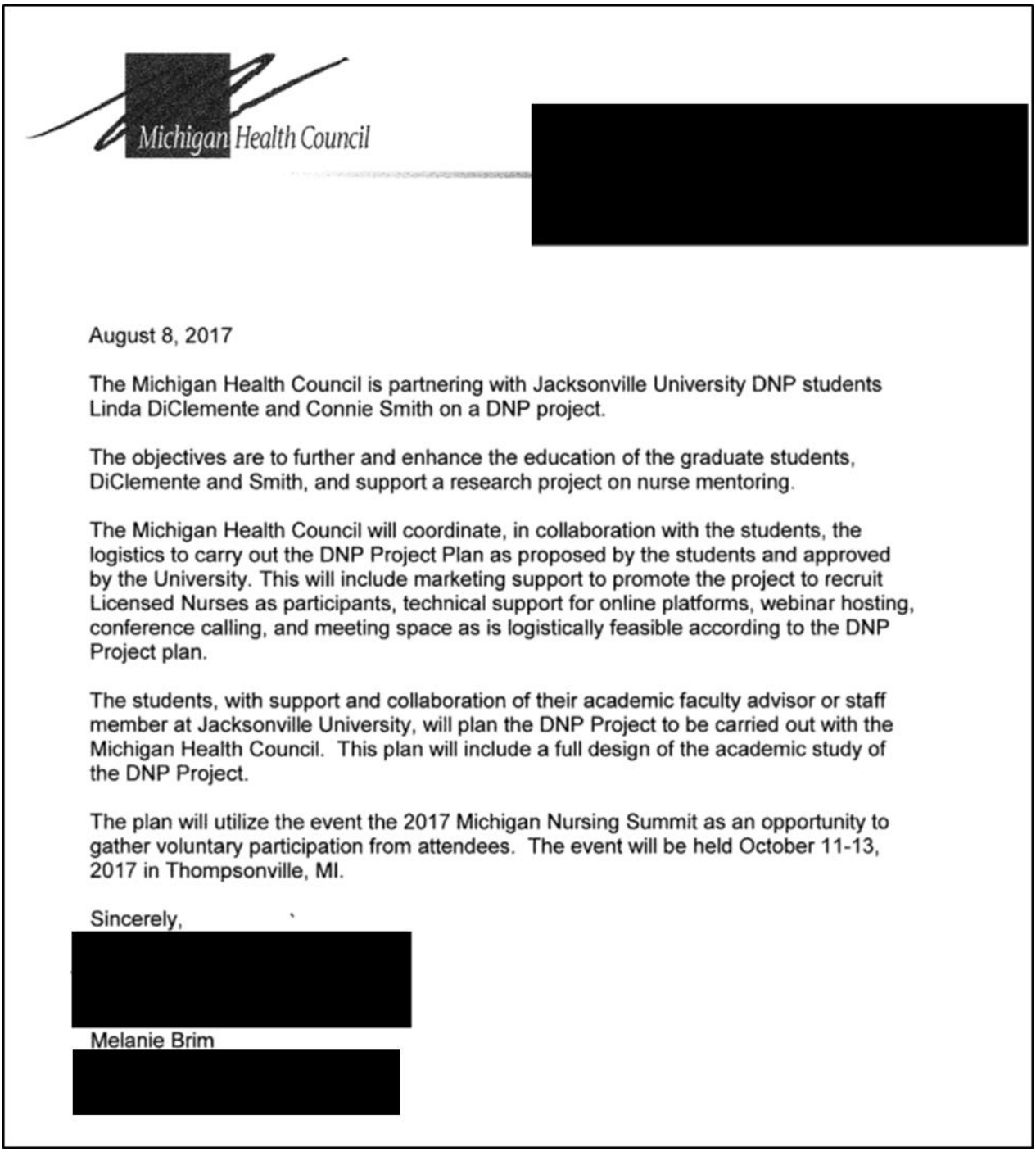
Appendix A

Letter of Agreement for Collaboration



Michigan Health Council

[redacted]

August 8, 2017

The Michigan Health Council is partnering with Jacksonville University DNP students Linda DiClemente and Connie Smith on a DNP project.

The objectives are to further and enhance the education of the graduate students, DiClemente and Smith, and support a research project on nurse mentoring.

The Michigan Health Council will coordinate, in collaboration with the students, the logistics to carry out the DNP Project Plan as proposed by the students and approved by the University. This will include marketing support to promote the project to recruit Licensed Nurses as participants, technical support for online platforms, webinar hosting, conference calling, and meeting space as is logistically feasible according to the DNP Project plan.

The students, with support and collaboration of their academic faculty advisor or staff member at Jacksonville University, will plan the DNP Project to be carried out with the Michigan Health Council. This plan will include a full design of the academic study of the DNP Project.

The plan will utilize the event the 2017 Michigan Nursing Summit as an opportunity to gather voluntary participation from attendees. The event will be held October 11-13, 2017 in Thompsonville, MI.

Sincerely,

[redacted]

Melanie Brim

[redacted]

Appendix B1

Leadership Practice Inventory Instrument – Model the Way

LPI

Leadership Practices Inventory

Profile for Sample Leader
Sample Organization
December 22, 2003

The rating scale runs from 1 to 10

1 - Almost Never	6 - Sometimes
2 - Rarely	7 - Fairly Often
3 - Seldom	8 - Usually
4 - Once in a While	9 - Very Frequently
5 - Occasionally	10 - Almost Always

Model the Way Data Summary

- *Find your voice by clarifying your personal values*
- *Set the example by aligning actions with shared values*

This page shows the scores for each of the six leadership behaviors related to this Practice. The Self column shows the scores you gave yourself for each behavior. The AVG column shows the averages of all the Observers' ratings. The Individual Observers columns show each Observer's rating for each behavioral item. Scores can range from 1 to 10.

Manager Direct Report Co-Worker Other
AVG Average of all LPI Observer Ratings

		Self	AVG	Individual Observers					
				M	C1	C2	D1	D2	O1
26.	Is clear about his/her philosophy of leadership	4	7.5	6	8	6	10	8	7
16.	Asks for feedback on how his/her actions affect people's performance	6	7.0	3	7	7	7	9	9
6.	Makes certain that people adhere to agreed-on standards	8	6.5	9	6	2	7	9	6
21.	Builds consensus around organization's values	7	5.3	4	8	5	6	1	8
1.	Sets a personal example of what is expected	6	5.2	4	4	4	8	3	8
11.	Follows through on promises and commitments	8	4.5	4	2	1	10	2	8

Appendix B2

Leadership Practice Inventory Instrument – Inspire a Shared Vision

LPI

Leadership Practices Inventory

Profile for Sample Leader
Sample Organization
December 22, 2003

The rating scale runs from 1 to 10

1 - Almost Never	6 - Sometimes
2 - Rarely	7 - Fairly Often
3 - Seldom	8 - Usually
4 - Once in a While	9 - Very Frequently
5 - Occasionally	10 - Almost Always

Inspire a Shared Vision Data Summary

- *Envision the future by imagining exciting and ennobling possibilities*
- *Enlist others in a common vision by appealing to shared aspirations*

This page shows the scores for each of the six leadership behaviors related to this Practice. The Self column shows the scores you gave yourself for each behavior. The AVG column shows the averages of all the Observers' ratings. The Individual Observers columns show each Observer's rating for each behavioral item. Scores can range from 1 to 10.

Manager Direct Report Co-Worker Other
AVG Average of all LPI Observer Ratings

		Self	AVG	Individual Observers					
				M	C1	C2	D1	D2	O1
17.	Shows others how their interests can be realized	5	8.3	9	9	6	8	8	10
27.	Speaks with conviction about meaning of work	5	7.3	8	6	9	9	3	9
12.	Appeals to others to share dream of the future	2	6.5	5	9	4	9	4	8
7.	Describes a compelling image of the future	7	6.3	4	5	8	7	7	7
22.	Paints "big picture" of group aspirations	5	5.8	3	9	8	7	4	4
2.	Talks about future trends influencing our work	7	5.3	4	8	3	5	4	8

Appendix B3

Leadership Practice Inventory Instrument – Challenge the Process

LPI

Profile for Sample Leader
Sample Organization
December 22, 2003

Leadership Practices Inventory

The rating scale runs from 1 to 10
1 - Almost Never
2 - Rarely
3 - Seldom
4 - Once in a While
5 - Occasionally
6 - Sometimes
7 - Fairly Often
8 - Usually
9 - Very Frequently
10 - Almost Always

Challenge the Process Data Summary

- *Search for opportunities by seeking innovative ways to change, grow, and improve*
- *Experiment and take risks by constantly generating small wins and learning from mistakes*

This page shows the scores for each of the six leadership behaviors related to this Practice. The Self column shows the scores you gave yourself for each behavior. The AVG column shows the averages of all the Observers' ratings. The Individual Observers columns show each Observer's rating for each behavioral item. Scores can range from 1 to 10.

Manager Direct Report Co-Worker Other
AVG Average of all LPI Observer Ratings

		Self	*AVG*	*Individual Observers*					
				M	*C1*	*C2*	*D1*	*D2*	*O1*
13.	Searches outside organization for innovative ways to improve	4	7.8	6	10	8	9	7	7
3.	Seeks challenging opportunities to test skills	4	7.5	7	9	8	7	7	7
18.	Asks "What can we learn?"	8	7.3	8	9	8	7	6	6
23.	Makes certain that goals, plans, and milestones are set	4	7.0	7	10	7	8	3	7
28.	Experiments and takes risks	6	7.0	9	8	3	8	8	6
8.	Challenges people to try new approaches	4	5.8	3	10	4	7	4	7

Appendix B4

Leadership Practice Inventory Instrument – Encourage the Heart

LPI

Profile for Sample Leader
Sample Organization
December 22, 2003

Leadership Practices Inventory

The rating scale runs from 1 to 10

1 - Almost Never	6 - Sometimes
2 - Rarely	7 - Fairly Often
3 - Seldom	8 - Usually
4 - Once in a While	9 - Very Frequently
5 - Occasionally	10 - Almost Always

Encourage the Heart Data Summary

- *Recognize contributions by showing appreciation for individual excellence*
- *Celebrate the values and victories by creating a spirit of community*

This page shows the scores for each of the six leadership behaviors related to this Practice. The Self column shows the scores you gave yourself for each behavior. The AVG column shows the averages of all the Observers' ratings. The Individual Observers columns show each Observer's rating for each behavioral item. Scores can range from 1 to 10.

Manager Direct Report Co-Worker Other
AVG Average of all LPI Observer Ratings

		Self	***AVG***	***Individual Observers***					
				M	*C1*	*C2*	*D1*	*D2*	*O1*
30.	Gives team members appreciation and support	4	7.5	8	9	7	7	6	8
20.	Recognizes people for commitment to shared values	9	7.2	6	9	7	9	4	8
15.	Creatively rewards people for their contributions	4	6.8	4	10	8	7	3	9
10.	Expresses confidence in people's abilities	5	6.2	2	9	4	9	6	7
5.	Praises people for a job well done	9	6.0	4	9	3	7	4	9
25.	Finds ways to celebrate accomplishments	7	5.8	6	9	4	5	4	7

Appendix B5

Leadership Practice Inventory Instrument – Enable Others to Act

LPI

Leadership Practices Inventory

Profile for Sample Leader
Sample Organization
December 22, 2003

The rating scale runs from 1 to 10

1 - Almost Never	6 - Sometimes
2 - Rarely	7 - Fairly Often
3 - Seldom	8 - Usually
4 - Once in a While	9 - Very Frequently
5 - Occasionally	10 - Almost Always

Enable Others to Act Data Summary

- *Foster collaboration by promoting cooperative goals and building trust*
- *Strengthen others by sharing power and discretion*

This page shows the scores for each of the six leadership behaviors related to this Practice. The Self column shows the scores you gave yourself for each behavior. The AVG column shows the averages of all the Observers' ratings. The Individual Observers columns show each Observer's rating for each behavioral item. Scores can range from 1 to 10.

Manager Direct Report Co-Worker Other
AVG Average of all LPI Observer Ratings

		Self	AVG	Individual Observers					
				M	C1	C2	D1	D2	O1
9.	Actively listens to diverse points of view	4	7.7	8	8	8	8	5	9
14.	Treats people with dignity and respect	5	7.5	9	8	9	6	8	5
19.	Supports decisions other people make	4	7.2	4	7	9	8	7	8
4.	Develops cooperative relationships	8	6.8	8	10	4	4	8	7
29.	Ensures that people grow in their jobs	7	6.5	4	8	8	7	4	8
24.	Gives people choice about how to do their work	6	6.3	8	7	3	7	6	7

Appendix B6

LPI Permission Letter – Linda Macera-DiClemente

WILEY

July 20, 2017

Linda Macera-DiClemente
[redacted]

Dear Ms. Macera-DiClemente:

Thank you for your request to use the LPI®: Leadership Practices Inventory® in your research. This letter grants you permission to use either the print or electronic LPI [Self/Observer/Self and Observer] instrument[s] in your research. You may ***reproduce*** the instrument in printed form at no charge beyond the discounted one-time cost of purchasing a single copy; however, you may not distribute any photocopies except for specific research purposes. If you prefer to use the electronic distribution of the LPI you will need to separately contact Joshua Carter (jocarter@wiley.com) directly for further details regarding product access and payment. Please be sure to review the product information resources before reaching out with pricing questions.

Permission to use either the written or electronic versions is contingent upon the following:

(1) The LPI may be used only for research purposes and may not be sold or used in conjunction with any compensated activities;
(2) Copyright in the LPI, and all derivative works based on the LPI, is retained by James M. Kouzes and Barry Z. Posner. The following copyright statement must be included on all reproduced copies of the instrument(s); "Copyright © 2013 James M. Kouzes and Barry Z. Posner. Published by John Wiley & Sons, Inc. All rights reserved. Used with permission";
(3) One (1) **electronic** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data must be sent **promptly** to my attention at the address below; and,
(4) We have the right to include the results of your research in publication, promotion, distribution and sale of the LPI and all related products.

Permission is limited to the rights granted in this letter and does not include the right to grant others permission to reproduce the instrument(s) except for versions made by nonprofit organizations for visually or physically handicapped persons. No additions or changes may be made without our prior written consent. You understand that your use of the LPI shall in no way place the LPI in the public domain or in any way compromise our copyright in the LPI. This license is nontransferable. We reserve the right to revoke this permission at any time, effective upon written notice to you, in the event we conclude, in our reasonable judgment, that your use of the LPI is compromising our proprietary rights in the LPI.

Best wishes for every success with your research project.

Cordially,

[redacted]

Ellen Peterson
Permissions Editor
[redacted]

[redacted]

Appendix B7

LPI Permission Letter – Connie Smith

WILEY

July 20, 2017

Connie Smith
[redacted]

Dear Ms. Smith:

Thank you for your request to use the LPI®: Leadership Practices Inventory® in your research. This letter grants you permission to use either the print or electronic LPI [Self/Observer/Self and Observer] instrument[s] in your research. You may ***reproduce*** the instrument in printed form at no charge beyond the discounted one-time cost of purchasing a single copy; however, you may not distribute any photocopies except for specific research purposes. If you prefer to use the electronic distribution of the LPI you will need to separately contact Joshua Carter (jocarter@wiley.com) directly for further details regarding product access and payment. Please be sure to review the product information resources before reaching out with pricing questions.

Permission to use either the written or electronic versions is contingent upon the following:

(1) The LPI may be used only for research purposes and may not be sold or used in conjunction with any compensated activities;
(2) Copyright in the LPI, and all derivative works based on the LPI, is retained by James M. Kouzes and Barry Z. Posner. The following copyright statement must be included on all reproduced copies of the instrument(s); "Copyright © 2013 James M. Kouzes and Barry Z. Posner. Published by John Wiley & Sons, Inc. All rights reserved. Used with permission";
(3) One (1) **electronic** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data must be sent **promptly** to my attention at the address below; and,
(4) We have the right to include the results of your research in publication, promotion, distribution and sale of the LPI and all related products.

Permission is limited to the rights granted in this letter and does not include the right to grant others permission to reproduce the instrument(s) except for versions made by nonprofit organizations for visually or physically handicapped persons. No additions or changes may be made without our prior written consent. You understand that your use of the LPI shall in no way place the LPI in the public domain or in any way compromise our copyright in the LPI. This license is nontransferable. We reserve the right to revoke this permission at any time, effective upon written notice to you, in the event we conclude, in our reasonable judgment, that your use of the LPI is compromising our proprietary rights in the LPI.

Best wishes for every success with your research project.

Cordially,

[redacted]

Ellen Peterson
[redacted]

[redacted]
www.wiley.com

Appendix C

Email to Participants

Thank you for your interest in the Mentoring Pilot project to be launched at the annual Nursing Summit Conference. The project is a partnership with the Center for Nursing.

The pilot project will need mentors and mentees to participate in the project to evaluate the process and the program. There will need to be an equal number of mentors and mentees for the pilot project. A mentee must be a registered nurse that self-determines the need for a mentor. The mentor role must be a registered nurse and have practiced for a minimum of five years to be eligible to participate.

What to Expect:

The project will be launched at the Conference. There will be two events that will require attendance to participate.

The first event will be a speed meeting event which will be include a timed event for a defined rotation for mentors and mentees to meet. The meeting room and time to be announced at the conference.

The second session will be the training session. The participants will be asked to review and sign informed consents and complete initial survey questionnaire at the conference.

The mentoring program will be piloted from October 2017 – January 2018. The time commitment is to interact with your mentor/ mentee a minimum of one time per month.

To measure the success of the program, there will be initial surveys, monthly feedback on meetings and post surveys.

The responses to the surveys will be anonymous.

We encourage each participant, if possible, to bring a laptop to the orientation to log in and complete surveys while at the conference session.

Response Required

Participants will need to respond to us by October 9, 2017, with preference to participate as a mentor or a mentee, or your willingness to participate in either role to have adequate number of matches.

Our contact information:

Linda DiClemente:

Connie Smith:

Appendix D

Speed Mentoring Tally

Mentee Name_____

Please list mentors first and last name. Then rank using nunber1-5 with 1 as first choice and 5 as last choice.

_____ (Ranking_____)

_____ (Ranking_____)

_____ (Ranking_____)

_____ (Ranking_____)

_____ (Ranking_____)

Appendix E

Monthly Feedback Form

RNmentor2mentor Monthly Feedback Form

Thank you for participation in the pilot mentoring program. Please take a few minutes to provide feedback on the monthly interaction as a mentor or mentee.
All information provided on this survey will be kept completely confidential.

* Required

Email address *

Your email

What is your first name?

Your answer

What is your last name?

Your answer

I am participating as the:

- [ ] Mentor
- [ ] Mentee

The monthly meeting response is for:

- [ ] October 2017
- [ ] November 2017
- [ ] December 2017
- [ ] January 2018

The number of meetings this month is:

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] Five
- [ ] Six
- [ ] Seven or more

The meeting format this month: (include all that apply)

- [ ] Face to face
- [ ] Visual (Skype/Facetime/Virtual)
- [ ] Written (text or email)

Modules completed this month include:

- [ ] Challenge the Process: Required: Section 4: Current Role
- [ ] Inspire a Shared Vision: Required: Section 5: Understanding Self and Others
- [ ] Enable Others to Act: Required: Section 6: Communication
- [ ] Challenge the Process: Required: Section 7: Problem Solving
- [ ] Enable Others to Act: Optional: Section 8: Time Management
- [ ] Model the Way: Required: Section 9: Leadership
- [ ] Encourage the Heart: Required: Section 10: Leadership Development

SUBMIT

Page 1 of 1

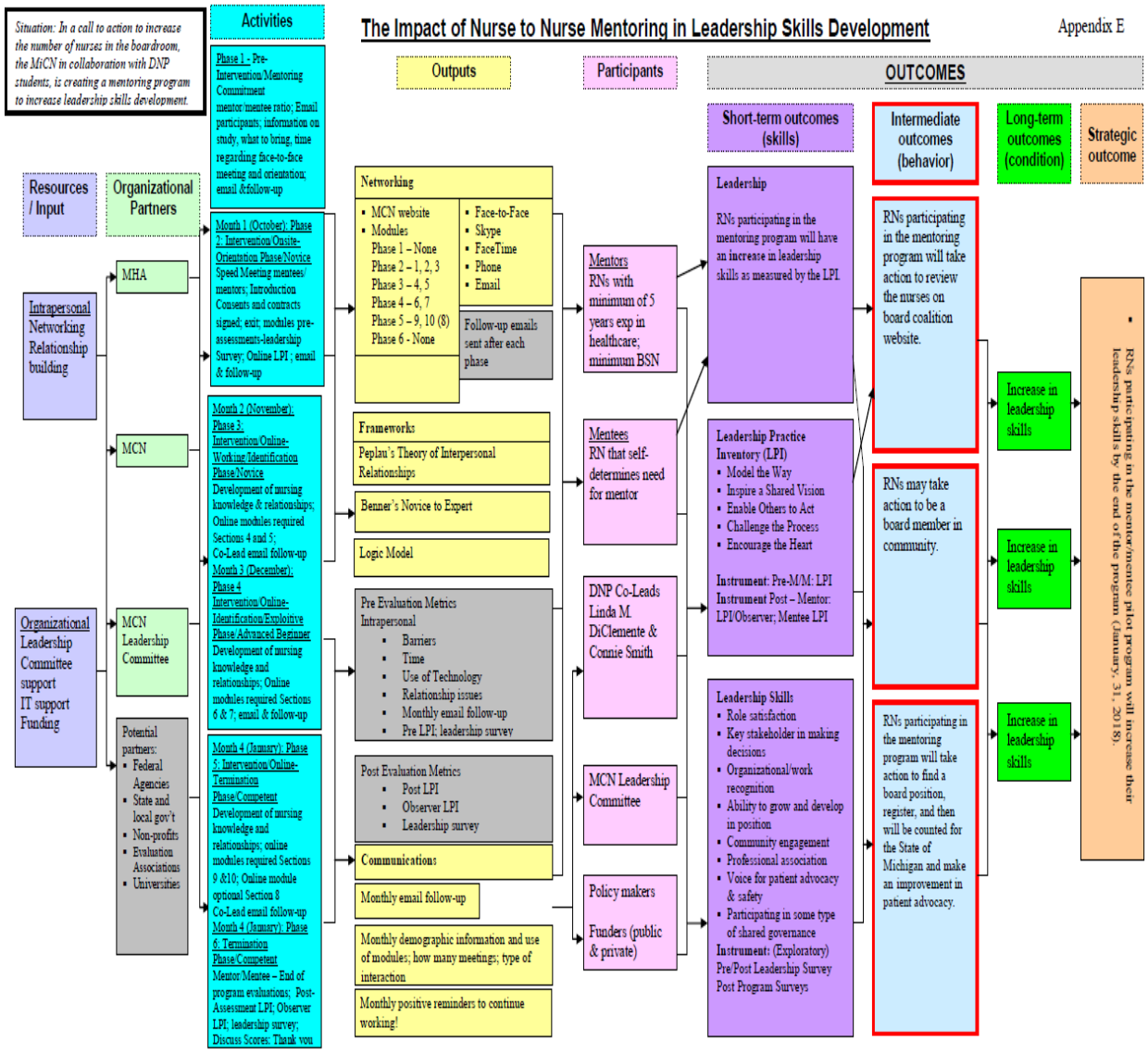
Appendix F

Theory of Novice to Expert Practice

http://theclinicalpreceptor.weebly.com/novice-to-expert.html

Appendix G

Program-Action-Logic-Model



Appendix H

Module Timeline

Module Timeline

Phase 1(September, 2017) – Pre-Intervention/Pre-Mentoring Commitment
Prepare email to be sent to participants indicating they are interested in the DNP project.
Confirm participants and divide mentors and mentees based on self-selection and inclusion criteria.
Email confirmed participants to prepare for project.
Advise them to bring paper, pencil, lap-top, and/or computer.

Month 1 (October, 2017): Phase 2 – Intervention/Onsite - Orientation Phase/Novice

Day 1: October, 2017

Mentor/Mentee: Speed Meeting - Takes place during lunch for maximum of one hour.

Mentor/Mentees - Matching Mentor/Mentee – Takes place during leadership breakout session. One hour

Section 1: Introduction — basic intent and overview of the toolkit.
Sections 3 through 10 are designed for the mentors to use with the mentees. Each of these sections include the introduction page (which states the purpose, perspective, how to prepare for this topic, tools and pointers), discussion starters, tools, handouts and resources. Handouts and tools that are intended for the mentee are designated by this star ( ) in the top right corner.
Mentor/Mentee Meeting:
Review/Sign Consents

- Review/Sign Mentoring Contracts
- Review/Sign Confidentiality
- Explain Monthly Data Collection
- Exit Strategy
- Other housekeeping items
- Ask for emails and/or text numbers to send out reminders for meetings to meet minimum inclusionary criteria. Excel spread sheet
- Pencil/Paper – Pre-Leadership Survey
- Online - Pre-Assessment LPI - Asked to complete prior to exiting conference; however, deadline to complete is Wednesday, October 18, 2017 at 8 am. If not completed, excluded from study and may affect dyad.

Review **Section 3: Overview/Getting Started** for face-to-face discussion prior to leaving conference: Getting Started: First Meeting Guide and Setting Goals* — The intent of the first two meetings is to start building trust between the mentors and mentees, to determine clear expectations and to establish a plan for future meetings based on the mentees' goals. Ideally, the mentees will start to develop general goals by the end of the second meeting.

Separate Mentor/Mentees:

Mentor: Section 2: Keys to a Successful Mentoring Relationship —
Unlike the other sections in this toolkit, Section 2 is written for the mentor and is not to be used with the mentees. The goal of this section is to prepare mentors for their journey with the mentees.

Mentee: Section 1: Introduction –
To be covered in orientation session at conference. During the session the co-lead 2 will discuss the mentee role and the required documentation for the project.

Co-Lead to email follow-up survey (Google Form).

Month 2 (November, 2017): Phase 3 – Intervention/Online- Working/Identification Phase/Novice

Challenge the Process: *Required:* Section 4: Current Role — Use this section to explore the mentees' current position and focus on their job satisfaction, workplace engagement and empowerment. The goal for the mentees is an increased understanding of their current position that results in increased effectiveness.
Discuss: Review LPI gap and tie to module content.
Mentor: Focus on Power Content 4.7; 4.8; 4.9
Mentee Homework: Supplement material in Power Content

Inspire a Shared Vision: *Required:* Section 5: Understanding Self and Others — This section provides a knowledge base for the mentees to better understand themselves and others as they grow in their role as a nurse.

Co-Lead to email follow-up survey (Google Form).

Month 3 (December, 2017): Phase 4 – Intervention/Online- Identification/Exploitive Phase/Advanced Beginner

Enable Others to Act: *Required:* Section 6: Communication — with a focus on effective communication skills, this section has a dual purpose: 1) to support the mentors' ability to work with mentees and 2) to strengthen the mentees' communication skills. This section includes tips and concrete examples to assist in effective communication.
Mentor: Focus on Crucial Conversations/Bullying
Mentee: Supplement material in Crucial Conversations Content

Challenge the Process: *Required*: Section 7: Problem Solving — this section is designed to help mentees learn to problem solve and practice conflict management in the daily work environment.

Co-Lead to email follow-up survey (Google Form).

Month 4 (January, 2017): Phase 5 – Intervention/Online- Termination Phase/Competent

Enable Others to Act: *Optional:* Section 8: Time Management — it is a positive experience when mentees feel they have accomplished what needs to be completed during their shift. The purpose of this section is to assist mentees in learning how to manage their time.

Model the Way: *Required*: Section 9: Leadership — this section will help mentees gain a better understanding of leadership and workplace dynamics. With knowledge and awareness based on realistic expectations, mentees will be able to build optimal work relationships. Mentees also can use the tools to assess their ability and desire to be a leader.

Encourage the Heart: *Required:* Section 10: Leadership Development — this section helps mentees develop a better understanding of the meaning of leadership in nursing. Wrap-up to discuss intention to serve on boards.

Co-Lead to email follow-up survey (Google Form).

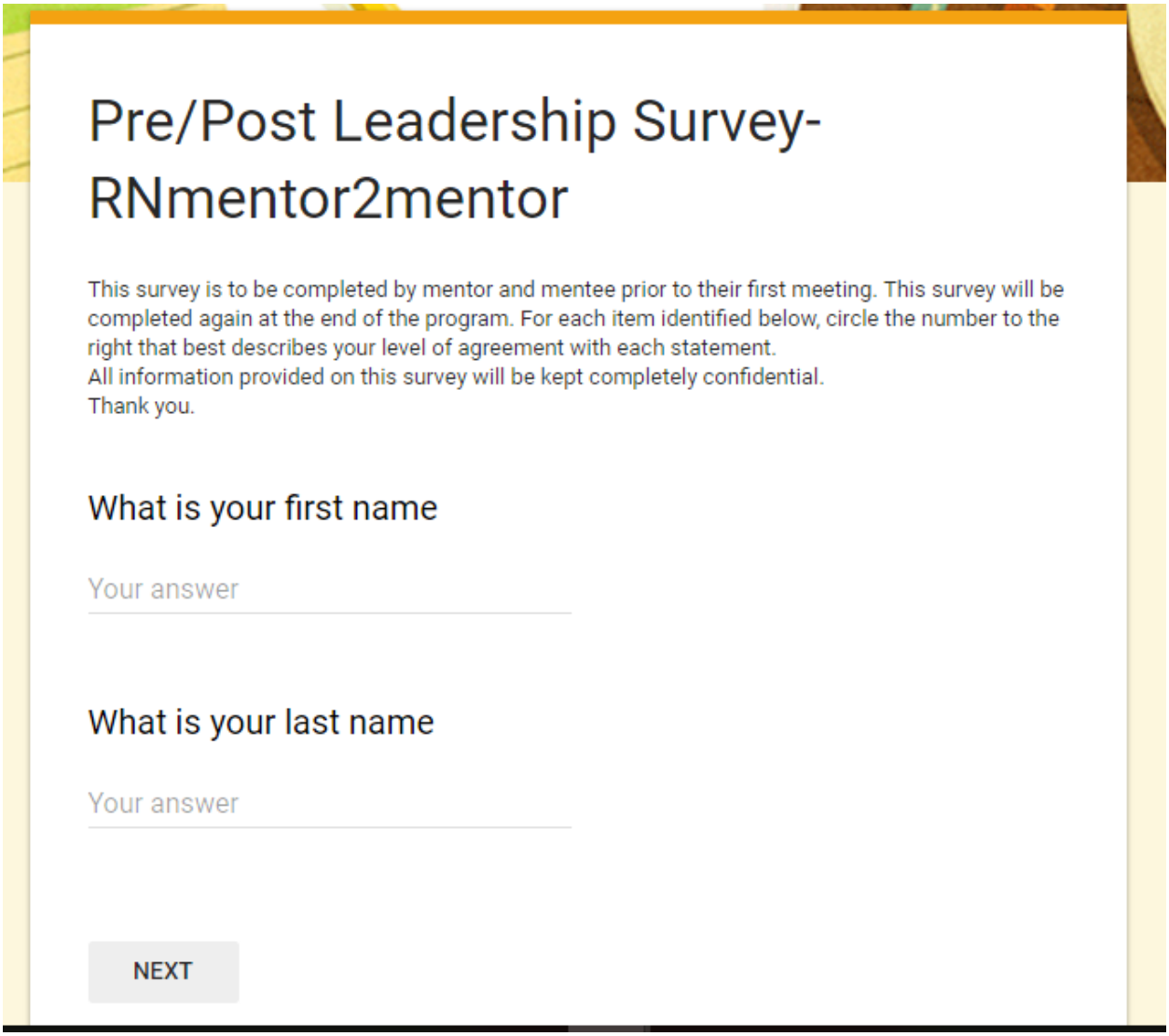
Month 4 (January, 2018): Phase 6 – Termination Phase/Competent (January)

Mentor/Mentee - End of program evaluations
Complete final LPI and Observer LPI
Discuss Scores
Thank you notes

Co-Lead to email follow-up survey (Google Form).

Appendix I1

Leadership Survey



Pre/Post Leadership Survey-RNmentor2mentor

This survey is to be completed by mentor and mentee prior to their first meeting. This survey will be completed again at the end of the program. For each item identified below, circle the number to the right that best describes your level of agreement with each statement.
All information provided on this survey will be kept completely confidential.
Thank you.

What is your first name

Your answer

What is your last name

Your answer

NEXT

Pre/Post Leadership Survey-RNmentor2mentor

Overall I am satisfied with my job.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

Overall I am satisfied with my workload.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am involved in planning for the future of my organization.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am allowed to make decisions that I feel make a difference in my work.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I feel I have opportunity for advancement.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agreen

I feel secure with my job.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agreen

I have goals at work.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

My workplace motivates me to a higher level of performance.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I can communicate with my supervisor about my successes.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I can communicate with my supervisor about my needs.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am recognized for my work.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am part of a team that works together to accomplish goals.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I feel my organization uses my time and talents well.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I plan on working at my organization a year from now.

1 2 3 4 5

I have the opportunity to work on interesting projects.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am able to manage my time so that I can grow and develop.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I take advantage of learning opportunities my workplace offers.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I take advantage of learning opportunities offered in the community.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am involved in a professional association outside of work.

	1	2	3	4	5	

I have the opportunity to work on interesting projects.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am able to manage my time so that I can grow and develop.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I take advantage of learning opportunities my workplace offers.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I take advantage of learning opportunities offered in the community.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am involved in a professional association outside of work.

	1	2	3	4	5	

I am motivated to higher levels of performance.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I am able to influence patient safety.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I communicate effectively with my co-workers.

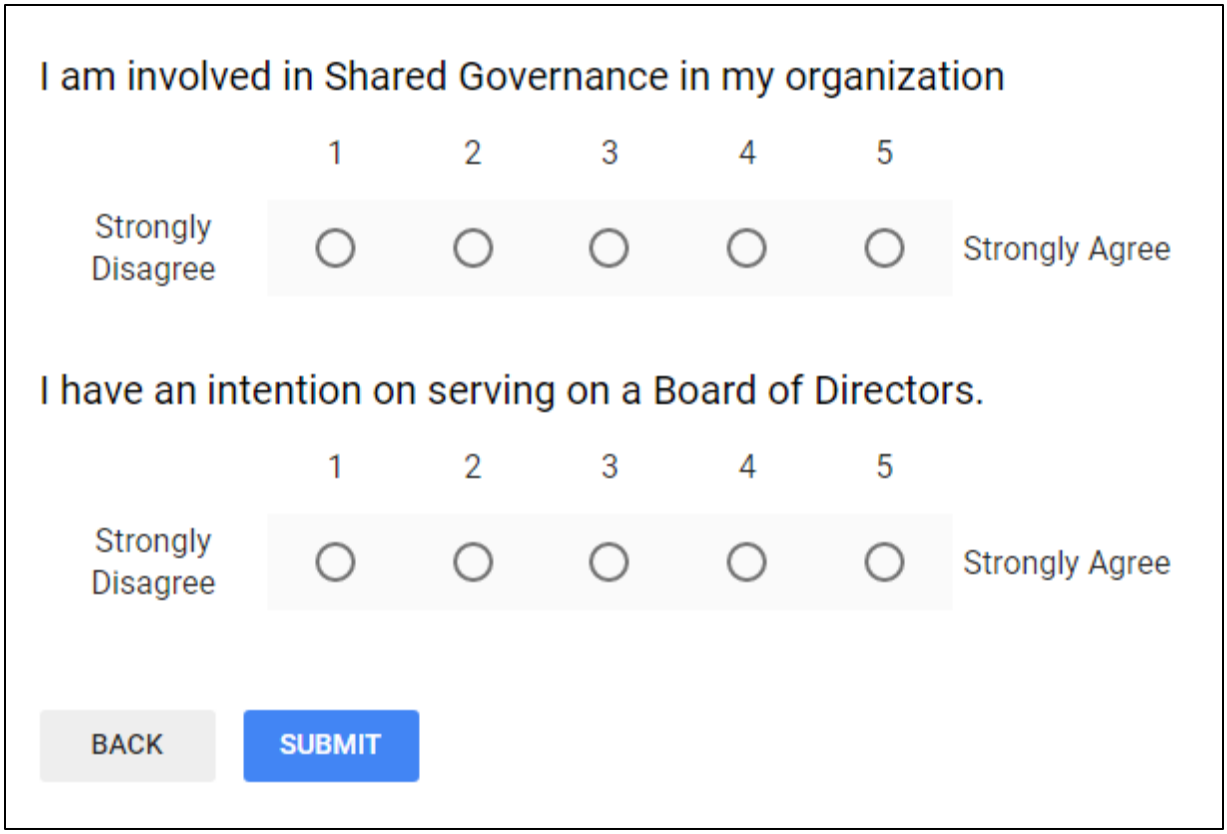
	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

Most days, I enjoy coming to work.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

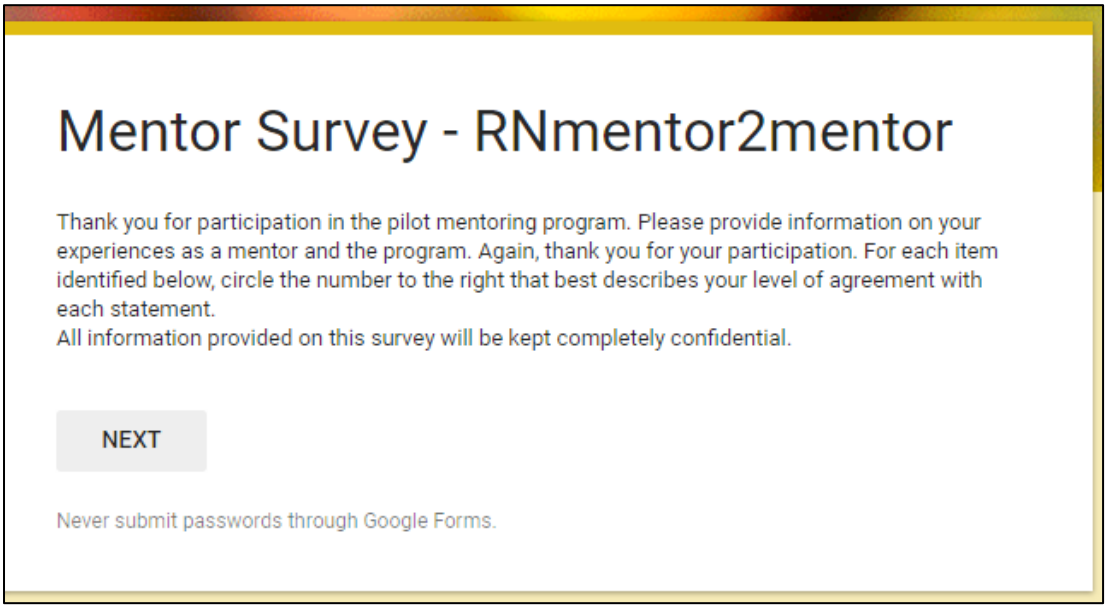
I understand how decisions are made in my organization.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree


I am involved in Shared Governance in my organization
1 2 3 4 5
Strongly Disagree
Strongly Agree
I have an intention on serving on a Board of Directors.
1 2 3 4 5
Strongly Disagree
Strongly Agree
BACK
SUBMIT

Appendix I2

Mentor Exit Survey



Mentor Survey - RNmentor2mentor

Thank you for participation in the pilot mentoring program. Please provide information on your experiences as a mentor and the program. Again, thank you for your participation. For each item identified below, circle the number to the right that best describes your level of agreement with each statement.
All information provided on this survey will be kept completely confidential.

NEXT

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Mentor Survey - RNmentor2mentor

Initial Information

Please provide your first name

Your answer

Please provide your last name

Your answer

Please provide the first and last name of your mentee

Your answer

I mentored this mentee from

Your answer

BACK NEXT

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Mentor Survey - RNmentor2mentor

Untitled Section

Mentoring offered me an opportunity to strengthen my knowledge base and improved my communication.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

Mentoring provided me intrinsic satisfaction.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

This mentoring relationship was a positive experience for me.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt my mentee was respectful of my time.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt my mentee and I were a good match.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt I effectively transferred knowledge to the mentee.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt supported by the mentor coordinator.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I would recommend this program.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

Were the goals you and your mentee established met during the duration of your relationship? If not, what could have been changed to help you meet those goals?

Your answer

List three challenges you have encountered in the mentoring program.

Your answer

List three successes you see with the mentoring program.

Your answer

BACK SUBMIT

Never submit passwords through Google Forms.

Appendix I3

Mentee Exit Survey

Mentee Survey - RNmentor2mentor

Thank you for participation in the pilot mentoring program. Please provide information on your experiences as a mentee and the program. Again, thank you for your participation. For each item identified below, circle the number to the right that best describes your level of agreement with each statement.
All information provided on this survey will be kept completely confidential.

What is your first name?

Your answer

What is your last name?

Your answer

What is the first and last name of your mentor?

Your answer

I was mentored from _____ to _____

Your answer

My mentor/mentee relationship experience was positive.

1 2 3 4 5

My mentor and I were a good match.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I would recommend this program.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

My mentor was accessible to me.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt supported by my mentor

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I felt my mentor was respectful of my time.

	1	2	3	4	5

My mentor challenged me to grow professionally.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

My mentor challenged me to grow personally.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I feel my mentor effectively transferred knowledge to me.

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

I would be willing to be a mentor in the future

	1	2	3	4	5	
Strongly Disagree	○	○	○	○	○	Strongly Agree

If you rated any item(s) a “1” or “2” please provide an explanation in the space below:

Your answer

Were the goals you and your mentor established met during the duration of your relationship?

- ○ Yes
- ○ No
- ○ Still in Progress

If not, what could have been changed to help you meet those goals?

Your answer

List three challenges you have encountered in the mentoring program.

Your answer

List three successes you have experienced with the mentoring program.

Your answer

SUBMIT

Appendix J1

Jacksonville University Informed Consent

JACKSONVILLE UNIVERSITY
Informed Consent Document to Participate in Research

You are being asked to take part in a research study. Before you decide whether to take part, please read the information below and ask questions about anything you do not understand.
PARTICIPANT'S NAME: _____
TITLE OF THE RESEARCH STUDY: The Impact of Nurse to Nurse Mentoring in Leadership Skills Development - RNmentor2mentor

RESEARCH INVESTIGATORS:

- Co Primary Investigator: Linda Macera-DiClemente, [redacted].
- Co Primary Investigator: Connie Smith, [redacted]
- Faculty Chair: Dr. Roberta Christopher, [redacted]

  Jacksonville University, [redacted]

THE PURPOSE OF THE STUDY is to measure the impact of nurse-to-nurse mentoring in leadership skills development using a formal mentoring program.

As a participant in the RNmentor2mentor program, you will be asked to:

1. Participate in program orientation activities:
   a. Participate in a one-hour lunch Speed Meeting at the nursing summit. This will allow you to meet potential mentors/mentees.
   b. One to two-hour session matching and orientation session during a breakout session at the conference. This will include reviewing and signing of mentoring agreements, confidentiality statements, informed consents, and completion of pre-program assessment forms. We anticipate the pre-program assessment forms to take one hour to complete. The forms include demographic and contact information, leadership practice inventory and the leadership survey.

2. Interact monthly with your mentee/mentor. The provided program modules will guide the mentoring sessions and enhancement of leadership skills. You will then be asked to provide an update on your mentoring relationship interactions and activities via an online form. It is anticipated that the interactions will be an hour in length per month, but may be more as determined by you and your mentor/mentee. You will have three months of

3. program tracked interactions (November 2017-January 2018). You and your mentor/mentee will decide meeting format (e.g. face to face, Skype, Facetime, email, text, etc.), length, and frequency.
4. Complete end of program evaluation forms. We anticipate the post program evaluation forms to take one to two hours to complete. You will complete the Leadership Practice Inventory, Leadership Survey, and the Mentor/Mentee Exit Survey.

If you decide to be in the study, the investigators will collect the following information, including personal identifiers.

- Name, work phone, home phone, cell, email address, emergency contact number, age, gender, race, years as a nurse, and education level.

If you have any questions now or at any time during the study, you may contact anyone listed under Investigators.

If you agree, you will take part for a minimum for 4 encounters as a mentor/mentee. We anticipate total time commitment for all program activities to be 10-12 hours. About 20 pairs of mentors/mentees will take part in the study.

BENEFITS OF THE STUDY: You may or may not benefit from being in this study. The anticipated benefits of participating in this program include increased leadership skills and competence, development of professional nursing relationships, and increased skills to participate on boards of directors. Knowledge acquired from this project will inform future projects by the Michigan Health Council and Michigan Center for Nursing (MHC/MCN).

RISKS OF THE STUDY: There are minimal risks involved in participating in this program. Participation involves spending time with and building a relationship with a mentor/mentee. While every effort will be made to recruit dedicated mentors and mentees, it is possible that the mentor or mentee may not follow through in building the relationship or spending time as agreed upon. Thus, the key risk of taking part in this study is a possible negative relationship between the mentor/mentee.

COSTS / COMPENSATION: You will not have to pay for taking part in this program. There will be no monetary compensation for participation in this program.

ALTERNATIVE TO BE IN THE STUDY: There are no alternative options or treatments available if you should choose not to participate in this study.

RIGHT TO PARTICIPATE OR WITHDRAW: You are free to stop taking part in this research study at any time without penalty and without losing any benefits to which you are entitled. If you decide to stop taking part in this research study for any reason, you should contact Linda Macera-DiClemente at [redacted] or Connie Smith at [redacted]. If you have any questions regarding your rights as a

research participant, you may call the JU Institutional Review Board at [redacted]. If you have any concerns about the conduct of the study, you may also contact the Faculty Chair, Dr. Roberta Christopher at [redacted]

CONFIDENTIALITY: Only the researchers and certain Jacksonville University officials have the legal right to review research records, and they will protect the secrecy (confidentiality) of these records as much as the law allows. Otherwise, your research records will not be released without your permission unless required by law or a court order. Paper files will be stored in a double locked office and cabinet until scanned into a password protected, encrypted cloud based server. All electronic data will be stored on password protected, secure cloud based servers. Data will be de-identified at the conclusion of the data analysis. All data will be reported as aggregate data only.

CONFLICT OF INTEREST: In general, presenting research results helps the career of a scientist. The researchers may benefit if the results of this study are presented at scientific meetings or published in scientific journals but your name and/or pictures will not be used.

CONSENT TO PARTICIPATE: You have been informed about this study's purpose, procedures, possible benefits, and risks; and the alternatives to being in the study. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

By signing this form, you voluntarily agree to take part in this study. You are not waiving any of your legal rights. You will receive a copy of this form.

Participant:

_____	_____	_____
Participant's Name Printed	Participant's Signature	Date

Person Obtaining Consent and Authorization:

_____	_____	_____
Witness's Name Printed	Witness's Signature	Date

Appendix J2

Mentoring Agreement

Mentoring Agreement for _____
& _____

Determinations	Agreement
Frequency of Meeting **Recommendation: Minimum once a month** **Remember: The project requires a minimum of 4 encounters/once per month October-January, 2018**	☐ Once a month ☐ Twice a month ☐ Once a week ☐ _____
Type of Meeting **Face-to-face meetings are best. However, e-mail or phone meetings also can work.**	☐ Face to face ☐ Phone conference ☐ E-mail ☐ _____
When to Meet **A standard time and place, such as the 1st Monday of the month at _____, helps make mentoring part of your routine.**	☐
Meeting Time **30 to 40 minutes is typically optimal.**	☐
Where to Meet **Make it convenient and confidential. It is okay to change the place as this fosters different conversations. Just be clear on the location.**	☐ My office/your office ☐ Cafeteria during a quiet time ☐ Unit conference room ☐ Coffee shop _____ ☐ _____
Person Responsible for Scheduling Meetings **Confirm and agree on the next meeting time and place at the conclusion of each meeting.**	☐ Mentor ☐ Mentee ☐ _____
Ground Rules for Discussions **Consider confidentiality, openness, candor and truthfulness.**	☐ Confidential ☐ Honest ☐ Meaningful ☐ Seek first to understand then to be understood. ☐ Have fun. ☐ Be tough on issues, soft on people. ☐ Encourage healthy debate. ☐ It's not about *being right.* ☐ Give people the benefit of the doubt. ☐ Say thank you.

Nurse Mentoring Toolkit

Getting Started: First & Second Meeting Guides

Additional Ground Rules	☐ Ask questions. ☐ Be prepared. ☐ _____ ☐ _____ ☐ _____
Plan for Scheduling Conflicts **Be specific here. For example, we will give ____ hours notice if we cannot make a meeting. Always be on time.**	☐ If I cannot make a meeting, I will let my mentor/mentee know _____ hours in advance via e-mail, and I will leave a message on his or her _____ phone (work and/or cell). ☐ _____
Additional Discussion Areas/Issues	
Mentee Signature/Date	
Mentor Signature/Date	

Mentor Contact Information
Work Phone: _____
Home Phone: _____
Cell: _____
Additional e-mail address: _____
* star the preferred contact method

Mentee Contact Information
Work Phone: _____
Home Phone: _____
Cell: _____
Additional e-mail address: _____
* star the preferred contact method
Emergency Contact Person/Number: _____
(This number will remain confidential and used for emergency purposes only.)

Complete, sign and make three copies (mentor, mentee, mentor coordinator).

Appendix J3

Mentoring Contract

We are both voluntarily entering into a mentoring relationship which we expect will benefit both of us and the doctoral project of Linda Macera-DiClemente and Connie Smith in association with the Michigan Health Council/Michigan Nursing Coalition. We want this to be a rewarding experience, with most of our time to be spent on developmental activities. The following are mutually agreed upon terms.

1. The mentoring relationship will last approximately four months. After an initial period, it will be mutually agreed to end or to continue.

2. The two of us will meet _____ (frequency). Once a month from October (1st face-to-face meeting) and a minimum of once through the months of November, December, and January. You may decide to meet more often, no problem!

3. Between meetings, we will contact each other by phone _____or e-mail_____.

4. We agree that the role of the mentor and the role of the mentee are as discussed on the Definition of a Mentor Worksheet in Section 3.

5. We agree to be trustworthy, respectful and supportive of each other and to communicate effectively with each other.

6. We agree that if the relationship is no longer productive to us that we will respectfully end it and attribute no fault to either of us. To end the relationship please contact Linda Macera-DiClemente at [redacted] or Connie Smith at [redacted]

Mentee's Signature/Date

Mentor's Signature/Date

Complete, sign and make three copies (mentor, mentee, mentor coordinator).

Appendix J4

Mentor/Mentee Confidentiality

The mentor/mentee relationship is a privileged one that is built on trust and integrity. Therefore, we agree that anything that is shared during our mentoring meetings is confidential and will not be shared with another person, including friends, family, co-workers, supervisors and managers.

Mentee's Signature/Date

Mentor's Signature/Date

(Rev 7-10)

Nurse Mentoring Toolkit

Getting Started: First & Second Meeting Guides

Appendix K

Coding for Demographic Data

Demographic Survey-RNmentor2mentor

Thank you for participating in the mentoring program. Please take a few minutes to provide demographic information for the project.
All information provided on this survey will be kept completely confidential.

* Required

Do you currently serve on a board?

- ○ Yes
- ○ No

Are you a mentor or mentee? *

- ☐ Mentor
- ☐ Mentee

What is your age? *

- [ ] 20-29 years
- [ ] 30-39 years
- [ ] 40-49 years
- [ ] 50-59 years
- [ ] 60-69 years
- [ ] ≥70 years
- [ ] Other: _____

What is your gender *

- [ ] Male
- [ ] Female
- [ ] Choose Not to Identify
- [ ] Other: _____

What is your ethnicity *

- [ ] White
- [ ] Black/ African American
- [ ] Hispanic
- [ ] Native American
- [ ] Asian/Pacific Islander
- [ ] Mixed Race/Other
- [ ] Choose Not to Identify

How many years have you been a nurse?

- [ ] 1-5 years
- [ ] 6- 10 years
- [ ] 11-15 years
- [ ] 16-20 years
- [ ] 21-25 years
- [ ] 26-30 years
- [ ] >30 years

What is your highest level of previous education, certification or degree completion

- [ ] completed associate degree
- [ ] completed bachelor degree
- [ ] completed master's degree
- [ ] completed doctoral degree

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Appendix L

Divided Work Template

Linda M. DiClemente	Connie Smith
Literature Review – September 1, 2017 • Barriers to get on boards (intention) • Nurses on boards history/background • Background problem/Statement/Significance • Aligned with MCN • LPI Validity/Reliability • Module Timeline • Logic Model • Barriers to nurses on boards • PEERLA – APA • References • Table of Contents • Appendices • Modules Reviewed and Revised	Literature Review – September 1, 2017 • E-mentoring • workforce narrative • Abstract Project Design/ Implementation section • Goal of project/outcome • Setting • Population • Timeline • Procedures • Fiscal • Ethical Data Analysis Plan
Project Implementation- After project approval • Orientation - Mentor • Modules Reviewed and Revised • Mentor Toolkit • Consents	Project Implementation – After project approval Orientation – Mentee • Demographics Email for pre-intervention Sept 22 • Monthly email reminders/monitoring
Measure mentoring relationship using the mentor evaluations	Measure mentoring relationship using the mentee evaluations
Results: Data Analysis - Mentor – After project completion – February 1, 2018	Results: Data Analysis - Mentee – After project completion – February 1, 2018
Completion of Project	Completion of Project

Appendix M1

Research Mentor Agreements

Office of Research & Sponsored Programs
JACKSONVILLE UNIVERSITY

Research Mentor Agreement

Study Title: The Impact of Nurse to Nurse Mentoring in Leadership Skills Development - RNmentor2mentor

As mentor, I understand that I am considered the responsible party for the legal and ethical performance of the project, helping to ensure that all research procedures comply with Federal, State and University policies pertaining to the protection of human subjects. I certify that the student investigator of the submitted protocol is knowledgeable about the regulations and policies governing research with human subjects and has sufficient training and experience to conduct the study in accordance with the approved protocol.

In addition, I agree to:

-meet with the student investigator on a regular basis to monitor the study progress;

-agree to be available, personally, to supervise the student investigator in solving problems should they arise during the course of the study

-assure that the student investigator will promptly report significant or untoward adverse effects according to applicable policies;

-be available to the IRB should questions or issues develop;

-arrange for an alternate faculty mentor to assume responsibility during periods of absence (e.g. sabbatical leave or vacation), and advise the IRB by letter of such arrangements; and

-to serve as a principal investigator on the study.

Connie Smith

Printed Name of Student

Dr. Roberta Christopher

Printed Name of Faculty Mentor

[redacted] 9/9/17

Signature of Faculty Mentor Date

Version:12/2/16

Appendix M2

Research Mentor Agreements

Office of Research
& Sponsored Programs
JACKSONVILLE UNIVERSITY

Research Mentor Agreement

Study Title: The Impact of Nurse to Nurse Mentoring in Leadership Skills Development - RNmentor2mentor

As mentor, I understand that I am considered the responsible party for the legal and ethical performance of the project, helping to ensure that all research procedures comply with Federal, State and University policies pertaining to the protection of human subjects. I certify that the student investigator of the submitted protocol is knowledgeable about the regulations and policies governing research with human subjects and has sufficient training and experience to conduct the study in accordance with the approved protocol.

In addition, I agree to:

-meet with the student investigator on a regular basis to monitor the study progress;

-agree to be available, personally, to supervise the student investigator in solving problems should they arise during the course of the study

-assure that the student investigator will promptly report significant or untoward adverse effects according to applicable policies;

-be available to the IRB should questions or issues develop;

-arrange for an alternate faculty mentor to assume responsibility during periods of absence (e.g. sabbatical leave or vacation), and advise the IRB by letter of such arrangements; and

-to serve as a principal investigator on the study.

Linda Macera-DiClemente

Printed Name of Student

Dr. Roberta Christopher

Printed Name of Faculty Mentor

9/9/17

Signature of Faculty Mentor Date

Version:12/2/16