THE CLINICAL RESOURCE NURSE'S PEER MENTORING ROLE IN SEHA FACILITIES IN ABU DHABI, UNITED ARAB EMIRATES

By

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DECLARATION

I, **Agnes Ntlaletse de Langen**, solemnly declare that:

THE ROLE OF A CLINICAL RESOURCE IN PEER MENTORING, is my own original work; and to the best of my knowledge, it has not been previously submitted for degree or examination purposes at any other institution of higher learning.

I declare further that all the sources that I have used or quoted have been duly indicated and acknowledged by means of complete bibliographic references.

Signed: _____ _____

Agnes Ntlaletse de Langen Date

DEDICATION

I dedicate this exegetic work posthumously to my parents, Mr Aaron and Mrs Herminah Ramasehla, for instilling in me a culture of discipline and inculcating an appreciation of the value of education. I greatly appreciate and admire their resolute courage and determination.

Agee, Mokone 'a Mabula le Kwena e kgolo ya ka meetseng!!!

To Leago Ramasehla, my recently born granddaughter, I communicate the same lessons still etched in my mind from my parents' teachings:

Kodumela moepa thutse, ga go lehumo le tšwago kgauswi".

(Perseverance is the mother of success)!

I am now passing the baton on to you, Leago.

ACKNOWLEDGEMENTS

I acknowledge the invaluable contributions made to this study by a host of individuals and organizations whose names are mentioned below. That others are not mentioned by name hereunder, does not in any way constitute a non-recognition or diminishment of their immeasurable efforts and various other relevant contributions expended. I have neither omitted their names condescendingly, nor attenuated their indelible personal and professional insights. I take full responsibility for any omission that may arise.

- I extend my most hearfelt gratitude to my Heavenly Father; for His numinous guidance to first seek His kingdom and its righteousness, and that everything else will be added unto me. My Creator enabled me to depend on Him for everything. Without Him, I am nothing. He sent His holy angels to lift me up, lest I tread on stones. Thank you Father God for good health and your numinous guidance throughout this journey;
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LIST OF ACRONYMS USED IN THE STUDY

AADON	Acting Assistant Director of Nursing
AAHSA	American Association of Homes and Services for the Aging
ADDIE	Analysis, Design, Development, Implementation, and Evaluation
ADON	Assistant Director of Nursing
AED	Arab Emirates Dirham
ANCC	American Nurses Credentialing Center
BLS	Basic Life Support
CAP	College of American Pathologists
CNC	Clinical Nurse Coordinator
CNEP	Continuing Nursing Education Program
CRN	Clinical Resource Nurse
DGN	Diploma in General Nursing
DHA	Dubai Health Authority
ED	Emergency Department
ENTT	Ear, Nose, Throat, and Thoracic
GNI	Graduate Nurse Intern
GT	Grounded Theory
HAAD	Health Authority Abu Dhabi
HDU	High Dependency Unit
HRM	Human Resources Management
IFAS	Institute for the Future Aging Services
IRB	Internal Review Board
JCI	Joint Commission International
MOH	Ministry of Health
NMC	Nursing and Midwifery Council
PALS	Paediatric Advanced Life Support
PICU	Pediatric Intensive Care Unit
REC	Research Ethics Committee
RN	Registered Nurse
SKMC	Sheikh Khalifa Medical City
SEHA	Abu Dhabi Health Service Company
UAE	United Arab Emirates
UAENMC	United Arab Emirates Nursing and Midwifery Council
UK	United Kingdom
UMs	Unit Managers
USA	United States of America
WHO	World Health Organisation

ABSTRACT

The nursing profession is premised on the moral and ethical maxim: *do unto others as you would they do unto you*. Advanced beginner nurses progress to become fully fledged professional nurses as a result of the socialisation, support and nurturing by the proficient and expert counterparts. Socialisation engenders a spirit of brotherhood and sisterhood within the nursing profession. However, there is evidence to suggest that nurses 'eat their young'. In the event that advanced nurses consider themselves as dinner for the expert nurses, they are inclined to leave the profession due to their real or perceived unpalatable experiences of suffering under the tutelage of the expert nurses.

Proceeding from the grounded theory paradigm, the purpose of the study is to explore and describe the extent (if any) to which the role of the clinical resource nurse affects staff retention. The study was conducted at two SEHA (Abu Dhabi Health Service Company) facilities in Abu Dhabi. The study followed a qualitative design that is explorative, descriptive and contextual in nature, with some quantitative aspects developed by means of questionnaires. The purposive non-probability sampling technique was employed in the study, with the sample size comprised of 1 Assistant Director of Nursing; 1 Acting Assistant Director of Nursing; 5 Unit Managers; 3 Clinical Nurse Coordinators; 16 Clinical Resource Nurses; 11 Graduate Nurse Interns; and 14 Registered Nurses. Quantitative data will be collected using semi-structured interviews, as well as open-ended surveys. Data was analysed qualitatively. Guba's model in Polit & Beck (2012:582) was utilised to ensure trustworthiness of the study. Ethical requirements were considered throughout the study.

Findings showed that the responsibility of peer mentoring does not rest solely on the shoulders of the CRN (Clinical Resource Nurse) but is a team effort is a team effort between senior leadership unit managers, CNCs (Clinical Nurse Coordinators) and external stakeholders such as HAAD (Health Authority Abu Dhabi), SEHA, NMC (Nursing and Midwifery Council) and higher education.

Key words: clinical resource nurse, peer mentoring, staff retention

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Mentorship is an experiential learning approach to clinical education in which a reciprocal teaching-learning relationship is established between the advanced beginner nurse, competent nurse, and the clinical resource nurse (CRN) with the view to assisting the advanced beginner nurse to develop confidence and competence in a transition to the role of the professional nurse (Bott, Mohide & Lawlor 2011: 35). This transition is enabled through orientation, induction and mentorship/ preceptorship. (For purposes of this study, mentorship and preceptorship are used interchangeably). The advanced beginner nurse undergoes orientation for a duration of two weeks.

The terms 'orientation' and 'induction' connote an adjustment to new surroundings, circumstances and/ or facts (Oxford Dictionary, 2006). In the nursing context, 'orientation' refers to a formal course of learning by means of which a new nurse beginner is introduced to a new environment or situation, in order to enhance work-compliant knowledge and skills, as well as integration of nursing theory to nursing practice. The purpose of orientation is to introduce the advanced beginner to the organisation's culture, and generate support and resources to facilitate the beginner's meeting of the job expectations. Orientation also provides a feeling of being welcomed into the organisation. Orientation is conducted at different levels of the nursing career pathway, namely: for a newly qualified staff member, the newly employed, on promotion to a new position, and for a staff member returning to work after a long period of absenteeism.

A clinical resource nurse is responsible for, amongst other functions, bridging the gap between nursing theory and nursing practice, as well as advancing the promotion and maintenance of high-quality patient care by managing nursing operations. Merging theory and practice poses a problem to both new nursing recruits and newly qualified registered nurses in the nursing profession. This problematic state of affairs leads to a high incident rate of operational challenges, especially among newly qualified registered nurses facing new clinical situations such as: the provision of patient care; inadequate professional guidance; difficulty in handling on-the-job realities; the theoretical nature of training received at nursing college; information overload; staffing shortages; and short retention periods in the profession (Li, Wang & Lee, 2011: 204). Additionally, a clinical resource nurse facilitates clinical teaching and enforces policies, procedures, practices, and standards of the particular nursing facility (HAAD, 2007: 1). This relationship

between the clinical resource nurse and other registered nurses fosters personal and professional growth and advancement of the less experienced nurses.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

Globally, there is a high turnover of graduate nurse interns and newly employed registered nurses (RNs). Between 35% and 60% of graduate nurse interns and newly employed registered nurses resign from their first positions due to a plethora of factors, such as stress, the fear of making mistakes, interaction with doctors, bullying, work group culture, communication skills, dissatisfaction with professional goals, deficient critical thinking, the gap in correlating theory and practice, as well as low confidence levels (Macke, 2011:3; Chandler, 2012: 107; Lenox, 2012: 26).

Sheikh Khalifa Medical City (SKMC) recruits professional nurses internationally, including from countries such as Canada, Australia, New Zealand, the United Kingdom (UK), India, Gulf countries, Philippines, and South Africa. In addition, SKMC employs graduate nurse interns (GNIs) from mainstream education institutions locally (in the United Arab Emirates/ UAE) on their completion of the Diploma in General Nursing (DGN). All expatriate nurses employed at SKMC should have a minimum of two years' working experience in medical, surgical, nursing, or any other field of specialty within the nursing profession.

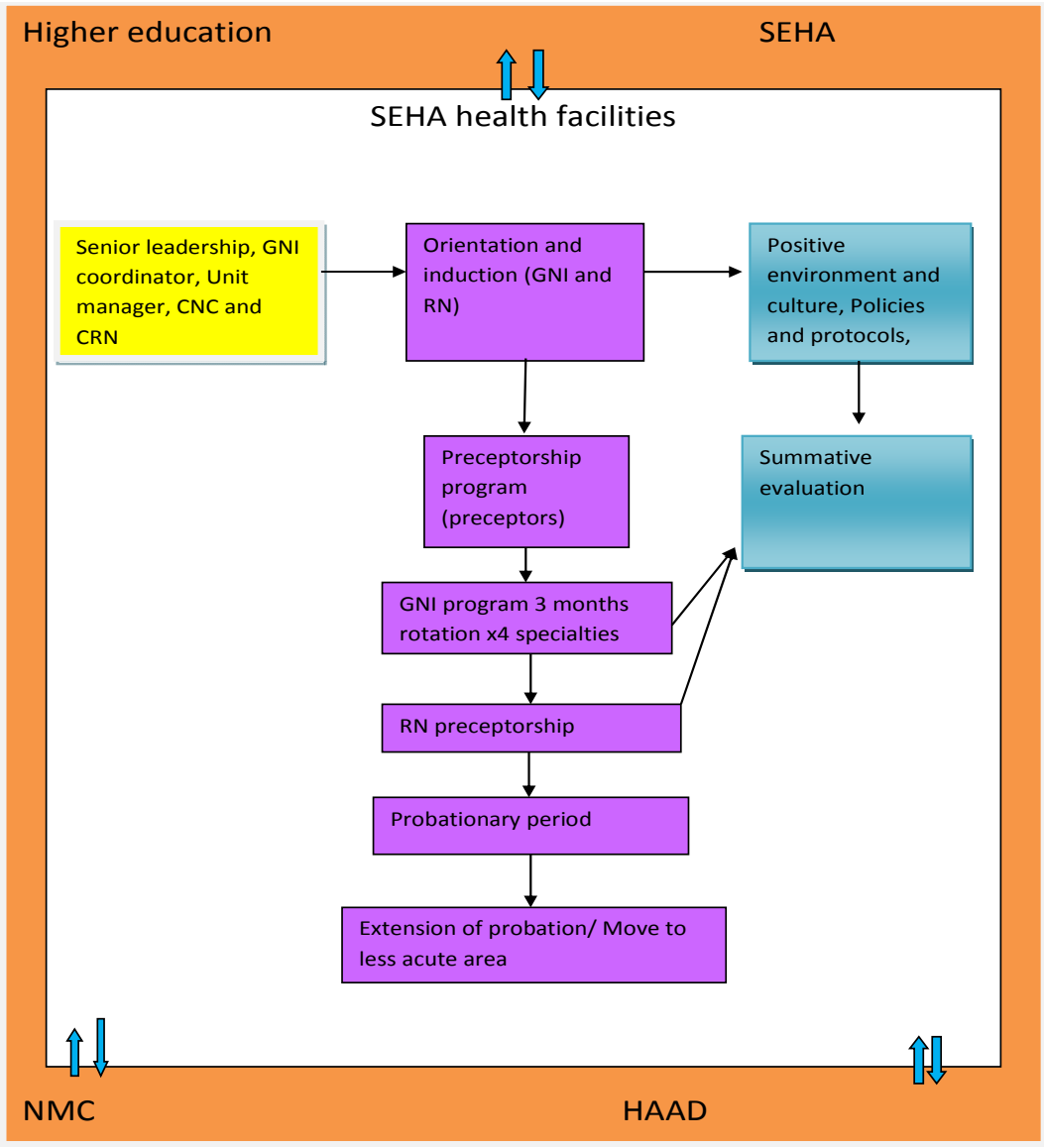
All new employees at SKMC are obligated to go through an orientation and induction process, after which they are then assigned a preceptor to familiarise them with the clinical setting. The GNIs are assigned an administrative clinical resource nurse who co-ordinates the mentorship programme. In the first year, the GNIs work on a three-month rotation system in the medical, surgical, paediatric, and emergency departments. The GNIs are also assigned a mentor in each area, and work under the tutelage of the unit-based clinical resource nurse facilitating the learning of clinical skills, offering guidance and support in order to develop the graduate nurse interns both professionally and personally.

1.2.1 Current Peer Mentoring and Staff Retention Approach

Figure 1.1 below depicts the current model of peer mentoring and its impact on staff retention in the SEHA facilities. Presently, HAAD and NMC are responsible for the licensing of nurses in the UAE. Higher education learning institutions are responsible for the formal education and training of GNIs. Together with senior management and GNI Coordinators, higher education institutions also ensure the placement and three month rotation of the GNI upon completion of their formal training. Unit CRNs are responsible

for assigning a mentor, and to ensure that the GNIs fulfil the requirements for the particular rotation. CRNs, unit managers, and clinical nurse coordinators conduct the formative interview, and report the progress to the GNI coordinator. The latter then liaises with senior leadership on all aspects of the reported progress. GNIs then write HAAD exams at the end of the intern programme in order to be promoted as registered nurses. Figure 1.1 below depicts the above-cited SEHA approach to peer mentoring.

Figure 1.1: Current SEHA peer mentoring and staff retention approach



1.3 STATEMENT AND CONTEXT OF THE RESEARCH PROBLEM

A research problem essentially refers to the justification of the actual reasons that necessitated the study being undertaken in the first place (de Vos, Strydom, Fouche & Delport, 2011: 360). In conjunction with the research purpose and objectives, as well as the significance of the study, the research problem is therefore, the aspect of the study

that is intended to resolve the gap between current knowledge and / or new insights in an area of knowledge about which little or no knowledge exists. The identification and description of the research problem was also critical in providing a perspective and context for the role of a clinical resource nurse in the peer mentoring of newly recruited or employed professional registered nurses. Both the literature review and the researcher's actual experiences and observation contributed to the articulation of the pertinent research problem in this study (de Vos et al., 2011: 360).

The researcher observed that there was a high turnover of graduate nurses at two SEHA facilities (Sheikh Khalifa Medical City and Al Mafraq Hospital), especially in the first and second years of employment. The researcher was interested in discovering whether the high attrition rate was linked to the role of the clinical resource nurse in peer mentoring. Such a link highlighted the association between the research aim and objectives, the research questions, and the study's significance on the one hand; as well as the data collection processes and possible difficulties encountered by the researcher during the entire study (Polit & Beck, 2008: 764; Burns & Groove, 2011: 218). In this regard then, the researcher pondered on the following questions in order to make sense of the research project: What is the role and responsibility of the clinical resource nurse in peer mentoring? How is the peer mentoring relationship facilitated? How are nurses prepared to become peer mentors? How is the effectiveness of peer mentoring measured? What are the strengths and weaknesses of peer mentoring?

In this study, the research problem is located within the larger context of the retention of newly employed professional registered nurses. Non-retention eventually results in a high nurse attrition rate of the nursing workforce, with huge financial consequences incurred in that health care facilities may lose up to 200 000 AED individually per annum (Arab Emirates Dollars) (Rimando, 2013; SKMC 2013 recruitment data). Jones and Gates (2007: 20) corroborate the latter view, mentioning that the global staff turnover costs supersede the staff retention costs. For instance, turnover costs are estimated to be 1.3 times the salary of the departing nurse. The above-cited authors cite further that the cost of replacing just one registered nurse ranges from 40 000 to 80 000 AED, depending on the geographic location within the Emirates, as well as the specialty area within the nursing profession. Direct costs include advertising, recruitment, hiring, orientation and training, whilst indirect costs include organisational knowledge and productivity (Jones & Gates, 2007: 20).

Bell (2016: 1) illuminates that the United Arab Emirates has an estimated 31 nurses per 100,000 members of its population. While the ratio is higher than that of many countries in the world, it is comparatively lower than that of most Gulf countries, whose ratios are as follows: Kuwait (45), Saudi Arabia (48), Oman (53), and Qatar (118). The UAE's ratio (of 31) is almost three times less than that of countries such as Canada (92), and well below half the nursing capacity of countries such as the UK (88), France (93), and Germany (115) (Bell, 2016: 1).

The researcher's concern with the retention of newly employed professional registered nurses is exacerbated by the observation that non-retention seems to continue unabatedly. For instance, the Nursing and Midwifery Council (NMC) and Health Authority Abu Dhabi (HAAD) have over the years attempted to lure Emirati citizens to the nursing profession by means of incentives such as full scholarship and high salaries. Despite such noble measures, interest in nursing by UAE citizens ***has not increased*** (Bladd, 2009: 1; Bell, 2016: 1; Zain, 2010: 1). The latter state of affairs is manifested by the fact that Emirati nurses constitute only 1.6 percent of the workforce of 7, 000 nurses employed in SEHA facilities across the entire UAE (Bell, 2016: 1).

1.4 AIM/ PURPOSE OF THE STUDY

According to Henning (2009: 44), the aim or purpose of a study refers to the more general or broadly stated intentions of the particular study. A review of current studies by the researcher indicates that numerous investigations have been conducted on various aspects of mentorship, such as the influence of peer mentoring on nursing education as well school-based mentoring programmes (Randolph & Johnson, 2008; Gisi, 2011: 20). However, no study has been conducted on the role of a clinical resource nurse in peer mentoring and its impact on nursing staff retention. In this regard, the broadly stated intention of the study is to explore and describe the role of a clinical resource nurse in peer mentoring. On the basis of the generated evidence, it is further envisaged that a regime of recommendations will be developed to facilitate and strengthen peer mentoring strategies at SEHA facilities.

1.4.1 Study Objectives

The research objectives specifically relate to the narrower and irreducible intentions of the study (Henning, 2009: 44). The following statements of intent constitute the core objectives of the study:

- To explore and to describe the nature of processes and strategies involved in the partnering of mentors and mentees at SEHA facilities;

- To explore and to describe the strengths and weaknesses of peer mentoring at SEHA facilities; and
- To develop a regime of recommendations for SEHA facilities accruing from the findings/ results of the study.

1.5 THE RESEARCH QUESTIONS

The following research questions have been formulated in order to guide the researcher's adherence to the broader and more specific intentions of the study:

- How is the peer mentoring relationship facilitated?
- What is the role and responsibility of the clinical resource nurse in peer mentoring?
- What are the strengths and weaknesses of peer mentoring? and
- To what extent will the findings of the study yield a credible base for the formulation of recommendations pertinent to the role of a clinical resource nurse in peer mentoring?

1.6 SIGNIFICANCE AND RELEVANCE OF THE STUDY

The significance and relevance of the study premise on the extent to which the reasons for the study's execution are justified or motivated. From the researcher's point of view, the *practical* contribution of this study is the most profound measure of its efficacy, significance, or relevance. It is in this context that the study is envisaged to make a significant two-fold contribution, namely: its disciplinary or epistemological significance or relevance and its institutional or organisational significance or relevance.

1.6.1 Disciplinary/Epistemological Significance

The study's epistemological significance is located within the corpus of knowledge relating to the field or discipline of peer mentoring. The disciplinary or epistemological significance or relevance of the study was derived from the review of relevant literature pertaining to the research. In this regard, the study adopts a perspective according to which the notion of "scholarship review" is differentiated from a mere compilation of lists of secondary sources of information (Muller, 2004; Mouton, 2001). Accordingly, "scholarship review" informed the study's disciplinary/ epistemological contribution, rather than a bibliographic generation of a compendium of general content analysis on peer mentoring.

Mouton (2001) and Muller (2004: 3) illuminate on the salience of the orientation towards a more focused and comprehensive review of literature in order to develop a conceptual and analytic logic. The latter author, in particular, contends: "… every research project should be innovative or original in nature and therefore in its own unique way contribute to the state of knowledge in a particular field" (Muller, 2004: 3). Furthermore, the

specific purpose of a comprehensive review of current literature is “to ensure that adequate and relevant literature is available to inform the theoretical approach, the research design and methodology, the instrument development and to assist in data analysis and findings made” (Muller, 2004: 5). Additionally, the comprehensive review of literature on the research topic provided a theoretical and authoritative context that has the potential to “… pronounce on what has, and what has not been established in a particular field” (Muller, 2004: 5). In this case, the particular field of knowledge (discipline) is embodied in the research topic *per se.*

By its orientation towards “scholarship review” (rather than the mere bibliographic listing of consulted secondary data sources), the study’s disciplinary or epistemological contribution focuses on specific variables or themes such as emergent trends and practices within the sphere of the role of CRNs; while exploring the benefits, challenges and gaps in order to provide support and performance improvement programmes. The study will also aid future researchers as a guide for future studies in clinical education. Peer mentoring increases the confidence of mentors as they take responsibility in introducing the GNIs and new recruits into the nursing community, while also assisting them in professional development – from advanced beginner to expert nurses.

1.6.1.1 Significance to Peer Mentors

The teaching-learning relationship between the mentor and mentee improves the mentor’s confidence when imparting knowledge and skills, as well as improving the mentee’s communication skills. Mentors derive satisfaction in helping to shape the professional life of mentees; leading to mentor’s sense of self fulfilment and personal growth. Mentoring improves relationship between mentor and mentee and may result in lifelong friendship In addition peer mentoring helps to improve retention of staff. Furthermore peer mentoring is a strategy for developing leadership skills of the mentor thereby increasing his or her motivation and confidence. Also mentoring enhances the mentor’s resume.

1.6.1.2 Significance to Nurses in General

Health facilities that embraced and implemented peer mentoring have welcomed the educational benefits it offers. Exploring the CRN’s peer mentoring role will help raise the ***awareness*** of those who are not familiar with this role and its long-term benefits within clinical settings. By means of peer mentoring, mentees are able to find a niche in the organisation, as well as foster professional relationships with other health care providers in order to promote team spirit. Consequently, barriers between middle management and end users are broken, as collegial relationships are forged and elevated.

1.6.2 Institutional/ Organisational Significance

The institutional or organisational significance of the study relates to the study's usefulness or contribution to the enhancement of the performance or reputation of a particular organisation or institution. In this regard, SEHA is of paramount significance, since it is the institution serving as the employer and regulator of nursing norms and standards in the UAE, in addition to serving as the primary research site.

For the employer, the study has direct and immediate consequences. As the primary research sites, SEHA facilities granted the permission for the empirical aspect of the study to be conducted on its premises and facilities. As health institutions, SEHA facilities will benefit from the empirically generated knowledge in order to appreciate the role of peer mentoring as one of the strategies for staff retention. In the latter regard, SEHA's staff retention profile would also benefit from the improvement measures generated through this study's findings and recommendations.

Furthermore, a sustainable and stable employment environment induced by effective and efficient staff retention policies and strategies will inevitably yield immense financial benefits, in that the employer would be in a position to absorb possible losses accruing from disruptive employment factors such as the attrition of nurses leaving the profession.

1.7 CONCEPTUAL/ THEORETICAL FRAMEWORK OF THE STUDY

Knobloch (2010:1) defines a theoretical framework as a systematic ordering of ideas about the phenomenon being studied. A theoretical framework helps in the formulation of the research question(s), thus leading to a better understanding of the phenomenon or phenomena under investigation; that is, to explore and describe the role of a clinical resource nurse in peer mentoring. In its most elementary form, such a role is intended to transform nurses from novice to expert status.

The researcher employed and adapted the following theories to guide the study: Benner's theory of learning; Peplau's interpersonal relationships theory; Mulaudzi's Ubuntu; and the ADDIE (assessment, design, develop and evaluation) model. The theoretical framework is discussed in details in Chapter Three.

1.7.1 Definition of Key Concepts

The definition of the key concepts in this study obviates ambiguity and vacuous lexical or semantic messages. These definitions are intended to provide textual, factual, and technical clarity to the reader. In addition, the definition of key concepts allocated contextually relevant meaning to those terms and concepts that are thematically linked to the research topic, its research problem, and to the research process as a whole.

Cast in this thematic mould, the key concepts themselves are construed as cognitive units of meaning, abstract ideas, or mental symbols defined as units of knowledge relevant to a phenomenon or phenomena under investigation (Mouton, 2008: 175).

1.7.1.1 Clinical Resource Nurse (CRN)

For purposes of this study, the CRN is a registered nurse who has obtained a degree or equivalent qualification in nursing education, and is responsible for facilitating the preceptorship or mentorship programme. A CRN is also a registered nurse with a post graduate qualification in nursing education.

1.7.1.2 Graduate Nurse Intern (GNI)

According to Health Authority of Abu Dhabi (2007: 39), a graduate nurse intern (GNI) is a nurse who underwent a three-year nursing programme from an accredited nursing school in the United Arab Emirates. In this study, the graduate nurse intern is an advanced beginner who works on a supernumerary basis with an experienced registered nurse in order to grow both professionally and personally.

1.7.1.3 Mentoring

A reciprocal teaching-learning professional relationship between a less experienced and an expert registered nurse. Such a professional relationship is intended to foster personal and professional growth, role effectiveness, confidence development, and advancement of the less experienced nurse. The relationship is based on mutual trust, empathy, cultural sensitivity, critical friendship, and openness (Donner & Wheeler, 2007: 20). For purposes of this study, mentoring also encompasses a relationship between a competent or expert nurse and an advanced beginner.

1.7.1.4 Peer

In this study, a peer denotes a registered nurse at the same or different experience level.

1.7.1.5 Peer Mentoring

The professional relationship between an expert nurse and an advanced beginner, intended to aid in the professional growth, role effectiveness, confidence development, and advancement of the advanced beginner.

1.7.1.6 Registered Nurse

According to the Health Authority of Abu Dhabi (2007: 12), a registered nurse is “a first level nurse who is registered to practice without supervision and is responsible and accountable for all their own actions. It is expected that registered nurse works within current legislative and licensing authority guidelines and is educated to a minimum level

of three years general nurse training from an accredited programme which must be at post-secondary school level".

1.7.1.7 Role in Peer Mentoring

The clinical resource nurse's mentoring role in the facilitation of the teaching-learning relationship and socialisation process between the mentor and mentee.

1.7.1.8 Staff Shortage

In this study, staff shortage is described as the prevalence of insufficiently skilled and educated nursing staff who are able to provide optimum patient care.

1.7.1.9 Staff Turnover

In this study, staff turnover refers to a process by which nursing staff members leave or transfer within the health care facility or health care system. Staff turnover may have negative consequences on a health care facility, such as loss of productivity; as well as loss of patient and staff morale – leading to work related stress.

1.7.2 Assumptions of the Study

Assumptions are statements that are taken for granted or considered to be true without evidence (Burns & Grove 2009: 40). They can be consciously or unconsciously embedded in the thoughts and behaviour of the researcher. In addition they are embedded in the philosophical framework, study design and interpretation of findings. Therefore, assumptions influence the logic of the study. Accordingly, the researcher holds beliefs and assumptions regarding the role of the clinical resource nurse in peer mentoring. However, such beliefs were secondary to those expounded by the research participants.

1.7.2.1 Ontological Assumptions

Ontology is defined as "the study of being" (Van Rensberg, Alpaslan, du Plooy, Gelderblom, van Eeden & Wigston, 2009:18). Its main focus is on the structure and nature of reality and human beings in the world. There are two ontological perspectives, the critical realist and the relativist (Levers, 2013: 2). The relativists posit that reality is a finite subjective and nothing exists outside of our thoughts. Critical realists on the other hand, assert that truth exists independent of human observation. In this regard, the purpose of this study is to understand assumptions in the context of the study. The following ontological assumptions are made in the study:

- Multiple realities of individuals are central to the exploration, description, and meaning of the role of the clinical resource nurse in peer mentoring and its impact on staff retention;

- Participants' experience, feelings, and meaning-making will enable the researcher to appreciate the diversity and complexity of multiple social realities; and
- Knowledge, experience, and meaning-making can be known through the participants' description of the role of the clinical resource nurse in peer mentoring, and the impact of such a role on staff retention.

1.7.2.2 Epistemological Assumptions

Crotty (2003, cited in Ahmed (2008: 3), defines epistemology as "a way of explaining and understanding how we know what we know". The researcher interacted with participants, thus minimising the distance between the researcher and the participants in order to understand their experience and emotions. The research findings are also a reflection of the result of the interaction between the researcher and the research participants. The relevant and applicable epistemological assumptions in this study are stated below:

- An individual participant could reflect and state his or her feelings, experiences, and provide meaning to the role of the clinical resource nurse in peer mentoring and its impact on staff retention in a particular context;
- The natural setting of participants enables them to express their views uninhibited; and
- The knowledge that participants share with the researcher is maximised, since the researcher is part of the research.

1.7.2.3 Methodological Assumptions

Methodological assumptions consist of the assumptions made by the researcher regarding the methods used in the process of qualitative research. In this study, the researcher generated data inductively, and used semi-structured interviews and open-ended questionnaires due to their comprehensive elicitation of data for purposes of exploring and describing the role of the clinical resource nurse in peer mentoring; as well as the impact of such a role on staff retention.

1.7.3 Theoretical/ Meta-Theoretical Grounding

Knobloch (2010) defines a theoretical framework as a systematic ordering of ideas about the phenomenon being studied. A theoretical framework helps in the formulation of the research question(s), thus leading to a better understanding of the phenomenon or phenomena under investigation; that is, to explore and describe the role of a clinical resource nurse in peer mentoring. In its most elementary form, such a role is intended to transform nurses from novice to expert status.

Benner (in George, 2011: 582) uses the Dreyfus model of skill acquisition to provide a framework on nurses' progression from novice to expert status. The model identifies five different stages of nurses' opinions of their tasks as their professional nursing skills improve. These stages are: the novice, the advanced beginner, the competent, proficient and expert stages.

The *novice* stage is completed during the course of the student nurse training programme. During this stage, the nurse is exposed to new experiences and opportunities for the performance of tasks. Decision-making is dependent on the recognisable features of a particular situation.

The *advanced beginner* is at the growing stage of realizing the complexity of the situation and performs tasks based on the experience gained by coping in real-life situations; remains task-oriented; relies on the expertise of senior colleagues for decision-making; recognises change in a patient's clinical state. Notwithstanding all of the aforementioned variables, the advanced beginner still has insufficient experience to manage the change(s) taking place; the ability to prioritise the importance of a situation; and views all situations as being of similar importance. Benner (in George, 2011: 582) asserts further that it is during this stage that the nurse needs clinical support, without which the prioritisation of patients' needs may be conflated due to the nurse's insufficient experience in discriminating aspects of patient care that may take precedence over others. Clinical support is a mechanism to ease challenges faced in the first year, such as inadequate confidence in clinical knowledge and skills; workload demands; prioritisation and organisation related to care delivery; and interaction with physicians (Elridge, 2007; Duchscher, 2008).

1.8 RESEARCH DESIGN AND METHODS

It is worth mentioning at this juncture that the research design and methodology of this study – including the sampling procedures and techniques – is presented and discussed in more detail in Chapter Four of this research report.

1.9 LIMITATIONS OF THE STUDY

The limitations of the study are discussed in details in Chapter Six, and encompass discipline-specific, literature-based, and empirically-derived limitations.

1.10 ORGANISATION OF CHAPTERS IN THE STUDY

The thesis is divided into six chapters, all of which are pertinently linked to the research topic in order to present a logical and coherent concatenation of the entire research process.

Chapter 1: Introduction to the Study

Chapter 2: Literature Review

Chapter 3: The Conceptual and Theoretical Frameworks

Chapter 4: The Research Design and Methods

Chapter 5: Data Presentation and Analysis/ Interpretation

Chapter 6: The Findings, Conclusions, Recommendations, and Study Limitations

1.11 CONCLUSION

The current chapter provides an overview of the entire research project in respect of statement of the research problem; the presentation of the research aim/ purpose and objectives; the research questions; the conceptual and theoretical frameworks; the significance or relevance of the study; a synopsis of the data collection and analysis processes; as well as the limitations of the study. It is worth mentioning that most of the research variables cited above are presented and discussed in more detail in subsequent chapters of this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The primary objective of this chapter is to present and discuss the review of relevant literature pertaining to the research topic. This chapter, therefore, highlights the conceptual and theoretical parameters of the research topic (addressed in more detail in Chapter 3); the emerging themes, perspectives, trends, and practices; as well as policy implications obtained from the review of relevant literature pertaining to the role of the clinical resource nurse in peer mentoring. The purpose of this literature review is to provide a background of the study and to familiarise the researcher with the core aspects and issues relating to the topic being studied (de Vos et al., 2011: 115). A phalanx of conceptual lexicon included nuances such as mentee; preceptor; preceptee; coaching; nursing staff shortages; characteristics of the work environment; attributes and roles of mentors; criteria for matching; peer mentor matching; phases of peer mentoring relationships; description of mentoring styles; as well as the strengths and weaknesses of the peer mentoring process. All of these textually derived terms, established a profound background for better understanding of the research topic and its associated dynamics and variables.

2.2 NURSING DYNAMICS IN THE UNITED ARAB EMIRATES

In this study, the nursing dynamics in the UAE have been situated within both the *macrocosmic* (e.g. organisational or institutional) and the *microcosmic* domains of nursing as both a profession and as a field of study in its own right. In this regard, nursing dynamics in the UAE are discussed in the contexts of the workforce human resources management (HRM) perspective and the cultural dimension.

2.2.1 The Cultural Dimension

The cultural dimension of nursing dynamics in the UAE reflect the extent to which lifestyle, norms, and practices have played a role in the sphere of nursing clinical standards and professional nursing workforce imperatives. UAE culture is profoundly influenced by Islam as a form of religion (Khalaf, 2009: 2329). Accordingly, gender segregation is institutionalised; therefore, socially allowed, sanctioned, and actualised by the various structures of government. Different genders do not interact publicly, and nursing care is provided by nurses of the ***same*** gender as the patient, unless it is dictated to contrarily under absolutely exceptional circumstances. Furthermore, peer mentoring is complicated by gender issues as mentor and mentee should be of the same gender; given the ‘conventional’ perception that nursing is a predominantly female

dominated low-status profession (Shallal, 2011: 116).

2.2.1.1 Perceived Low Status of the Nursing Profession in the UAE

Nursing is arguably a female dominated profession, and as such, fails to attract considerable numbers of Emirati males (El Sabibi, 2012: 5). According to D'Souza (2013: 1), professionally trained nurses of Emirati origin comprise only four percent of the UAE nurse workforce, despite all the efforts from the government to recruit the locals to nursing as a voluntary career of choice. The reasons for this magnitude of reluctance among the Emirati females joining the nursing profession vary from low salaries, perceived low status of nursing, and the associated working conditions. However, the figure of only four percent is expected to rise to eight percent by 2015 (D'Souza, 2013: 1).

Due to the tremendous nursing workforce shortage in the UAE, the country is compelled to depend on expatriate registered nurses and GNIs from the local nursing colleges to meet the country's health care needs. The expatriate nurses are mostly recruited from the Western, Asian, and Arab Gulf countries. Since all countries have different systems of nursing education programmes and inter-cultural communication mechanisms, multiple adaptations to clinical and cultural competence may impact on the quality of patient care and health care facilities in countries recruiting expatriate nursing skills (McKusick & Minick, 2010: 334). To counteract the negative experience of new expatriate recruits and nurse interns, organisations provide planned orientation programmes. All new expatriate nurses go through the hospital orientation programme for two weeks, after which they are assigned a preceptor or mentor for three months to equip and empower their smooth transition and acculturation into the new work environment. In this context, the role of the CRN is to facilitate peer mentoring and to enhance staff retention within the broader realm of UAE acculturation.

Although the number of employed females in the UAE is smaller compared to the overall workforce, they contribute $3.4 billion to the country's economy. This is due to companies placing restrictions on the number of females on their employment register. Also, some jobs are considered to be of low status, especially those within the nursing and the hospitality sectors. The perceived low status of nursing is largely attributed to factors such as variation in nursing programmes; inadequate Arabic educational resources; affluent lifestyles and cultural norms and values by which UAE nationals live; as well as unsupportive working conditions characterised by insufficient empowerment opportunities (Shallal, 2011: 115; Jardali et al., 2008: 41).

2.2.2 The Organisational/ Institutional Environment

As opposed to the cultural dimension of nursing in the UAE (which focuses mainly on the impact of lifestyle-induced factors), the organisational or institutional environment focuses on those inhibitive factors that are confined to, or induced by the professional nursing workforce environment.

2.2.2.1 Discrepant Uniformity in Licensing and Regulation

There are currently three nursing and health regulatory bodies that are responsible for the licensing and regulation of nurses employed in the different emirates in the UAE, namely: the Ministry of Health (MOH), Health Authority Abu Dhabi (HAAD), and the Dubai Health Authority (DHA) (Underwood, 2010: 1). These bodies have different rules and requirements pertaining to nursing education qualifications, standards, and verification. Unifying the regulation and licensing of nurses will ensure that all patients in different emirates enjoy the same standardised quality of care from nurses in various healthcare institutions. Currently, all expatriate nurses maintain a dual professional identity; their home license and the HAAD license due to the UAE's Nursing and Midwifery Council not yet being a fully functional regulatory organisation. Al Rifai (cited in Underwood, 2010: 1) asserts that "by 2015 we would like to have a new system where nurses and midwives only need to register with one agency and will all meet the same minimum standard".

2.2.2.2 Limited Career Opportunities

Following the policy of the Health Authority of Abu Dhabi (HAAD), only nurses who hold a Bachelor of Nursing Science (BNS) degree may be employed in critical care areas. Nurses with only diploma qualifications work in non-critical areas, or are even allocated practical nurse status (El Salibi, 2012: 5). The prevalence of limited career opportunities inadvertently leads to high staff turnover. Al Rifai (cited in Underwood, 2010: 1) mentions that the UAE Nursing and Midwifery Council will increase, improve, and develop relevant and effective strategies to regulate and standardise nursing education and qualifications requirements. Such measures are envisaged to encourage nurses to take up specialties such as critical care and neonatal nursing, broadening the scope of currently limited career opportunities.

2.2.2.3 Nursing Turnover and Nursing Staff Shortages

WHO (cited in Etienne, 2013: 1) predicts that the shortage of nurses is on the rise, such that by 2020, more than 1.8 million nurses will be required worldwide, including in the UAE (Bell, 2014: 1). The projected chronic shortage of nurses worldwide has engendered a nursing atmosphere characterised by detrimental factors such as the

sub-optimal provision of patient care, burn-out, and disgruntled staff members; with the latter as an apex expression of low staff morale. A World Health Organization (WHO) report (cited in Lavoie-Tremblay et al. 2008: 290) mentions poor nursing practice environments and working conditions as some of the contributory factors to staff recruitment and retention challenges. Nurse turnover and retention affect both staff and patients alike. High staff turnover impacts negatively on the quality of patient care, access to patient care, as well as staff satisfaction. Shortage of nursing worldwide affects the United Arab Emirates as well, and is compounded by various factors, such as: cultural dynamics; retirement of the baby boomer nurses; fewer younger people entering the nursing profession; low status and self-esteem; limited career opportunities; as well as discrepancies in licensure and regulation of the nursing profession will be discussed below (Park & Jones, 2010: 142; Underwood, 2010: 1; Welding, 2011: 37).

In Section 1.3 (pp. 2-4) of the study, the research problem has been ***quantified*** in the context of challenges induced by nursing turnover and nursing staff shortages. The rationale for the quantification aspect is premised on the demonstration of the ***magnitude*** (scale and size) of the problem. The UAE's estimated 31 nurses per 100,000 members of its population is relatively ***lower*** than that of many countries (Bell, 2016:1). For instance, in the Gulf states, Kuwait's ratio for its population is 45; Saudi Arabia (48); Oman (53); and Qatar (118). In the same vein, the UAE's above-cited estimate of 31 nurses per 100, 000 members of its population is almost three times less than the nursing capacity of Western countries such as Canada (92); the UK (88); France (93); and Germany (115) (Bell, 2016: 1). The UAE's nursing shortages and staff retention and turnover challenges are ***extant***, despite efforts by nursing colleges, the NMC, and HAAD of enticing Emiratis to join the nursing profession by utilising incentives such as full nursing scholarships and high salaries (Bladd, 2009: 1; Bell, 2016: 1; Zain, 2010: 1. Such commendable initiatives have not ameliorated a state of affairs in which Emirati nurses make up only 1.6 percent of a nurse workforce of 7, 000 nurses employed in SEHA facilities throughout the UAE (Bell 2016:1).

As perhaps the most centripetal phenomenon of nursing dynamics in the UAE, nursing shortages straddles both cultural and organisational boundaries. For purposes of this study, 'staff turnover' is defined as a process by which professional nursing staff members leave a particular health care facility for another, or transfer within the same health care facility or health care system. On the other hand, 'staff shortage' is described as the predominance of insufficiently skilled and trained nursing staff capable of providing optimum patient care. Staff turnover may have a negative impact on a

health care facility, such as loss of productivity and declining patient and staff morale; leading to work overload and its related stress.

Staff turnover may be beneficial to a health care facility, such as: inducing a reduction of salaries and benefits of new employees against those of the departing nurses, as well as savings from bonuses not being paid to outgoing nurses (Jones & Gates, 2007: 24). There is evidence that certain levels of staffing turnover may help build a quality nurse force and thus eliminate poor performers. Instilling a culture of monitoring and evaluating staff turnover is essential. Amongst other factors, such a culture reinforces improved staff morale, productivity, and patient care; decreased costs associated with turnover; as well as replacement nurses brining new ideas, creativity, innovation, and knowledge of competition (Jones & Gates, 2007: 24). Consequent to a turnover at a particular health care facility, those who are retained are safe practitioners who will serve and be role models and mentors to the graduate interns and new employees. A study by Jones and Gates (2007: 20), showed that the cost of staff turnover transcends the benefits associated with staff retention. The actual estimates vary, depending on years of experience and education, amongst other determining variables. Turnover costs are estimated to be 1.3 times the salary of the departing nurse. The above-cited authors cite further that the cost of replacing just one registered nurse ranges from 40 000 to 80 000 AED, depending on the geographic location (within the Emirates) and specialty area within the nursing profession. Direct costs include advertising, recruitment, hiring, orientation and training; whilst indirect costs include organisational knowledge and productivity (Jones & Gates, 2007: 20).

An effective workforce strategy should focus on the recruitment and retention of staff, and assisting the existing staff to improve on their clinical performance. Such a strategy inevitably enhances productive nursing practice environments and working conditions. Correspondingly, the Nursing and Midwifery Council of the UAE alerts that population growth and the changing demands of the UAE's health services are some of the factors which elevate the increased need for more professional medical services in order to improve the health needs of the country. Due to unhealthy life styles, longevity of the population, as well as chronic co-morbidities such as diabetes, the UAE in particular will require more nurses in its workforce. In response, the Nursing and Midwifery Council of the UAE and other stake holders have developed strategies to improve the quality of nursing (UAE NMC, 2013: 7; Bell, 2014: 1).

2.2.3 The Individual Psychological Domain

The individual psychological domain – which inevitably has an affinity with both the cultural and organisational or institutional contexts of nursing in the UAE – is mainly concerned with the extent to which the *personal* circumstances, characteristics, or attributes translate and conform to both the cultural and the organisational/ institutional environments of nursing in the UAE context. For instance, some study findings relating to individual factors show an inverse relationship between nurses' *age* and *turnover* intentions (Townsend, 2012: 14). The younger nurses are more likely to leave nursing than their older counterparts, due to the availability of attractive job opportunities elsewhere (Hayes et al., 2011: 889). On the other hand, the older nurses may be loyal to the organisation, but resistant to change. Minimal kinship responsibilities also contribute to nursing turnover. Nurses who have families are likely to stay than those who do not have. Furthermore, younger and neophyte nurses may consider nursing as a less attractive employment destination due to the perceived unfriendly and psychologically oppressive working environment; as well as insufficient support from senior management within the organisation.

2.2.3.1 The Transition Stage

The transition period is the 'make or break' moment of a graduate nurse (Hayes et al., 2011: 889). It is the valuable and fragile period during which decisions are made regarding the intention to remain in, or leave the nursing profession. In addition to nursing turnover and the individual peculiarities of GNIs, shortages of staff, inadequate resources and team support, high patient demands, as well as the declining image of the nursing profession; individual inexperience and the inability to deal with complicated situations are consequences of the 51-61 per cent of GNIs' staff turnover (Lee et al., 2009:1218). The contradictions or tensions between turnover and the actual work *expectations* may induce an environment of role ambiguity.

Role ambiguity affects the GNIs' ability to meet the demands of the organisation, whilst maintaining professionalism at the same time. Disparity between the characteristics of the *idealized* role and actual achievement is viewed as contributing to role stress. Role stress itself is related to the inability to have control in one's own work situation, characterised by factors such as: insufficient support from colleagues; high workloads and the inability to cope with challenges of the new job; as well as unclear information regarding expected behaviour in the new role (Hayes et al., 2011: 889; Parker et al., 2012: 3). The transition stage of graduate nurse interns, therefore, may be influenced positively or otherwise by the culture and various dynamics of the workplace; resulting

in either job satisfaction or their feeling overwhelmed by the reality of the job situation in relation to their perceived or idealised role (Parker et al., 2012: 3). The latter state of affairs inevitably leads to the prevalence of a high nursing turnover.

2.2.3.2 Interpersonal Relationships Building

The nursing profession is founded on the dictum: *do unto others what you would them do unto you*. It is dedicated to the nurturing and compassionate care of others. Furthermore, nursing socialises neophyte nurses into the profession; where a collective spirit of brotherhood and sisterhood is inculcated irrespective of the members' gender, religion, or social standing. Patients trust nurses to care for them*, yet nurses often times fail to care for each other*. This latter tendency is known as 'nurses eating their young' (Freshwater, cited in Szutenbach, 2013: 17). Such a response by nurses to conflict and stress is compared to the behaviour of animals; according to which stress causes the animals to turn on their young and devour them. In nursing, the 'nurses eating their young' phenomenon is also known as bullying; the "repeated, offensive, abusive, intimidating, or insulting behaviours; abuse of power; or unfair sanctions that make recipients feel humiliated, vulnerable, or threatened, thus creating stress and undermining their self-confidence" (Townsend, 2012: 12). Bullying manifests itself in various forms, such as: gossiping, ignoring, disrespectfulness and condescension, as well as verbal and physical attacks. Bullying affects both the self-confidence and self-image of the person being bullied, and leads to high turnover of GNIs. Bullying is also referred to as lateral violence, aggression, incivility, horizontal aggression, lateral hostility, and the 'tall poppy syndrome' (Szutenbach, 2013: 8; Kuntz, 2015: 6).

In spite of the prevalence of such a phenomenon, Mulaudzi et al. (2009: 46), argue that historically, there is evidence to prove that senior nurses have been supportive to their younger counterparts. The latter authors cite that the history of *Daughters of Charity* in Europe and the United States show that the good senior-nurse-to-junior-nurse relationship of the past 400 years, still prevails to date.

The 'nurses eating their young' phenomenon originates from the power relations that characterised the early stages of nursing. Nursing was physician-led, and nurses felt oppressed and powerless to express their feelings and concerns to physicians, despite their interdependent function with physicians. As a result, older nurses reciprocated and vindicated their frustrations on their younger counterparts. The results of such unpalatable experiences are manifested in the prevalence of inimical factors such as threat to patient safety and low morale, and may also cause nurses to seek employment elsewhere or leave the profession entirely (Ludwig, 2013: 23).

In a study on nurses 'eating' their own, Baker (2012: 9) and Johnson and Rea (2009: 85) posit that GNIs suffer bullying from peers, experienced nurses, or CRNs whom they view as mentors in the clinical setting. Other studies also indicate that a combination of bullying and stress takes place in nursing colleges also – sometimes with devastating outcomes; for example, a professor who killed other professors at Concordia University (Cooper et al., 2011: 2).

In an attempt to obviate the prevalence of bullying and its potential damage to the character of nursing in general, the JCI issued regulations in 2008 as a pre-requisite in health care facilities to address uncivil workplace behaviour by nurses. The JCI's action was based on the relationship between uncivil behaviour and its potential negative impact on patient care, staff turnover; and therefore, staff shortage (Cooper et. al., 2011: 2; Szutenbach, 2013: 14).

2.3 PEER MENTORING

Retention of staff continues to pose a challenge in the nursing profession, as indicated in the 2004 survey conducted by Boychuk et al. (cited in Lavoie-Tremblay et al., 2008: 291), which showed that 53 percent of GNIs left their jobs in the first year of work due to horizontal violence and inadequate support from senior or expert nurses. Horizontal violence itself is characterised by "hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words and/or behaviors [as well as] the presence of a series of undermining incidents over time, as opposed to one isolated conflict in the workplace" (Becher & Vivosky, 2012: 210). In addition to inadequate support from senior or expert nurses, the assertion by the above-cited authors irrefutably makes a case for peer mentoring.

What makes an effective peer mentor/ preceptor? According to Dunn (2012: 401), "the desire and drive to maintain an active connection with advanced beginner nurse", constitutes a vital aspect of a competent nurse who contributes effectively to a learning and teaching environment. Competent nurses should be supportive, knowledgeable, and sensitive to the needs, ideas, fears and insecurities of the advanced beginner nurse; fosters opportunities for continuing education for professional growth; creates a safe and enabling environment for mentees to share their feelings and ideas; and builds a healthy relationship based on trust, empathy, and empowerment (Dunn, 2012: 401). Wagner and Seymour (2011: 201) add further that mentors should provide a safe space that promotes learning and a non-threatening environment to ask questions, considering that more stress is added by clinical practice at bedside – thus reinforcing the case for peer mentoring.

According to Dunn (2012: 402), the root (*men)* in 'mentor' means 'to remember', think or counsel. A mentor guides the mentee in remembering the experiences and required expectations. Therefore, a mentor or preceptor is a role model, a guide, or a sponsor. As a role model, the mentor shares past experience with the mentee (the one being mentored), and provides information gained through past experience. A mentor guides and supports confidently, provides encouragement, professional judgment, and insight. The mentor-mentee relationship is open and based on mutual trust, feedback, and confidence; thus enabling both parties to share ideas, feelings and job realities. As a sponsor, the mentor familiarises the mentee with the culture of the nursing profession by means of counselling, advice, and feedback. In doing so, the mentor has to explore the mentees' "needs, motivation, decisions, skills and thought processes" (Dunn, 2012: 402). The role of the mentor also includes assessing the readiness of the GNI's critical thinking, reflection, and debating skills by questioning the GNIs behaviour based on their understanding of the clinical situation (Mills & Mullins, 2008: 311).

2.3.1 Seminal Studies in Support of Peer Mentoring

There are numerous studies that have been conducted on peer mentorship, such as the review of research on the influence of peer mentoring on education and student attrition (Gisi, 2011), as well as on school-based mentoring programmes (Randolph & Johnson, 2008). However, the role of the CRN in peer mentoring and its impact on staff retention has not been adequately investigated. A 2008 study by Lavoie-Tremblay (cited in Harrison-White & Simons, 2013: 24) found that 43.4 percent of registered nurses reported high levels of stress, and that support through mentorship programmes was likely to influence the GNIs and new employees to stay in the profession. Research studies also demonstrated that high turnover of GNIs is associated with poor patient outcomes related to medication errors and patient falls (Joyce & Choi, 2013: 23). The results of a 2004 JCI study showed that 24 percent of the adverse clinical errors in the health care facilities were induced by inadequately trained nursing staff, and 58 per cent were due to inappropriate training of new staff (Lee et al., 2009: 1218).

Other surveys of newly graduate nurses showed that inadequately prepared job readiness and co-worker support led to increased intentions to leave the profession (McKusick & Minick, 201: 335). The study by Lavoie-Tremblay et al. (2008: 292) highlighted the different characteristics of the new generation of nurses, describing them as the generation Y of GNIs; who are technologically skilled ideal workers and risk takers with a high work ethic. Furthermore, "they value participation, collaboration and support as opposed to competition" (Lavoie-Tremblay et al. 2008: 292). They are

confident extroverts who expect constant feedback, frequent praise, constant rewards, and recognition. An understanding of these generation Y characteristics, of improvement in the work environment, and of the effective pairing or matching in peer mentoring will positively impact on the retention of staff in nursing and health care facilities.

Randolph and Johnson (2008: 177) conducted a study on a school based mentoring programme for children with behavioural problems and learning difficulties. The primary focus of the study was on the learners' academic development and relationship between activities. The study concluded that the relationship between mentor and mentee could either be formal or informal, and that mentorship provides empathy and attention to students. It also helps to create a healthy relationship between the mentor and the mentee. Hilli et al. (2014: 566) add further that the mentor-mentee relationship promotes clinical competence, organisational skills, improves critical thinking and "nursing thinking" as well as promoting a successful learning milieu. The primary purpose of the mentor-mentee relationship is to provide guidance in complexities, skills, and knowledge regarding the profession; all of which lead to personal and professional growth and encouragement aimed at developing the confidence and character of a mentee (Dunn, 2012: 401).

A study by Epstein and Carlin (2012: 898) concluded further that the mentor-mentee relationship has an ethical dimension. The values of a clinical environment should support good patient care. Otherwise, low morality in the work environment precludes the preceptor's/ mentor's ability to recognise ethical issues. A research study by Aiken (cited in Dawson et al., 2014: 13) concluded that workplace variables such as: low morale, management issues, high workloads, time spent on non-nursing tasks, inappropriate skills mix, inadequate patient-staff ratios, low involvement in decision-making, as well as insufficient autonomy increased patient demands, poor support, limited career opportunities and reward systems (incentivisation) and recognition as causes of the high turnover in nursing. Such a state of affairs (as indicated collectively under the cultural, organisational, and individual domains) justifies the prevalence of mentorship/ preceptorship as a concerted means to retain the services of neophyte nurses in health care facilities. The (formal or informal) relationship between an advanced beginner nurse and a competent nurse could be positive, and continue beyond the transitional period of the neophyte registered nurse. However, the relationship could occasionally be fraught with strife and inadvertently become a contributory factor to a high staff turnover.

2.3.1.1 A Peer Mentoring Model

Different orientation models are offered by health care facilities, including mentorship/ preceptorship and residency programmes. There is evidence that these programmes are successful globally. However, factors such as the composition, duration and degree of supernumerary support, the extent of clinical exposure, and the autonomy in the early stages of these programmes have not been fully tested or examined (Zizzo & Xu, cited in Parker et al., 2012: 3). While these programmes are tailor-made to meet the needs of health care organisations, research studies show that their transparency, efficiency and consistency need to be revised (Zizzo & Xu, cited in Parker et al., 2012: 3). In an effort to retain GNIs and newly employed staff, SEHA facilities offer a two-day "nurses as teachers" programme for competent nurses, and a one-year residency programme for GNIs. The prospective mentors then complete mentorship competencies with the unit manager. The table below depicts aspects of the two-day preceptorship offered at SEHA facilities.

Table 2.1: Aspects of the two-day SEHA preceptorship workshop

Day 1	Introduction of 'nurses as teachers' training programme model
	Socialisation
	Socialisation exercises
Day 2	Learning needs assessment
	Planning of learning needs
	Conflict and cooperation management and exercises

Source: Babu (2010)

The above table emphasises the nurturing of the advanced beginner nurse by a competent nurse. In this regard, the nurturing process is viewed as part of the facilitation of learning and professional development. The mentor has a non-judgmental disposition, is an active listener, and also asks questions to clarify mentees' goals and objectives. Questions asked by the competent nurse should enable the advanced beginner nurse to develop decisions making, problem-solving and critical thinking skills.

2.3.2 Peer Mentoring Styles

The relationship between mentor and mentee largely defines the parameters of a mentoring style. Furthermore, mentoring styles differ according to the setting, the individuals involved, the level of professional achievement, the expectations of the advanced beginner, and the mentoring purpose (Holmes, 2010: 338). Furthermore, the

uses of mentoring styles are situational, and no style is better than the other. The styles, whether structured or unstructured, offer a valuable opportunity for the advanced beginner in terms of obtaining observation and presentation skills, as well as assessing the needs of others (Holmes et al., 2010: 339). Leinndenfrost et al. (2011: 349) have identified four mentoring styles, distinguishable by the *quality* of support, the *activities* involved, and the *structure* provided by the competent nurse in peer mentoring:

- Moderate mentoring: provides conditional support and moderate levels of activity of structures;
- Unconditionally supportive mentoring: provides moderate levels of structure, activity, and highest levels of support, the focus of which is on building relationship, goal setting and problem solving than assignments
- Active mentoring: provides lowest level structure, support, and highest level of activity; and
- Low key mentoring: provides lowest of activity and structure and highest level of support.

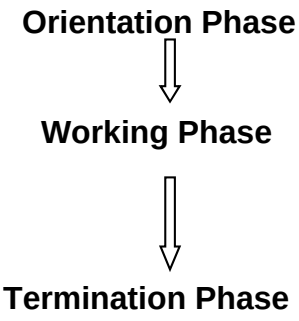
The moderate mentoring style was found to be beneficial to advanced beginners, as a moderate level of activity is indicative of competent nurse involvement (Leinndnfrost et al, 2011: 352). In spite of its known advantages, the latter authors argue that on-line mentoring was more beneficial than the traditional mentoring Leinndfrost et al (2011: 354).

In their study to explore the form and function of the mentor-mentee relationship in an undergraduate nursing course. Vafeas and others (2009: 1) identified four fundamental aspects that are crucial to any mentoring style, namely: engagement, nurturing, empowerment, and reflection; all of which are also critical to the success of a mentor-mentee learning relationship. Depending on the situation, these strategies could be used on any phase of the peer mentoring relationship cycle, as well as the mentoring style of the competent nurse. For instance, in the orientation phase of mentoring, the competent nurse establishes a rapport with the advanced beginner nurse and raises his/ her awareness regarding the health care plan or patient needs. The competent nurse may then prompt or further probe the thinking process, problem solving and decision making skills of the advanced beginner nurse. Such processes lead to staff retention.

2.3.3 The Phases of a Peer Mentoring Relationship

Peplau (cited in George, 2011: 66) identified four phases of the life cycle of in the interpersonal relationship between the nurse and the patient, namely: orientation, identification, exploitation and resolution. These phases overlap and are interrelated, varying in duration as the relationship progresses towards its ultimate conclusion. Peplau wrote that the nurse-patient relationship is composed of three phases: orientation phase, working phase, and termination phase as depicted below in figure 2.1 below (George, 2011:66). Identification and exploitation were fused into the working phase. The researcher used Peplau's theory of inter-personal relationships due to its applicability and relevance to the study.

Figure 2.1: Peplau's three-phase model of a peer mentoring relationship



Source: Researcher's own adaptation from Peplau's theory of interpersonal relations in nursing from (George 2011: 67)

2.3.3.1 The Orientation Phase

The first step of this learning relationship is about establishing rapport and trust. Both parties (the mentor and mentee) initially meet as strangers and are anxious about the manner in which they will relate to each other as individuals. In most cases, they would have no input regarding their pairing. The advanced beginner is assigned to a competent nurse, who may initially worry about whether his/ her mentoring abilities would be able to meet the learning needs of the advanced beginner. Each individual brings their own expectations, uniqueness, worldview, and preconceived ideas that influence their opinions. Differing perceptions are vital to the interpersonal relationship. The competent nurse, however, brings an array of nursing knowledge and experience in areas such as stress and crisis management, as well as developmental theories that lead to better understanding of the role of the mentor in peer mentoring (George, 2011: 66).

During the orientation phase, contact time for mentoring activities is essential, as well as for assessing the learning styles and learning needs. The attitudes of both parties affect how they give and receive support. They need to be aware of how they react to each

other in the context of their culture, age, race, educational background, experience, preconceived ideas and expectations. The success of peer mentoring relationship lies on both parties working collaboratively to identify and clarify learning needs, as well as planning a course of action to meet those learning needs. By discussing issues concerning tension, anxiety and fear, trust and confidentiality are established as the parties' progress towards the working phase (George, 2011: 67).

2.3.3.2 The Working Phase

The working phase involves building the confidence and learning needs of the advanced beginner. Throughout this phase, both parties clarify each other's expectations and perceptions. Also, learning contracts are drawn, and time of contact and objectives are set. Recording of observations is required. The advanced beginner may begin to accumulate a sense of belonging, feel optimistic about the learning milieu, and shows interest by attending unit activities such as the skills day (George, 2011: 68).

During this phase, some advanced beginners may make begin to make more demands and minor requests, or use other attention-getting techniques based on their individual needs. In order to facilitate the subsequent learning expectations, the competent nurse may involve additional help of the Clinical Resource Nurse, Clinical Nurse Coordinator, or Unit Manager. The competent nurse needs to explain the professional role of the people involved, so that the advanced beginner nurse is aware of the advantages and disadvantages of consulting with each of these professionals (George, 2011: 69).

The competent nurse may also use interviewing techniques to explore, understand, and deal with underlying problems. The competent nurse needs to convey an attitude of acceptance and trust in order to maintain a healthy learning relationship. Reciprocally, the advanced beginner nurse should also be encouraged to explore feelings, thoughts, emotions, and behaviour by providing a non-judgmental atmosphere and a conducive learning environment. Such a state of affairs will lead to self-sufficiency, establishment of appropriate behaviour for goal attainment, meeting challenges, and progress to the termination phase (George, 2011: 70).

2.3.3.3 The Termination Phase

Effective collaboration, clarification of misconception, and exploration of feelings and emotions, enhance the advanced beginner nurse's learning needs. The advanced beginner nurses are encouraged to make decisions and utilise their problem solving skills, creativity and innovation. The learning relationship is ready for termination and dissolution of links between the two parties (George, 2011: 71).

Sometimes, both parties have psychological difficulty in dissolving the relationship, despite the actualisation and realisation of the learning needs of the advanced beginner nurse. The competent nurse is able to determine whether or not the learning objectives have been achieved, as this will be evident by the advanced beginner nurse's performance in the clinical practice. The termination might also be difficult for the competent nurse who may still wish to observe the other party's progress. However, tension and anxiety may increase between the parties in the event that the completion of the phase was unsuccessful. In the case of a successful termination, both parties begin to work independently, and emerge as stronger and mature individuals. The termination phase is accomplished with the successful completion of the previous phases supported by various mentoring styles (George, 2011: 71).

2.3.4 Peer Mentor Matching

There are different schools of thought and persuasions regarding the suitable matching of mentor and mentee. Some schools of thought suggest that similar personality traits, learning styles, age, or gender constitute the success of this professional learning relationship. Different personality traits may put a strain on the learning relationship, thus causing setbacks of the anticipated mentoring progress and its associated phases. Another school of thought suggests that different personality traits are conducive to learning and commitment, as parties learn from each other (Nick et al., 2012: 3). Mentor-mentee ***compatibility*** is further enhanced by the strength and experience of the mentor, which will lead to mutual growth and success of the peer mentoring experience by sharing of ideas. Both parties should therefore, be willing to commit to the learning relationship (Beecroft et al., 2006: 738). Newly employed nurses are assigned mentors/ preceptors who have completed the two-day preceptorship programme, and are found to be competent as preceptors after the two-day training programme. If they are unavailable, any available staff member who completed the two-day 'Nurses as Teachers' workshop is allocated the assignment. Beecroft et al. (2006: 738) suggest that although procedures such as compatibility and interest assignment may be employed to find the ideal match for a mentee, working in the same shift during peer mentoring enhances the learning relationship. SEHA facilities employ random pairing, which is found to be mostly effective. Successful learning relationship in peer mentoring is equally enhanced by means of dissimilar personalities, perceptions, experiences, and learning from each other than in the case of similar personalities. Nick et al. (2012: 5) offer various best practice pairing methods, which are discussed below.

2.3.4.1 Peer Mentor Matching Criteria

Appropriate fit (compatible personalities) is vital for success in peer mentoring. Such appropriate fit ensures that a successful mentor-mentee relationship exists, according to which high turnover and other clinical and other human resources anomalies are pre-empted in order to restore the integrity of both the nursing profession and health care facilities employing these nursing practitioners (George, 2011: 67; Townsend, 2012: 12). According to Nick et al. (2012: 5), successful or appropriately matched pairing may be accomplished by adopting the following methods, though there is no clear evidence as to the pre-eminence of one method above the other:

- Pairing influenced by mainly administrative considerations;
- Pairing based on specified criteria;
- Pairing based on advanced beginner's choice of mentor;
- Pairing based on the mentor's desire to take the advanced beginner 'under his/ her wing' due to the recognised potential of the advanced beginner by the prospective mentor; and
- Pairing based on both the advanced beginner and mentor finding each other.

2.3.4.1.1 Seeking Pair Input During the Matching Process

Nick et al. (2012: 8) assert that the input of both mentor and mentee enhances best practice matching or pairing. However, the input of the advanced beginner nurse and competent nurse are not considered, in most cases (Nick et al., 2012: 6). The input of the advanced beginner nurse is associated with greater mentorship quality and role modelling (Allen et al., 2006: 140). Notwithstanding this oversight, many researchers believe that the input of the competent nurse and the advanced beginner nurse during the matching process demonstrates the two parties' commitment, and leads to a better relationship and career advice from the competent nurse.

In their study on the relationship between voluntary participation and mentor input on the matching process and training, Parise and Forret (2008: 230) demonstrated that competent nurses value the positive rewards accruing from voluntary participation in the peer mentor transaction. On the other hand, less input by competent nurses was viewed as being unfavourable to the pairing transaction. However, the group interview results of the self-same study showed that the input of the advanced beginner nurses is vital to the selection, as they were the vital determiners of in the requirements of the mentor-mentee transaction. Competent nurses on the other hand, regarded the mentor-mentee assignment as a job expectation. The latter's main concern was the erosion of the success of the peer mentoring experience, which was based on their ability to teach.

2.3.4.1.2 Compatibility

Nick et al. (2012: 5) recommended a method designed by Headlam-Wells et al. (2005), intended to increase the potential for compatibility (appropriate personality fit). The latter authors used eleven mentor pairing criteria based on:

- age;
- number of years of work experience;
- level of qualification;
- marital status;
- children;
- dependent care;
- life or personal history;
- career skills;
- professional skills;
- vocational sector; and
- personal values.

A similar, but simpler version of the compatibility model was designed for the Johnson and Johnson faculty leadership and mentoring programme – “the national league of nursing” (Nick et al. 2012: 5). Matches were made on the basis of the majority of responses by both parties regarding leadership qualities, interests, needs, goals, and ascertained expertise and the experience of the mentor /preceptor.

2.3.4.1.3 Variation of Speed Dating

A variation of speed dating is another peer matching strategy that encourages input by both parties, in terms of which both parties meet briefly to construct an impression of each other regarding their mentor-mentee transaction or relationship. In this regard, the relationship is based on the matching requests of both parties (Nick et al., 2012: 6).

Speed dating itself refers to a formalised matchmaking process which was originally created by Rabbi Yaacov Deyo for the Jewish community as a means of helping single individuals to meet their prospective marital partners (Deyo & Deyo, 2003 as cited in Berk, 2010: 87). Men and women were rotated over a series of short “dates”, usually for the duration of three to eight minutes depending on the organisation hosting the event. At the end of the interval, a bell would ring or whistle blown signalling to the participants to move to the next date. At the end of the event, the participants then submit the list of potential suitors to the organisers. In the event that a potential match has been found, the contact details would be forwarded to both parties (Finkel et al., 2012: 5).

2.3.4.1.4 Maximising Social Exchange

Social exchange relates to the process of negotiation between parties. Although the balance may be unequal between parties, it is based on the cost and benefits of the relationship. Social exchange explains how we feel about the relationship with the other person, the kind of relationship we deserve, and establishes the possible chance to have a better relationship with someone else.

In this study, social exchange refers to the relationship between mentor and mentee, as well as the overall well-being of such a relationship based on the mentee's collective attitude regarding the mentor's valuing of their relationship or association (Xerri & Brunetto, 2012: 647). The maximisation of the social exchange identifies three aspects on whose basis the mentor-mentee relationship or exchange could take place:

- ***Endowment:*** factors such as the knowledge, experience, and communication abilities of the mentor are critical;
- ***Mentoring content:*** factors such as programme content and historical insider knowledge of office politics contribute to the mentor-mentee relationship;
- ***Preferences:*** factors such as values placed on modes of communication, teaching or learning.

From the totality (collective effect) of studies in support of peer mentoring (in respect of its value); peer mentoring models and styles; the actual peer mentoring relationship and its consequent phases; a scenario then emerges that informs on the criteria for peer matching. The total effect referred to above is particularly indispensable, considering the impact of peer mentoring on staff retention and the ultimate betterment of patient care.

2.3.5 Peer Mentoring Strategies Impacting on Staff Retention: A Comparative Review

The three nuances, 'nurse turnover', nurse shortage' and 'retention' are conceptually interrelated. 'Nurse turnover' and 'nurse shortage' have been previously defined. 'Retention', on the other hand, denotes the ability to prevent nurse turnover and *keeping* the nurses employed within the organisation (Duffield, Roche, Blay & Stasa 2011:25).

The 2009 World Health Organization statistics for the UAE revealed a nurse-to-population ratio of 3.5:1000, as compared to 12.8:1000 in the UK and 9.4:1000 in the USA respectively (Zain, 2010: 1). A study by Chen et al. (2008: 279) attributed staff retention to factors such as job satisfaction, supervision, support, resource adequacy, workload and distributive justice. Bell (2014:1) cites further that staff growth is accounted for by a professional environment which allows employees to grow both

personally and professionally. A study conducted in Texas among staff members employed in a long-term care facility revealed that nurses opted to stay in health care facilities that offer pay increase and paid annual leave, provide continuing education, ensure that employees have access to health insurance, and have employee recognition programmes (Long-term Care Nurse Staffing Study, 2014: 1). A national home survey among direct care workers in a nursing home corroborated the findings by Chen et al. (2008: 279) and Bell (2014: 1) above – that job satisfaction and staff retention contributed to an organisational culture that emphasises patient-centred care, staff empowerment, staff training, and peer mentoring programmes; which is also confirmed by Barbarotta (2010: 18).

Findings from a comparative-explorative study conducted by Sherry (2013: 32) revealed that the following factors were instrumental to effective job satisfaction, patient care, and staff retention increases in the UAE and European countries: improvement of work environment; reduction of burnout; staff involvement in hospital affairs; mentoring of nurse managers; opening opportunities for career upward mobility; as well as reward recognition programmes. In addition to the propositions from the study by Sherry (2013: 32), Barbarotta (2012: 19) asserts that staff retention is enhanced by practices such as: high quality management plan; organisational culture that respects and values its employees; provision of feedback; as well as sufficient staffing ratio leading to high quality of patient care and positive patient experiences. The latter author (Barbarotta) provides a twelve-step guide to excellent recruitment, selection, and retention strategies. These are:

2.3.5.1 Agency Preparation for Effective Employee Recruitment and Selection

Staff turnover, shortage, and retention are interrelated concepts that senior nursing management needs to take cognisance of. Successful retention begins with effective selection process. Leadership should be knowledgeable on the salience of recruitment and selection in retention. The success of retention processes includes staff involvement and measures that are undertaken to evaluate the very success, such as: conducting staff engagement surveys; adopting a participatory team approach to recruitment and retention; as well as deploying a key person responsible for organising the recruitment and selection process.

2.3.5.2 Staffing Needs Assessment

A key person may conduct needs assessment in preparation for work with the team. Clear vision of staff needs is essential for transformation of the organisation's recruitment and retention of high quality staff. Needs analysis address issues such as

the rate of previous turnover; occurrence of highest attrition; and establishing goals for subsequent effective recruitment strategies.

2.3.5.3 Designing and Implementing Effective Recruitment Strategies

An effective recruitment strategy should be a shared goal between leadership and frontline employees, helping the team to review materials related to recruitment and retention, in order to attract the best possible staff. This will ensure that the organisation invests in recruiting successful suitable candidates, and therefore, boost staff morale**.**

2.3.5.4 Designing and Implementing Successful Selection Processes

The prevalence of a selection process ensures that the organisation recruits candidates who have ideal and desired qualities that the team has identified in the recruitment process. Such qualities include self-reporting and observational skills.

2.3.5.5 Management Capacity Building to Support Staff Retention

Employees thrive in a climate of mutual responsiveness, respect and shared governance. Senior leadership and middle management commitment to the employees' participation and development is vital to staff retention.

2.3.5.6 Early Employee Orientation and Induction

Orientation helps new employees 'find their feet' in the organisation regarding their job expectations, job description, policies, as well as familiarisation with the organisation's culture. Furthermore, orientation ensures that new employees are prepared and supported in order to become confident employees. Its effectiveness is based on keeping track of the outcomes and retention data. It is therefore critical that orientation or induction programmes be implemented in the very early weeks of the employees' commencement of their duties.

2.3.5.7 Providing Employee Support to Address Life Changes

Employees who are provided with resources such as transportation, housing, childcare facilities, etc., and feel supported in addressing changes that affect their personal and professional concerns, are most likely to stay in the organisation than those who are not privy to such amenities or perks.

2.3.5.8 Establishing a Peer Mentorship Programme

A formal and well-structured peer mentoring programme is a platform to facilitate communication and support among employees. It provides initial training and support for new employees as well. Older employees are offered the opportunity for vertical career mobility, improved decision making skills, as well as a culture of lifelong learning.

2.3.5.9 Ensuring Constructive and Effective Coach Supervision

Middle management requires empowerment in supervisory coaching roles through formal training or in-service education in order to empower them in carrying out their responsibilities thus leading to job satisfaction, commitment and retention.

2.3.5.10 Offering on-the-job learning for Career Development and Advancement

A culture of life-long learning ensures employee and patient satisfaction. Job satisfaction creates a stable workforce and opportunities for career advancement. It is important to recognise a culture of learning with added job responsibilities such as pay raises or other incentives.

2.3.5.11 Establishing Worker Participation Infrastructure

The involvement of staff in decision making is a major component of maintaining a healthy work environment. Staff involvement provides a sense of ownership, thus enabling employees to provide their best skills and talent for the success of the organisation. An organisation needs to ensure that systems and processes are in place for the advancement of employees in all aspects of decisions affecting their employees' status within the particular organisation. Such an enabling environment has the desired effect to optimise employee's potential, skills, and commitment.

2.3.5.12 Establishing Worker-Management Oversight Teams

Establishing a worker-management team to oversee and evaluate staff retention strategies enhances team work and support, which leads to stability and success of the organisation. Such teams exercise oversight and on-going improvement and evaluation roles in the context of employee recruitment and retention strategies developed by an organisation.

2.3.6 Strengths and Weaknesses of Peer Mentoring

As a means of improving patient care and reducing staff turnover, among other positive factors, the strengths and weaknesses of peer mentoring determine the extent to which staff retention strategies may be successful or unsuccessful.

2.3.6.1 Strengths of Peer Mentoring

The following factors are associated with the strengths of peer:

2.3.6.1.1 Increased Self-confidence

The advanced beginner nurse's self-confidence increases with the cumulative effect of factors such as: the competent nurse's familiarity with the routine and culture of the clinical setting; a positive attitude; professional and personal support and guidance; competence; as well as the ability to share experiences and impart knowledge (Li et al., 2010: 204; Hilli et al., 2014: 566).

2.3.6.1.2 Positive Preceptor Experience

Positive preceptor experience, the preceptor input, and choice of being a preceptor impact positively on the GNI's decision to stay in the profession (Hilli et al., 2014: 566).

2.3.6.1.3 Enhanced Leadership Skills

Collaboration between mentor and mentee and prioritisation of learning needs leads to the success of the peer mentoring relationship and enhances leadership skills (Evans, 2012: 235).

2.3.6.1.4 Reduced Stress

According to Li et al. (2010: 204), effective interpersonal relationship between the advanced beginner nurse, the competent nurse, and other members of the health team provides a platform for support systems that lead to stress reduction.

2.3.6.1.5 Professional Socialisation

Socialisation is defined as a "process of learning new roles, knowledge, skills and characteristics of a group in the society" (Xerri & Brunetto, 2012: 647). Professional socialisation occurs as a result of exposure to factors that play an active role in the socialisation process. These factors include patient, family and health care providers. Peer mentoring helps the advanced beginner nurse to 'learn the ropes' of the new job and adapting to the culture of the unit or the entire organisation, and have the opportunity to interact with health care providers, thereby creating opportunities to learn from each other's' experiences and to professional and personal growth (Donner et al., 2007: 24; Lai & Lim, 2012: 33). Mentors also benefit by learning from mentees, reassessing their own knowledge, and taking pride in facilitating the socialisation of the GNI into the nursing profession (Yonge et al., 2013: 125).

2.3.6.2 Weaknesses of Peer Mentoring

The weaknesses of peer mentoring relate particularly to those factors that are associated with inducing limitations in the mentor-mentee relationship, including the following:

2.3.6.2.1 Potential Ineffective Pairing Strategies

The pairing strategies may be ineffective, with one un-cooperative partner pulling in a different direction, thus leading to negative outcomes for both parties in the mentor-mentee transaction (Hilli et al., 2014: 566).

2.3.6.2.2 Inadequate Commitment Levels

Peer mentoring may be negatively affected by inadequate follow-up and commitment from the competent nurse, who provides no feedback and inundates the advanced beginner nurse with work; and also compels the advanced beginner to emulate and adopt his/ her mentoring style.

2.3.6.2.3 Negative Mentor Attitude

The competent nurse may be inaccessible, unavailable, and unapproachable to the advanced beginner, 'throwing him/ her in the deep end', dehumanising and criticising

him/ her unconstructively; and the mentee may be dependent only on one mentor. Furthermore, the mentee's limited teaching experience and expertise may induce negative attitudes to the mentor in the event that the mentee is 'thrown in the deep end' (Hill et al., 2014: 566).

2.4 CONCLUSION

The current chapter discussed the role, attributes, pairing strategies, mentoring phases, peer mentoring strategies that impact on retention; as well as the strengths and weaknesses of the peer mentoring process.

The health care needs of the increasing population of the UAE are mostly fulfilled with the employment of expatriate nurses, to whom the nursing or organisational and country culture are utterly unfamiliar. SEHA facilities utilise peer mentoring in order to facilitate the smooth transition of new employees and GNIs. The failure to successfully orientate newly employed staff to the culture of the United Arab Emirates and SEHA through peer mentoring is attributable to nursing turnover and staff attrition and shortages. Prevailing challenges in the retention of existing and new staff are multi-factorial, including inadequate support, bullying, and shift work.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The previous chapter discussed available literature on the subject of mentoring. The consulted literature provided, amongst others, insights on the qualities of a mentor; the pairing of mentor/ preceptor and mentee/ preceptee; as well as general causes of attrition in the health care sector. This chapter then, focuses on the theoretical framework applicable to the study; and describes the interaction and interconnectedness of concepts and factors that share commonality in this study.

A framework is referred to as an abstract, logical structure or systematic ordering of meaning and ideas that guide the study, enabling the researcher to link the findings to the body of knowledge in nursing and the phenomenon being studied (Burns & Grove, 2009: 613). Furthermore, a framework is philosophically consistent with a theory it supports or disproves, and may be integrated to a study's research questions and methodology. A framework may also be developed as an outcome of a study (Burns & Grove, 2009: 126). An understanding of the logic within the framework determines the extent of the efficacy of the study's findings in respect of its relevance and applicability to nursing practice (Burns & Grove, 2009: 126).

3.2 THEORETICAL FRAMEWORK

A theory is defined as a set of interrelated constructs or propositions that present and explain a systematic view of a phenomenon by specifying relations among its (phenomenon's) variables in order to explain and predict the phenomenon's frequency of occurrence of (Mateo & Kirchhoff, 2009: 107; George, 2011: 4). Theories are classified as descriptive, explanatory or predictive, and should be used according to the research design of the study. Theories, furthermore, provide a context for a meaningful and clear interpretation of findings and the associated with those findings (George, 2011: 4). Within such a framework of specifying relations of a nursing phenomenon, the nexus between different theories will enable the researcher to map out the role of the clinical resource nurse in peer mentoring; as well as the impact of peer mentoring on staff retention.

As a systematic and philosophical means for providing a particular orientation regarding our interpretation of the world, a theoretical framework could – deductively or inductively – also provide the basis for the philosophical contextualisation and explanation of previous existing theories, assumptions, concepts, or proposition of abstract ideas between two or more variables (Van der Walt & Van Rensburg, (2010: 22). By virtue of

theoretical frameworks providing the direction of the study, three theoretical models and propositions have been opted for in this study. They are the ADDIE model, Benner's skill acquisition model, and the interpersonal relations in nursing model by Peplau. The purpose of theory in research is to guide the researcher and the research process. In deductively driven studies, the theory directs the research design and findings; and in inductive studies, the purpose is to provide the researcher with different lenses through which to look at the phenomenon being studied (Gerrish & Lacey, 2010: 133; George, 2010: 56).

3.3 APPLICABLE NURSING THEORIES

Nursing theory is defined as a set of interrelated concepts that are communicated as a meaningful whole (George, 2010: 56). The aim of the study was to explore and describe the role of CRNs in peer mentoring and its impact on the retention of staff. As applied in this study, theory triangulation was incorporated in the context of three theoretical models, namely: the ADDIE model of instruction; Patricia Benner's theory of the philosophy of caring and expert practice; Peplau's theory of interpersonal relationship in nursing; as well as Mulaudzi's philosophy of Ubuntu, cultural diplomacy, and mentoring.

3.3.1 The ADDIE Model

Theoretical models are used to help us structure and make sense of the world around us (Hyett et al., 2014: 119). The ADDIE model is a cyclical model used for instructional and programme development, and could be employed by clinical resource nurses in their facilitation of peer mentoring. The model consists of five phases, namely: the analysis, design, development, implementation, and evaluation phases. These phases overlap, and offer flexible and dynamic guidelines for building an effective training and performance tool (Davis, 2013: 205).

3.3.1.1 The Analysis Phase

This is a pre-planning phase according to which the instructor gathers information about the mentoring programme. Accordingly, the instructor identifies the target audience in order to determine their learning needs and constraints; while defining the training goals and objectives of the learning programme as well.

3.3.1.2 The Design Phase

This phase specifies how learning should take place, the content to be covered, media of instruction, as well as the expected behavioural outcomes.

3.3.1.3 The Development Phase

In this phase, the clinical resource nurse identifies resources such as workbooks to be used during the period of mentoring, as well as methods and strategies to be used in order to achieve the desired outcome.

3.3.1.4 The Implementation Phase

This phase encompasses the actual training or preparation of mentors prior to the commencement of the peer mentoring process of newly qualified or newly employed nurse interns.

3.3.1.5 The Evaluation Phase

Each of the afore-cited phases is reviewed and evaluated to ascertain the degree to which the peer mentoring objectives have been accomplished. During this phase, programmes may be revised for improvement. The effectiveness of the learning programme is evaluated in respect of the change in the learners' behaviour; the learners' ability to apply the content of the programme; as well as the impact of the programme on the organisation.

3.3.2 Benner's Skill Acquisition Model

Benner's (1984) model of skill acquisition is derived from the earlier Dreyfus model (George, 2011: 572). The Benner model is essentially a framework outlining nurses' progress from the novice to the expert level. The model identifies five different stages of nurses' views relating to their task as their skills improve. These stages are: the novice, advanced beginner, competent, proficient, and expert levels. For purposes of this study, the advanced beginner is described as the individual nurse who needs peer mentoring; and the competent and proficient nurse is described as the individual nurse responsible for helping the advanced beginner in the transitional stage. The following levels of skills acquisition were identified by Benner as components of nurses' progress from novice to expert level.

3.3.2.1 The Novice Stage

The *novice* stage is completed during the course of the student nurse's training programme. During this stage, the nurse is exposed to new experiences and opportunities for the performance of tasks. Decision-making is critical, and is dependent on the recognisable features of a particular situation (George, 2011: 583).

3.3.2.2 The Advanced Beginner Stage

The advanced beginner refers to a new graduate nurse, or an experienced nurse working in an unfamiliar environment. The advanced beginner performs at acceptable levels due to their ***experience*** in previous occupational environments. However, due to unfamiliarity in an environment, they have to be task oriented, relying on orders and standards of care, as well as colleagues for decision making. Challenges faced in the first year include low confidence levels, inadequate clinical knowledge and skills, workload demands (Elridge, 2007: 27); as well as prioritisation and organisation related to care delivery and interaction with physicians (Duchscher, 2008:447). Accordingly, the

advanced beginner recognises changes in patients' clinical state, but is inexperienced to manage the particular change. The advanced beginner also displays the inability to prioritise the importance of a particular situation, and views all situations as similar (George, 2011: 583).

Benner asserts that it is during the advanced beginner stage that the nurse needs clinical support in order to prioritise patients' needs. However, inexperience in discriminating aspects of patient care, takes precedence over other aspects (George 2011: 583).

3.3.2.3 The Competent Nurse Stage

According to Benner (1984, cited in George, 2011: 583), a competent nurse should have worked in a specific unit for two to three years. S/he has developed clinical and technical skills as well as the ability to organise and prioritise the needs of others in order of their importance. Due to her/ his knowledge base, s/he is relied upon and is able to correlate theory to practice in a clinical setting.

3.3.2.4 The Proficient Nurse Stage

The proficient nurse is in the transition of becoming an expert nurse. S/he has worked in a department for over five years. S/he is an independent thinker whose decision-making skills are dependent on knowledge of the situation in its totality. S/he has developed increased communication and negotiation skills in order to assess and meet the needs of others (George, 2011: 584).

3.3.2.5 The Expert Nurse Stage

The proficient or expert nurse has gained more clinical experience and no longer relies on principles or guidelines for decision-making. She is clinically proficient, and performs at above-average level (George, 2011: 585).

3.3.3 Peplau's Interpersonal Relations in Nursing

Hildegard Peplau identified four phases of interpersonal relationships, namely: the orientation, identification, exploitation, and the resolution phase. These phases are inter-connected, vary and overlap in duration, leading to a solution and conclusion of the identified problem. For nursing, he later wrote that nursing is composed of three phases, *viz.:* the orientation phase, working phase, and the termination phase. In this latter mould, the identification and exploitation phases identified earlier were combined (George, 2011: 66). The three phases are described below.

3.3.3.1 The Orientation Phase

The first aspect of the orientation phase focuses on establishing relationships, rapport and trust, in order to facilitate learning during the peer mentoring process (George, 2011: 67). Both parties (mentor and mentee) initially meet as strangers and are anxious

about the manner in which they will relate to each other as individuals. In most cases, none of the two parties (advanced beginner and competent nurse) would have had any input regarding their pairing. The advanced beginner nurse is assigned to the competent nurse. The competent nurse might be concerned with her/his mentoring abilities, whether she/ he will be able to meet the learning needs of the advanced beginner. Each individual brings their own uniqueness, world view, and pre-conceived ideas which influenced their previous experiences, and skills. Differing perceptions are vital to their inter-personal relationship. The competent nurse however, brings an array of nursing knowledge, such as stress and crisis management and developmental theories that lead to better understanding of the role of the mentor in peer mentoring. In the context of the above, the orientation phase involves considering the expectations of both competent and advance beginner – such as their interaction with each other in relation to contact time and assessment of the learning styles and needs.

The attitude of both parties (mentor and mentee) affects and reciprocates their support of each other. They need to be aware of the manner in which they react to each other, based on such variables as their culture, age, race, educational background, experience, preconceived ideas, attitudes, and expectations. The success of peer mentoring relationships resides in both parties working collaboratively to identify and to clarify learning needs on whose basis a planned course of action is developed to meet those learning needs. By discussing issues such as tension, anxiety, and fear, trust is established as the parties involved progress to the working phase (George, 2011: 67).

3.3.3.2 The Work (Contact-Contact) Phase

This phase involves building the confidence of the advanced beginners by identifying and reflecting on their learning needs. Throughout this phase, both parties clarify each other's expectations and perceptions; learning contracts are drawn, and contact time and objectives are set. Recording of observations is required in order to plan for the appropriate course of action (George, 2011: 68).

During this phase, some advanced beginners may make more demands, minor requests, or use other attention-seeking schemes, depending on their individual needs. In order to facilitate their subsequent learning expectations, the competent nurse may involve the additional help of the clinical resource nurse, the clinical nurse coordinator, or the unit manager. The competent nurse needs to explain the professional role of the other parties who may be involved in the mentoring transaction, in order that the advanced beginner nurse is aware of the advantages and disadvantages of consulting with each professional.

The competent nurse may also use interviewing techniques to explore, understand, and address any other underlying problems. The competent nurse needs to project an attitude of acceptance and trust in order to maintain a healthy learning relationship. The advanced beginner nurse should be encouraged to explore feelings, thoughts, emotions and behaviour by providing a non-judgmental attitude and develop an environment conducive to learning. Such an orientation will lead to self- sufficiency, establish appropriate behaviour for goal attainment, meet challenges, and progress to the termination phase.

3.3.3.3 The Termination Phase

According to Peplau, nursing involves inter-personal relationships between two or more parties sharing common goals which are set and achieved by following a specified programme or course of action. The first step of the termination phase focuses on the identification of needs, and developing strategies to meet those needs. The needs are viewed from different view points, including cultural background, personal beliefs, individual uniqueness, and possible pre-conceived ideas which could influence the success of the mentor-mentee interaction. Through this interaction, people learn to respect each other and resultantly grow as individuals (George, 2011: 65).

Effective collaboration, clarification of misconceptions, and exploration of feelings and emotions engender the meeting of the advanced beginner nurse's learning needs. The advanced beginner nurse is encouraged to make decisions, apply problem solving skills, creativity, and innovation. The learning relationship is then ready for termination and dissolution of links between the two parties.

Sometimes, due to the psychological inter-dependence already established, both parties may have difficulty dissolving the relationship in spite of the physical learning needs having been met. The competent nurse is able to evaluate the extent to which the learning objectives have been achieved, as this will be evident by application in the actual clinical setting. The termination phase might also be difficult for the competent nurse, who might still wish to observe the other party's progress. Tension and anxiety may increase from both parties, in the event that the completion of the phase was unsuccessful. In case of a successful termination, both parties work independently from each other and subsequently emerge as stronger and mature individuals (George, 2011: 71).

The competent or expert nurse, by virtue of her/ his experience and vast knowledge in nursing, is vital in peer mentoring. In all encounters with advanced beginner nurses, the

expert nurse observes and interprets the observations, taking concomitant action to aid in the personal and professional development of the advanced beginner nurse. Knowledge and understanding of the role expectations and responsibilities of competent and advanced beginner nurses leads to mature collaborative efforts. It also impacts on high quality clinical practice and outcomes of patient care (George, 2011: 66).

3.3.4 Mulaudzi's Philosophy of Ubuntu, Cultural Diplomacy, and Mentoring

Mulaudzi's philosophy of Ubuntu, cultural diplomacy, and mentoring is premised on the tenets of the human's spirit's tenacious inter-dependence, multicultural coexistence, and helping the other person to reach their maximum potential.

3.3.4.1 Philosophy of Ubuntu

Any philosophy espoused by an individual or group offers a perspective according to which a particular view of the world is endorsed. 'Ubuntu' is a term used in the Nguni languages of South Africa, and is derived from a Nguni proverb that states: *"Umuntu ngumuntu ngabantu",* translated as: *My humanity/ being is manifest in your humanity/ being*; or, "I am, because you are" (Mulaudzi, 2009: 47). The Ubuntu philosophy is a community building mind-set encompassing values such as caring, sharing, empathy, synergy, and inclusiveness. The philosophy is analogous to the nursing profession's core value of caring. Peer mentors (knowingly or unknowingly) subscribe to the philosophy of Ubuntu by virtue of their welcoming and nurturing newly qualified nurses into the nursing profession, helping them to become part of the larger nursing community. This nurturing process fosters a sense of inclusivity, team spirit, and belongingness. The newly qualified nurses bring their uniqueness to the profession, as derived from their culture, their experiences, and their inter-personal communication skills. The role of the peer mentors, in the context of Ubuntu, is to inculcate the value of caring for each other, which is pivotal to the profession.

3.3.4.2 Cultural Diplomacy

Inculcating nursing culture to the advanced beginner nurse is a complex means of sharing the ethos and values of the profession. The sharing and communication of different cultures enable nurses to reach out to each other, and also learn more about the culture of the nursing profession and its core value of caring. However, the advanced beginner may sometimes experience culturally induced conflict occasioned by an attempt to assimilate the influence of the foreign culture on the nursing profession; as well as the mentee's degree of exposure to the foreign culture.

Culture clash is a hindrance to community building. This hindrance occurs among colleagues with diverse viewpoints imposing their perceived cultural correctness and

hegemony on others. Sensitivity to other cultures and the ability to negotiate and communicate tactfully or responsibly, dispels perceived cultural superiority. This multilateral obviation of perceived cultural superiority is known as cultural diplomacy, and is vital to community building. The role of the peer mentor in this regard is to negotiate the integration of the advanced beginner nurse to the existing structures of the nursing profession (Mulaudzi, 2009: 50).

3.3.4.3 Mentoring

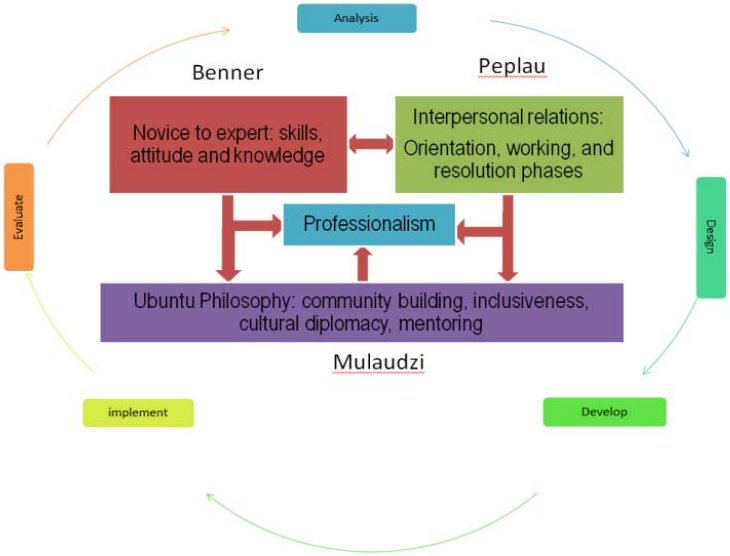
Mentoring relates to the professional relationship between a less experienced and an expert registered nurse. Mentoring fosters personal and professional growth, role effectiveness, confidence development, and advancement of the less experienced nurse. Accordingly, mentoring is based on mutual trust, empathy, cultural sensitivity, critical friendship, and openness (Donner & Wheeler, 2007: 51).

Peer mentoring enhances a professional relationship between an expert nurse and an advanced beginner. In addition, peer mentoring is intended to assist in the professional growth, role effectiveness, confidence development, and advancement of the advanced beginner. The philosophy of Ubuntu embraces the notion of mentoring, as well as capacity and community building among nurses. In this regard, the role of peer mentoring is to provide an environment conducive to learning. This environment should foster vision, encouragement, trust, caring, and protection. By means of the peer mentoring process, the mentor and mentee learn to care and value each other, thus engendering team spirit – a spirit of togetherness. Accordingly, the preceptee feels nurtured and supported. However, failure from the mentor or preceptor to openly display Ubuntu will result in the mentee/ preceptee feeling isolated and unwelcomed into the profession or particular group of members of the profession; and may result in the mentee leaving the nursing profession.

In the light of the above, the peer mentoring process enables the newly qualified nurse to fully absorb what is entailed in the nursing culture, including its “beliefs, norms and ways of being” (Mulaudzi, 2009: 49).

The figure below (Figure 3.1) is an ***integrated*** representation of the peer mentoring model encapsulating the theoretical perspectives explored in this chapter, namely: the ADDIE model; Benner’s skill acquisition model; Peplau’s interpersonal relations in nursing; and Mulaudzi’s philosophy of Ubuntu, cultural diplomacy, and mentoring.

Figure 3.1: Integrated view of the peer mentoring process



Source: Researcher's own adaptation

The role of the clinical resource nurse in the facilitation of peer mentoring includes identifying the learning needs of the advanced beginner, and subsequently developing strategies to meet those needs from different points of view; including cultural considerations, personal beliefs, individual uniqueness, and the pre conceived ideas that influence the vital success of the interaction. The CRN assigns a competent nurse who has completed the preceptorship programme as a preceptor. The pair is then acquainted to the clinical resource nurse to each other during the introductory meeting. The mentor and mentee establish a rapport during the orientation period, each bringing their uniqueness and share professional experiences, skills and culture. During the orientation period, the mentor and mentee meet to discuss the learning needs of the mentee, and discuss each other's expectations in the professional relationship. They also assess the learning styles, go through the workbook of the mentee, draw up a learning contract, meeting times, and set goals and objectives.

As the relationship progresses, the mentor provides a welcoming and non-judgmental atmosphere conducive to learning by encouraging, supporting, showing empathy, and caring for the advanced beginner in order to engender self-confidence and professional growth. During this stage, the mentor has to be sensitive to the needs of the advanced beginner and minimise conflict by being culturally diplomatic; especially when discussing sensitive issues.

The success of the relationship is evaluated during and after the mentorship period. The advanced beginner will eventually demonstrate professional behaviour in terms of

competency in problem solving skills, effective collaboration, decision making, critical thinking skills, and the ability to ***apply*** what was learnt during the mentorship.

3.4 CONCLUSION

In this chapter, four theoretical perspectives were discussed in a convergent manner, in order to highlight a multi-paradigmatic (theory triangulation) on the peer mentoring transaction as facilitated by a competent clinical resource nurse. It is evident from this multi-pronged theoretical approach that the culture of the nursing profession is not monolithic. For instance, organisational or institutional dynamics influence and shape both clinical practice and interpersonal performance. Similarly, cultural (dis)similarities have an effect on the manner in which the mentor and mentee may relate to each other. Among the milieu of variables and dynamics, are the critical aspects of the *respect* for the profession and peers. It is this respect which bonds nursing professionals from various backgrounds to maintain and restore the ethos of nursing as a *caring* profession.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The previous chapter focused on the conceptual and theoretical framework of the study. The current chapter, on the other hand, focuses on the research design and methodological aspects of the study, whose purpose is to establish the factors that lead to graduate nurse interns' attrition in particular, and registered nurses in general. In this study, the researcher utilised the grounded theory to gain insights and explore the overall experience concerning the impact of the clinical resource nurse on peer mentoring and staff retention. The ''experience'' referred to involves thoughts, feelings, actions, interactions with others, and interpretations of events associated with the phenomenon being studied (Mateo & Kirchhoff, 2009: 133).

A closer scrutiny of the research aims, purpose and objectives proved Grounded Theory (GT) to be the most amenable research approach that adapts well to a variety of research contexts. In grounded theory, the generated data serves as the basis on which to develop evidence regarding the phenomena being studied (Burns & Grove, 2009: 56). The grounded theory approach remains relevant even in health care, despite its origin from symbolic interactionism in the Sociology field.

Grounded theory was developed by Glaser and Strauss in 1967 as an inductive research technique. In this (inductive) regard, the researcher proceeds from the specific to the general, and theory is developed is based on the data from which it was obtained (Burns & Grove, 2009: 56). It is necessary to clarify some misconceptions concerning grounded theory, which is typically not a theory, but "a methodological approach to qualitative data collection and analysis, ultimately generating a theoretical explanation for the phenomenon being studied" (Chesnay, 2015: 1). It is in the latter regard that grounded theory may be viewed as a methodological approach to qualitative research, as well as an outcome of such research (Chesnay, 2015: 1). On the other hand, Holloway and Wheeler (2010: 173) posit that grounded theory entails both qualitative and quantitative characteristics in view that its developers were trained in both methods.

The purpose of grounded theory is to develop a theory about a phenomenon of interest, by showing links and relationships between concepts. The researcher not only presents an overview of the phenomenon being studied, but also explains the phenomenon itself. The researcher has explained the role of the clinical resource nurse in peer mentoring, as well as the relationship between peer mentoring and staff retention. The use of

research question in the grounded theory helps to guide, and not to confine the research process (Gerrish & Lacy, 2010: 156).

The grounded theory approach enabled the researcher to study the relationship between the clinical resource nurses and other registered nurses, which is important for actions and solutions to retention of staff. Such professional relationships further provide an opportunity for the clinical resource nurses to fully understand their roles and compare their own perspectives with those of others; as well as obtain detailed information from clinical resource nurses and significant others who had similar experiences. Furthermore, CRNs are enabled to explore the extent to which staff retention is impacted on by their peer mentoring of registered nurses. There is evidence to suggest that some graduate nurse interns leave their jobs in their first year of employment, whilst a certain percentage leaves during the second year.

4.1.1 Key Aspects of Grounded Theory

Chasney (2015: 3) and Polit and Beck (2012: 498) highlight the following key aspects or features which characterise Grounded Theory:

- It entails a process according to which data collection and analysis are iterative, on-going, and occur simultaneously. This means data analysis begins with initial data collection, leading to on-going data collection and data analysis. Initial data collection is inductive. However, as the study progresses, the questions become more focused and deductive, based on on-going data analysis until the point of theoretical saturation is reached (Burns & Grove, 2011: 405; Holloway & Wheeler, 2010: 103).
- It uses constant comparison of data with an emerging theory.
- Rich description is important but not a primary focus.
- .Common data collection methods include in-depth interviews, semi-structured interviews and observation. Other methods such as documents may also be used (Polit & Beck 2012: 498).

4.2 RESEARCH DESIGN

The research design refers to the broader or overall action plan of the manner in which the research was conducted and managed, in relation to *how*, *where* and *when* data are to be collected and analysed (Wood & Ross-Kerr, 2011: 114). Furthermore, research design guides a study and to provide answers to specific questions as unambiguously as possible (De Vos et al., 2011: 142). Wood & Ross-Kerr (2011: 114) illuminate further that the overall management plan also describes *how*, *where*, and *when* data are to be collected and analysed. The questions appearing in Section 1.5 (p. 5) of Chapter One were instrumental in shaping the overall management plan of the study.

4.2.1 The Qualitative Research Approach

In this study, the researcher utilised the non-experimental qualitative research design to explore and describe the peer mentoring role of the clinical resource nurse. Burns and Grove (2009: 22) describe the qualitative research approach as a "systematic, interactive and subjective approach used to describe life experiences and give them meaning". Holloway and Wheeler add that this approach is a form of "social inquiry on the way people make sense of their experiences and the way in which they live. Researchers use qualitative approach to explore behaviour, experiences and feelings of people being studied".

4.2.2 Justification for the Qualitative Research Approach

For purposes of this study, the researcher opted for the qualitative non-experimental research design in the exploration, description, and analysis of the role of the clinical resource nurse in peer mentoring and its impact on staff retention. The researcher was able to view the peer mentoring situation holistically in the context of all the people involved in the mentor-mentee transaction (Mateo & Kirchoff, 2009: 131).

The qualitative research approach complemented and enhanced an understanding of multiple perspectives regarding the dynamics of both the research topic and its attendant research problem (Burns & Grove, 2011: 202). The latter authors illuminate further that the qualitative research approach has the advantage of "bringing together the different strengths and non-overlapping weaknesses of quantitative methods" (Burns & Grove, 2011: 202). The authors cite that quantitative variables such as large sample size, trends, and generalisations are most likely to be compatible with those variables associated with qualitative research approaches. Most importantly, the qualitative research approach was most suited to the narrative conversations between the researcher and research participants during the empirical phase of data collection (De Vos et al., 2011: 171).

4.2.3 Stages in the Qualitative Research Design Approach

The study was conducted in three phases, namely: the conceptual, the narrative, and the interpretative phases, all of which are discussed below. The various stages illustrate the syllogistic *convergence* of the study's overall management plan (research design), the research instrumentation, as well as the associated data collection techniques. It is worth mentioning also, that all, or some of these stages have an overlap effect on each other. No single stage is absolute or effective by itself.

4.2.3.1 The Conceptual Stage

The conceptual stage relates to the theoretical or abstract terrain of the research topic (Morse & Richards, 2002: 169). During this 'incubation' stage, the researcher conducted an extensive review of literature consonant with the notion of nurse peer mentoring. It was on the basis of the extensive literature review that the researcher's familiarity was enhanced with regard to the content and the concepts related to the role of the clinical resource nurse in peer mentoring. Accordingly, the review of literature and other relevant documentation was *not* focused on the mere compilation of bibliographic references. Rather, the focus was on the review of scholarship in respect of the research topic; that is, ***what*** other scholars have done in the field of nurse peer mentoring, ***how*** they have contributed to existing knowledge in the field, as well as any emergent themes and/ or epistemological gaps that may exist (Burns & Groove, 2009: 41).

4.2.3.2 The Exploratory Stages

Exploratory studies are undertaken in the event that knowledge gaps are found to exist in the researcher's area of interest, or in the event of a new area in a particular field of knowledge being investigated in order to explore the investigated phenomenon in its more comprehensive nature (Polit & Beck, 2012: 18). The exploratory stages of the study outlined the ***preliminary*** stages of the study's progression from conceptualisation to implementation of the actual research process as a whole. The exploration itself relates to the ***pre-investigation*** stage, during which the efficacy and compatibility of the research instruments with the research environment are determined. The compatibility and efficacy of the research instrumentation are usually not easily pre-determined or predictable, until during the pre-testing process itself. The purpose of such exploration in this context, was to gain new insight and better understanding of the variety of critical units of analysis and phenomena entailed in the study; that is, the role of the clinical resource nurse in peer mentoring, as well as the effects of such a role (if any) in the retention of nursing staff and prevention of staff turnover.

The exploration of the role of clinical nurses in peer mentoring was also necessitated by the limited availability of knowledge concerning the specific research setting; that is the two SEHA facilities selected as the research sites. In this regard, the exploratory research design served the purpose of extending the preliminary stages of the investigation into a more logical and coherent whole (Burns & Grove, 2009: 60). Since exploratory studies are designed to provide an understanding on the manifestation of a phenomenon, two factors became instrumental; namely, the negotiating of entry to the

actual research sites, as well as the implementation of the pilot study, which was the pre-testing exercise conducted with ten research participants who met the sampling criteria and would not form part of the main study. In this study, the role of the clinical resource in peer mentoring was explored by means of piloting unstructured and semi-structured interviews, which were utilised in the construction of both an exploratory and *participatory* framework within which the finalisation of the questionnaire would be conducted. Negotiating entry into the "social reality" of the research environment itself was virtually indispensable for exploring beforehand, the possible trajectories of the research process and its instrumentation.

4.2.3.3 The Participatory/ Consultative Stage

As indicated earlier, none of the research design stages mentioned here carries stand-alone currency. The overlap effect implies that any, or all of the stages is functionally effective in conjunction with another closely associated stage. For instance, the participatory or consultative stage integrates all of the preceding and succeeding stages, in that the researcher *consulted* various (secondary and primary) sources of information and personally *participated* in engagements (conversations, narratives, and dialogues) with the research participants in order to determine their social reality and lived experiences. Between the exploratory phase and the conclusion of the study, various forms and levels of research stakeholder engagements were critical to the researcher's better understanding of the research topic and its attendant environment or milieu. The *reciprocated* nature of the stakeholder engagement (interaction) during both the exploratory period and the actual implementation stages of the study ensured that the nature of the conversations and narratives between the researcher and the research subjects was continuous (Polit & Beck, 2012: 278). The reciprocal consultative process further ensured that the researcher's views (subjectivity) were not imposed on the research subjects (Holloway & Wheeler, 2009: 175). In the process of resolving the research problem, the researcher also participated in the problem solving (albeit to a very limited extent) during the narrative stages.

4.2.3.4 The Narrative Stage

The narrative statements by the research participants provided a ***context*** for a discourse analysis in terms of which "a text or speech tells a story of *events and experiences*, usually *involving the personal dimension and told from the individual's* [study participant's] *point of view* [researcher's own italicised emphasis]" (Gibbs, 2007: 150). The perspectives of the research participants are crucial in data collection, and may also become a source for a contradictory analysis. Gibbs (2007: 94) highlights the

informant (study participant) situation thus:

> "There is always a possibility that informants are not consistent in what they say and do. They can change their minds about what they think and say from occasion to occasion, and they may do something different from what they say they do. Forms of data triangulation [e.g. participant observation and interviewing] are useful here, not to show that informants are lying or wrong, *but to reveal new dimensions of social reality where people do not always act consistently* [researcher's own italicised emphasis]".

Securing the narrative statements of the sampled research participants during the pilot stage served as a mechanism for the data collection of the *first-hand* or *lived experience* of the respondents in their *own words,* and in their *own habitat*. The cross-referencing of thematically similar questionnaire items assisted the researcher to either confirm or negate the truth value of contradictory narrative statements. The accurate transcription of the verbatim statements improved and validated the content of the various statements made by the respondents, as well as authenticated the source, content and context upon which interpretation and analysis of the study's findings could be based (Polit & Beck, 2012: 270).

4.2.3.5 The Descriptive and Interpretative Stage

According to Burns and Grove (2009: 495), descriptive research design is intended to provide a holistic view of the research participants' social reality. For purposes of this study, the descriptive orientation was most helpful in obtaining a wholesome perspective of the mentor-mentee relationship as a critical and integral part of examining *the role of the clinical resource nurse in peer* mentoring.

The researcher's own interpretation of information and data allocated relevance and meaningfulness to the study, in order to dislodge it from the notion of 'research for research's sake' (Polit & Beck, 2012: 272); which serves no particular significance to societal needs and concerns. The interpretative stage is not a stand-alone component in the entire research process. During this phase of the investigation, the researcher's own understanding and analytic versatility on a particular aspect of the subject matter is of utmost importance.

Since "interpretation" is based on a particular form of understanding, it is inevitable that *every* stage and aspect of the study – theoretical and empirical – would require, and benefit from the researcher's own interpretative and analytic skills. In this regard, "interpretation" encompasses ***all*** of the stages mentioned from sub-sections 4.2.3.1 to 4.2.3.5.

4.3 SAMPLING AND SAMPLING PROCEDURES

Sampling refers to the selection of groups of individuals, elements, or events for conducting a study in accordance with a pre-determined representative set of criteria (Burns &Grove, 2011: 343). The purpose of initiating a sampling exercise is to apportion a semblance of *representativity* to the selected individuals, elements, or events in order to establish the basis for participation in the study and its generalisability or transferability of the findings (Polit & Beck, 2012: 275). The selection criteria could be representative of either similar (homogeneous) or dissimilar (heterogeneity) attributes or qualities of the groups of individuals, elements, or events.

Sampling procedures adopted in the study ***cohere*** with the research site, the study population or universe, and the sampling procedures and sampling size on the one hand; as well as the sampling methods/ techniques and the selection criteria on the other hand. It is by means of the sampling procedures that the fieldwork or experiential data collection was enhanced *by means of the semi-structured interviews* with clinical resource nurses and registered nurses who are mentors to graduate nurse interns. Focus group interviews were excluded as pieces of information gathered may pose limitations in fully uncovering the mentor-mentee process (Morse, 2001 cited in Gerrish & Lacy, 2010: 157; Katzenellenbogen & Joubert, 2007: 9). In order to effect the coherence referred to above, the following sampling procedure was followed:

- The researcher sought the approval and involvement of the Chief Directors (CDS) and Assistant Directors of Nursing (ADONS) at the three SEHA facilities in order to identify potential research participants from among the CRNs and RNs;
- Following the assistance and involvement referred to above, the possible list of the research participants was finalised according to the criteria determined in sub-section 4.3.4.1 below;
- The full disclosure, informed consent, and other relevant ethical issues were made known to the sampled group to participate in the semi-structured interviews; and

In the event of identifying the prospective participants who meet the selection criteria, each participant was asked to refer other colleagues with similar experiences.

4.3.1 Study Population and Sampling Size

A study population refers to the entire aggregate of cases (universe) of all the elements (individuals, objects or subjects) that meet the criteria for inclusion in the study (Burns & Grove, 2009: 24, 344). Typically, a study population possess similar characteristics, attributes, or qualities that are basically representative of the entire aggregated cases (Polit & Beck, 2012: 273; Botma et al., 2010: 124).

In this study, the population comprises all registered nurse categories employed at Al Mafraq Hospital and Sheikh Khalifa Medical City. Accordingly, the study population consisted of the following research participants:

- 17 unit-based CRNs and 1 212 registered nurses (total of 1 229) employed at SKMC (Rimando, 2013); and
- 12 CRNs and 768 registered nurses (total of 780) employed by Al Mafraq Hospital (Mentor, 2013).

The overall total of the study population is 2 009, from which the researcher had access to 11 unit-based CRNs and 700 registered nurses from SKMC; and 5 CRNs and 500 registered nurses at Al Mafraq Hospital (a total of 505). In essence the accessible population was 1 261, from which the study's sample size had to be established (See Annexure I, p. 116).

4.3.1.1 Sample Size

A sample's representativity is established on the basis of the degree of similarity (***homogeneity)*** between the sampled research participants and the population or universe from which they have been selected. It is of vital importance to note that the sample size is viewed as an approximation of the whole, rather than as a whole by itself (Polit & Beck, 2008: 765; Burns & Groove, 2009: 42). From the entire population or universe of registered professional nurses at Mafraq Hospital and Sheikh Khalifa Medical City, the researcher sampled the research participants (or respondents) according to clearly defined criteria outlined under the sub-section labelled *Inclusion Criteria* below.

In this study, ***the sample size consisted of 50 research participants***, categorised as follows: 18 Clinical Resource Nurses, 22 Registered Nurses, 5 Unit Managers, 3 Clinical Nurse Coordinators, and 2 Acting Directors of Nursing.

4.3.2 The Research Site and Negotiated Entry

The study was conducted at ***two*** SEHA facilities offering tertiary health services in the city of Abu Dhabi, United Arab Emirates. These facilities are: Sheikh Khalifa Medical City (SKMC) and Al Mafraq Hospital. Sheikh Khalifa Medical City is managed by the Cleveland Clinic of Cleveland, Ohio, in the United States. SKMC also has a 500-bed capacity, and it is the *main* provider of comprehensive (preventive, promotive, curative, and rehabilitative) health care to the entire population of the Abu Dhabi emirate. Furthermore, SKMC's stature has been elevated by accreditation accolades awarded by Joint Commission International (JCI) in 2014 and College of American Pathologists in

2012 for the treatment of chest pain.

Al Mafraq Hospital is managed directly by Abu Dhabi Health Service Company (SEHA), and has a 451-bed capacity. It is the largest trauma and burns unit in Abu Dhabi, providing curative services to this entire emirate. The hospital is an ear, nose, throat, and thoracic (ENTT) centre of excellence in the entire country (UAE), having received JCI accreditation status and the Diamond Sheikh Khalifa excellence award in 2011.

In compliance with both professional and ethical conduct, formal written requests were made to the relevant SEHA authorities, requesting for permission to conduct the study on their two afore-mentioned facilities. As a procedural pre-requisite, this negotiated entry into the "social reality" of the research environment itself (notwithstanding the researcher's position as a SEHA employee) was virtually indispensable for exploring beforehand, the likely trajectory the research process would follow.

4.3.3 Sampling Techniques/ Methods

Polit and Beck (2012), Neuman (2011), and Bryman (2012) ascertain that sampling techniques or methods are typically classified according to their ***probability*** or ***non-probability*** status. The above-cited authors illuminated that the categorisation of probability techniques include simple random, systematic sampling, stratified sampling, and cluster sampling. On the other hand, the non-probability sampling techniques include convenience sampling, quota sampling, snowball sampling, and judgment sampling. According to the above-cited authors, probability sampling techniques are advantageous as the sampling error can be calculated on the basis of either homogeneity (the sample features' similarity with those of the larger population or universe of CRNs and RNs at both SKMC and Al Mafraq); or heterogeneity (the sample features' dissimilarity with those features of the larger population or universe of CRNs and RNs at both SKMC and Al Mafraq).

Non-probability judgment or purposive sampling was opted for in this study. Purposive sampling is described as "a method of sampling where a researcher deliberately chooses who to include in the study based on their ability to provide the required data" (Polit & Beck, 2012: 517). Accordingly, the researcher's familiarity with, and knowledgeability of the research milieu stood her in good stead as she is an experienced SEHA employee (Polit & Beck, 2008: 343). The reason for this approach was influenced by the researcher's intention to explore, describe, and analyse the role of CRNs in peer mentoring. The participants would be able to provide the required information based on their experience and expertise (Gerrish & Lacy, 2010: 144).

4.3.4 Sampling Criteria

The sampling criteria of a study refer to the researcher's pre-determined standard for justifying participants' inclusion or exclusion in the study (Burns & Grove, 2009: 344). In this study, sampling criteria was implemented specifically to advance the stated research objectives (Polit & Beck, 2011: 218). Therefore, research participants could either be included or excluded in the study in accordance with the degree to which their representativity advanced (or deviated from) the specific intentions (objectives) of the study.

4.3.4.1 Inclusion Criteria

Inclusion or eligibility criteria refer to the specific characteristics, features, or qualities which ***selected*** research participants possess in relation to those (attributes) of the larger population or universe in order to achieve the objectives of the study (Polit & Beck, 2011: 306). Inclusion or eligibility criteria are therefore inextricable from both the general population and the target group (Burns & Grove, 2009: 344). The following criteria influenced the selection of the specific research participants for inclusion in this study:

- Clinical Resource Nurses employed at Al Mafraq Hospital;
- Graduate Nurse Interns and newly employed Registered Nurses employed at Al Mafraq Hospital;
- Registered Nurses participating in the mentorship of GNIs and new hires at Al Mafraq Hospital;
- Clinical Resource Nurses employed at SKMC;
- Graduate Nurse Interns and newly employed Registered Nurses employed at SKMC; and
- Registered Nurses participating in the mentorship of GNIs and new hires at SKMC.

4.3.4.2 Exclusion Criteria

Polit and Beck (2012: 727) postulate that the exclusion criteria of a study relate to the deficiency or inadequacy of features, characteristics, or attributes which justify the disqualification or nullification of members of a particular universal group from being involved in the study. Such inadequacy pre-empts those members even in the sampling frame due to their unsuitable profiles in respect of the research objectives. In this study, the following considerations justified the exclusion for involvement in the determination of the role of CRNs in peer mentoring at SKMC and Al Mafraq Hospital:

- Any nursing category (CRNs and RNs included) not employed at SKMC and Al Mafraq Hospital;

- Any administrative personnel in the employment of SKMC and Al Mafraq Hospital; and not involved in peer mentoring of graduate nurse interns and newly hired registered nurses.
- Any CRN and RN who is not actively involved in peer mentoring.

4.3.5 Some Remarks Concerning Sampling Rationale

The remarks or comments pertaining to the sampling rationale highlight and provide more insight on the unique dynamics of the research environment in the context of the research site, the respondents' profile, as well as the possible implications for data collection. The research setting of this study is culturally and organisationally unique, due to the pre-eminence of Arab culture. As an expatriate professional nurse, the researcher is obviously obliged to observe and adhere to the inherent cultural diversity, while also observing the ethical and clinical requirements of the nursing profession. In this regard, the researcher's artificial (in the context of *globalisation*) black South African) *national* boundaries were confronted with the inevitable task of mediating and navigating the ***universality*** of professional and ethical norms and standards associated with nursing, healthcare, and clinical practice on the one hand; as well as organisational culture (as expressed by dynamics such as workplace practices, human relations management and development), and social conditioning (as manifested by human interaction and socialisation) on the other hand.

The stages of sample selection attest to the researcher's discreet effort in the integration of cultural, professional, personal, and national idiosyncrasies. From a population/ universal total of 2 009 members (1 229 from SKMC, and 780 from Al Mafraq Hospital), the numbers were further pared to an accessible population/ universe of 1 216 (505 from Al Mafraq Hospital, and 711 from SKMC). This reduction from the initial 2 009 to 1 216 (a total reduction of 793) is a further indication of the purposefulness with which an accurate and genuinely representative sample was to be achieved. The accuracy and genuine representativity is crucial, given the dynamic mix of the nursing personnel at the two research sites.

4.4 DATA COLLECTION

Data collection refers to the process of systematically obtaining pertinent information from primary and/ or secondary sources (Burns & Grove, 2011: 430). Data collection and analysis occurred concurrently, and the researcher's professional experiences also served as a source of data (Holloway & Wheeler, 2010: 176). During the data collection phase, the opinions, experiences, and perceptions on peer mentoring were obtained from individual nurse professionals who participated in peer mentoring, and were still

employed at the two SEHA facilities. The ultimate intention of data collection was to explore and identify staff turnover challenges in the context of the peer mentoring role of clinical resource nurses.

In this study, data collection was conducted ***primarily*** by means of field-based semi-structured interviews, and included some quantitative aspects. This aspect of the study focuses mainly on the integration of the *fieldwork or experiential* and the various research design stages mentioned in sub-section 4.2.3 (pp. 48-51). The rationale for such an approach is premised on the need to highlight the coordination of both the theoretical or abstract and practical perspectives as meaningful deviation from the *research-for-research's sake* mode of enquiry. A linking of the abstract and the empirical therefore, nullified the gap or 'distance' between the researcher and the research participants. Since the study assumes the form of a qualitative, exploratory, descriptive, and contextual research design, the researcher's understanding of the participants' perspectives and experiences during the data collection phase was greatly enhanced (Polit & Beck, 2008: 170).

4.4.1 Qualitative Data Collection

In this study, the semi-structured interviews formed main body of data collection. Informal observation of participants and analysis of clinical and demographic data were also undertaken to complement the qualitative aspects of data collection.

4.4.1.1 Semi-structured Interviews

"Interviews are not just conversations. They are conversations *with a purpose* [authors' italics] – to collect information about a certain topic or research question. These 'conversations' do not just happen by chance, rather they are *deliberately set up* and follow certain rules and procedures" (Burns & Grove, 2009: 403). In this study, the "conversations" with the research participants took the form of ***semi-structured interviews.*** The semi-structured interviews was opted for, in order to construct both an exploratory and participatory context within which the views (real-life experiences or social reality) of the research participants could be conclusively and coherently established.

That the interviews are semi-structured means that there was "… no restrictions in the wording of the questions, [and] the order of the questions or the interview schedule" (Burns & Grove, 2009: 406). It is therefore implied that the face-to-face oral information-gathering interaction between the researcher and the interviewees is largely characterised by a more relaxed atmosphere that is not subjected to the rigidity of

protocol and convention. For instance, questions entailed in the interview guide could be posed to the interviewees in a sequence that does not necessarily conform to the order in which they were originally written, depending on the researcher's prioritisation of issues in accordance with the prevailing context and circumstances of the interview.

The semi-structured face-to-face interviews constituted an important aspect of the qualitative phase of this study, as they provided an opportunity for the researcher to investigate unresolved questions further, and to gather data which could not have been obtained quantitatively (Gerrish & Lacy, 2010: 349). Furthermore, the flexible face-to-face interview approach is arguably a suitable approach for ensuring a ***high response rate*** to a sample survey (Gerrish & Lacy, 2010: 349). The semi-structured interview format is different from that of the structured interview, which is procedurally rigid. In the latter regard, the structured interview assumes the mould of a questionnaire read by the interviewer as prescribed by the researcher, based on a strict procedure and a highly structured interview guide (Miller & Brewer, 2003: 166).

By virtue of its *flexibility,* the semi-structured interview is advantageous in other respects as well (Burns & Grove, 2009: 405; Holloway & Wheeler, 2010: 103). The researcher is able to prompt and probe the research participants for more information, and the participants are able to fully express their own thoughts and take control of the interview as ideas emerge, thus giving way to honest and spontaneous responses. An interview environment characterised by flexibility and spontaneity engenders trust between the researcher and the participants. Such an environment further provides an opportunity to explore and resolve complex issues from the participants' perspectives. Furthermore, being interviewed tends to create a positive experience of self-worth in some people (Holloway & Wheeler, 2010: 103).

In spite of its inherent structural and functional efficacy, the semi-structured interview mode does present some limitations. There is a high risk of researcher bias (prejudice or subjectivity) induced by inadequate sampling, extensive questioning, or involvement of the researcher in the interview. Researcher bias in itself is an affront to the notion of ***non-interventionism,*** which emphasises on the researcher's complete *neutrality;* thus restricting and limiting the researcher's 'excessive' involvement in the participatory proceedings of an investigation (Polit & Beck, 2008: 196). The probing of participants may result in the inconsistency of statements, and thus tend to compromise the validity of the findings. In terms of time and cost, interviews are even more financially demanding than questionnaires. As a result, the researcher may require funding for

such items as travelling, refreshments, recording equipment, and transcription costs. The expenses factor may also impact adversely on the availability of adequate sampling sizes (Burns & Grove, 2009: 406).

From the 50 (fifty) sampled research participants, 28 (twenty-eight) took part in the semi-structured focus group interview sessions. This group consisted of 18 clinical resource nurses (CRNs), 3 clinical nurse coordinators (CNCs), 5 unit managers (UMs), and 2 assistant directors of nursing (ADONs) (See Annexure 1, p. 116).

4.4.1.2 Informal Observation of Research Participants

The observation of research participants was a continuous mission, undertaken during both the pre-investigative and actual investigative stages of the study (Gibbs, 2007: 150). Since clinical trials were not the focus of this study, the nature of the general participant observation was focused on only those members of the universe of CRNs and RNs at both SKMC and Al Mafraq Hospital. Secondly, participant observation occurred during the determination of the accessible population. However, the most congenial observation of the research participants was undertaken during the semi-structured interview stages with the sampled individual nurse who met the inclusion criteria (Gibbs, 2007: 150).

The semi-structured interview sessions provided an opportunity to interact with the sampled research participants in a less formal environment, which prompted them to respond honestly and spontaneously to the interview questions. The researcher recorded their *non-verbal* attributes (such as their behaviour, attitudes, reaction, gestures, and so on) during these sessions on a field notebook, which served a complementary purpose in conjunction with the participants' actual verbatim responses (Gibbs, 2007: 150).

During both the pre-investigative and the actual stages of the investigation, the researcher's observation was mostly guided by the following considerations (Polit & Beck, 2004: 378):

- Levels of ***awareness*** on *the role of CRNs in peer mentoring* by members of each nursing category or constituency (e.g. CRNs and RNs);
- The extent to which each nursing category embraced or discarded culturally-induced, personal, and other forms of ***attitudes*** (if any) in their ***conceptualisation*** of the role of CRNs in peer mentoring;

- The nature of the mentor-mentee ***association or relationship*** at all levels (personal, professional, social, and so on) as a constructive determinant of the outcome of the association/ relationship itself; and;
- How individuals in different nursing categories react to ***peer mentoring conversations*** among themselves.

All of the above were achieved over a period of time, commencing from the date of the granting of permission by SEHA authorities for the study to be conducted (See Annexure C and Annexure D).

4.4.2 Quantitative Data Collection

Triangulation was employed in order to incorporate both qualitative and quantitative data collection approaches. The quantitative research process refers to a formal objective, systematic study process to describe and test relationships, and intended to examine cause-and-effect interactions amongst variables (Burn & Grove, 2009: 717). Triangulation itself refers to “the use of multiple methods or perspectives to collect data and interpret data about a phenomenon, to converge on an accurate representation of reality” (Polit et al., 2012: 478). Multiple forms of triangulation were opted for in this study in order to maximise the study objectives, the key findings, and the associated recommendations (Polit et al., 2012: 490). Triangulation methods are categorised in respect of the data to be collected; the methods employed to collect the data; the theory or theories guiding the process of data collection; as well as investigators involved in the study (Burns and Grove, 2011: 37). In this study, the questionnaire was the primary quantitative data collection instrument.

4.4.2.1 Open-ended Questionnaire Development and Administration

In addition to the (qualitatively-oriented) semi-structured interviews, the development and administration of the questionnaire as a quantitative research instrument served a ***complementary*** function in the method-triangulated data collection process of this study (See Annexure H). An appropriately developed and constructed questionnaire is advantageous in that it facilitated the efficient collection of the required data with a minimum error coefficient. The error coefficient is determined as a numerical index (Burns & Grove, 2011: 353). Furthermore, it facilitates the coding and capturing of data, and it leads to an overall reduction in the cost and time associated with data collection and processing (Polit & Beck, 2012: 179). Also, questionnaires were simple and relatively inexpensive and could provide information from large numbers of subjects.

The open-ended questionnaire was developed by considering prior measurements corresponding to each variable in the literature and theories in the context of the role of

clinical resource nurses in peer mentoring. Each variable was measured by multiple items in order to increase the reliability and validity of the measurements. Closed-ended questionnaire items were intended to obtain quantitative-based results, while open-ended questions mainly served a qualitative function (Burns & Grove, 2011: 353). The open-ended-questions were used for complex questions that could not be answered in a few simple statements, but required more detail and discussion; while close-ended questions relied on fixed responses for structured questions. In addition, the open-ended question allowed for the participants to interpret any particular question in the manner they understood it.

The close-ended questions on the other hand, restrict the respondents to select an answer from the specified response options. For the respondent, a close-ended question is easier and faster to respond to. For the researcher, close-ended questions are easier and less expensive to categorise and analyse. Also, closed questions provide consistency, a factor that is rare in an open-ended questionnaire. The following factors were considered by the researcher during the administration phase of the questionnaire:

- Respondents were informed that there were no correct or incorrect responses;
- Ethical issues – such as respondents' privacy, anonymity, and confidentiality – were strictly adhered to;
- Considering the geographic location of the research sites and the researcher's nationality and employment status, questionnaire items were sensitive to issues of race, gender, ethnicity, and cultural practices;
- Both close- and open-ended questions were included in order to facilitate unrestricted, but direct responses;
- The questionnaires were administered during the respondents' lunch hour in pre-arranged lecture halls;
- All the critical questionnaire items were thematically linked to clinical resource nurses, peer mentoring, and staff retention: and
- The researcher personally collected the completed questionnaires for further analytic attention by the statistician.

In addition to the 28 (twenty eight) research participants who took part in the semi-structured focus group interview sessions, ***another group of twenty two (22) research participants took part in the open-ended questionnaire sessions.*** This latter group consisted of *8 (eight)* graduate nurse interns (GNIs) and 14 (fourteen) registered nurses (RNS). The registered nurses conducted peer mentoring classes in the clinical settings

and during evaluation of the new recruits' early clinical performance (See Annexure 1).

4.5 DATA ANALYSIS

Data analysis mainly involves the breaking of data into comparable themes, principles, or concepts, structural or process features or patterns, tendencies, and associations or experiences (Brink et al., 2012: 179; RSC201H, 2009: 239). The main purpose of data analysis is "to organize, to provide structure, and to elicit meaning from the data that has been collected" (Polit & Beck, 2010: 463). In this study the purpose of data analysis was to elicit meaning of the clinical resource nurse's role in peer mentoring from the participants' perspective. The effectiveness of data analysis is informed by the extent to which the research instrumentation was developed and applied. It is on the basis of the research instrumentation's effectiveness that the reliability, validity, and credibility of the study could be determined. Data analysis, therefore, provided a form of standardisation, quality assurance management, and monitoring of the collected data.

The inductive presentation, interpretation, and analysis of the collected interview-based data served as the evidentiary mechanism on whose basis the key findings and recommendations were established. As such, the quality assurance, management, and preservation of the collected data were a sacrosanct requirement of the data analysis process. Data was preserved in its original form by the audio-recording of the interviews. Additionally, the researcher wrote memos and field notes throughout the interview sessions and during participant observation in order to capture all emerging ideas.

Audio-recorded interviews were transcribed verbatim, and recurring facts were grouped and assigned codes. Burns and Grove (2009: 522) define these codes as "symbols or abbreviations used to classify data, and may be placed during data collection to help the researcher to define the area of interest in the study". The breaking down of data into comparable themes, principles, concepts, or categories involves comparing elements that are present in one interview with those present in other interviews in order to establish their dissimilarities and similarities (Polit & Beck, 2011: 499). The latter authors describe three levels of coding/ classification of the thematically categorised data, namely: open, axial, and selective coding.

4.5.1 Open Coding

During this data coding phase, the recurring concepts or themes on the transcribed notes were coded as closely as possible to the participants' actual responses. The codes were grouped into inter-related categories. This process of coding and

categorisation is repeated until no new interrelated concepts are identified. The latter process is known as theoretical saturation (Hollow & Wheeler, 2010: 146).

4.5.2 Axial Coding

Axial coding occurs after open coding. The purpose of this stage is to examine the relationship between concepts by using a "coding paradigm" – a system of coding that seeks to identify a relationship between categories (Hollow & Wheeler, 2010: 180). The aim of this coding paradigm is to integrate structure and process in the systematisation of data labeling. The integration of research findings is coding paradigm intended to determine the core category, which is the main theme of research.

4.5.3 Selective Coding

This form of coding occurs once the core variables or categories have been found. Selective coding reflects the research participants' resolution of the main concerns regarding an aspect or aspects of the study. Once the core category or core variables are found, new data is coded according to the core variables identified. New data may be sampled, mindful of the core variable; this process is known as theoretical sampling (Gerrish & Lacey, 2010: 159).

4.5.4 Memos

The researcher kept memos throughout the empirical phase of the research. Memos are defined as "records of analysis, thoughts, interpretations, questions and directions for further data collection" (Hollow & Wheeler, 2009: 185). These memos should be dated and be written in detail. Memos could be anything written, diagrams, or flow charts. They help in reminding the researcher in the structuring of the study in respect of the participants' actions and interactions. Furthermore, ideas about the naming and inter-connectedness of concepts are documented in the memo by the researcher.

4.6 MEASURES TO ENSURE TRUSWORTHINESS

The measures employed to ensure the study's worthiness were intended to collate the quality assurance management plan in respect of the data collection methods and the methodology that guided or influenced the very data collection processes. It is in this regard that Holloway and Wheeler (2010: 302) portray "trustworthiness" as the "methodological soundness and adequacy" of the study. Accordingly, the researcher ensured the "methodological soundness and adequacy" of the study by means of credibility, applicability, dependability and confirmability quality assurance mechanisms.

4.6.1 Credibility

According to Holloway and Wheeler (2010: 303), credibility is linked to internal validity. It addresses the confidence in the findings as a true reflection of the research aim and the

participants' experiences. The study's credibility reinforces the researcher's ability to compare the findings with the actual experiences of the participants, while also exploring the compatibility of the findings with the participants' experiences. Credibility was therefore achieved by means of the following processes:

4.6.1.1 Prolonged Engagement

The researcher has worked in the employment of SEHA for nine years and has therefore spent enough time (prolonged engagements) established rapport and has built a relationship with the research participants based on trust, professionalism, and openness; thus enabling participants to share valuable information. It is on the basis of these prolonged engagements that the researcher was also able to understand the participants' perspectives, emotions, and levels of knowledge on the research subject (Mateo & Kirchhoff, 2009: 149).

4.6.1.2 Triangulation

Triangulation refers to "the use of multiple methods to collect and interpret data, so as to converge on an accurate representation of reality" (Polit & Beck, 2012: 745). Triangulation manifests itself as either *data* triangulation, *method* triangulation, *theory triangulation*, or *investigator* triangulation. In terms of this four-fold approach, the data collection in this study was achieved by means of the semi structured interviews and the open-ended questionnaires. These two research instruments were administered only to the selected research participants.

4.6.1.3 Peer Debriefing

Peer debriefing or peer review refers to the external *collegiate* validation intended to obtain further objective perspectives on some latently and/ or patently problematic aspects that were not previously observed during the study's execution. Henning (2009: 103) and Polit et al. (2001: 472) concur that peer review or debriefing involves the researcher discussing some thoughts and ideas pertaining to the research process and findings with an *impartial* colleague who was not part of the study, but experienced and fully conversant with research methods. In this study, peer debriefing was applied by means of talking through the study with two CRNs who were conversant with the study. The debriefing illuminated on potential misinterpretations, while encouraging further exploration of the study.

4.6.1.4 Member Checking

Member checking refers to a *reciprocal (post-investigative) feedback mechanism* according to which the researcher returns to the participants to ***share*** the research findings and verify that the researcher correctly understood the experiences and perceptions as described by participants during the semi-structured interview phase of

the study. Member checking could be undertaken at either the completion of the interview, to give the participants a brief summary of the interview for their feedback; or it could be at the conclusion of the study, taking back the findings to the participants for their review, confirmation, or final consideration (Hollow & Wheeler, 2010: 303).

Member checking was achieved by means of the researcher returning to the research participants to ensure the veracity of the researcher's understanding of the participants' views and experiences shared during the interview sessions. At the end of each interview session, the researcher gave a brief summary of the participants' feedback.

4.6.2 Transferability

Transferability refers to the extent to which the findings could be transferred to ***other*** similar situations or participants under the same conditions as those that existed in the original study (Gibbs, 2007: 100; Holloway & Wheeler, 2010: 303). Accordingly, the researcher provided a detailed description of the research milieu, enabling the reader to determine objectively whether or not the results are likely to be applicable in other research settings (Grove et al., 2013: 598).

4.6.3 Dependability/ Reliability

According to Holloway and Wheeler (2010: 303), research findings and instrumentation are said to be dependable and reliable on account of their consistency and accuracy. It means that the reader should be able to evaluate the accuracy of the analysis by following the researcher's decision making process. These authors confirm that dependability is achieved when "the research findings achieve their aim and are not the result of the researcher's assumptions and preconceptions" (Holloway & Wheeler, 2010: 303), allowing for the *traceability* of data back to the source. In this study, dependability was achieved by means of an audit trail, reflexivity, and bracketing.

4.6.3.1 Audit Trail

By means of the audit trail, readers are able to honestly follow the research trajectory and determine the manner in which the study's themes and interpretations were arrived at by the researcher. The audit trail also helps those researches who intend to carry out similar studies. It is on the basis of a reliable and documented audit trail that those researchers intending to undertake a similar study as the one they are audit-trailing, would benefit from, amongst others, the research perspective adopted and challenges experienced. In this study, the researcher had the opportunity to present a poster of the study in November 2015 at an international nursing conference held in Abu Dhabi. The poster is added in appendices, and serves as a typical audit trail of this study.

4.6.3.2 Reflexivity

Reflexivity is a continuous process according to which the researcher explores the personal feelings and experiences that may influence the study (Burns & Grove, 2009: 544), as well as the manner in which this exploration has been integrated to the study. Holloway and Wheeler, (2009: 8) add that reflexivity is a conscious and self-monitoring attempt by the researchers to acknowledge their involvement in a study. The researcher continually reflected on her actions, experiences, values, background and prejudices and those of participants, such as reflecting on how data collection, analysis, and integration of the findings will be influenced by how participants perceived the researcher.

In qualitative research, the researcher is both the researcher and the participant, and can therefore not be easily separated from the phenomenon under study. It is difficult to stand back and examine the effects of one's assumptions and preconceptions. Some researchers validate data by going back to the participants to confirm whether the interpretation was correct. According to Holloway & Wheeler (2010: 303) validation of data provides an opportunity for clarification and for the researchers to recognise their own prejudice. It is therefore indispensable for the researcher to adopt a self-critical stance towards the study, the participants, their role, their relationships, as well as their assumptions.

There are basically three reasons for the incorporation of reflexivity as one of the integral measures to ensure the study's trustworthiness. These are:

- Enhancing the quality of the study in respect of the researcher's self-awareness and introspection regarding any preconceptions and their correction;
- It is an on-going process through data collection, analysis and interpretation of findings; and
- The researcher's adoption of a self-critical stance regarding their own involvement and assumptions in the study.

In this study, the researcher documented any feelings, preconceptions, conflicts, and assumptions she had about the study. This enhanced self-monitoring to prevent researcher bias and increase objectivity. While reflexivity is credited for its enhancement of researcher self-introspection, it does, however, present some challenges; including the following:

- Some researchers may exceed the boundaries of self –monitoring; and

- The researcher is the main research instrument, deciding on critical aspects such as the focus of the study, *what* constitutes data, as well as the appropriate *content* of the entire research report.

4.6.3.3 Bracketing

Qualitative researchers advocate for the usage and application of bracketing, as preconceived ideas regarding the study give rise to bias. Gerrish and Lacy (2010: 178) describe bracketing as the suspension of the researcher's preconceived ideas, beliefs, and prejudiced beliefs which are put in writing in order that they do not interfere with, or influence the participants' experience. Bracketing is first achieved by the researcher writing the experiences or thoughts about the research topic in detail. Holloway and Wheeler (2010: 221) add further that bracketing is the exclusion of prior assumptions gained through experience or research-related literature, in order to view the phenomenon under investigation from a totally different perspective. It means that the researchers de-activate their prior knowledge about the phenomenon being studied.

Qualitative researchers use bracketing to improve rigour and reduce bias in research. Burns and Grove (2009:546) posit that it is insufficient to state that bracketing has occurred; the researcher needs to show *how* and *where* this took place. It is advisable to apply bracketing in the early stages of the study for self-reflection and external review by means of a reflective journal. On the other hand, Polit and Beck (2008: 495) assert that bracketing cannot be fully achievable due to the possible pre-eminence of pre-conceived ideas. However, qualitative researchers identify beliefs, pre-conceptions, and assumptions about the research topic. Hence the advisability of writing down (bracketing) such preconceptions at the beginning of the study for self-reflection and external review.

In this study, the researcher wrote a narrative description of her personal views, beliefs, and assumptions on the role of the clinical resource nurse in peer mentoring in the beginning of the study. These views and thoughts were extricated from the actual proceedings of the study, such that researcher objectivity and neutrality were not compromised. Such an approach to bracketing was extremely useful in maintaining an open and non-interventionist approach during interviews and the stages of analysis of the findings.

4.7 CONCLUSION

This chapter described the research design and research methods, and attempted to clarify the distinction between these two research concepts. The semi-structured interviews and questionnaire administration were respectively utilised to effect the

qualitative and quantitative (triangulation) aspects of the study. The researcher's role in the study is highlighted writ large, in order to indicate the seriousness with which objectivity and non-interventionism were taken cognisance of in the study. The next chapter focuses on the presentation, discussion, and interpretation/ analysis of the study's findings.

CHAPTER 5

DATA ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS

5.1 INTRODUCTION

This chapter focuses on data analysis and the presentation of findings in the context of the participants' interpretation of the clinical resource nurse's role in peer mentoring. The data analysis is categorised into three critical domains, namely: the study participants' bibliographic information (for demographic purposes); their levels of knowledge and understanding of the role of clinical resource nurses in *peer mentoring*; as well as their views on the efficacy of *peer mentoring.* In addition, the researcher presents and discusses other related factors such as the maintenance of patient safety; staff orientation and induction; professional development; maintenance of healthy interpersonal relationships; evaluation, and the change agent factor. In this regard, the presented discussion is necessarily a collation of both the interview guide and its questionnaire. The collected data is presented by means of diagrammatic *visuals,* such as tables, figures, charts, and graphs.

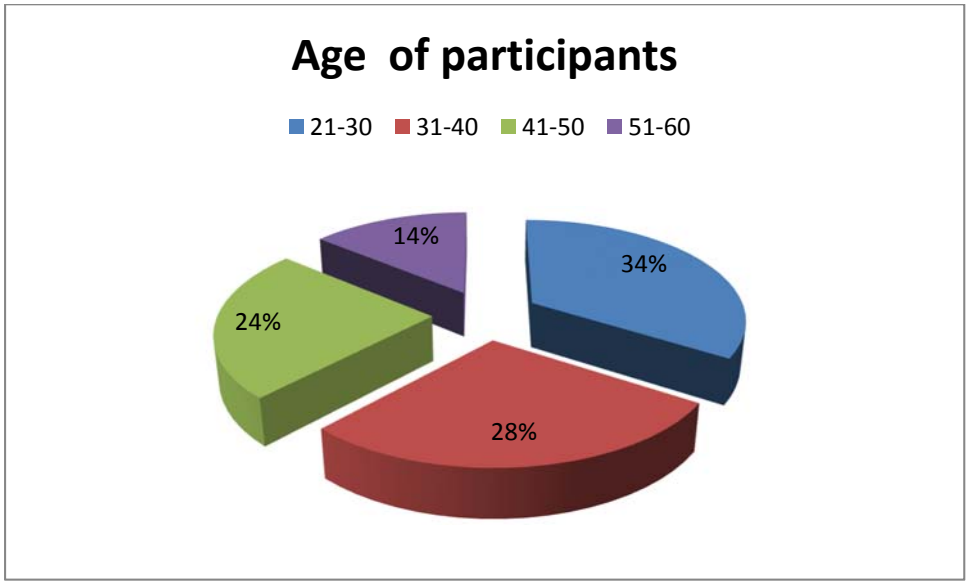
5.2 PART A: PARTICIPANTS' BIOGRAPHIC INFORMATION

The participants' biographical data included variables such as their age, country of origin, gender, professional status and experience.

5.2.1 Participants' Age Distribution

The figure below depicts the age distribution of the research participants.

Figure 5.1: Participants' age distribution



It is worth mentioning that there is a statistically inverse relationship between the participants' age and level of representativity. The younger the respondents, the more or bigger is their representativity. For instance, the youngest age cohort (21-30 year olds) represented 34% of the entire sampled respondents; whereas the oldest age cohort (51-60 year olds) represented the lowest level of representation (14%). Interestingly, the median age groups (those in the 31-40 year age cohort and the 41-50 years age cohort) – who constituted 28% and 24% were only separated by a 4% difference.

5.2.2 Participants' Countries of Origin and Professional Status

Table 5.1 below depicts the participants' countries of origin and respective professional status and academic achievements. From the statistical information below, it is evident that, despite the majority of countries (5 of the 10) being Arabic (Egypt, Jordan, Lebanon, Oman, and Yemen) – with a total of 10 from a grand total of 50 respondents, the majority of respondents (40) are from non-Arabic countries; while ***only*** 10 respondents were from the Arabic countries.

The diverse range of nursing categories (professional status) represented in the sample, ranges from ADONs, CNCs, CRNs, GNIs, new RNs, old RNs, and UMs from the range of countries represented in Table 5.1 below.

Table 5.1: Participants' countries of origin

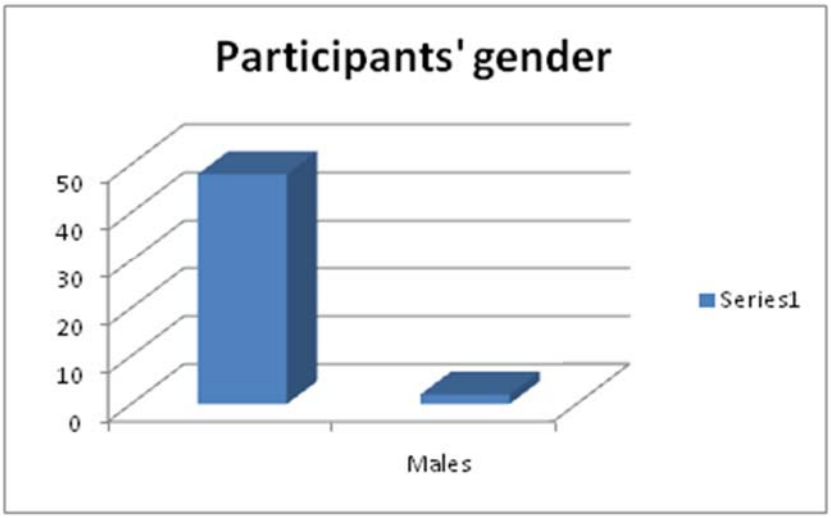
Country of Origin	Assistant Director of Nursing	Clinical Nurse Coordinator	Clinical Resource Nurses	Graduate Nurse Interns	Registered Nurse Preceptees	Registered Nurse Preceptors	Unit Managers	TOTAL
Egypt	0	1	0	1	0	0	0	**2**
India	1	0	2	0	0	2	1	**6**
Ireland	0	0	1	0	0	0	0	**1**
Jordan	0	0	3	0	0	0	1	**4**
Lebanon	0	0	0	0	0	0	1	**1**
Oman	0	0	0	1	0	0	0	**1**
Philippines	0	0	4	0	2	9	1	**16**
South Africa	1	2	7	0	0	0	2	**12**
Somalia	0	0	1	4	0	0	0	**5**
Yemen	0	0	0	2	0	0	0	**2**
TOTAL	**2**	**3**	**18**	**8**	**2**	**11**	**6**	**50**

Table 5. 1 above represents a motley of nationalities characterised by cultural diversity – a factor that has been observed to have a bearing on nursing clinical and professional practice, as well as on ethical norms and values. In total, 80% (n=40) participants were from non-Arabic countries; while only 20% (n=10) were from Arabic countries. The highest non-Arabic countries were the Philippines (32%, n=16), followed by South Africa (24%, n=12) and India (12%, n=6). The lowest numbers (n=1) were from Ireland, Lebanon, Oman, and Yemen respectively. The general observation emanating from the above state of affairs appears to confirm the view that nursing is not one of ***the*** 'prestigious' professions in Arabic countries, hence the influx of expatriate nurses from (predominantly non-Arabic) other countries to the UAE.

5.2.3 Participants' Gender Distribution

Figure 5.2 below indicates the gender distribution of the research participants.

Figure 5.2: Participants' Gender Distribution



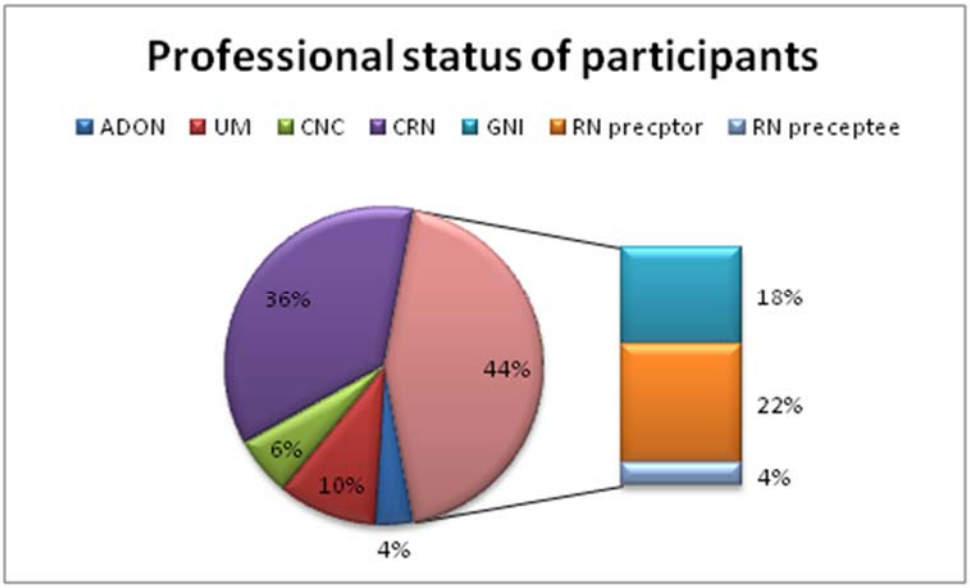
There were 48 female study participants and only 2 males. This highlights the fact that nursing was still a predominantly female profession, even in Arabic countries. Only few males enter nursing profession in this region. In such a state of affairs, the cultural stereotypes of female submissiveness and male domination would inevitably find concrete expression and manifestation. The perception of nursing as a ***caring*** profession allocates to it a ***feminist*** character; therefore, a characteristic that is supposedly ***not*** in accord with a stereotypical worldview that promotes the ***machoistic*** character of men to reflect that they are in charge. In such a mode of thought, "caring" and "feminine" are perceived as singularly synonymous. Furthermore, some cultural and patriarchal entrenchments presuppose that the domination of men as "heads" would not be completely expressed in a predominantly female territory.

5.2.4 Participants' Professional Status

The diverse range of nursing categories (professional status) represented in the sample, ranges from ADONs, CNCs, CRNs, GNIs, new RNs, old RNs, and UMs from the range of countries represented in Table 5.1 above.

The figure below reflects the participants' professional status in respect of the various nursing categories sampled.

Figure 5.3: Participants' professional status

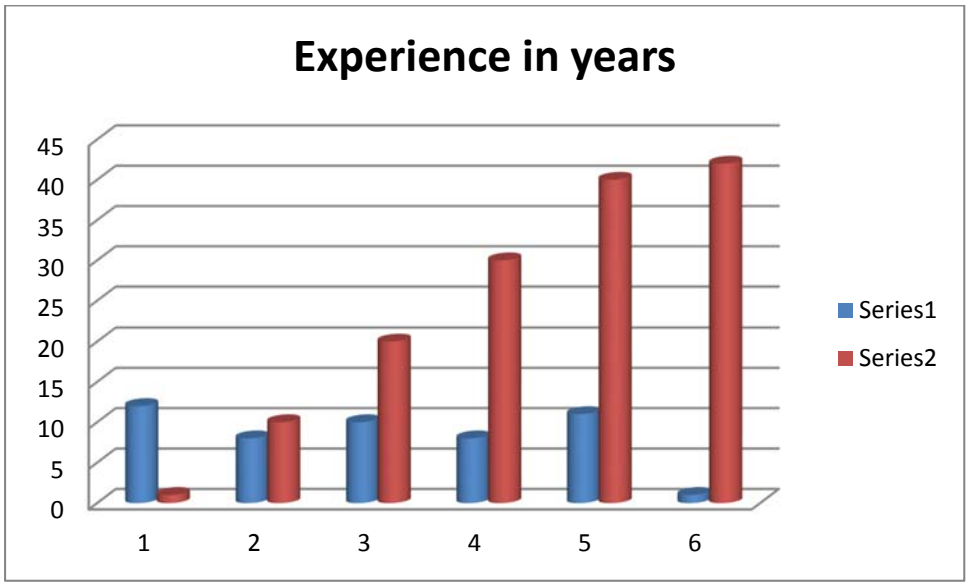


In Figure 5.3 above, the professional status of the research participants is reflected as follows: 18 CRNs, 11 RN mentors, 2 RN mentees, 8 GNIs, 1 ADON, 1 Acting ADON, 3 CNCs, and 6 UMs. The fact that the majority of respondents (n=18, 36%) are clinical resource nurses (CRNs), augurs well for the study; which is essentially about the role of CRNs in peer mentoring.

5.2.5 Participants' Nursing Experience

The figure below depicts the participants' number of years (experience) in the nursing profession. All the participants had a post basic qualification, which is the most minimum requirement.

Figure 5.4: Participants' nursing experience



In Figure 5.4 above, the experience of the participants in years, is reflected as follows: 8 participants had 1 years' nursing experience; 12 participants had 8 to 10 years of

experience; 10 participants had 11 to 20 years' experience; 8 participants had 21 to 30 years of experience; while 11 had 31 to 40 years' experience; and 1 had a remarkable record of 42 years of experience in the nursing profession. All participants, except for the 8 GNIs are registered nurses, and the ADON is a PhD candidate. The total average in years of experience for the 50 participants is 17.08 years, a profound indication that SEHA facilities adhere to the philosophy of employing experienced registered nurses. That the majority of participants (n=12) had 8-10 years' experience between them, and another group of 11 had 31-40 years' experience, is a manifestation of such an employment trend.

5.3 PART B: DISCUSSION OF FINDINGS

Due to the qualitative aspect of the data, the researcher employed the inductive data analysis approach, according to which data was analysed manually in order to organise, provide structure, and elicit meaning from (Polit & Beck, 2008: 401). The following themes emerged from the participant interviews, and provided a context for the subsequent critical discussion:

- Maintenance of patient safety;
- Orientation and induction;
- Professional development;
- Assigning of mentor;
- Maintenance of healthy interpersonal relationships;
- Formative Evaluation; and
- The Change Agent Factor.

The identified themes were categorised according to the most general to the most specific in respect of the following matrix:

Level 1: Themes;

Level 2: Categories; and

Level 3: Text (data) units (participants' verbatim responses).

The identified themes were discussed with corresponding reference to relevant literature pertaining to the description of the role of the clinical resource nurse in peer mentoring and its impact on staff retention. The systematisation of themes according to categories and the subsequent coding was instrumental in assisting the researcher's exploration and description of the following critical factors pertinent to the research topic:

- The role and responsibilities of the CRN in peer mentoring;

- Contributory factors to effective peer mentoring;
- Power relations and resistance experienced during peer mentoring; and
- The strength and weaknesses of peer mentoring.

5.3.1 Maintenance of Patient Safety

WHO (2011: 1) describes patient safety as the prevention of errors and adverse effects associated with patients' health care. Patient safety is the responsibility of every member of the health care community. The relationship between senior leadership and frontline management is a pivotal lifelong learning mechanism to creating and sustaining patient safety and quality, which are dependent on the availability of competent staff and other infrastructural resources.

Vincent (2011: 15) posits the view that the implementation of patients' safety protocols and procedures remains a challenge; rather than the staff shortage perspective, since nurses and physician are already conscious and ware of patient safety.

In the current study, the participants' elicited responses indicate that patient safety was ensured by means of identifying and determining practice gaps, learning needs of staff, annual validation of competencies, supporting and guiding staff in clinical practice, and providing evidence-based education. All these factors are indicated narratively in table 5.2 below.

Table 5.2: Patient safety factors

Sub-category	Meaning (Participants' Narrative Texts)
Resource person P005	Well from my side, I try to determine where there are gaps in the practice because my aim is to ensure [that] safe patient care is done.
Determining practice gaps P016	If you have any gaps identified in the clinical skills of the staff, you get back to appropriate resources; you get your CRNs coming there. It is more of collaboration.
Provision of safe environment P012	I have to provide a safe, healthy, and up-to-date education-based practice environment for my staff to take care of the patients. I also have to provide a safe environment for the patient. I do that with all the knowledge and skills that I have acquired in my training. I also make sure that certain groups, such as my Clinical Nurse Coordinator and Clinical Resource Nurse, are involved in a safe, healthy, and up-to-date education-based practice environment.
Support P04	It is giving guidance and support to the clinical staff that you are working directly with, regarding procedures, guidelines and new updates. Technology will also be used to support

Sub-category	Meaning (Participants' Narrative Texts)
	clinical means of improving patient safety".
Assisting staff on the floor P13	For instance, if they need help with monitoring some patients, with blood extractions that are difficult draw, or if they need help with translating and talking to patients…
Competency P022	We do go around to our clinical areas and observe how people are practicing. So, we check on competency and other work-related skills. If people need support to develop their skills, we support and encourage them, and provide further education opportunities, as well as feedback.

5.3.2 Orientation and Induction

All employees receive orientation and induction upon commencement of a new work assignment. Clinical resource nurses are responsible for assisting new staff to 'find their feet' in the organisation by means of hospital-wide orientation and unit-based induction programmes. Orientation and induction have a two-fold function. For the newly employed staff, they feel welcomed, they gain a positive and safe outlook of the workplace, and they are able to locate their role and placement in the organisation. On the other hand, orientation and induction familiarises new staff members with the organisational culture; while also contributing to staff retention and optimisation of time for staff to be effective in their various role allocations. Gowrie (2011: 3) adds further that formally constituted and organised induction and orientation programmes foster better professional relations and mutual co-existence between old staff members and newly employed staff, helping both parties to develop realistic expectations of each other and one another.

Table 5.3 Orientation and induction

Sub-category	Meaning (Participants' Narrative Texts)
Orientation and induction of new staff P06	For the new hires, we have the orientation programme. All of us in every unit have an orientation package, so we go through the package. [Ok so[the first one, we have to tell them the organisational structure, and then we have the physical setup and the clinical routines orientation. The physical setup locates where the rooms are, so that you will not be lost. The clinical orientation is the routine of what we are doing in the ward. It [the routine] is in our folder, and then we assign. The manager and me and the CNC will go through the list of assignments.
Orientation of GNIs P05	Yes, for the new hires and GNIs I have what we call an orientation discussion with them. I do go through the orientation manual

Sub-category	Meaning (Participants' Narrative Texts)
Welcome programme P08	There is a Welcoming Group of nurses from each department. They have special responsibilities and duties. A part of their responsibility is to welcome the new staff to our department. That group supports the preceptor a lot. We also explain a little about that group's role with the new staff. The group provides help and advice on issues outside the hospital, such as hotels, restaurants, shopping, and so on.

5.3.3 Professional Development

The primary role of the clinical resource nurse includes the professional development of staff by means of education and training initiatives. Such initiatives and programmes are intended to ensure that nurses provide safe, high-quality, and evidence-based care by means of correlating of theory and practice; thus keeping abreast of new trends, maintaining competence, as well as enforcing policies and procedures based on these new trends. The American Nurses Credentialing Center (ANCC) (2014: 1) posits that clinical resource nurses play a vital role in developing activities that meet the registered nurses' learning needs. However, there are also factors that impede on staff development.

The CRNs raised concerns regarding circumstances that hamper professional or staff development. These factors included disruptive staff behaviour; bullying; unwillingness to learn engendered by overtime; staff shortages; as well as the unavailability of resources such as training rooms and simulation laboratories. A compendium of professional development factors is presented in table 5.4 below.

Table 5.4: Professional development factors

Sub-heading	Meaning (Participants' Narrative Texts)
Teaching by precept and example P021	I should be a role model as well, so that they should do what they see me doing. That is what they will be doing on the floor. We try to develop and empower them into more competent nurses.
Accreditation of courses P017	I am the coordinator of the CNEP (Continuing Nursing Education Programme). I do send some of the programmes to HAAD for Category II accreditation, after the CRN in that particular area of nursing or clinical practice has reviewed the programme. I am the one who eventually gives approval for Category II accreditation after the CRN's submission to me.
Life support courses P020	Basically, the purpose is to facilitate education and training for the relevant areas. My main area is Paediatrics because I am trained in that area. Part of my

Sub-heading	Meaning (Participants' Narrative Texts)
	responsibilities include life support skills. I am a Basic Life Support (BLS) instructor since this year, and also a Paediatric Advanced Life Support (PALS) instructor. I am also responsible for making sure every year that all the nurses are competent in those areas.
Bedside teaching P004	It is about giving guidance and support to the clinical staff that you are working directly with regarding procedures, guidelines, and new updates. They are also supported technologically on these clinical aspects.
Education of GNIs and new employees P023	We are allocated different roles that are expected to be fulfilled. In the units, we have GNIs (Graduate Nurse Interns) whom we have to teach during the study days.
Family education P06	I sometimes need to teach basic life support to a mother of a sick baby.
Cross training of staff P03	There was a shortage of paediatric staff, so adult staff had to be rotated to the paediatric unit. At the time there was a gap identified, and we decided to give a workshop for the paediatric Emergency Department (ED).
Acceptance as a team member P027	The acceptance of the patient and their family is important to us as trainees.
Initial relationship with mentor P030	In the beginning, I had to get used to the new preceptor environment. It improved after a while.
Staff shortage P03	The staff is working overtime due to shortages. They are tired, and it is not easy to give them lectures. We have introduced some new things, and when you call them to attend, they really 'hate' us you know… Another challenge is that we share the education room with the doctors.
Teaching resources P015	I think what we could really benefit from having a simulation lab, where we could have our nurses for, say, at least 8 hours or even two weeks to a month long. They could work under supervision in a simulated situation, and not almost run out in the deep end…

5.3.4 Facilitation of Peer Mentoring

Peer mentoring is vital for staff empowerment and retention. It provides an opportunity for the mentor to network with CRNs and other mentors, in order to help others gain the respect of colleagues by imparting knowledge to the mentee (Dennison, 2010: 341). For the mentee, peer mentoring provides a learning environment, increases confidence, as well as presenting an opportunity to learn from the experience of the mentor. Ironically, mentorship could also yield unpleasant experiences to both mentor and mentee. Senior Nursing Leadership (SNL) determines the number of new graduate interns that could be accommodated by the hospital, on the basis of which CRNs and unit managers then assign mentors according to the mentors' positive qualities.

Table 5.5 Facilitation of peer mentoring

Sub-heading	Meaning (Participants' Narrative Texts)
Role of senior leadership P024	They decide how many vacancies we want, and how many GNIs we can accommodate according to availability of preceptors in our units. They communicate with SEHA and HAAD if we have any issue with these GNIs. For instance, if we want to terminate somebody, they should be involved.
Criteria for pairing mentor and mentee P011	I do not think there is written criteria. I also think that, unfortunately, there is a lot emotion and personal things involved when applying the pairing. For me, it is usually a Team Leader or the Charge Nurse in the Unit. It could be somebody that I need to trust, somebody that I trust to do the right thing whenever I am not looking…
Qualities of a mentor P019	We were providing peer validation of the preceptor programmes. Those people were actually selected by the unit managers because they found that they have potential in teaching, so they were identified from the clinical areas. They were also provided by the education department with programmes such as the preceptor programme and the peer validator programme and therefore, they became our preceptors.
Negative attitude of mentors P021	Some of them could have all the knowledge but they have this attitude. That [attitude] somehow is a deterrent factor against instilling knowledge and skills to another person. So how do I know that? Because I've been with them …somewhat strict, somewhat rude … you know. I don't want to say the word, but bully type or something. They cannot be effective teachers to their mentees or students, because that will create a wall…
Negative attitude of mentee P024	I have another situation where the GNI thinks she is the boss and she can do anything she wants. [She thinks] She can choose her own preferred preceptor … change her duty, the time that suits her to come for competency classes. If she does not like the area, she will come to the senior leader to say, "I don't like". She does not know how to go through the proper channel. She abused the whole system.

5.3.5 Fostering and Maintenance of Healthy Interpersonal Relationships

A successful interpersonal relationship between mentors and mentees is the product of effective communication between them (Vertino, 2014: 3). Such successful relationships are shaped by factors such as language, attitude, nationality, age, the educational background of the pair, and the organisational environment (Vertino, 2014: 3). The latter is influenced by the nature and manner of the communication. The CRN is then obliged to take all these factors into consideration when assigning the pair. The success of the

mentor-mentee relationship is based on both parties demonstrating courtesy, kindness sincerity, as well as maintaining confidentiality regarding each other or the patient. The CRN also meets with the pair to determine the progress of peer mentoring by means of meetings and feedback. Interpersonal relationship is not devoid of challenges, as reflected in some of the responses in table 5.6 below.

Table 5.6: Establishing and maintaining healthy interpersonal relationships

Sub-heading	Meaning **(Participants' Narrative Texts)**
Regular meetings P07	We also tell them that they need to have regular meetings where they discuss "how am I doing, what are my areas of strength and weakness?" Things should be clear from the beginning so that they if there are issues or things to work on, these are resolved…
Relationship of trust P02	I have a group that asks questions that were essentially similar to my job interview… They wanted to know what my experience with paediatrics was, how qualified I was, what my experience was working with graduates and students… They decided they were going to keep me as a mentor. They built their trust on me … It was amazing to see how they grow, and how they became productive when you push them to perform at a higher level.
Work schedule P41	Prior to their exposure to the wards, the mentees knows that their schedule would be the same shift with the mentors. But due to unavoidable circumstances, the mentee could sometimes also be with other senior staff in the ward in the absence of their appointed mentors. This can help also, so that different strategies are learnt from different individuals.
Conflict management P023	…If there is any problem, the preceptee and the preceptor are given the freedom to come and report to the CRNs. We try to make meetings and sit with them in those meetings. If there are any personality clashes, we try to solve them in those meetings. If it happens, unresolved personality clashes will be escalated to the Unit Manager, and all four of us may agree to change the preceptors.
P025	…If it is really something that is social, we can relate it to the ADON. We need to exhaust all in-house avenues. I believe in this. I do not like to hang my dirty linen in public. I would like to hang it inside and let it dry. If you do not get it to dry, it will become wet forever, and you have to show it to the neighbour who will help you…
Management of diversity P014	We also try not to put them (mentees) with same nationalities in order to prevent them from speaking their own language. Since English is the official language on duty, we hope the preceptorship programme will go very well. But sometimes, it happens that the period does not go well and they would like to have their own nationality in their mentoring groups…
P015	I would say 90% of my staff is probably from either India or

Sub-heading	Meaning **(Participants' Narrative Texts)**
	Philippines. The local nurses were trained here in the UAE or Jordan. Unfortunately, not many of them; but the language is a big bonus for us in that they are Arabic speaking as we are getting more and more trained here in the UAE.
Unhealthy relationship between mentor and mentee P027	Colleagues who do not tell you everything about your patients
Healthy relationship between mentor and mentee P04	The preceptor and preceptee relationship is specifically a strong relationship because you were my preceptor before. I am now part of the unit, so you are one part of the family. On this basis, they are even going along better together…

5.3.6 Formative Evaluation

The Concise Oxford Dictionary (2006: 355) defines "formative evaluation" as "a formal measurement of progress". The purpose of formative evaluation is to monitor progress, and to determine the extent to which the stated objectives have been achieved; as well as concentrating on areas that need improvement.

The duration of the probation of new employees and the rotation of GNIs is three months, during which time they are evaluated at the end of each month to monitor their progress. Table 5.7 below indicates the level of formative evaluation conducted by unit managers and clinical resource nurses, as well as action based on the results of the evaluation.

Table 5.7: Level of formative evaluation by unit managers and clinical resource nurses

Sub-heading	**Meaning (Participants' Narrative Texts)**
Monitoring progress P08	In the hospital, we have a programme called 30/60/90 days' evaluation. We meet with our new staff monthly, and we conduct an evaluation. We set objectives and goals for the new staff members
Action for GNIs who do not meet objectives P09	When the coordinator discussed the graduate nurse internship programme, we decided initially that the nine months will be normal rotation. If anyone failed to complete the requirements in one rotation, then the last rotation (that is, the Critical Care rotation) will be the repeat of the previous nine months' normal rotation.
Action for RNs who do not meet objectives P011	We can actually pick up if they are not coping within the first 30 days. Whenever someone is struggling within 60 days, we know that he/she is going to struggle for the rest of the time. When we realise that they are struggling already within 30 and 60 days, we work more with them. I go to them on the floor and look at their clinical skills. I then assist them accordingly.
Extension of probationary	I actually have a nurse right now who has completed 15 shifts

Sub-heading	Meaning (Participants' Narrative Texts)
period P015	with the preceptor. She comes from a private hospital here in the city. She is struggling, not because she does not have the requisite skills and knowledge. It is mainly due to the acuity of the patients and the electronic medical records system. They are not used to it. If you are not very computer literate, just getting to know your way through the corner system is difficult enough.
Step down to non-acute area P011	We can look at an alternative place for them in which to work. We have two units, the PICU (Paediatric Intensive Care Unit) for patients who are really sick in bed and have high acuity is quite high. We also have the HDU (High Dependency Unit. If they do not cope in our High Dependency Unit, we send them to our Paediatric Ward.

5.3.7 The Change Agent Factor

Change is inevitable in any organisational situation (Kezar & Eckel, 2002: 440; Castells, 2001: 10). Health care is therefore no exception. Technology innovations warrant that nurses adapt to new trends in order to provide quality evidence-based patient care. Clinical resource nurses facilitate, guide, and inspire others to embrace change. Change is necessary and leads to the improvement of services rendered to patients, nurses, and the community being served (Vertino, 2014: 3). In table 5.8 below, the CRNs outline their role as change agents, as well as the impact of such a role on staff retention.

Table 5.8: Role of CRNs as change agents and impact on staff retention

Sub-heading	Meaning (Participants' Narrative Texts)
More preceptorship programmes P013	I would advocate for the professional preceptorship programme. Previously, we did have a preceptorship programme. I would advocate for the return of that programme because I need more preceptors.
Involve GNIs in preceptorship P011	I think when they are at the college, they should be educated on how to precept staff… not only with the procedures, but also psychological and social interaction … how to keep GNIs happy so that they can learn and be productive.
Time and attendance P015	I know it is going to be very, very difficult, but I would advise on 8-hour shift for the staff.
Reward and recognition P03 P022	They say "What development?" Some hospitals give one month's salary bonus when you precept someone. It might be a reward in some ways. So people always want a financial reward, but it could be that they have some sort of badge…
Reducing the mentor's workload	I will ensure that a preceptor doesn't get the most

Sub-heading	Meaning (Participants' Narrative Texts)
P01	demanding patients; the least demanding patients afford more time for mentors to educate their mentees.
Ensure that all nurses attend the preceptorship course P019	If I was the head of the nursing department, I would make sure that all the RNs in each department are trained to precept. With the influx of GNIs and students, we are running out of preceptors. It's very difficult to allocate preceptors, so we need to have more in the units to precept because right now we don't have enough
Teaching resources P04	More simulation labs in the beginning. In the first month, especially…
Uniform P015	Do away with the white uniforms.

5.4 CONCLUSION

The focus of this chapter was on data analysis. The empirically-focused semi-structured interview questionnaire provided the most seminal source, context, and point of reference for the analysis of data. Themes, categories, and narrative texts were also discussed with reference to the reviewed literature. The ensuing chapter (Chapter 6) concludes the study and makes recommendations for practice and future research in peer mentoring.

CHAPTER 6

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

Chapter Five explored the views and perceptions of research participants concerning the impact of the peer mentoring role of the clinical resource nurse on staff retention. The responses of the participants were compared to the literature review, and the findings were contextualised inductively in order to allocate real-life meaningfulness to the study. The core of the current chapter focuses on the emerging themes and topical issues in the findings of the study; the associated limitations of the study; the recommendations based on the findings; as well as the main conclusions of the study. The continuum of, and affinity between the findings, recommendations, limitations, and the conclusions appropriated the connection between the abstract and the practical nursing and policy implications; the scientific worth and rationale; as well as the rationale and significance of the entire research project.

6.1.1 Study Objectives and Their Realisation

From the researcher's point of view, the study objectives and the extent of their ***realisation*** served as an objective determination of any discussion pertaining to the emerging themes and findings of the study; the associated recommendations based on the main findings; as well as the conclusion accruing from the study as a whole. Accordingly, the objectives of the study were articulated thus:

- To explore and to describe the nature of processes and strategies involved in the partnering of mentor and mentee;
- To explore and to describe the strengths and weaknesses of peer mentoring; and
- To develop a regime of recommendations accruing from the findings or results of the study.

The study was conducted at two SEHA health care facilities in Abu Dhabi. The initial sample consisted of thirteen CRNs, eleven GNIs, two newly employed RNs and twelve RNs (preceptors). However the involvement of other stake holders in peer mentoring was highlighted during the interviews with the CRNs, the GNIs, the new RNs, and the mentors. The sample was increased to include four unit managers, one acting unit manager, three CNCs, one GNI co-coordinator, a CRN, an acting ADON who is also a GNI coordinator, and one ADON who is involved in nursing education. The participants included two males and forty eight females from a motley of English-speaking nationalities.

6.1.1.1 Realisation of First Objective

The first objective of the study is: *To explore and to describe the nature of processes and strategies involved in the partnering of mentor and mentee*. In this regard, the peer mentoring processes and strategies were discussed in relation to their associated impact on staff retention. In Chapter Two (p.p. 13-35) of this study, and Section 2.3 in particular (p.p. 20-35), adequately addressed this objective. The nature of processes and strategies in peer mentoring were discussed in the context of the mentoring styles; the phases of the mentoring relationship; the peer mentor matching strategies; as well as the comparative review of peer mentoring strategies that impact on staff retention (pp. 30-33).

6.1.1.2 Realisation of Second Objective

The second objective of the study is: *To explore and to describe the strengths and weaknesses of peer mentoring.* This objective was satisfactorily realised in sub-section 2.3.6 (pp. 33-35) of the current study. Furthermore, the following ***advantages*** of the mentor-mentee transaction below underpin some of the strengths of the peer mentoring process; notwithstanding the weaknesses highlighted in sub-section 2.3.6.2 (pp. 34-35).

6.1.1.2.1 Maintenance of Patient Safety

The success of the role of the CRN in peer mentoring and its impact on staff retention is not solely the responsibility of the CRN, but was realisable with the support of a team consisting of ADONs, the GNI co-coordinator, the unit manager, CNCs, and RN preceptors. The themes that emerged during the semi-structured interview sessions reflected on the role of the CRN in peer mentoring as ensuring patient safety, orientation and induction, professional development, qualities identified when assigning a mentor, maintenance of healthy interpersonal relations between mentor and mentee, mentoring evaluation, as well as the CRN as a change agent.

CRNs encounter staff members from different cultural and educational backgrounds. Each staff member brings their uniqueness and experience to nursing, which may not be at par with their places of employment. This results in practice gaps. Ensuring patient safety could pose a challenge due to these differences. One of the challenges is the language barrier. When staff members are unable to communicate with patients, errors become inevitable. In addressing the problem, staff members are sometimes used as translators. The role of the CRN is to bridge educational gaps through identification of learning needs in order to address these gaps (Race & Skees, 2010: 169). Other CRN roles include the facilitation of lifelong education, as well as the provision of staff members with awareness and compliance procedures, policies, and equipment.

The data was collected from two SEHA facilities. However, there is a difference in approach used in both facilities regarding maintenance of patient safety. One facility has unit based CRNs, and the other facility has an education department where all CRNs are based. In one facility, the managers identify learning needs, then refer them to CRNs; whereas in the other facility, both CRNs and managers identify the learning needs, and then address them.

6.1.1.2.2 Orientation and Induction

Orientation and induction are sometimes erroneously construed as synonyms (Botma et al., 2012: 3; Hyrkas et al., 2014: 128). Although they happen simultaneously, the application and meaning of these two nuances is not the same. During orientation, the new employee is provided with an information package that serves as a point of reference regarding job description, their expected role, and employment terms and conditions. Orientation is conducted ***informally*** and may last for a few days, depending on the requirements of the organisation. Orientation may also involve familiarisation with the geographical layout of the institution and its various units.

Conversely, induction is a reference to more ***formal*** training and service requirement that the staff completes in the early stages of employment, and includes information on expectations of the employer and employee; procedures; policies; as well as unit orientation. Induction may take few hours or a day to accomplish.

All participants concur that the role of the CRN involves welcoming new staff and introducing them to the new environment and its organisational culture. By means of orientation and induction, new staff feels welcomed. The new staff also gains a positive outlook about the workplace, knowing their respective roles, and their placement or correct fit in the organisation. Old staff members are also able to impart their experience and establish rapport with the new staff. The process of orientation follows a similar pattern with that of induction. However, the duration of orientation differs between specialties from one facility to another. The duration of orientation and induction differs in both facilities. In one facility, the duration is between eight to twelve shifts. Other departments in the same facility offer orientation for fifteen shifts. The other facility offers orientation for at least sixteen shifts. In spite of the differences in the implementation of induction and orientation at the two SEHA facilities, the advantage is that both orientation and induction processes contribute to the effective ‘absorption’ of new employees into the workplace as an organisation.

6.1.1.2.3 Professional Development

The American Nurses Credentialing Center (2014: 1) posits that clinical resource nurses play a vital role in developing activities that meet the learning needs of registered nurses. Participants agreed that the role of the CRN is to ensure staff competency by means of the application for accreditation of courses necessary to ensure that they keep abreast of recent developments; while correlating theory and practice for the GNIs and registered nurses. The benefits of professional development also include intimate knowledge of staff; thus decreasing the barrier of communication, empowering staff, and watching them grow into fully fledged competent nurses.

6.1.1.2.4 Facilitation of Peer Mentoring

There are different schools of thought regarding the pairing of mentors and mentees. One school of thought postulates that factors such as similar personality traits; learning styles; gender; age; experience; and nationality entrench a viable mentor-mentee relationship (Beecroft et. al., 2006: 738). In this study, all participants agreed that SEHA facilities have no written criteria for assigning mentors.

Any prospective mentor should have attended a preceptorship course, be knowledgeable, be willing and able to teach, have good interpersonal skills, and be a seasoned practitioner. SEHA facilities employ random pairing, which is found to be most effective. Successful learning relationships in peer mentoring equally benefited by dissimilar personalities, perceptions, experience and learning from each other than in similar ones (Beecroft et. al., 2006: 738). The latter perspective is in concurrence with the view by Nick et al. (2013: 3), who maintain that different personality traits are also conducive to learning and commitment, as parties learn from each other.

6.1.1.2.5 Fostering and Maintenance of Interpersonal Relationships

The mentor-mentee relationship is based on trust and respect for each other and one another. The purpose of the mentor-mentee relationship is to empower the mentee by means of guidance and support. Such a relationship allows the mentee to grow, to recognise their strengths and weaknesses; while improving their performance and evaluating the success in respect of goal attainment.

All participants support an effective mentor-mentee relationship fostered by holding regular meetings with middle management. The purpose of such meetings should be to assess the performance and progress of the mentees during competency validation and study days held for GNIs. Maintaining such a healthy relationship between the mentor and mentee is also vital for staff retention. The mentee will be able to stay in the profession in an environment that is conducive to learning and growth. On the one

hand, such an environment is engendered by ***qualities*** of the mentor, including: his/ her approachability, nurturing, role modelling, knowledgeability, competence, a positive approach to life, and effective interpersonal skills (Race & Skees, 2010: 170). On the other hand, the mentor-mentee relationship is enhanced by the willingness of both parties to learn from each other (Teatheredge, 2010: 19). All participants agree with the qualities of effective mentoring mentioned above as being vital to the success of the mentor-mentee relationship. The participants also added that a necessary element for the success of the relationship was premised on the involvement of senior leadership.

The participants also mentioned that the mentor-mentee relationship could be thawed by uncivil behaviour, such as withholding information from colleagues and not being accepted as a member of the team by older colleagues. Other factors that impact negatively on the mentor-mentee relationship included high patient acuity and heavy workloads, coupled with the fact that ‘nurses eat their young ‘and shortage of staff.

6.1.1.2.6 Formative Evaluation

Competency in clinical practice is a vital aspect of professional nursing practice. CRNs are responsible for monitoring the learning process by means of evaluation. Evaluation is itself the most objective means for assessing the extent to which learning goals and objectives have been achieved. It provides the feedback necessary to improve learning, identify learning gaps, and correct any misconceptions that may exist (Boyde & Sheen, 2014: 32).

The research participants stated that the role of the CRN includes the preparation and organisation of evaluative procedures. The new nurse recruits are usually informed about evaluation during the orientation sessions. The evaluation is undertaken either during the thirty, sixty and ninety days or probationary period, or during the GNI rotation system. In order to ensure that openness and transparency prevail, evaluation is held in a friendly environment in the presence of the mentor, the mentee, the UM, and the CNC. Misconceptions and concerns are thoroughly addressed in real time during formative evaluation. Some participants, however, raised concerns regarding this practice (of openness). Their considered view was that, for fear of reprisals and victimisation, they were unable to raise their concerns regarding their mentors in the presence of the self-same mentors.

6.1.1.2.7 The Change Agent Factor

The research participants mentioned that they viewed themselves as change agents in the peer mentoring improvement process (Bratt, 2013: 3; Bowers, 2011: 19). They maintained further that such improvement could be achieved by means of measures such as: reducing the workload of mentors in order that they could spend more time with the mentees; providing rewards and recognition to individuals involved in peer mentoring. Rewards and recognition could be in the form of salary bonuses or a badge to keep them motivated and appreciated. A reward system enhances their value as serving the organisation. The participants endorsed the change agent factor further by citing that the provision of a simulation laboratory would enhance the mentor-mentee process. Amongst other functions, such a simulation lab would enable new recruits to navigate electronic medical records and other practice documentation, instead of merely 'throwing' new recruits 'in the deep end' with minimal skills to survive 'the deep end'. Participants also suggested increasing the orientation programme with at least one month, in order to allow the new recruits enough time to familiarise themselves with the organisation's culture, which would help them to find a 'fit' into the organisation.

6.1.1.3 Realisation of Third Objective

The third objective of the study is: *To develop a regime of recommendations accruing from the findings/ results of the study*. This objective was adequately achieved. The researcher has compiled a regime of recommendations, all of which were derived from the main findings of the study. Section 6.2 below outlines the range of recommendations, which are largely categorised into organisational/ institutional, discipline-based recommendations, as well as recommendations for further research.

6.2 RECOMMENDATIONS

The study's recommendations reflect the researcher's juxtaposition or study's continuum of the data collection and analysis processes and the findings on the one hand; as well as the research problem and research objectives on the one other. It is on the basis of such juxtaposition or continuum that a set of propositions (recommendations) were developed in order to validate and authenticate the study and its significance, contribution, or relevance. In their entirety, the recommendations are specifically intended to contribute towards the ***improvement*** of the peer mentoring process in the context of both professional and individual growth and development. It is worth mentioning that the recommendations and limitations of the study are mutually inclusive. For that reason, the recommendations are ***inherently*** remedial propositions in the context of the study's limitations. In this regard then, each of the recommendations

simultaneously embraces and addresses a particular aspect of the study's limitation – whether or not any particular limitation has been referred to.

6.2.1 Organisational/ Institutional Recommendations

The organisational or institutional recommendations are a set of propositions which specifically relate to the two SEHA facilities as the primary ***workplace*** and research sites. Based on the findings, the following recommendations were deemed to be relevant.

- All SEHA facilities should standardise orientation and induction programmes from sixteen to twenty shifts, thus increasing the confidence of employees who were never exposed to ***electronic*** medical records navigation and documentation systems;
- All SEHA facilities should ***standardise*** the peer mentoring programme, in order to infuse uniform or similar requirements and expectations in the event that an employee transfers from one facility to another;
- Only ***willing*** and ***able*** mentors should be given mentoring opportunities to enable them to form peer mentoring networks. Malcontent mentors may induce undesirable behaviour, attitudes, and expectations from mentees;
- All SEHA facilities should provide ***basic conversational Arabic lessons*** during the orientation and induction of new employees, in order to improve ***communication*** between health care providers and patients; thus improving patient safety and promoting positive patient experience. The medium of communication in SEHA facilities is English. Participants came from different cultural and educational backgrounds, with English being their second or third language. Most participants have limited use of the English language, which impacts negatively on their form of verbal and written expression. These language barriers largely accounted for the participants' reluctance to be involved in the study's empirical phase;
- A formal system of ***incentives*** (such as badges, salary bonuses, or certificates) should be introduced to reward, recognise, and motivate mentors;
- All newly recruited staff should also possess a ***HAAD licence*** after undergoing hospital orientation and peer mentoring. The initial probation period is three months. At the end of the thirty, sixty and ninety days, a formative evaluation is conducted to monitor progress. The probation should be ***extended*** in case the nurse is not well adapted to the new workplace environment, especially to acute areas such as the intensive care or acute paediatrics units;

- Similar or ***uniform peer mentoring requirements*** should apply in the entire facility, and not differ from one specialty to the other, such as similar requirements in paediatrics and surgical;
- ***Self-assessment questionnaires*** should be restored to ensure effective placement of new staff, thus reducing turnover; and

6.2.2 Discipline-based Recommendations

The discipline-based recommendations relate to the researcher's propositions which focus on closing the identified gap(s) between nursing theory and practice in the context of peer mentoring, the role of the CRN, as well as staff retention. Such propositions are derived from the generated evidence, and are intended to improve the quality of both patient care and the nurse(s) providing such care.

- The introduction of mentoring programmes during the basic training of nurses should not be only for the familiarisation of GNIS with peer mentoring programmes from the earliest stages of their careers and professional development. Rather, an integrated approach by HAAD, NMC, SEHA, and institutions of higher learning should be embarked on in a concerted manner in order to enhance the standardisation of ***nursing education policy*** and practice;
- ***Multiple stakeholder partnerships*** should be established between the UAE government and health authorities (HAAD, NMC, etc.), NGOs, and nursing institutions to promote nursing as a profession and attractive career choice. This will help to remove the negative stigma and stereotype attached to nursing as a predominantly (expatriate) female profession. Such awareness will contribute towards the recruitment of more national males and females to the nursing profession;
- Peer mentoring should constitute an obligatory component of the ***basic*** nursing education programme in collaboration with SEHA and nursing higher education institutions, in order that ***graduate nurse interns*** participate in the peer mentoring programme from the earliest stages of their careers and professional development as future leaders; and
- Partnerships between nursing colleges and SEHA facilities should develop and institute ***collaborative*** programmes to assist ***advanced beginners*** in the spheres of competency; change and complex health systems; leadership development; patient safety; as well as resource management, including the human resources dynamics of nursing as part of the nursing education programme.

6.2.3 Recommendations for Further Study

The recommendations for further study are closely related with various aspects of the discipline-based recommendations, as well as the study's limitations – particularly those limitations concerning the scope of the study (explained in Section 6.3 below). However, these recommendations and limitations do not in any way attenuate the envisaged impact and significance of the study. The impact and significance of the study is demonstrated by advances made in the various segments of the entire research process. The following recommendations imply that the specific segments (units of analysis) referred to, are critical to the improvement of any exegetic approaches to *the role of CRNs in peer mentoring, and the impact of such a role in staff retention.*

- The official medium of ***communication*** in SEHA facilities is English. Table 5.1 (p. 87) of this study reflects the multi-national origins and cultural diversity of nurses in the UAE. The research participants themselves were culturally heterogeneous and educationally diverse, with English as their second or third language. For this reason alone, language and communication are critical 'tools of the trade' and instruments for interpersonal understanding even in the peer mentoring context*. Future research is therefore necessary to establish the cumulative effect of language barriers to staff productivity at SEHA facilities*;
- Since ***cultural dynamics*** are entailed in the future research proposed above (bearing in mind that language is also a cultural symbol), such a study proposed above should also include *gender* issues. Nursing is a predominantly female profession, but cultural dynamics in the UAE engender an 'efficacy deficit'. For instance concerns of treating and communicating with members of a different ***gender*** could not be attenuated, especially in countries such as the UAE; and
- Although the study focused on the role of the clinical resource nurse in peer mentoring and its impact on staff retention, the success of the ***transitional period*** involves knowledge of language and culture of the clients/ patients being served. It might be beneficial to conduct a study that explores the role and effects of nursing education in the graduate nurse intern's transition period in a culturally ***patriarchal*** society.

6.3 LIMITATIONS OF THE STUDY

In spite of the notable strengths of this study, limitations were also noted. According to Grove et al. (2013: 598), a study's limitations are located within those areas or units of analysis that may most likely reduce the study's generalisability. In this study, the units

of analysis referred to are mainly premised on the ***scope*** of the study and its attendant elements.

6.3.1 Scope of the Study

The scope of a study is informed by the degree to which it qualitatively and quantitatively addresses core issues and aspects of the research topic. In this regard, discipline-specific, literature-based, and empirically-based limitations form critical and relevant points of reference.

6.3.1.1 Discipline-specific Limitations

The discipline-specific limitations are associated with those constraints that have the potential to deprive the study of the benefits of a wider consultation of ***literature*** sources in order to illuminate on other ('unseen') aspects of the research topic. In this regard, the current study is strictly premised on peer mentoring (as an aspect of nursing clinical practice) and staff retention (as an aspect of human resources management). However, a focus on the ***multicultural*** aspect of nursing education would have blended meaningfully with the multinational composition of nurses (as human resources products) in their employment by SEHA. A multicultural perspective of ***nursing education*** would further illuminate on the extent (if any) to which nursing qualifications obtained in various non-Arabic countries do affect these (non-Arabic) nurses' capacity to optimally perform their tasks and understand the organisational culture within which such duties or tasks are to be performed.

6.3.1.2 Literature-based Limitations

In tandem with the discipline-specific limitation referred to in sub-section 6.3.1.1 above, the study would have benefited from a broadened literature base that objectively reflects on multiple perspectives of the ***universality*** or ***indivisibility*** of nursing education in a globalised context. Such broadening of the scope of pertinent literature would inevitably provide insights into nursing education in the context of culturally-rooted and 'genderised' societies.

The reviewed literature provided information mostly on turnover and shortage of nurses, recruitment and retention, the transition from student to registered nurse status, and some aspects of peer mentoring – such as peer mentoring for nurse educators. There is minimal literature on the actual matching of mentor and mentee. There was also insufficient literature to develop and sustain the relationship between mentor and mentee. During literature review, there were no studies exploring how the role of clinical resource nurse in peer mentoring impacts on staff retention. This identified gap justifies the researcher's undertaking the study in order to explore and describe how the role of

clinical resource nurse in peer mentoring impacts on staff retention. The researcher's realisation of the relationship between peer mentoring and staff retention provided new insights for further exploration by other researchers and readers.

6.3.1.3 Empirically-based Limitations

Following the theoretical or literature-based information and data, the empirical aspect of the study provided 'first-hand' or practical, real-life experiences of the research subjects, who are themselves representative of the larger nursing universe or population employed at SEHA health care facilities. Most notably, the empirical phase of the study was important insofar as it constituted the most foundational means for the study's generalisability. In this regard, the researcher could have specified the respective nationalities of the research participants; that would not in any way constitute any violation of any ethical protocol. The ***'nationality factor'*** could help answer the question: *Is there any link between nationality and views on peer mentoring?*

Secondly, the qualitative research employed the grounded theory as its pivotal methodological approach around which the collected data was analysed. This method was opted for due to its capacity to obtain in-depth data during the interviews with a smaller sample of respondents. The researcher desired to explore the role of the CRN in peer mentoring from different perspectives and experiences, hence the choice of different facilities. The researcher initially planned to conduct the study at three SEHA facilities in Abu Dhabi, but only two of those responded to the invitation. In this regard, the researcher is of the view that the current sample of respondents from only two health care facilities might not be a completely true representation of the totality of SEHA facilities.

6.4 CONCLUSION

The impact of the CRN's role on staff retention constituted the primary focus of this study. There is irrefutable evidence attesting that the main role of the clinical resource nurse is to facilitate education, thus enhancing the bridging of the gap between nursing theory and practice. The exhaustive evidence accruing from the consulted literature search emphasised on the indispensability of successful mentor-mentee relationships as the cornerstone of both personal and professional development and growth of all the parties involved.

The researcher employed the qualitative design, employing grounded theory to explore the peer mentoring of CRNs on staff retention. As the preferred method of enquiry the grounded theory approach enabled the researcher to "experience and gain insight" into

the manner and extent to which the role of the clinical resource nurse in peer mentoring impacts on staff retention.

The findings of the study revealed that peer mentoring is not the sole responsibility of the CRN, but is also dependent on the unit managers, CNCs, and external stake holders such as HAAD, SEHA, NMC, and higher education institutions. It is envisaged that the range of findings and recommendations that guided this study will be of immense value to SEHA as the employer of both local Arabic nurses and others from various multi-national, educational, cultural, and professional backgrounds outside of the United Arab Emirates.

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On-Line:

http://www.haad.ae. Health Authority-Abu Dhabi

http://www.seha.ae SEHA

ANNEXURE A: UNISA ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/287/2013

Date:	10 December 2013	Student No:	672-420-5
Project Title:	The role of the clinical resource nurse in peer mentoring at one hospital in Abu Dhabi.		
Researcher:	Agnes Ntlaletse De Langen		
Degree:	D Litt et Phil	Code:	TFHLS05
Supervisor:	Prof ON Makhubela-Nkondo		
Qualification:	Harvard University Doctorate		
Joint Supervisor:	Dr MC Matlakala		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B: LETTER OF REQUEST

TO CONDUCT THE STUDY AT THE RESEARCH SITE

RESEARCH LETTER TO RESEARCH SITE

The Chief Executive Officer,
Sheikh Khalifa Medical City
P.O box 51900
Abu Dhabi
United Arab Emirates

Dear Sir/Madam,

REQUEST PERMISSION TO CONDUCT RESEARCH

I am a doctoral student of the University of South Africa, Department of Health Studies in the College of Human Sciences. I request your permission to the use of the students as participants for my research study to fulfill doctoral degree requirement on **Clinical Resource Nurse's Role in Peer Mentoring leads to peer mentoring.**

The participants will be required to provide the researcher with their experiences so as to assist with descriptions or meaning of the research topic. Ethical issues will be adhered to throughout the research. Confidentiality and privacy will be maintained. Participants' identity will not be possible through the information.

I hope you will grant permission to enter the research site and gain access to participants.
Yours sincerely,

Ntlaletshe Agnes de Langen

30/04/13

ANNEXURE C: APPROVAL LETTER FROM AL MAFRAQ HOSPITAL

مستشفى المفرق
Mafraq Hospital

RESEARCH ETHICS COMMITTEE
APPROVAL LETTER

Reference No:	MAF-REC_03/2015_01	Date:	03/05/2015

To:
Principal Investigator:
Ntlaletshe Agnes de Langen
SKMC,
Abu Dhabi, UAE

Study Title:

"The role of the clinical resource nurse in peer mentoring impacts staff retention"

Dear Ntlaletshe,

On behalf of ***Research Ethics Committee,*** please be informed that your proposal was reviewed and approved as there are no ethical concerns of the project.

Please note that the Principal Investigator should report the Research Ethics Committee of the following:

1. Any adverse events
2. Protocol amendments
3. Informed Consent Form amendments
4. Annual progress reports
5. End of study reports

Mafraq Hospital Research Ethics Committee (REC) has been organized and operates according to the Good Clinical Practice (ICH-GCP) Guidelines.

Please note that this approval is valid for one year from the date of issuing this letter. It is your responsibility to ensure that an application for continuing review has been submitted at the required time.

Regards,

مستشفى المفرق
Mafraq Hospital
Dr.Mustafa Al Maini

Mustafa Al-Maini, MD FRCPC Msc
Chair of Ethics & Research Committee
Deputy Medical Director
Chief of Rheumatology, Allergy and Clinical Immunology Division

ص.ب: ٢٩٥١، أبوظبي - إ.ع.م تليفون: ٠٠ ٥٨٢٣١٠٠، ١١١١ ٥٠١ ٢ ٩٧١+ فاكس: ١٥٤٩ ٥٨٢ ٢ ٩٧١+
P.O. Box 2951, Abu Dhabi - United Arab Emirates Tel: +971 2 501 1111, 5823100 Fax: +971 2 582 1549

ANNEXURE D: APPROVAL LETTER FROM SKMC

managed by Cleveland Clinic

SHEIKH KHALIFA MEDICAL CITY
NURSING SERVICES

P.O Box 51900
Abu Dhabi United Arab Emirates
07 August 2014

Dear Sir/Madam

Re: Approval to conduct a research study

It is my understanding that Ntlaletshe Agnes de Langen will be conducting a research study at Sheikh Khalifa Medical City on "THE ROLE OF CLINICAL RESOURCE NURSE LEADS TO STAFF RETENTION".

I support this effort and will provide any assistance necessary for the successful implementation of this study.

Sincerely,

Samah Mahmoud
Assistant Director of Nursing

SHEIKH KHALIFA MEDICAL CITY
Samah Mahmoud
GN#15195
Assistant Director Of Nursing
Managed By Cleveland Clinic

www.skmc.gov.ae مباشر: ٢٠٠٠ ٦١٠ ٢ ٩٧١+ فاكس: ٤٩٦٢ ٦١٠ ٢ ٩٧١+ ص.ب: ٥١٩٠٠ أبوظبي، الإمارات العربية المتحدة
Tel: +971 2 610 2000 Fax: +971 2 610 4962 P.O.Box: 51900, Abu Dhabi - U.A.E www.skmc.gov.ae

ANNEXURE E: INFORMED CONSENT FORM

The Clinical resource nurse is responsible to bridge the gap between theory and practice in the clinical setting, promotion and maintenance of high standards of quality patient care by managing nursing operations. Merging theory and practice poses a challenge, especially to newly qualified registered nurses who are overwhelmed by disparities between what was taught in the nursing college and job realities; such as inadequate support, information overload, shortage of staff and short length of stay. This leads to high attrition of the newly qualified nurses.

The role of the CRN is to facilitate learning; foster personal, professional growth and advancement of the less experienced registered nurse.

You are hereby invited to participate in the research study on the “role of CRN in peer mentoring”. The purpose of the study is to explore and describe the role of the CRN in peer mentoring. The information obtained will benefit the organisation, personnel and community, as the result will be used to determine what could be done to improve the situation.

This research will involve you participating in a face to face interview that will be conducted for at least 45 minutes. There will be no direct benefits to you. However, your participation in the study due to your experience will contribute to our understanding of the knowledge of the role of CRN in peer mentoring.

There is no risk or discomfort involved in the study. Your participation is voluntary and the choice you make will have no bearing on your job or work related evaluations. You have the right to stop participating anytime during the course of the study or chose not to respond to questions should the feel sensitive or personal without penalties.

<table>
<tr><td colspan="2">Researcher</td><td>Date</td></tr>
<tr><td colspan="3">I confirm that I have received and understand all the information regarding the study. It was also explained to me that my participation is voluntary and that I may refuse to participate or give consent to the study without any penalty. I hereby freely consent to take part in this research study.</td></tr>
<tr><td>Signature of respondent</td><td>Signature of witness</td><td>Date</td></tr>
</table>

ANNEXURE F: TRANSCRIPTIONIST'S DISCLAIMER FORM

CONFIDENTIALITY STATEMENT

I understand that as an interpreter / transcriber / research assistant (circle one) for a study being conducted by **_Ntlaletshe Agnes de Langen** of the Department of Health Sciences University of South Africa under the supervision of Professor **ON Makhubela- Nkondo**, I am privy to confidential information. I agree to keep all data collected during this study confidential and will not reveal it to anyone outside the research team.

Name: DIANA DAGA LIM Signature: _____

Date: 05 Nov. 2015 Witness Signature: _____

ANNEXURE G: INTERVIEW GUIDE FOR SEMI-STRUCTURED INTERVIEWS

1. What are your roles and responsibilities as a clinical resource nurse?
2. What do you value most about your job?
3. Which job situations are particularly stressful to you?
4. What is your role regarding peer mentoring/ preceptorship of GNIs and registered nurses?
5. What criteria is used for assigning a mentor/preceptor? Does a-mentor/ preceptor have an input in this matter?
6. How do you sustain a healthy relationship between a preceptor/ mentor and the preceptee/mentee?
7. If you were a head of your department, what would you change about the preceptorship programme?

ANNEXURE H: OPEN-ENDED RESEARCH QUESTIONAIRE

SECTION A: DEMOGRAPHIC DATA

Code_____

Instructions: Please cross (x) in the appropriate spaces provided

Gender	Male	Female

Age	30-40 years	41-50 years	51 and above

Nationality	Arabic	Non-Arabic		

Academic Qualifications	RN	MD	B Ed	BNS	MSN	Ph D

Years of experience as RN: **Date:** Month _____ Year_____

Work experience in Medical/ Surgical Unit: **Date:** Month_____ Year _____

SECTION B: OPEN-ENDED QUESTIONS

INSTRUCTIONS: Please write and explain your views regarding peer mentoring in the Medical/Surgical Unit, next to each of the allocated spaces below. Please note further that there is no correct or incorrect answer**.**

Appointment of a Mentor
1. How are new mentees informed that they will be provided a mentor? Please explain
2. How are new mentees informed about the purpose of mentorship? Please explain
3. How are new mentees informed about the duration of the mentorship programme? Please explain
4. What happens if the mentee requires further mentoring? Please explain
5. How do new mentees stipulate qualities that they prefer in a mentor, in terms of age, nationality, gender, etc.? Please explain
6. How are mentees informed that they will work in the same shifts as their mentor? Please explain
7. How are mentees encouraged to discuss their concerns with their mentor, and be assured of an escalation to senior management in case there is such a need? Please explain

8. How are mentees informed that they can change the mentor if there is a conflict of interest, or a personality clash? Please explain
Orientation to the Environment/Persons
9. How do mentors introduce themselves to the mentees? Please explain
10. How are the mentees introduced to other staff members in the unit? Please explain
11. How are the mentees orientated to their work environment? Please explain
12. Which aspects of your work environment keep you enthusiastic as a nurse? Please explain
13. What are the challenges that you face during your mentoring programme? Please explain
Information Regarding Peer Mentoring
14. Where/how is communication between mentor and mentee discussed and documented? Please explain
15. How are the results of the 30/60 and 90 days evaluation discussed with the mentee and documented? Please explain
16. Where/how/which untoward concerns between mentor and mentee are discussed and documented? Please explain
17. Is a mentee allowed to provide documented feedback regarding the mentorship programme? Please explain
18. Is the mentee allowed to provide feedback regarding the mentor? Please explain
19. What would you wish to change in the mentorships programme? Please explain

ANNEXURE I: RESEARCH PARTICIPANTS' DIFFERENTIATED DATA COLLECTION ENGAGEMENTS

	STUDY POPULATION		TOTAL
INSTITUTION/ RESEARCH SITE	**NURSING CATEGORY**	**POPULATION SIZE**	
SKMC	Unit-based CRNs	17	
	Registered Nurses	1, 212	
Total		**1, 229**	**1, 229**
Al-Mafraq	Clinical Resource Nurses	12	
	Registered Nurses	768	
Total		**780**	**780**
Grand Total			**2, 009**

STUDY SAMPLE SIZE BY INSTITUTION						
NURSING CATEGORY	**INSTITUTION NAME**				**TOTAL**	
	Sheik Khalifa Medical City		**Al-Mafraq Hospital**		**Number**	**Percent**
	Number	**Percent**	**Number**	**Percent**		
Assistant Directors of Nursing	1	4%	1	4%	2	**4%**
Clinical Nurse Coordinators	3	12%	-	-	3	**6%**
Unit Managers	2	8%	3	12%	5	**10%**
Clinical Resource Nurse	13	52%	5	20%	18	**36%**
Graduate Nurse Interns	6	24%	12	48%	18	**36%**
Registered Nurses		-	4	16%	4	**8%**
Total	**25**	**100%**	**25**	**100%**	**50%**	**100%**

SAMPLE SIZE PARTICIPATION BY RESEARCH INSTRUMENT TYPE						
	RESEARCH INSTRUMENT TYPE					
NURSING CATEGORY	**INTERVIEW**		**QUESTIONNAIRE**		**TOTAL OF 50**	**PERCENT OF 50**
	Number	**Percent**	**Number**	**Percent**		
Clinical Resource Nurses	18	64.2%	-	-	18	36%
Clinical Nurse Coordinators	3	10.8%	-	-	3	6%
Assistant Directors of Nursing	2	7.1%	-	-	2	4%
Unit Managers	5	17.9%	-	-	5	10%
Graduate Nurse Interns	-	-	8	36.3%	8	16%
Registered Nurses	-	-	14	63.7	14	28%
Total	**28**	**100%**	**22**	**100%**	**50**	**100%**

ANNEXURE J: SEHA ORGANISING COMMITTEE POSTER ANNOUNCEMENT

ANNOUNCEMENT

Dear Ntlaletshe De Langen

On behalf of the chair and SEHA Organizing Committee, we would like to thank you for your submission to the 4th SEHA International Nursing Conference at the Emirates Palace in Abu Dhabi on 24-25 November, 2015.
As a Poster Presenter, you may attend the conference for free on 24th November 2015. Kindly print your poster.

If you would like to register for 25th November 2015, you may do so at a discounted SEHA rate of AED 350. We are very excited to have so many registrants and an exciting schedule. We do hope that next year more delegates can attend compliments of SEHA, however, due to budget constraints we are restricted in the number of delegates who can attend for free. Your support is important to us and we thank you for your attendance.

1.Please click the following link
https://www.eiseverywhere.com/ereg/modifyreg.php?eventid=139033&
2. Enter your email address ndelangen@skmc.ae & your reference number 14648415
3. Click continue and choose which day you would like to attend
4. Click Continue
5. Choose credit card on the following page under 'Please select your method of payment'
6. Click 'Make Payment'
7. The following page will ask for your information, fill it in and submit
8 Your credit card payment will be successfully made

Please note that you will need to print your posters- SEHA is not responsible for poster printing.

An important reminder for those making hotel arrangements- the week of the conference is Formula 1 race and hotels are all filling up fast. There are no hotel arrangements made by the organizers for abstract presenters at this conference

THE FOLLOWING GUIDELINES ARE PREPARED TO HELP YOU PREPARE PROFESSIONAL POSTERS:

What is a poster?
A poster is a big piece of paper that can communicate your research or topic at a conference, and is composed of a short title, an introduction to your question or topic, an overview of your approach, your results in graphical form, some insightful discussion of aforementioned results, a listing of previously published articles that are important to your research, and some brief acknowledgement of the assistance and financial support conned from others (if any) — if all text is kept to a minimum, a person could fully read your poster in under 5 minutes.

Why a poster?
Presenting a poster allows you to more personally interact with the people who are interested in your topic. Posters are also handy because they can be viewed while you are away from the poster stand.

Posters format:
Unlike a manuscript, a poster can adopt a variety of layouts depending on the form of charts and photographs. Indeed, you probably don’t want your poster to look like every other poster in the room. You need to maintain sufficient white space, keep column alignments logical, and provide clear cues to your readers how they should travel through your poster elements. You should get creative.

The most important part of producing a great poster is to embrace the rough draft process. At least have a draft ready a month before the conference. Ask your colleagues to give you a feedback on the draft and embrace their comments. Note that you can print a miniature draft version of your poster on letter-sized paper for friends. Attached are some templates for posters. You can select any one of them.

What sections to include and what to put in them:

1. **Title:** Should briefly convey the interesting "issue," or the general experimental approach, needs to be catchy [approximately 1-2 lines].

2. **Abstract:** DO NOT include an abstract on a poster. A poster is an abstract of your research or project, so it's a waste of space to have an abstract of your abstract.

3. I**ntroduction:** Get your viewer interested in the issue or question while using the absolute minimum of background information and definitions; quickly place your issue in the context of published primary literature [approximately 200 words].

4. **Materials and methods (depends on your topic):** Briefly describe experimental equipment and procedure, but not with the details used for a manuscript; use figures and flow charts to illustrate experimental design if possible; include photograph or labeled drawing of setup; mention statistical analyses that were used (if any) and how they allowed you to address hypothesis [approximately 200 words.

5. **Results (depends on your topic):** First, mention whether your experiment procedure actually worked; in same paragraph, briefly describe qualitative and descriptive results to give a more personal tone to your poster; in second paragraph, begin presentation of data analysis that more specifically addresses your hypothesis; refer to supporting charts or images; provide extremely engaging figure legends that could stand on their own (i.e., could convey some point to reader if viewer skipped all other sections); place tables with legends, too, but opt for figures whenever possible. This is always the largest section (except if you have no data). If your topic is not a research based, you may discuss your outcomes or thoughts [approximately 200 words, not counting figure legends].

6. **Conclusions:** Remind the reader of the major result and quickly state whether your hypothesis was supported; try to convince the visitor why the outcome is interesting; state the relevance of your findings to other published work and future directions [approximately 200 words].

7. **Literature cited:** this includes scientific references. Find an actual journal article that supports your needed fact or opinion [5-10 citations].

8. **Acknowledgments:** Thank individuals for specific contributions (equipment donation, statistical advice, laboratory assistance, comments on earlier versions of the poster); mention who has provided funding [approximately 40 words]

We are looking forward to a successful and very full event. For an updated agenda, please see the website

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ANEXURE K: RESEARCHER'S POSTER SUBMISSION TO THE 4TH SEHA INTERNATIONAL NURSING CONFERENCE, ABU DH

The role of the CRN in peer mentoring: impact on staff retention

Ntaletshe Agnes de Langen

M Cur in Health Sciences, RN (general nursing, orthopedics and midwifery). Candidate: PhD in Health Sciences, University of South Africa.
Clinical Resource Nurse, Sheikh Khalifa Medical City (SKMC).

INTRODUCTION

Nurse shortage, turnover and retention affect both staff and patients alike. High staff turnover negatively impacts patient, care, access to patient care as well as staff satisfaction. The global nursing shortage is mirrored in the UAE. Currently Emirati nurses comprise only 3% of the nursing workforce. The balance is largely filled by foreign educated nurse supplemented by locally-trained, resident, non-nationals. All countries have different system of nursing education programs as well as intercultural communication. High expectations from both staff and patients, information overload, staffing shortage and short lengths of stay as well as the notion of "nurses eating their young" contribute to high staff turnover especially among new recruits. Clinical resource nurses are pivotal to the successful integration of new nurses as they facilitate clinical teaching, enforce policies, procedures, practices and standards of the facility to foster personal and professional growth and advancement of the less experienced nurses.

CATEGORY OF NURSES AND COUNTRY OF ORIGIN

	ADON	CNC	CRN	EN Preceptor	RN	GRN	LRN
Egypt	0	1	0	0	0	1	0
India	1	0	2	2	0	0	0
Ireland	0	0	1	0	0	0	0
Jordan	0	0	1	0	0	0	1
Lebanon	0	0	0	0	0	0	1
Oman	0	0	0	0	0	0	1
Philippines	0	0	4	9	4	0	1
Somalia	0	0	1	0	0	0	0
South Africa	1	0	1	0	0	0	2
Yemen	0	0	0	0	0	1	0

METHODOLOGY

Using grounded theory orientation, the purpose of the study was to explore and describe how, if at all the role of the clinical resource nurse impacts staff retention. The study was conducted from two SEHA health facilities in Abu Dhabi. The study followed a qualitative design that is explorative, descriptive and contextual in nature.

RESEARCH QUESTION

How does the role of the Clinical Resource Nurse (CRN) in peer mentoring impact staff retention?

THEORETICAL FRAMEWORK

The researcher employed nursing theories of Benner, Peplau, Ubuntu philosophy as well as ADDIE model to guide the study. The theoretical framework is explained below.

The role of the CRN in facilitating peer mentoring includes identifying the learning needs of the advanced beginner, developing strategies to meet those needs (viewed from different view points, including culture, personal beliefs, individual uniqueness and preconceived ideas). The CRN assigns a competent nurse who has completed the mentor/preceptorship program as a mentor/ preceptor.

The pair is introduced by the clinical resource nurse during the introductory meeting then establishes a rapport during the orientation period, each bringing their uniqueness and share professional experiences, skills and culture. The mentor and mentee meet to discuss the learning need of the mentee, discussing each other's expectations in the relationship, assessing the learning styles go through work book of the mentee, draw up a learning contract, meeting times, set goals and objectives.

As the relationship progresses, the mentor provides a welcoming and non-judgmental atmosphere conducive to learning by encouraging, supporting, showing empathy and caring for the advanced beginner to engender self confidence and professional growth . The mentor has to be sensitive to the needs of the advanced beginner and minimize conflict by being culturally diplomatic especially when discussing sensitive issue.

The success of the relationship is evaluated during and after the mentorship period. The advanced beginner will show professional behavior in terms of competency in problem solving skills, effective collaboration, decision making, and critical thinking skills and ability to apply what was learnt during the mentorship.

DATA ANALYSIS

The Data gathered through interviews regarding peer mentoring and staff retention were read and re-read, coded and analyzed by the researcher.

Rigor/Trustworthiness of the study:

Credibility was achieved by

a) data was taken back to the participants to ensure accuracy

b) the coded data was reviewed by the researcher's supervisor.

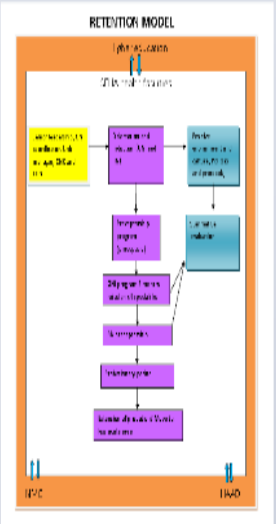
Dependability was achieved through bracketing and intuiting in each phase of the study to enhance stability (reliability).

Transferability: the findings can be applicable in other settings such as education, allied health and rehabilitation services.

RESULTS

Effective recruitment strategies engender staff retention. The role of the CRN encompasses orientation, induction and facilitation of peer mentoring. CRN liaise between the advanced beginners and other members of the multi disciplinary team. Effective collaboration between external stake holders such as SEHA, HAAD, NMC, senior leadership and frontline managers positively impacts staff retention.

Staff retention Model:



CONCLUSION

Shortage of nurses affect nurses globally including the UAE. Due to nurse shortage the UAE recruits from western, eastern counties as well as locally. The clinical resource nurse facilitates education of the new recruits for personal and professional development. Competent nurses increased patient experience and lead to job satisfaction and retention of staff.

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A special thank you is extended to all who contributed to the success of this study. I am grateful to all the staff members at Mafraq and SKMC for unfailing support during the data collection, the internal review boards of both Mafraq and SKMC for granting permission to conduct the study. Appreciation is extended to Diana, Jenny, Karen and Monica for the transcriptions. A special thanks to Profs O. Makhubela and Matlakala for supervising the study. Finally I owe a special debt to my friends and family for their unfailing support.

ABI, 24-25 NOVEMBER 2015