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Mentoring, Job Satisfaction, Job Dissatisfaction, and Organizational Commitment Among Graduate Nurses

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MENTORING, JOB SATISFACTION, JOB DISSATISFACTION, AND ORGANIZATIONAL
COMMITMENT AMONG GRADUATE NURSES

by

ABISOLA ADEYOMIBO SANTOS

A DISSERTATION

Presented to the Faculty of the University of the Incarnate Word
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF THE INCARNATE WORD

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Abisola Adeyomibo Santos

DEDICATION

I dedicate this work to the memory of my grandfather, Chief Okotako Enahoro, who laid the foundation for education in the family; to the memory of my father, G. F. Kolujo Santos, who was always proud of my achievements; and to the memory of my uncle, Henry E. Enahoro, Ph.D., who showed me that this degree was achievable. I also dedicate this dissertation to my mother, Bess A. Santos. I promised you a corner of my certificate for all those late nights you stayed up, correcting my work and offering constructive criticism. I could not have done this without you. Thank you!

MENTORING, JOB SATISFACTION, JOB DISSATISFACTION, AND ORGANIZATIONAL COMMITMENT AMONG GRADUATE NURSES

Abisola Adeyomibo Santos, PhD

University of the Incarnate Word, 2015

Shortage of bedside nurses has been researched for a long time. Many researchers have referred to different shortage percentages, but the American Nurse Association stated that the shortage of bedside nurses would increase in the range of 29% to 36% by 2020. It is also reported that a large number of newly graduated, newly hired nurses leave within one year as compared to newly hired experienced nurses.

The purpose of this correlational study was to evaluate the influence of mentoring, mediating job satisfaction, job dissatisfaction, and, therefore, organizational commitment, on nurses who completed the nurse residency program between January 2010 and December 2014. The two research questions were (a) Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring? and (b) Does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

This study was conducted in 2 south Texas hospitals with a sample of 100 nurses. A single stage convenience sampling technique was used to gather the data. To collect the data, 3 instruments and a demographic survey were used. The instruments used were the Organizational Commitment Questionnaire (Mowday, Steers, & Porter, 1979); the Index of Work Satisfaction Questionnaire (Stamps, 1997); and the Assessment of the Relationship With the Mentor (Academy of Medical-Surgical Nurses, 2012).

There was a 16.89% response rate to the survey. The majority of the respondents were female and between 26 and 30 years old. The highest response rate was from nurses who graduated in 2014. The variables were organizational commitment, job satisfaction, job dissatisfaction, and mentoring. Pearson correlation revealed that mentoring did not directly correlate with organizational commitment, but it did indirectly correlate with job satisfaction. The stepwise multiple regression analysis showed that job satisfaction and job dissatisfaction together accounted for 47.9% variability of organizational commitment.

This study found that professional status (a component of job satisfaction) and, pay and administration (a component of job dissatisfaction) had the largest impact on determining the nurses' organizational commitment. The study found that job satisfaction and job dissatisfaction were mediated by mentoring, which in turn influenced organizational commitment.

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Chapter 1: Quo Vadis

In his commentary in the *British Medical Journal*, Rogers (1961) reported that hospitals were already closing down wings due to a shortage of nurses. The author suggested that poor salary and lack of training of nurses were the main causes of for the decreasing number of nurses. The nursing shortage is not unique to the United Kingdom. In the United States, the American Nurses Association asserted that the registered nurse (RN) shortage will be felt in every state of the union, and the demand for bedside nurses will balloon by 29% to 36% by 2020 (as cited in Zinn, Guglielmi, Davis, & Moses, 2012). A minute 0.2% increase is expected in the supply of nurses between 2015 and 2025 as the baby boomers retire (Harrison & Ledbetter, 2014). Baby boomers are those individuals who were born between mid-1946 to 1964 (Hogan, Perez, & Bell, 2008).

Statement of the Problem

The Nursing Executive Center reported that 75% of newly hired, newly graduated nurses leave their jobs within 1 year as compared to their newly hired, experienced nurse colleagues (as cited in Welding, 2011). Reasons given in literature for this high turnover rate for new nurses' range from the rise of baby boomers to a separation between what they perceive their role should be and what it really is. Newly graduated nurses are expected to fill the gaps with the same level of expertise as the experienced nurses who have retired, causing a strain on the new nurses because they are unable to meet the expected high standards (Welding, 2011; Zinn et al., 2012).

This disconnect between expectation and reality has been described as role stress and transition shock (Hoffart, Waddell, & Young, 2011; Takase, Nakayoshi, & Teraoka, 2012). New nurses feel overwhelmed and lack the confidence to meet the increased responsibilities imposed upon them, thus leading to more disillusionment with the profession and complicating the

transition from student nurse to graduate nurse all the more difficult (Duchscher, 2008; Roberts, Jones, & Lynn, 2004). Hospitals must search for ways to build loyalty among their nurses. There are a myriad of factors that affect organizational commitment, including job satisfaction, stresses on the job, work schedules, and group cohesion. The remedies of recruiting and hiring nurses to cover the shortfall are expensive (Shader, Broome, Broome, West, & Nash, 2001). Health institutions spend \$42,000 to \$64,000 in replacement costs for each nurse who leaves (Frost, Nickolai, Desir, & Fairchild, 2013). Mentoring of new graduate RNs has been proven to be a means of increasing retention, reducing burnout, providing new graduate support, and training the next generation (Block, Claffey, Korow, & McCaffrey, 2005; Finley, Ivanitskaya, & Kennedy, 2007; Paterson, Henderson, & Trivella, 2010). Thomas and Lankau (2009) described burnout as a “state of physical, emotional, and mental exhaustion in employees” (p. 417).

In my practice, working in a health system, retention of graduate nurses is an issue of concern. The hospitals I surveyed use a nurse residency program (NRP), designed to train and transition new graduate nurses from the classroom to the bedside in order to decrease the turnover rate. Like many healthcare organizations, nurse residency programs invest considerable resources in training graduate nurses but still see a large exodus of these nurses soon after graduation. More than 50% of these nurses either leave the unit in which they trained or leave the healthcare system altogether. Therefore, to meet this problem, the relationships among organizational commitment, job satisfaction, job dissatisfaction, and mentoring of graduate nurses must be explored.

Purpose of the Study

The purpose of this correlational study was to evaluate the influence of mentoring, mediating job satisfaction, job dissatisfaction, and, therefore, organizational commitment, on

nurses who completed the nurse residency program between January 2010 and December 2014 in two south Texas healthcare institutions.

This correlational study examined the relationship between

- mentoring and organizational commitment;
- mentoring, job satisfaction, and job dissatisfaction;
- job satisfaction, job dissatisfaction, and organizational commitment; and
- job satisfaction and job dissatisfaction, mentoring, and organizational commitment.

Research Questions

The main research questions identified for this correlational study were the following:

1. Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring?
2. How does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

Methodology

This study used a quantitative correlational regression approach to answer the research questions. The dependent variable, organizational commitment, was defined by Mowday, Steers, and Porter (1979) as a behavior in which the individual has “sunk costs into the organization whereby the individuals forgo alternative courses of action and choose to link themselves to the organization” (p. 225). To measure this variable, Mowday et al.’s (1979) Measurement of Organizational Commitment survey was used. The independent variables, job satisfaction and job dissatisfaction, were described by Herzberg (1976) as an accumulation of factors. To measure both job satisfaction and job dissatisfaction, Stamps’ (1997) Index of Work Satisfaction questionnaire was used. Finally, the respondents’ perception of the mentoring experience was

measured using the survey instrument titled Assessment of the Relationship With the Mentor by the Academy of Medical-Surgical Nurses (AMSN, 2012). The AMSN (2012) described mentoring as a “mutual relationship between an experienced nurse (mentor) and a new nurse or nurse transitioning to a new role (mentee). It is a framework for the passage of wisdom, caring, and confidence between new and experienced nurses” (p. 1).

Setting for the Study

Nurses who completed the nurse residency program from two healthcare institutions in south Texas from January 2010 to December 2014 were surveyed. The nurse residency programs are designed as a bridge to help newly graduated nurses continue their education and to help them transition from the classroom to the bedside, ensuring their success as competent clinicians.

Significance of the Study

This study is important for several reasons. First, it may assist healthcare institutions prepare for the expected loss of RNs by determining whether mentoring could be used to help train new nurses and fill the gap left by the highly skilled nurses as they retire or separate from the institutions (Kuehn, 2007; Zinn et al., 2012). Second, it may help nurses understand how best to leverage their experience with their mentors during their nurse residency program, which will help them succeed in their jobs and improve the quality of care of their patients. Third, the study shows that mentoring practices could be beneficial in healthcare fields and across other service industries. Lastly, this study informs decision makers, professional organizations, and hospitals that nurse residency programs play an important role in the retention rate of nurses and, therefore, would benefit from receiving grant support.

Theoretical Framework of the Study

The theoretical framework that was used in this study was introduced by Herzberg in 1976. Herzberg's motivation-hygiene theory, also known as the two-factor theory, addresses the causes of job satisfaction or job dissatisfaction in the workplace. He further explained that job satisfaction and job dissatisfaction are distinctly different, and the factors that keep people satisfied and motivated on the job are distinctly different from those that make them dissatisfied. Job dissatisfaction, he said, is not the other end of the spectrum of job satisfaction but the two are on different spectrums.

Herzberg (2003) described the factors that lead to job satisfaction as intrinsic or motivational: "these intrinsic factors answer people's deep-seated need for growth and achievement" (p. 87). A person is either very satisfied or not satisfied at all. Motivational factors are described as achievement, recognition of achievement, the work itself, responsibility, advancement, and growth. He described the factors that lead to job dissatisfaction as hygiene factors. The components of the hygiene factors are extrinsic to the work, company policy and administration, supervision, interpersonal relations, working conditions, salary, status, and security. All hygiene factors are the same for all employees and are equally appropriate or unpleasant. The most common problems arise from policies and administration, as the employee may face them on a daily basis. Table 1 shows how different aspects of a job can serve as a motivator or a demotivator. The motivation-hygiene theory helps describe the reasons why graduate nurses decide to leave employment, and their reasons for leaving could be varied.

Delimitations of the Study

Due to the design of the study, the following are the delimitations:

1. The scope of the study is limited to job satisfaction, organizational commitment, and influence of the mentor. No other aspect of the NRP was discussed or investigated.
2. Only RNs who had completed their NRP from one of the two south Texas hospitals were included in the study.
3. Limiting the data collection from 2010 to 2014 put a limit on the number of nurses that may have chosen to participate in the program.
4. The NRP experiences and mentoring exposure vary within each hospital and specialty training.

Table 1

Herzberg's (1976) Factors Affecting Job Attitudes

Motivation (Intrinsic Factors)	Hygiene (Extrinsic Factors)
Contributing to Job Satisfaction	Contributing to Job Dissatisfaction
Achievement	Company policy and administration
Recognition	Supervision
Work itself	Relationships with others
Responsibility	Work conditions
Advancement	Salary
Growth	Personal life
	Status
	Security

Definition of Terms

For clarity, these are the definitions of some of the terms used.

Mentor. According to Hamilton (1981), a mentor “is the accomplished, more experienced professional who extends to a young, aspiring person, within the context of a one-to-one relationship, advice, teaching, sponsorship, guidance, and assistance toward her establishment in her chosen profession” (p. 4).

Preceptor. For the purposes of this study, the term preceptor may be used to refer to the role as of a mentor.

Experienced nurse. A RN who has more than 1 year of experience.

Newly graduated nurse. A person that has completed the practical hospital training and didactic course of study, resulting in an associate's degree or a bachelor's degree.

Nurse resident. A newly graduated nurse in a residency program.

Chapter 2: Literature Review

The purpose of the literature review is to discuss (a) the nurse residency program and the history of its existence in the hospitals studied, (b) mentoring in healthcare, and (c) the relationships between mentoring, job satisfaction, and job dissatisfaction and how they affect the graduate nurses' commitment to their current employment.

Training Options for Graduate Nurses

Successful completion of the NCLEX (National Council Licensure Examination) leads to nursing licensure in the United States and Canada. The exam, taken after graduation from an accredited nursing program, qualifies nurses for a state license and to practice in any hospital. Nurses then have the choice of working in a hospital that offers a nurse residency program or work in any other healthcare organization, such as in a doctor's office, a home care facility, a school, or a nursing home. Figure 1 shows the pathways that a nurse can take after completing a 2-year associate's degree in nursing or a 4-year bachelor's degree in nursing.

Nurse Residency Program

A nurse residency program is defined by Herdrich and Lindsay (2006) as a "joint partnership between academia and practice that is a learner focused, postgraduate experience designed to support the development of competency in nursing practice. . . . This partnership is essential in the transition from academia to practice" (p. 55). These NRPs were first reported in the 1980s as a successful means of transitioning newly graduated nurses into the medical practice world (Altier & Krsek, 2006).

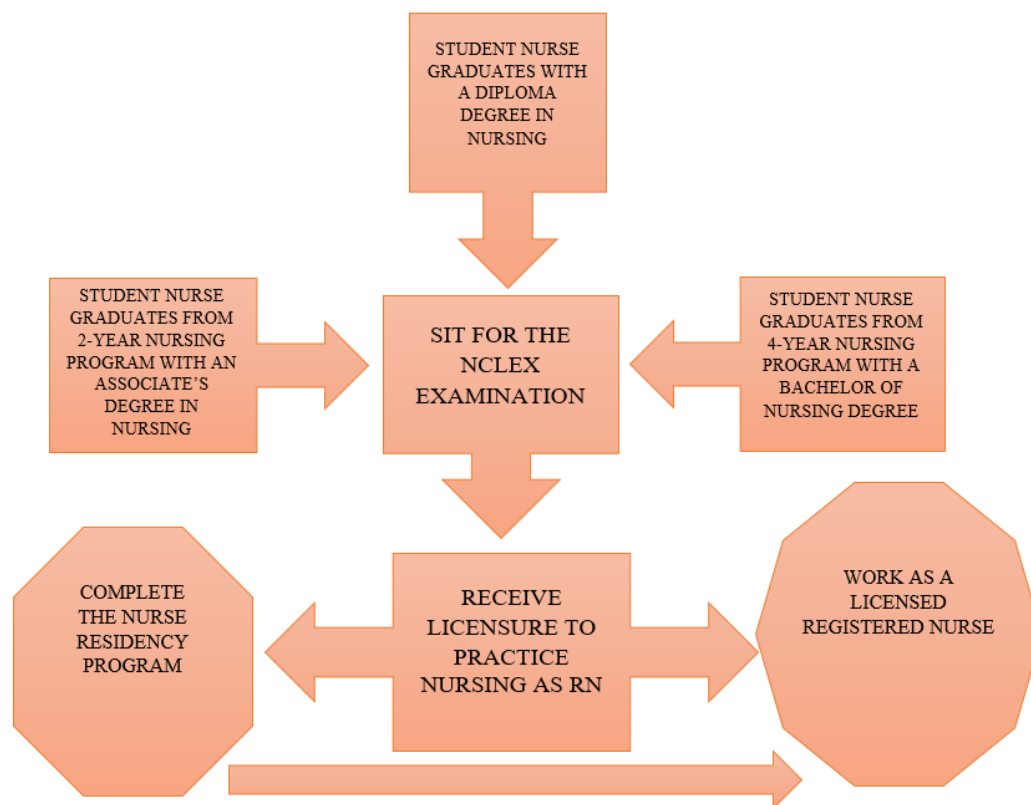


Figure 1. Pathways for training that a nurse graduate may take in order to work as a RN.

Efforts to standardize the programs started in the early 2000s by six medical centers based on the results of a survey carried out on RNs nearing retiring age. These RNs were asked to suggest ways to fill the foreseeable shortages of RNs. The veteran nurses suggested a program that provided extensive orientation focused on improving nursing students' skills, developing the nurses professionally, and helping these nurses transition into their new roles as bedside nurses (Barnett, Minnick, & Norman, 2014; Zinn et al., 2012).

In 2002, the Joint Commission recommended the development of nurse residency programs—planned, comprehensive periods of time during which nursing graduates can acquire the knowledge and skills to deliver safe, quality care that meets defined (organization or professional society) standards of practice. (Institute of Medicine, 2010, pp. 120 – 121)

This recommendation was supported by the American Association of Colleges of Nursing.

Krozek (2008) showed that these NRPs would provide an “integrated, interconnected program hard-wired throughout the organization” (p. 3) to systematically integrate the new nurses into the organization. This systematic approach is characterized by standardization of the process to ensure consistency of care with evidence based best-practice standards to consistently deliver safe patient care. The residents also attend classes to receive further clinical instructions on how to build their skills and care of the patient. The approach also allows for practical application of knowledge in which the nurse residents are allowed to apply didactic knowledge directly in a clinical setting. This allows them to sharpen their patient care skills and to better apply hospital policies to their practice. The NRPs build systems of support between experienced nurses and the nurse residents. In this system, experienced nurses act as a network of preceptors, mentors, and confidants, which allow the nurse residents to build confidence in their ability to render care, to improve their satisfaction with their employer, and to increase their commitment to the organization. The nurse residency program affords the hospital administration a means of continuously assessing the progress of the nurse residents and providing them with useful feedback. Finally, though mentoring is an aspect of the NRP, the main focus of the program is to help the newly graduated nurses transition from student nurses to professional nurses by offering them extensive orientation to improve their skills and develop them professionally (Barnett et al., 2014).

Length of the Program

Nurse residency programs were designed to run from a few weeks to a year, though some state-based or facility-based programs may be of shorter duration as they are designed to meet specific state or local needs (Barnett et al., 2014). Most of the programs are academically affiliated to include course content for professional development. Instruction in patient outcomes

include, but are not limited to, pain management, hospital acquired infection, fall prevention, and research-based program evaluations. The institutional partners guide the program implementation and day-to-day activities (Barnett et al., 2014; Herdrich & Lindsay, 2006).

Advantages of NRPs include:

1. Allowing the healthcare institution ability to assess the nurses over an extended period of time to see if they are a fit for the organization.
2. Continuous assessment of the RNs skills and matching them to the skills needed for the job.
3. Gives the RN an opportunity to garner the skills necessary to navigate the new work life and give support during the transition from school to hospital.
4. Offers the hospitals a positive return on their investments on the cost of their NRP because the program encourages a higher commitment to the organization and lower turnover rate.
5. Gives opportunity to and encourage a higher percentage of younger nurses right out of school to apply as they are guaranteed a “preparation to practice gap” training (Hansen, 2014, p. 48).

Mentoring in Healthcare

Ragins and Scandura (1999) described a mentor as “an influential individual in the work environment who has advanced experience and knowledge and who is committed to providing upward mobility and support [for the mentees’] career” (p. 496). The mentoring relationship is described by Rubens and Halperin (1996) as one between a senior and junior colleague, wherein the senior colleague gives guidance and emotional support, and motivates the mentee to aspire to career development. Webb and Shakespeare (2008) described a mentor in nursing as one that

assesses the mentees' clinical skills; supervises, advises, prepares the RN for practice, and offers support and training in the field of nursing.

May (2003) showed mentoring of the next generation as a good way of investing in the future of the profession and in the community it serves (p. 7). This is supported by Ramaswami and Dreher's (2010) study, which showed that mentoring influences career growth, enhances the skills required, and assists the mentee in getting acclimatized to the new work environment. Rush, Adamack, Gordon, Lilly, and Janke (2013) further buttressed this by showing that in nursing, mentoring gives the RN a dedicated "resource person" who helps with the socialization of the new nurse in his/her duties (p. 349). Mariani (2012) also restated that mentoring was an avenue wherein both the mentor and the mentee gained. The mentor gained by contributing toward the development of a new nurse in the profession, and the mentee gained by being trained to be a successful nurse. Mariani (2012) further observed that mentoring is seen as an emotional commitment between the mentor and mentee because of the "sharing of advice or expertise role development [and of the] formal and informal support to influence the career" (p. 2). Lack of this type of mentoring, she concluded, could add to a higher propensity to leave the job or the profession.

Historical Perspective of Mentoring in Healthcare

Tyler (1994) said that in the 1970s, mentoring was "alive and well" (p. 84) for healthcare executive leaders. It was normal practice to expect the healthcare executive to train the next generation, who, after having been well trained, would in turn train the next generation. This system of mentoring was abandoned in the mid-1980s with changes in the financial payment structure of healthcare institutions. The new payment structure resulted in changes in

reimbursements to healthcare institutions for patient care visits. In response to finances, many healthcare organizations stopped or reduced mentoring practices and programs.

In nursing, Jokelainen, Turunen, Tossavainen, Jamookeeah, and Coco (2011) stated that the term *mentoring* was first used in the late 1980s, with the earliest references to research in the nursing field being in the same decade. Their work supported that of Ketola (2009) who said that the interest in mentoring in nursing and research into the field of nursing began in response to Kramer's influential book, *Reality Shock: Why Nurses Leave Nursing*, written in 1974. This book shed light on the imminent shortage of nurses due to their mass exodus from the profession.

Organizational Commitment

Mowday et al. (1979) described organizational commitment as a set of behavioral attitudes in which the person identifies or is linked with the organization such that the organization's goals "become increasingly integrated or congruent" with the individuals' goals (p. 225)

This is also described as a means of individual alignment with the organization in exchange for rewards or payments from the organization. Mowday et al. (1979) further stated that this behavior is characterized by "three factors (1) a strong belief in and acceptance of the organization's goals and values; (2) a willingness to exert considerable effort on behalf of the organization; and (3) a strong desire to maintain membership in the organization" (p. 226). This forms an active relationship in which the individual is willing to "give something of themselves in order to contribute to the organization's well-being" (Mowday et al., 1979, pp. 225–226).

Furthermore, organizational commitment is an important predictor of whether the individual stays with the organization or not. The strongest variable to predict organizational commitment was found to be job satisfaction (Boyle, Bott, Hansen, Woods, & Taunton, 1999;

Ellenbecker, 2004; Shader et al., 2001; Taunton, Boyle, Woods, Hansen, & Bott, 1997). Shader et al. (2001) also pointed out that in nurses who were 41 years old to 50 years old, lack of job satisfaction and group cohesion best predicted intent to leave. Flinkman, Laine, Leino-Kilpi, Hasselhorn and Salanterä (2008) showed that organizational commitment was influenced by burnout, low professional commitment, more work conflicts, low job satisfaction, and reduced opportunities to balance work–family conflict, and little opportunities for professional development (p. 735).

Ninety-two percent of graduate nurses reported having difficulty transitioning to their new roles and 42% still reported having difficulty even after 1 year on the job. The new nurses were also found to have a higher turnover rate within a year of completing their nurse residency program (22.6% to 60%) as compared to 20% for experienced nurses. Tourigny and Pulich (2005) reported turnover rates of 35% to 69% within the first year for newly graduated nurses while nurse residency programs improve retention by 20% to 47%.

Theoretical Framework, Job Satisfaction, and Job Dissatisfaction

In his motivation-hygiene theory, or two-factor theory, Herzberg (1976) analyzes the factors that could lead to job satisfaction and dissatisfaction in the workplace. This motivation-hygiene theory was the basis for the job satisfaction survey designed by Stamps (1997) specifically for nurses and also used in this study. The reasons Herzberg gave for dissatisfaction on the job were items like company policies, supervision, work conditions, status, and security. The reasons given for satisfaction included achievements, recognition, the complexity of the job, and chances for advancement and growth (Herzberg, 2003). This theory was used as the basis for renaming the reduced components of job satisfaction and job dissatisfaction as shown in Figure 2 and Figure 3, respectively.

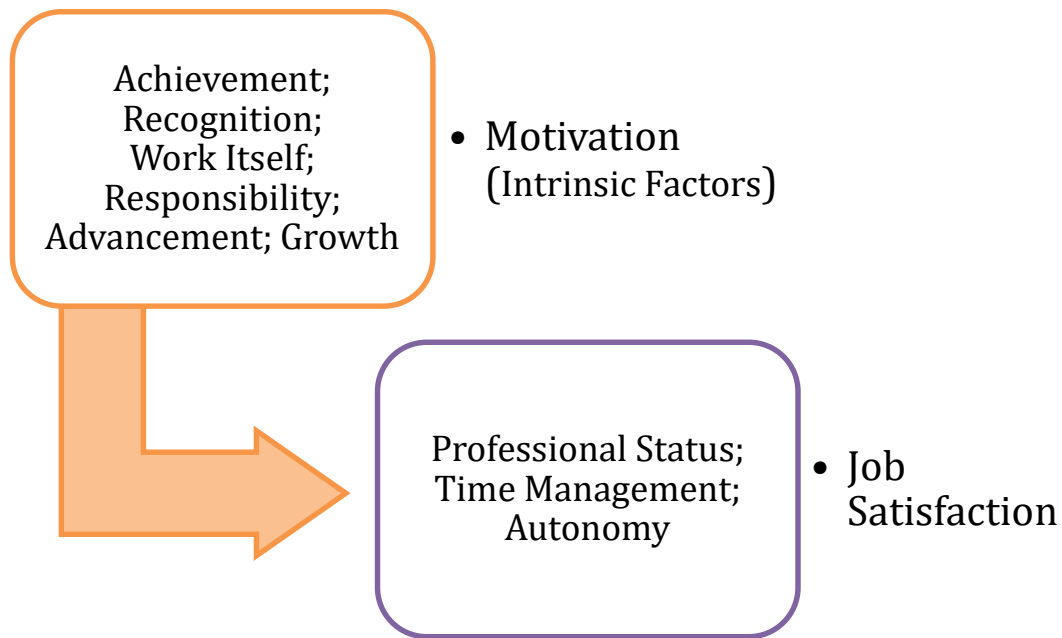


Figure 2. Herzberg's (1976) motivation factors and job satisfaction components.

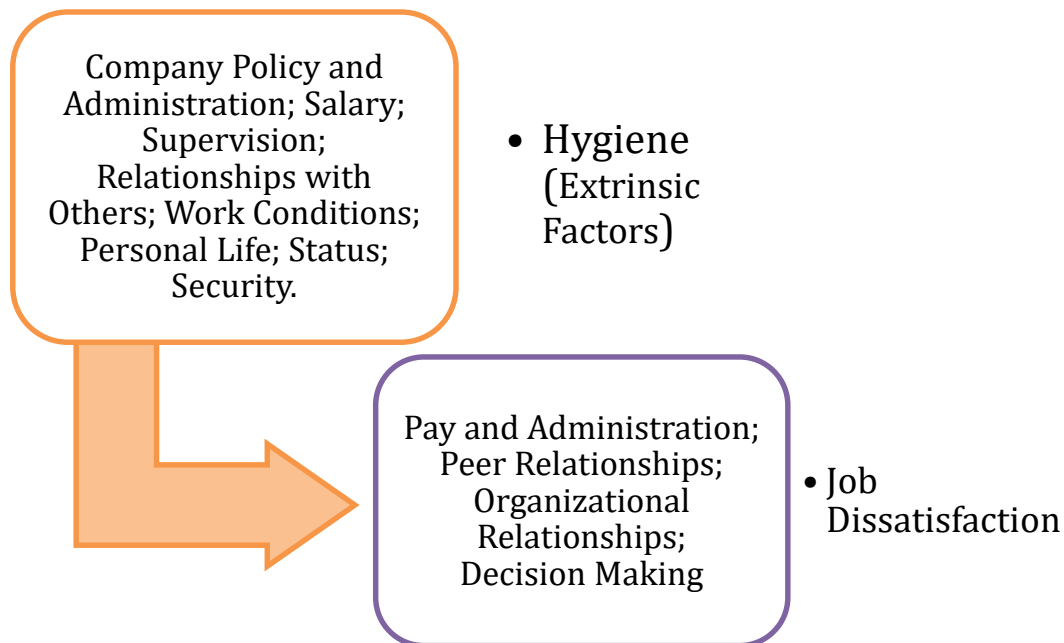


Figure 3. Herzberg's (1976) hygiene factors and job dissatisfaction components.

Job Satisfaction

Spector (1997) described job satisfaction of employees as "how they feel about different aspects of their job . . . the extent to which they like or dislike their jobs" (p. 2). He further

explained that attention to job satisfaction is important for humanitarian reasons because job satisfaction serves as a guide to how well staff members are treated. The level of job satisfaction also indicates the emotional health of the establishment. From a utilitarian aspect, job satisfaction leads to behaviors by employees that affect organizational functioning whether “positive and negative behaviors,” and attention to job satisfaction assists management in identifying areas of the organization that might be problematic (p. 2).

In nursing, job satisfaction was defined by Ma, Samuels, and Alexander (2003) as the difference between the workers’ expected rewards and the workers actual rewards. Geiger and Davit defined job satisfaction as the “extent to which a nurse [feels that her/his] needs are fulfilled by the job that she/he performs” (as cited by Ma et al., 2003, p. 292). This is rather similar to the definition given by Adams and Bond (2000): the “degree of positive affect towards a job both of the individual and the job and particularly how work is organized within the corporate work environment” (p. 538). Job satisfaction is also described as how positive a staff member feels about their job. Job satisfaction can be enhanced by working with a supportive staff and thus has an influence on whether the staff member decides to stay on the job or leave (Wang, Tao, Ellenbecker, & Liu, 2012).

Ragins, Cotton, and Miller (2000) and Chun, Sosik, and Yun (2012) revealed an increase in job satisfaction with formal or informal mentoring. They found that those mentored were more likely to be satisfied and had better attitudes than those who either had marginal mentoring or had no mentoring at all. Their studies were supported by Kalliath and Morris (2002) who also found that those satisfied with their mentoring relationships had better work and career attitudes and that this mentoring relationship was a contributing factor to job and career variances. The positive side is that Lee et al. (2010) found that having a mentor not only reduced the possibility

of job dissatisfaction, when done right, but also increased job satisfaction and commitment to the hospital (Weng et al., 2010). Having a mentor increased autonomy as well (Adams & Bond, 2000; Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002).

Best and Thurston (2004) showed that job satisfaction positively correlates with empowerment. They described empowerment as the perception of having “access to information, support, supplies, and opportunity” (p. 284). The empowerment was further divided as structural—support and resources—and psychological—autonomy and meaningful work. They concluded that in order for a nurse to be satisfied on the job, he/she would need to feel empowered, have autonomy, be supported, and recognized by both the supervisor and the community of colleagues and be able to make decisions (Best and Thurston, p. 284). These behaviors would lead to improved quality of care, a decrease in organizational commitment, and a increase in commitment to organizational goals (Ingersoll et al., 2002).

Finally, Ragins et al. (2000) showed that having a mentor alone does not make for a positive attitude at work; what makes for that attitude is having a quality relationship with their mentor. Best and Thurston (2004) suggested that teamwork and collegiality best predict job satisfaction. Wang et al. (2012) also showed that lack of job satisfaction was a strong predictor of resignation by staff members.

Job Dissatisfaction

According to Herzberg’s (2003) motivation-hygiene theory, dissatisfaction is derived from job duties like supervision, relationship with peers and supervisor, and balancing personal life and work. This job dissatisfaction usually sets in for the new nurse within the first year of work (Altier & Krsek, 2006). Best and Thurston (2004) found the causes of job dissatisfaction to include stress from the job or the mentor, burnout, routinization, role ambiguity, increase in

workload, change in patient to nurse ratio, and skill mix—the ratio of experienced nurses, new nurses, and nursing assistants.

Dissatisfaction can also be caused by increased stress in transitioning the nurse from a student role to a bedside nurse (Altier & Krsek, 2006). Larrabee et al. (2003) and Ingersoll et al. (2002) showed that giving a person more control or authority when the person does not desire it could increase job dissatisfaction. This dissatisfaction, Larrabee et al. (2003) further stated, increases the desire and the intention of the staff member to leave. Laschinger (2012) reported, in her study on newly graduated nurses, that “incivility/bullying” were highly correlated with incidences of job dissatisfaction, which could then cause a higher turnover (p. 473). She further stated that there needs to be a low tolerance for these behaviors in the workplace in order to encourage retention. Another strong indicator of job dissatisfaction was noted to be a feeling of cynicism and emotional withdrawal from the job, which adversely affected patient care (Laschinger, 2012). Laschinger described these behaviors as burnout. Burnout adversely influences job satisfaction, productivity, and turnover.

Mentoring

A mentor is defined as a person who develops a one-to-one learning relationship with a younger colleague with the aim of facilitating learning to inspire the next generation based on specific learning objectives (Chen & Lou, 2014). A mentor is friendly and patient, offers peer support, and has a good sense of humor. This person is also approachable, accessible, offers good quality time, and gives genuine feedback. Having a mentor helps improve newly graduated nurses’ retention, reduces turnover, improves job satisfaction, and improves the graduate’s comfort level with their nursing skills (Rush et al., 2013; Webb & Shakespeare, 2008). To further confirm this, Frost et al. (2013) showed that nurses’ confidence increase in the first 6

months of participating in mentoring that included inspirational motivation, individualized consideration, idealized influence, and intellectual stimulation, all of which are part of the components of a transformational leader. This environment also helps to hone the nurses' self-worth and professional confidence.

Effective mentor. Effective mentors inspire the next generation, reduce burnout, and teach the unspoken cultures of the institution. Mentors may inspire the next generation by participating in the mentoring program, sharing the vision of their mentors, developing the sociocultural aspect of the establishment through mentoring, and understanding the culture of the establishment. The mentor's unsaid assumed behaviors, mannerisms, and norms influence career development and improve the mentees' performance at work (Henley, 1999; Neumayer, 2003; Ramaswami & Dreher, 2010). McAlearney (2008) found that one of the three reasons given by employees for staying in an establishment is mentoring. In studies conducted by Erdem and Aytemur (2008) and Ramaswami and Dreher (2010), trust building was found to be one of the personality related characteristics mentees wanted in their mentors.

The functions of mentoring can help the mentor actualize a "developmental relationship effectiveness . . . manifested in transformational leadership behavior" (Chun et al., 2012, p. 1074). This view was supported by D' Ambra and Andrews's (2014) study, which showed that in an effective mentorship

- the mentors met with their mentees on a regular basis;
- the mentors gave guidance and feedback;
- the mentors acted as means for the mentees to relieve stress;
- the mentors created a positive environment, which encouraged strong relationships with their mentees to form; and

- the mentors provided good social support, which increased the sense of acceptance and comfort for the new nurses.

Lee et al. (2010) found that mentoring helped reduce the incidence of burnout by encouraging the development of social support networks. Chun et al. (2012) also stated that trust in the mentor enabled the mentee to learn how to overcome uncertainties and make the best use of career advancement opportunities, thus committing to their jobs and acquiring more of the unspoken norms and rules of the work environment.

Ragins et al. (2000) affirmed that for all programs, especially those that were designed to mentor women, taking the time to build an effective program would be beneficial. This is relevant in nursing where a higher percentage of nurses are female. In 2015, the Henry J. Kaiser Foundation reported that 8.1% of professionally active nurses were male (as cited in Rappleye, 2015). In support, Landivar (2013) reported that in 2011 9.6% of RNs were male.

Ineffective mentor. Lack of trust was found to be an inhibiting factor in the mentor/mentee relationship. In a poor mentoring relationship, the mentees felt ignored or used, and they felt they were not given enough time to learn from their mentor. The mentee might even be assigned to a nurse mentor that is burnt out (Ragins et al., 2000; Webb & Shakespeare, 2008). This situation allows for the relationship to spin out of control into one that may be described as dysfunctional.

Ineffective mentoring relationships could also expose the mentee to situations where personal information could be used against them or to the advantage of the mentor. Taherian and Shekarchian (2008) suggested that the mentors may intentionally or unintentionally reveal this kind of information to regulatory bodies to the disadvantage of the mentee. In conclusion, having an ineffective mentor could be worse than not having a mentor at all (Ragins et al., 2000).

Sambunjak and Marušić (2009) described the necessity to actively monitor and reassess the mentor/mentee relationship, setting new goals as the mentorship develops over time.

Marginal mentor. A marginal mentor is defined as one that is neither good nor bad but just “okay” (Ragins et al., 2000; Webb & Shakespeare, 2008). Tourigny and Pulich (2005) added that a marginal mentor could also be described as one that has a “high level of expertise” but who is not able to be an effective mentor (p. 70). Ragins et al. (2000) found that displeasure with the mentoring program stemmed from having a “pool of marginal mentors” (p. 1191). These marginal mentors do not meet the developmental needs of the mentees, thus leading to dissatisfaction. These relationships are then dysfunctional partly because the mentee might be reluctant to commit to this mentor.

Summary

I have discussed in this literature review the history of the nurse residency program, how it started, and how it serves as a conduit to introduce the new RN to clinical practice by helping the nurses to transition from the classroom to the bedside. This review also presented the historical perspective of mentoring in healthcare and explained the various factors that might lead to job satisfaction, job dissatisfaction, and how these factors affect occupational commitment. Based on the literature review, Figure 4 shows how mentoring affects job satisfaction and job dissatisfaction, and it shows how there is an increased commitment by the new nurse to stay with the organization when there is effective mentoring.

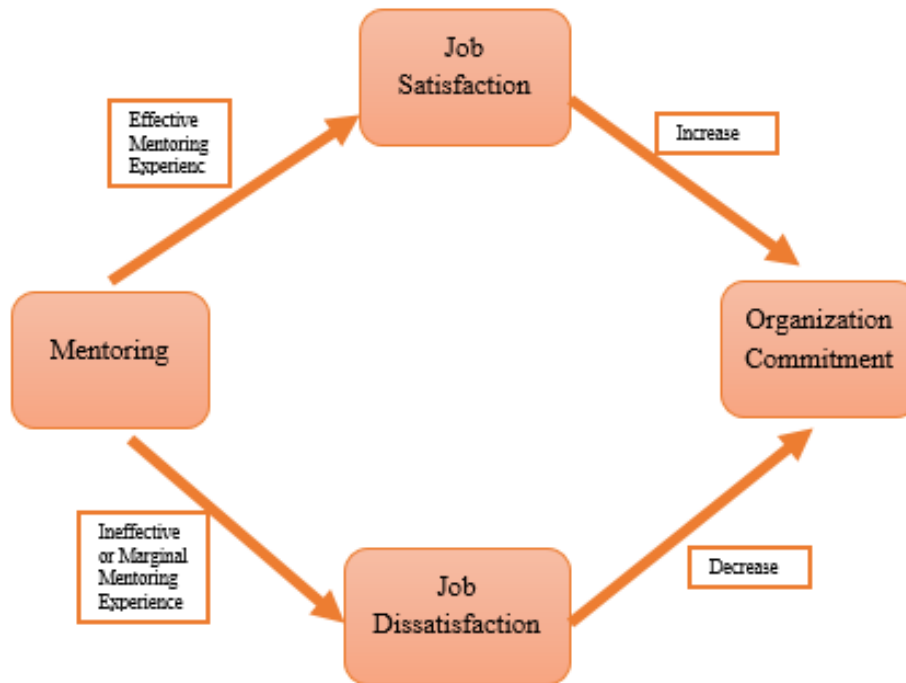


Figure 4. Conceptual diagram showing how mentoring influences job satisfaction, job dissatisfaction, and organizational commitment.

Chapter 3: Methodology

The purpose of this correlational study was to evaluate the influence of mentoring, mediating job satisfaction, job dissatisfaction, and, therefore, organizational commitment, on nurses who completed the nurse residency program between January 2010 and December 2014 in two south Texas healthcare institutions.

This study set out to answer the following research questions:

1. Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring?
2. Does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

Research Design

A correlational research design was used to assess the newly graduated nurse mentoring experience and its relationship with job satisfaction, job dissatisfaction, and organizational commitment. According to Creswell (2012), a quantitative descriptive correlational research design is chosen to “describe and measure the degree of association between” different variables (p. 338). This correlational study assessed the relationship among three variables, the strength of the relationship, the direction of the relationship, whether positive or negative, and, finally, the coefficient of determination of the relationship. The variables were organizational commitment, job satisfaction, job dissatisfaction, and perception of mentoring in current jobs of nurses who completed a nurse residency program between 2010 and 2014 in two south Texas healthcare institutions.

Organizational commitment was assessed to determine whether RNs had a desire to leave their current job. Job satisfaction measured contributory factors to satisfaction, such as

perception of job cohesion, salary, educational opportunities, benefits, and work schedules. Job dissatisfaction measured contributory factors to dissatisfaction, such as supervision, company policies and how they are administered, work conditions, relationships with peers and subordinates, status on the job, and, finally, security on the job. A mentor was evaluated as an effective mentor, an ineffective mentor, or a marginal mentor.

Research Instruments

Demographic data. The researcher developed the demographic instrument to collect data on the respondents' gender, age group, ethnicity, pay group, length of residency program, and year of graduation from the NRP (see Appendix A).

For this study, three well-tested and validated instruments were used and combined to create one survey instrument. The Organizational Commitment Questionnaire by Mowday et al. (1979) was used to assess commitment to the organization. Stamps' (1997) Index of Work Satisfaction questionnaire was used to measure job satisfaction of nurses. Lastly, to assess the perception of the relationship with the mentor, the survey tool used was the Assessment of the Relationship With the Mentor by the Academy of Medical-Surgical Nurses (2012). The survey instrument consisted of 90 questions and took 20–25 minutes to complete.

The Organizational Commitment Questionnaire (Mowday et al., 1979) was used to measure the nurses' commitment to the organization. Because this questionnaire is in public domain, it did not require permission to use or modify (see Appendix B for an explanation letter from Dr. Mowday). Figure 5 shows an example of the items included in the questionnaire. Each item was rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) with 4 being a neutral choice (*neither disagree nor agree*). This instrument has a published

Cronbach alpha of .90 from a sample of 2,563 employees from various jobs in nine different organizations.

Item	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Moderately Agree	Strongly Agree
1 I am willing to put in a great deal of effort beyond that normally expected in order to help this organization be successful.	1	2	3	4	5	6	7
2 I talk up this organization to my friends as a great organization to work for.	1	2	3	4	5	6	7
3 I feel very little loyalty to this organization.	1	2	3	4	5	6	7

Figure 5. Sample of the Organizational Commitment Questionnaire.

The Index of Work Satisfaction questionnaire (Stamps, 1997) assessed job satisfaction and job dissatisfaction. Permission to use the questionnaire was obtained from Market Street Research who administers it (see Appendix C for the permission letter). This questionnaire measured six components of the nurses' occupational satisfaction and dissatisfaction, namely pay, autonomy, task requirements, organizational policies, professional status, and interaction. These items were further assessed on a weighted scale. All 44 questions were rated on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) with 4 being a neutral choice (*neither disagree nor agree*). This instrument has a published Cronbach's alpha of .82 from a sample of 246 nurses who work in hospitals. Figure 6 shows an example of the items included in this questionnaire.

	Item	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Moderately Agree	Strongly Agree
1	My present salary is satisfactory	1	2	3	4	5	6	7
2	Nursing is not widely recognized as being an important profession	1	2	3	4	5	6	7
3	The nursing personnel on my service pitch in and help one another out when things get in a rush.	1	2	3	4	5	6	7

Figure 6. Section of the Index of Work Satisfaction questionnaire.

The Assessment of the Relationship With the Mentor (AMSN, 2012) assessed the perception of the relationship with the mentor. This instrument originally came with a 5-point Likert scale with a published Cronbach's alpha of .94 but was changed to a 7-point Likert scale for finer determination of perception of mentoring for this population. Permission was received from AMSN to modify and use the survey tool (see Appendix D). The responses for all 25 questions were rated using a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) with 4 being a neutral choice (*neither disagree nor agree*). Figure 7 shows an example of the items used in this instrument.

Population and sample. This study's population comprised 592 nurses who completed their nurse residency program between January 2010 and December 2014 in two south Texas hospitals. Table 2 shows the differences between each program's goals and objectives. Table 3 shows each hospital's implementation plan for their NRP.

	Item	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Moderately Agree	Strongly Agree
1	My mentor assisted me with long-range career planning.	1	2	3	4	5	6	7
2	My mentor discussed with me ways to handle challenging patient situations.	1	2	3	4	5	6	7
3	My mentor discussed with me ways to handle difficult situations with my co-workers.	1	2	3	4	5	6	7

Figure 7. Sample of Assessment of the Relationship With the Mentor.

Data collection procedures. A single stage convenience sampling technique was used to gather data from the nurses that completed the nurse residency programs from the two healthcare institutions in south Texas. Participants used Survey Monkey (<https://www.surveymonkey.com>), the electronic survey tool, to access the survey. The data were accessed through the gatekeepers who were the coordinators in charge of the NRP in each healthcare system. The first contact was made via e-mail as an introduction, after which a meeting was scheduled where the study was introduced. The researcher was then referred to the administrator of the Institutional Review Board (IRB) for the processing of the request for research. Once the IRB request was approved by the University of the Incarnate Word (UIW), the gatekeeper was contacted again to set follow-up appointments to start the distribution of surveys.

Time frame. The data were collected from nurses that graduated from the nurse residency program between January 2010 and December 2014. The survey was administered between January 2015 and June 2015.

Table 2

Comparison of Goals and Objectives in Hospital A's and Hospital B's Nurse Residency Programs

	Hospital A's NRP	Hospital B's NRP
Goals of the NRP	Improve the individual nurse's residency and improve the overall program	Transition newly licensed nurses to bedside nursing practice
Objectives of the NRP	<p>Quality Care</p> <ul style="list-style-type: none"> • Improve quality and safety by reducing workload • Increase professional nurses on the units <p>Patient-Centered Care</p> <ul style="list-style-type: none"> • Reduce nurse burn out • Improve support of the new nurses • Decrease errors in patient care <p>Organizational Development</p> <ul style="list-style-type: none"> • Support for the new nurse in the first year of work • Improving organizational commitment • Improve job satisfaction • Improve confidence and competence of newly graduated nurses <p>Financial Justification</p> <ul style="list-style-type: none"> • Decrease the work load • Decrease patient's length of stay • Reduce on-call pay • Reduce cost of turnover, recruitment, and hiring of nurses • Improve retention of newly graduated nurses 	<p>Quality Care</p> <ul style="list-style-type: none"> • Reduce the risk of harm • Improve compliance <p>Patient-Centered Care</p> <ul style="list-style-type: none"> • Improve care • Recognize personal limitations • Improve nurse to patient ratio • Incorporate information technology into patient care • Integrate evidence-based information into clinical practice <p>Organizational Development</p> <ul style="list-style-type: none"> • Improve team work and collaboration • Enable functioning within the department • Build interdepartmental relationships and mutual respect • Improve shared decision making

Table 3

Comparison of Implementation Plans in Hospital A's and Hospital B's Nurse Residency Programs

	Hospital A's NRP	Hospital B's NRP
Practice areas of residency covered	Critical & Monitored Care Nursing, Medical-Surgical Nursing, Newborn Intensive Care Nursing, Labor and Delivery Nursing, Pediatric & Pediatric Intensive Care Nursing, Perioperative Nursing	
Length of residency	18 weeks	8–22 weeks
When residency programs are offered	winter and summer	winter, summer, and fall
How to apply for the program	Apply for as new hire, hired and paid a stipend	Apply for as new hire, hired and paid a stipend
Program prerequisites	Nurse—new graduate nurse with less than 6 months experience. The nurse is required to be licensed prior to the start of the cohort.	Licensed nurse—new graduate nurse with 6 months or less experience. Bachelor's in nursing is not required, but it is required to enroll in a bachelor's program within 2 years and complete bachelor's within 5 years of hire.
How residency training is offered	36 hours per week. Need to complete 420 clinical hours in order to complete the residency, not including class time. Classroom hours are scheduled depending on the needs of the resident.	32–36 hours per week with 4–8 hours per week of simulation laboratory training, classroom teaching, or online self-paced learning

Data analysis procedures. The survey responses were imported aggregately, directly into IBM SPSS Statistics (Version 23.0) from Survey Monkey for coding and analysis. A codebook was developed on the SPSS platform. The alpha level was set at 0.05. The reverse scoring for job satisfaction, organizational commitment variables were carried out per the instructions from Mowday et al., (1979) and Stamps (1997) respectively. Subscales were then created for all the variables: organizational commitment, job satisfaction, job dissatisfaction, and

mentoring. First, a descriptive analysis was done to give a graphic description of the data identifying the number of males and females, ethnic background, salary range distribution, age group distribution, year of graduation from the NRP, and length of residency program. Second, the principal component analysis tests were run to determine the components among these variables, and the Cronbach's alpha tests were run to determine the reliability with the sample in this study. Finally, an inferential analysis was done to generalize the results received from the sample to the population from which it was drawn. Hypothesis testing was used to answer the major question of correlations among organizational commitment, job satisfaction, job dissatisfaction, and mentoring. The Pearson correlation tested whether there was a relationship between variables, the strength of the relationship, and the direction of the relationship. A regression analysis, a partial correlation, and a multiple regression analysis quantified the relationships.

The data were cleaned and normality tests run. The job satisfaction and job dissatisfaction responses were further analyzed as stated in the *Scoring Workbook for the Index of Work Satisfaction* (Stamps, 2012; see Appendix E). The analysis was performed using a multiple regression procedure with the dependent variable—organizational commitment—and the following independent variables—job satisfaction, job dissatisfaction, and mentoring.

Alternative Hypothesis

The hypothesis reflected the expectations left by the review of the literature. The alternative hypothesis is that there is a significant relationship among organizational commitment, job satisfaction, job dissatisfaction, and perception of mentoring of nurses who have completed a nurse residency program.

Protection of Human Subjects and Ethical Considerations

In September 2014, I completed the Collaborative Institutional Training Initiative (CITI PROGRAM) and the National Institutes of Health (NIH) web-based training course, “Protecting Human Research Participants.” The participants were given a consent form, which included items that stated the intent of the research. Participants were also informed that participation in the study was voluntary and that they could decline at any time during the taking of the survey with no detriment to themselves. All ethical considerations in the consent form were also covered with the participants. The names and addresses of both the supervising professor and the University of the Incarnate Word Institutional Review Board (IRB) were included for ease of reference. The approval number of each IRB application was added to the bottom of the consent form as well. In addition, permissions were received from the two healthcare institutions with stipulations laid down by their IRB boards.

The participants did not receive direct benefit from the survey. Responses were completely anonymous and stored in an aggregated form. The raw data were kept on the online Survey Monkey website for the duration of the survey and then taken down. Participants signified consent by clicking on the “next” button to take the participants to the survey. The participants could choose to opt out of the study anytime by clicking on the “exit” button. The survey will be kept accessible to me for 5 years. If participants have any questions, they may contact either the supervising professor at the reported number or the university’s IRB.

Chapter 4: Results

The purpose of this correlational study was to evaluate the influence of mentoring, mediating job satisfaction, job dissatisfaction, and, therefore, organizational commitment, on nurses who completed the nurse residency program between January 2010 and December 2014 in two south Texas healthcare institutions. The main research questions identified for this study were the following:

1. Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring?
2. Does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

The Schweinle method was used to determine outliers and remove them if appropriate. Z scores were calculated for outliers greater than 3.29 points. All the z scores for all four variables yielded scores within the limits set, though some points were close to the limits set. Therefore, no scores were removed.

Descriptive Analysis

Response rate. Nurses from two south Texas hospitals participated in the study. The overall response rate for the survey was approximately 17% as shown in Table 4.

Table 4

Response Rates From Hospitals A and B

Hospital	Total Population	Returned Surveys	Percent Response
Hospital A	330	60	18.2%
Hospital B	262	40	15.3%

The survey was divided into four parts: It included three surveys that reviewed organizational commitment, job satisfaction, job dissatisfaction, and mentoring, while the fourth part of the survey was demographic. One hundred questionnaires (16.89%) were returned. Of those 100 questionnaires, 98 respondents (16.55%) completed the organizational commitment section, 80 (13.51%) completed the job satisfaction section, and 80 (13.51%) completed the mentoring section. In the demographic section, 78 (13.17%) respondents completed gender, age, ethnicity, pay, and year of graduation; 75 (12.66%) respondents completed length of residency program.

Demographics. Figure 6 shows the gender distribution of the respondents: 68% were female, 10% were male, and 22% did not indicate gender. The gender distribution mirrors the profession where nursing is seen as a female-dominated field. Estimates report that 87% to 96% of new graduate nurses are female (Landivar, 2013; Laschinger, Wong, & Grau, 2012; Trepanier, Early, Ulrich, & Cherry, 2012).

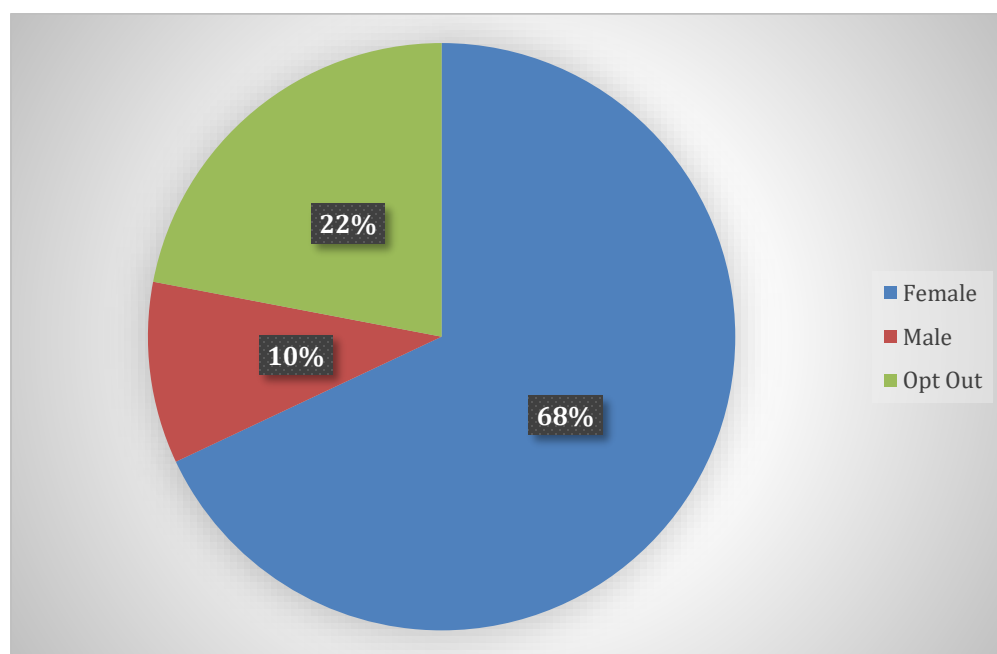


Figure 8. Gender distribution of survey respondents.

Ethnicity. Table 5 shows the ethnic distribution of the ne graduate nurses that responded to the survey.

Table 5

Response Rate of Ethnic Groups

Ethnic Groups	Frequency	Valid Percent
Hispanic or Latino	22	28.2
White (not of Hispanic origin)	41	52.6
Other	15	19.2
Total	78	100.0

Age group distribution. The age group distribution was treated as categorical data, dividing the ages into eight groups. The largest group was the 26- to 30-year-old group, followed closely by the 21- to 25-year-old group (see Figure 9).

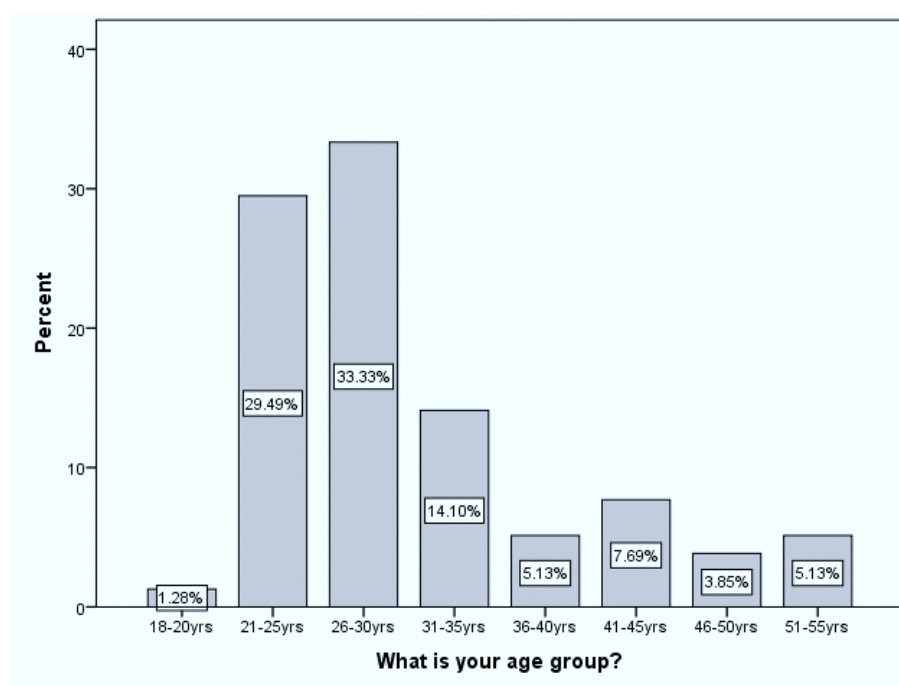


Figure 9. Age group distribution of survey respondents.

Table 6 shows that the highest participation in the survey came from respondents that graduated in 2010 (20%) and 2014 (37%).

Table 6

Year of Graduation

Year	Number	Percentage
2010	20	20%
2011	3	3%
2012	8	8%
2013	7	7%
2014	37	37%
Total	78	

As shown in Table 7, the longest residency program lasted 24 to 26 weeks; no indication was given as to the specialty of the residency. Table 8 shows the most common pay for the residents was \$20 to \$25 per hour, closely followed by \$25 to \$30 per hour.

Table 7

Length of Nurse Residency Program

	Frequency	Valid Percent
Other (please specify)	2	2.7
8–11 weeks	7	9.3
12–16 weeks	27	36.0
17–19 weeks	14	18.7
20–23 weeks	9	12.0
24–26 weeks	16	21.3
Total	75	100.0

Table 8

Salary Distribution

	Frequency	Valid Percent
\$20–\$25/hr	56	71.8
\$25.01–\$30/hr	16	20.5
> \$30.01/hr	4	5.1
I prefer not to answer	2	2.6
Total	78	100.0

Variables. The variables used in the survey were organizational commitment, job satisfaction, job dissatisfaction, and mentoring. The principal component analysis, Cronbach's alpha, and normality for each variable are further discussed.

Organizational commitment. Organizational commitment was reduced to one component using principal component analysis with Eigenvalues greater than 1 (see Table 9). The Bartlett's test of sphericity results showed significance ($p < .05$). The Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) was good at .901, indicating organizational commitment and accounting for 48.5% of variability. The Cronbach's alpha was strong at .977, indicating that the sample was reliable for the population.

Table 9

Principal Component Analysis of Organizational Commitment Components

Factor	KMO	Eigenvalue	% of Variance	Question	Factor Loading	Cronbach's alpha
Organizational Commitment	.901	7.27	48.47	1	.72	.977
				2	.86	
				3	.41	
				4	.34	
				5	.61	
				6	.85	
				7	.53	
				8	.81	
				9	.52	
				10	.82	
				11	.66	
				12	.64	
				13	.81	
				14	.82	
				15	.77	

Table 10 shows the normality tests results for organizational commitment. This variable had a mean score of 5.14 and a median score of 5.33, indicating symmetry since both numbers

were close. The ratio of the standard deviation to the range was .203, which was between the values needed for normality. The skewness and kurtosis values were between 3 and -3 and did support normality. The Kolmogorov-Smirnov test showed a $p < .05$, which did not indicate normality. This was further confirmed by the appearance of the histogram, which was slightly skewed to the left (see Figure 10). The values on the Q-Q plot were not close to the straight line, and the boxplot indicated some possible outliers.

Table 10

Normality Tests Results for PCA of Organizational Commitment

		Statistic	SE
Organizational Commitment	Mean	5.14	.114
	Median	5.33	
	Std. Deviation	1.015	
	Range	5	
	Skewness	-3.328	
	Kurtosis	3.691	
	Kolmogorov-Smirnov ^a	.032	

^aLilliefors significance correction.

Organizational commitment was transformed using square root and logarithm. Transformation did not improve organizational commitment, as can be seen in Figures 11 and 12. The Kolmogorov-Smirnov values for both the square root and logarithm were both $p < .05$, thus not supporting normality. Consequently, the original untransformed value of organizational commitment was used for further data analysis.

Job satisfaction. The principal component analysis (PCA) of job satisfaction was performed to determine which items were grouped into a set of linearly uncorrelated components. The variable, job satisfaction, was first subdivided into job satisfaction and job dissatisfaction following the model laid out by Herzberg (2003) in Table 1.

The PCA reduced job satisfaction to three components: professional status, time for quality care, and autonomy. The Bartlett's test of sphericity results showed significance ($p < .05$), and the KMO was good at .760.

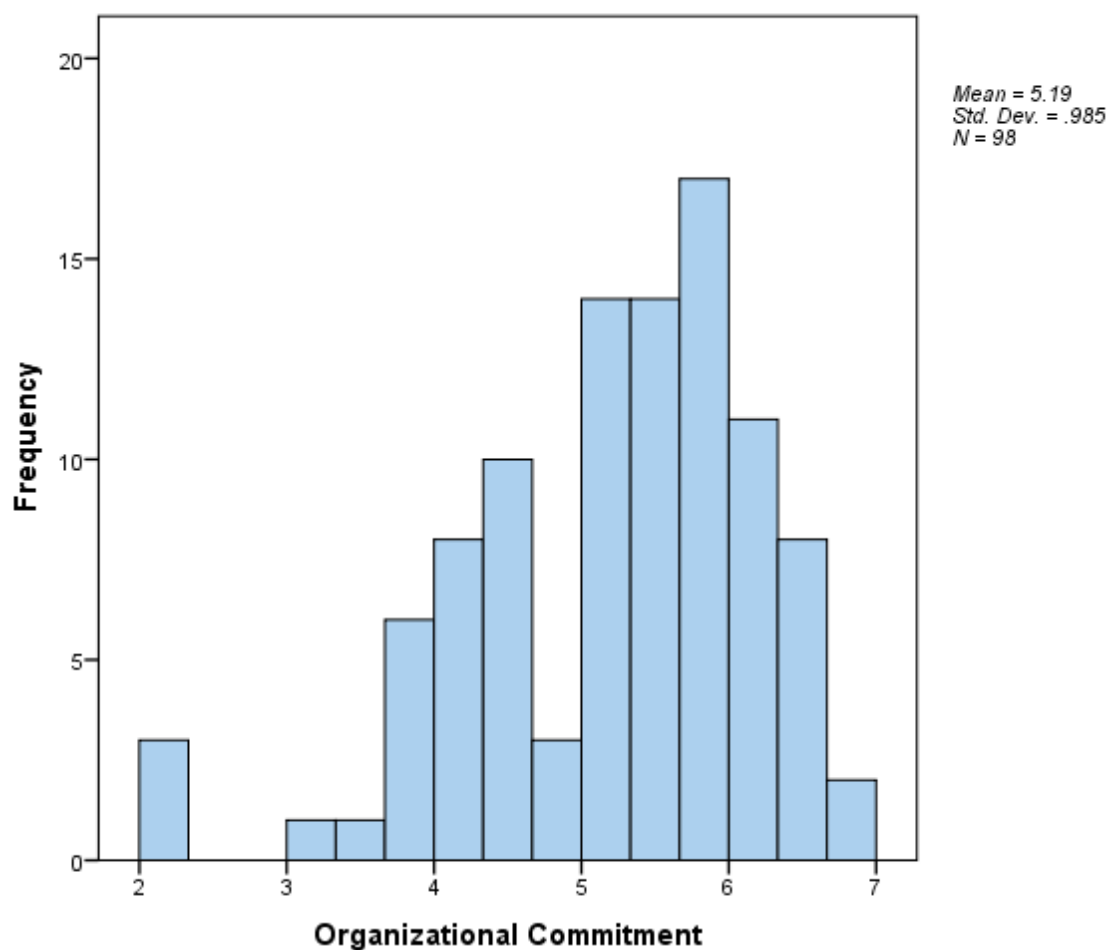


Figure 10. Histogram of organizational commitment.

Stamps (1997) defined professional status as an “overall importance or significance felt about your job, both in your view and in the view of others” (p. 1). Bengoa et al. (2006) described quality of care as a “process for making strategic choices in health systems” (p. 2). Autonomy was defined by Stamps (1997) as an “amount of job related independence, initiative, and freedom, either permitted or required in daily work activities” (p. 1).

Table 11 indicates professional status accounted for 30.4% of variance of job satisfaction, time for quality care accounted for 13.5% of variance of job satisfaction, and autonomy accounted for 7.1% of variance of job satisfaction. The components had moderately strong Cronbach's alphas, indicating that they were reliable for the population.

Table 11

Principal Component Analysis of Job Satisfaction Components

Factor	KMO	Eigenvalue	% of Variance	Question	Factor Loading	Cronbach's Alpha
Professional status	.813	5.783	30.43	26	.81	.785
				49	.76	
				42	.74	
				37	.68	
				56	.65	
				24	.62	
				53	.52	
				17	.79	
Time for quality care	.787	2.564	13.50	51	.81	.834
				30	.80	
				44	.78	
				39	.70	
Autonomy	.779	1.352	7.11	32	.74	.726
				41	.64	
				46	.63	
				28	.63	
				45	.63	
				20	.75	
				22	.55	

Normality tests for professional status, time for quality care, and autonomy showed that they were normally distributed. The Kolmogorov-Smirnov test showed significance ($p > .05$), as indicated in Table 12. The standard deviation was about a quarter of the range. The skewness and kurtosis values for all three variables were between 3 and -3, further suggesting that the samples were normally distributed (see Figures 13, 14, and 15). These three variables—professional status, time for quality care, and autonomy—were used for further inferential analysis.

Table 12

Normality Tests Results for PCA of Job Satisfaction

		Statistic	SE
Professional status	Mean	5.9549	.09738
	Median	6.1250	
	Std. Deviation	.82631	
	Range	3.63	
	Skewness	.369	
	Kurtosis	1.39	
	Kolmogorov-Smirnov ^a	.013	
Time for quality care	Mean	3.4792	.16294
	Median	3.5000	
	Std. Deviation	1.38258	
	Range	6.00	
	Skewness	.46	
	Kurtosis	.86	
	Kolmogorov-Smirnov ^a	.200*	
Autonomy	Mean	5.1111	.10294
	Median	5.1429	
	Std. Deviation	.87349	
	Range	4.71	
	Skewness	2.29	
	Kurtosis	2.11	
	Kolmogorov-Smirnov ^a	.190	

^aLilliefors significance correction.

*This is a lower bound of the true significance.

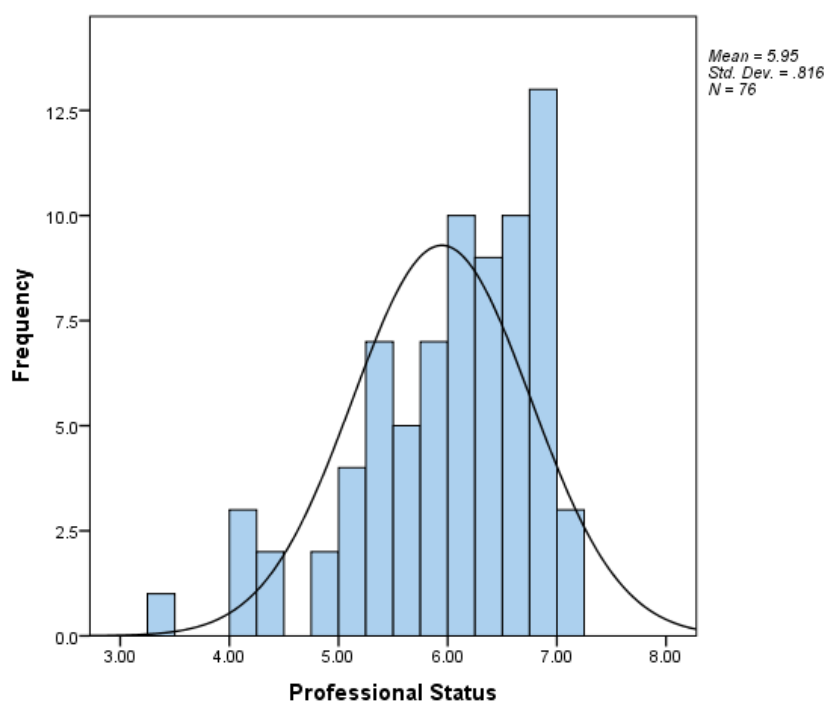


Figure 11. Histogram of professional status

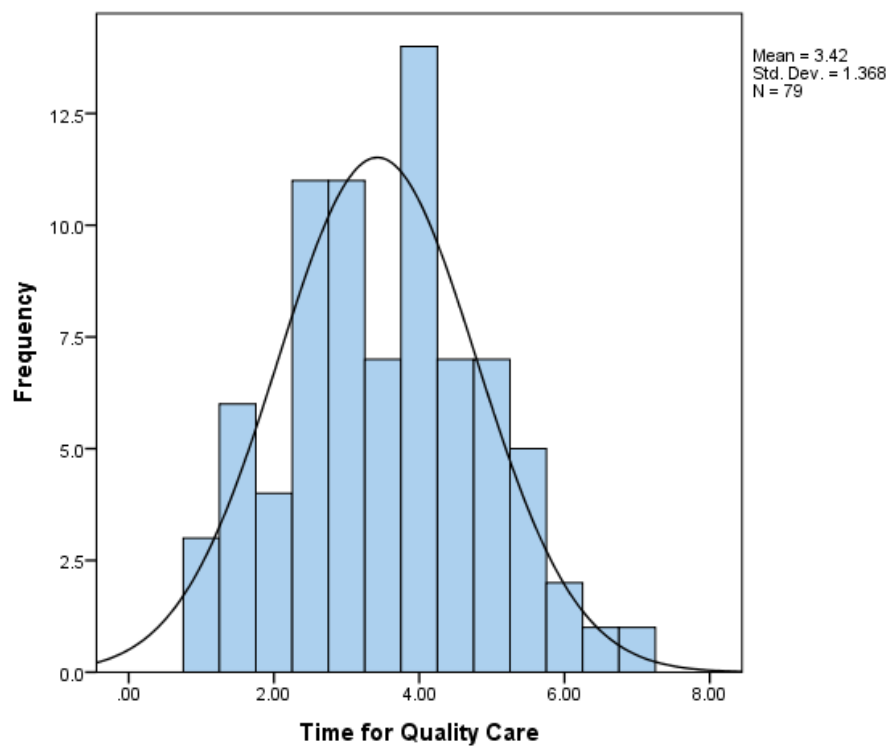


Figure 12. Histogram of time for quality care

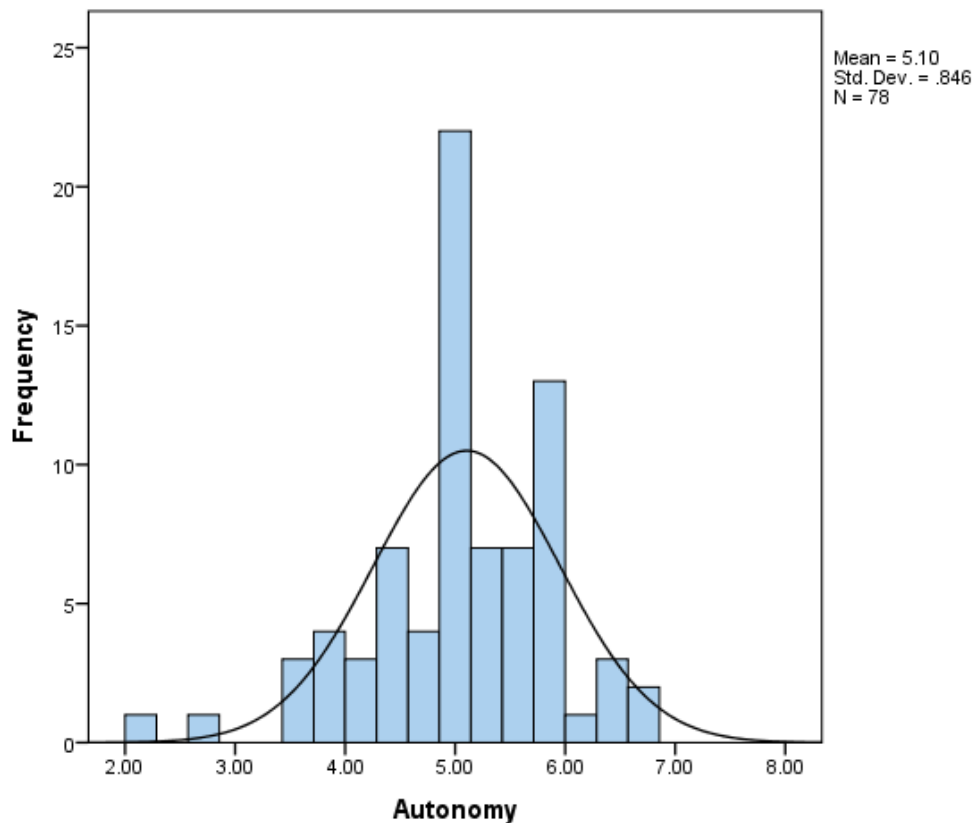


Figure 13. Histogram of autonomy.

Job dissatisfaction. The PCA of job dissatisfaction was reduced to four components:

- (a) pay and administration, which refers to the total benefit package and hospital or unit leadership;
- (b) peer relationships, which refers to the relationships between nurses;
- (c) organizational relationships, which refers to the relationships between nurses and other healthcare workers and doctors; and
- (d) decision making, which refers to the ability to decide how things are done in the unit.

Table 13 shows that pay and administration accounted for 52.82% of variance of job dissatisfaction, peer relationships accounted for 61.47% of variance, organizational relationships accounted for 67.32% of variance, and decision making accounted for 49.55% of variance. Here

also, the Bartlett's test of sphericity results showed significance ($p < .05$), and the KMO for all variables were good, which ranged between .739 and .853. The Cronbach's alphas for all variables were strong, ranging from .795 to .874, which indicated that the variables were reliable for the population.

Table 13

Principal Component Analysis of Job Dissatisfaction Components

Factor	KMO	Eigenvalue	% of Variance	Question	Factor Loading	Cronbach's alpha
Pay and administration	.853	4.754	52.82	47	.86	.874
				29	.86	
				16	.81	
				59	.79	
				23	.77	
				36	.77	
				27	.63	
				57	.55	
Peer relationships	.739	3.074	61.47	19	.28	.833
				38	.85	
				43	.78	
				25	.84	
				18	.72	
Organizational relationships	.811	3.366	67.32	31	.74	.870
				52	.87	
				54	.86	
				50	.83	
				34	.69	
Decision making	.767	2.973	49.55	21	.83	.795
				58	.71	
				35	.70	
				33	.75	
				48	.75	
				55	.68	
				40	.62	

Normality tests for the principal components of job dissatisfaction showed that pay and administration, peer relationships, organizational relationships, and decision-making were

normally distributed. The Kolmogorov-Smirnov test showed significance ($p > .05$), except for peer relationships ($p < .05$; see Table 14). The standard deviation for all four variables was about a quarter of their ranges. The skewness and kurtosis values for all four variables were between 3 and -3, further suggesting that the samples were normally distributed (see Figures 16, 17, 18, and 19). Based on the fact that the histograms all appeared to be slightly skewed to the left, these four variables—pay and administration, peer relationships, organizational relationships, and decision-making—were used for further inferential analysis.

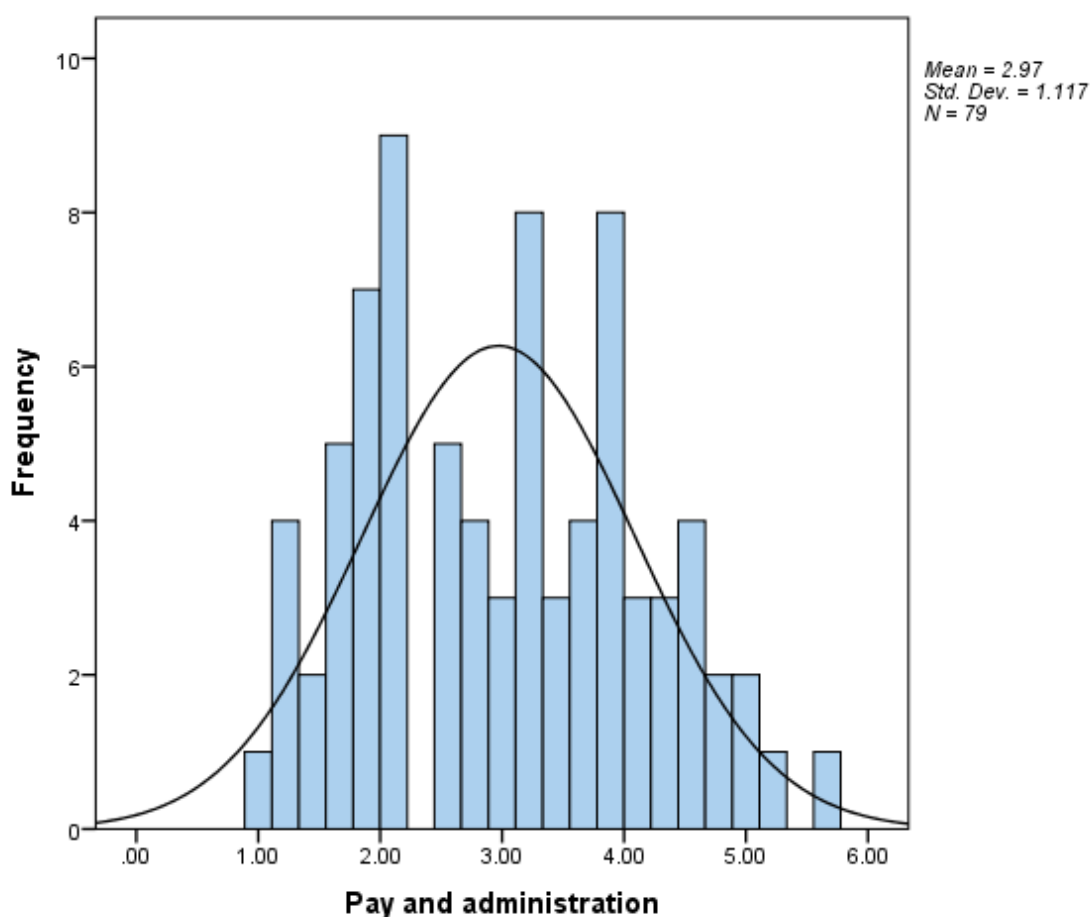


Figure 14. Histogram of pay and administration.

Table 14

Normality Tests Results for PCA of Job Satisfaction and Job Dissatisfaction

		Statistic	SE
Pay and administration	Mean	2.9429	.13381
	Median	2.8889	
	Std. Deviation	1.13541	
	Range	4.56	
	Skewness	.699	
	Kurtosis	-1.639	
	Kolmogorov-Smirnov ^a	.082	
Peer relationships	Mean	5.6417	.13066
	Median	6.0000	
	Std. Deviation	1.10870	
	Range	5.00	
	Skewness	-3.459	
	Kurtosis	.846	
	Kolmogorov-Smirnov ^a	.001	
Organizational relationships	Mean	5.2111	.14130
	Median	5.2000	
	Std. Deviation	1.19901	
	Range	5.20	
	Skewness	-2.311	
	Kurtosis	.2021	
	Kolmogorov-Smirnov ^a	.200*	
Decision making	Mean	4.2130	.13261
	Median	4.0000	
	Std. Deviation	1.12526	
	Range	5.17	
	Skewness	-0.268	
	Kurtosis	-.270	
	Kolmogorov-Smirnov ^a	.057	

^aLilliefors significance correction.

*This is a lower bound of the true significance.

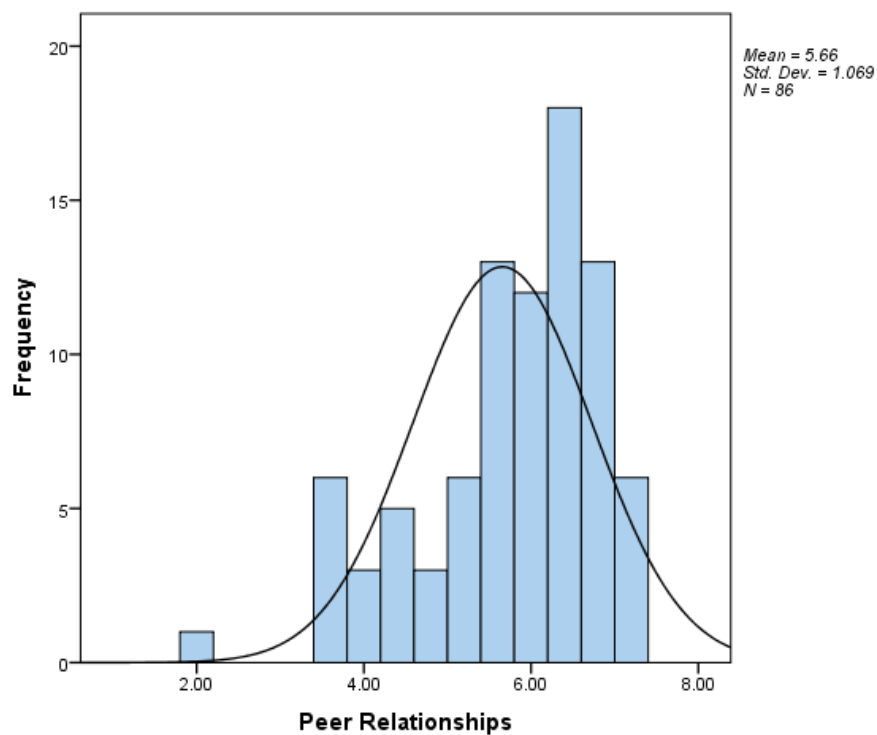


Figure 15. Histogram of peer relationships.

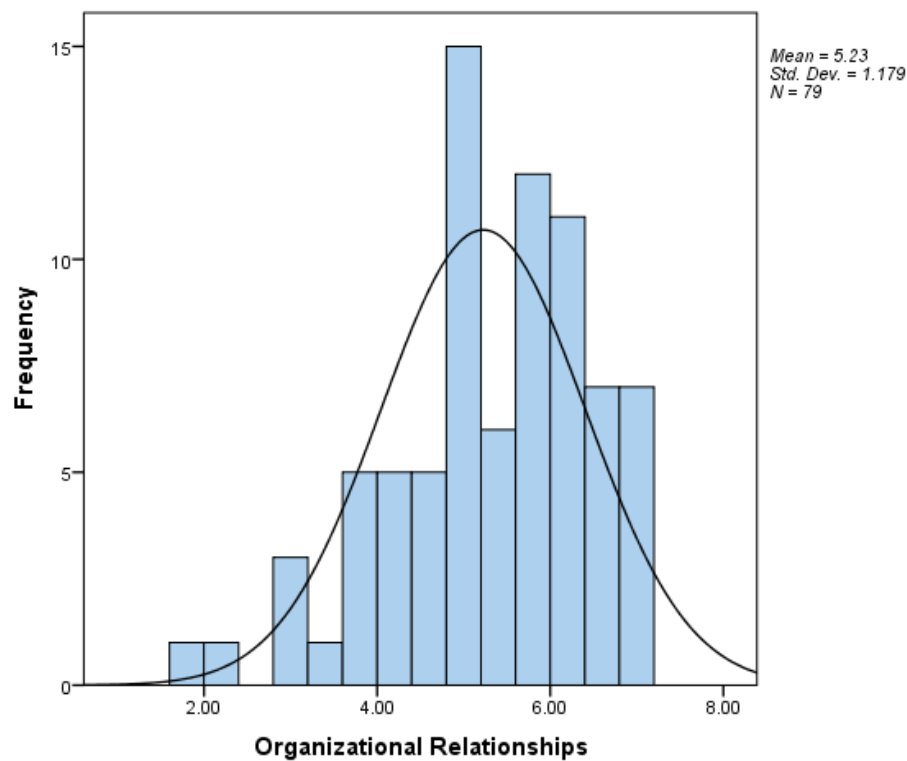


Figure 16. Histogram of organizational relationships

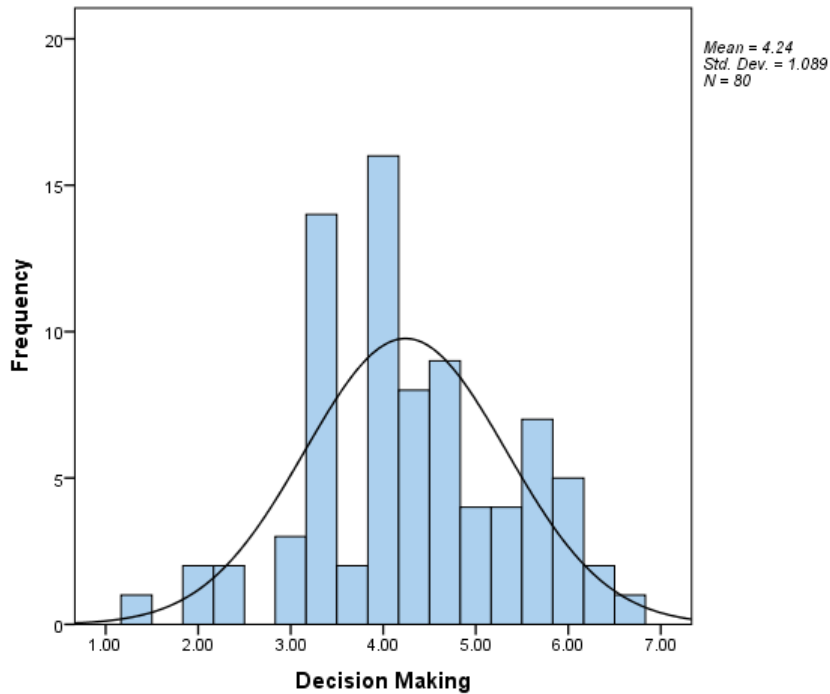


Figure 17. Histogram of decision making.

Mentoring. Principal component analysis of mentoring was carried out and it was reduced to two components personal development and strategic guidance. The Bartlett's test of sphericity results showed significance ($p < .05$), and the KMO were good at .985 and .975, respectively. The Cronbach's alphas were strong at .985 and .975, indicating that the samples were reliable for the population (see Table 15). The results of the normality tests of strategic guidance and personal development are shown in Table 16. The table shows that the standard deviation for both was about a fourth of the mean score. The skewness and kurtosis of both variables were between 3 and -3, except the skewness of personal development, which was slightly above the higher limit of 3. The Kolmogorov-Smirnov test value of strategic guidance supported normality ($p > .05$), but the Kolmogorov-Smirnov test value of personal development did not support the normal distribution of the variable ($p < .05$).

Table 15

Principal Component Analysis of Mentoring Components

Factor	KMO	Eigenvalue	% of Variance	Question	Factor Loading	Cronbach's alpha
Personal development	.940	11.8	84.27	60	.91	.985
				61	.89	
				63	.92	
				64	.92	
				66	.95	
				72	.89	
				73	.87	
				74	.94	
				75	.91	
				77	.92	
				78	.93	
				79	.93	
				83	.95	
				84	.93	
Strategic guidance	.942	8.82	80.22	62	.91	.975
				65	.90	
				67	.83	
				68	.94	
				69	.93	
				70	.92	
				71	.86	
				76	.89	
				80	.87	
				81	.87	
				82	.93	

The histograms were not bell-shaped, and they were slightly skewed to the left (see Figures 20 and 21). With a strong Cronbach's alpha for both variables, standard deviation range ratio, and kurtosis, and the fact that both histograms were skewed to the same direction, both variables were used for further inferential analysis. The mentoring variable was also transformed prior to reduction into principal components using square root and logarithm, and no improvement was seen with either skewness, kurtosis or the Kolmogorov-Smirnov values, which were also $p < .05$. As a result, the original untransformed values of mentoring were used for further analysis.

Table 16

Normality Tests Results for PCA of Mentoring

		Statistic	SE
Strategic guidance	Mean	55.1625	1.97800
	Median	59.0000	
	Std. Deviation	17.69177	
	Range	66.00	
	Skewness	3.234	
	Kurtosis	.308	
	Kolmogorov-Smirnov ^a	.021	
Personal development	Mean	76.1000	2.43956
	Median	82.0000	
	Std. Deviation	21.82009	
	Range	84.00	
	Skewness	4.631	
	Kurtosis	2.40	
	Kolmogorov-Smirnov ^a	.000	

^aLilliefors significance correction.

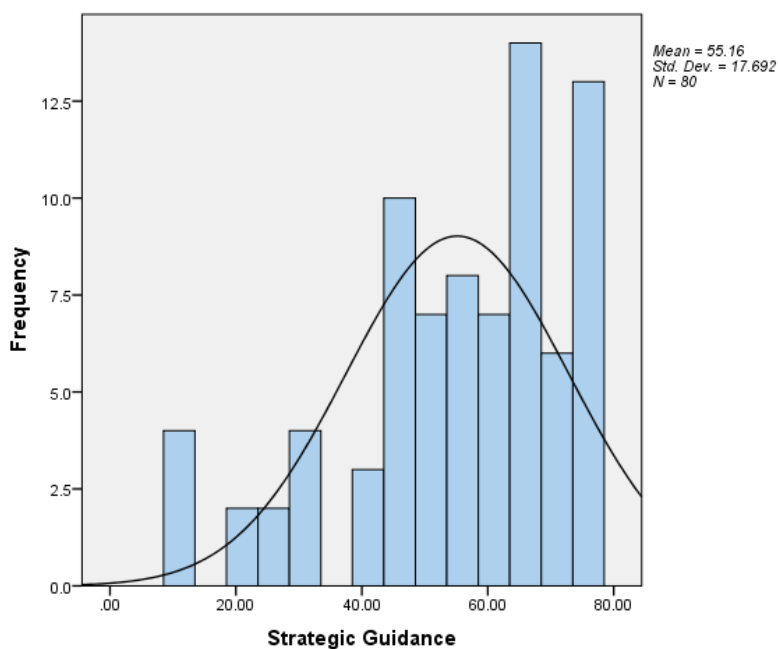


Figure 18. Histogram of strategic guidance.

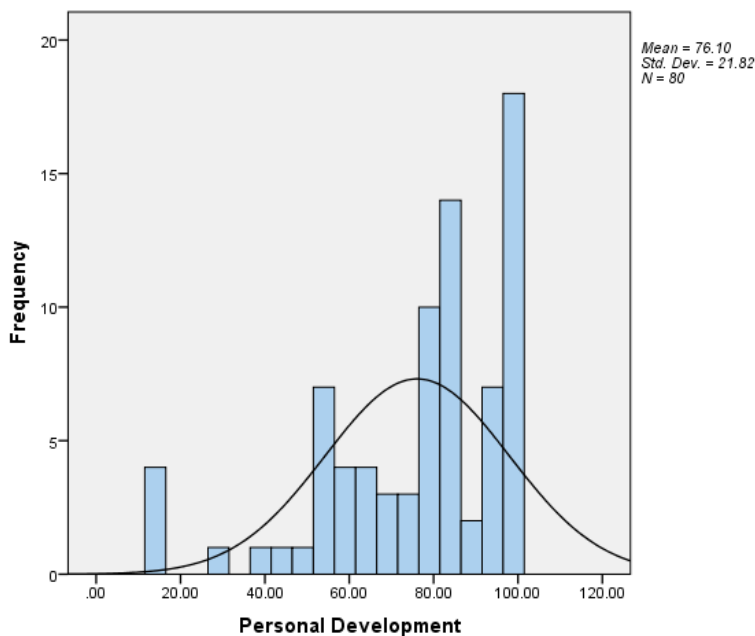


Figure 19. Histogram of personal development.

Inferential Analysis

There were two research questions designed to examine the relationships between organizational commitment, job satisfaction, job dissatisfaction, and mentoring.

Research Question 1. Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring? A Pearson correlation analysis was conducted to determine if there was a linear relationship between the variables, positive or negative, and to describe how strong the relationship was. The data were close enough to normality, and transformation did not improve them. The analysis examined the relationships between organizational commitment (organizational commitment), job satisfaction (professional status, time for quality care, and autonomy), job dissatisfaction (pay and administration, peer relationships, organizational relationships, and decision making), and mentoring (personal development and strategic guidance).

Table 17 shows that there was no statistical correlation between personal development, strategic guidance, and organizational commitment ($p > .05$). There was also no correlation between personal development, strategic guidance, and any of the reduced components of job satisfaction and job dissatisfaction ($p > .05$). Of great interest is that time for quality care correlated with both strategic guidance and personal development and with every other variable, including organizational commitment ($p > .05$).

Cohen and Steinberg (1992) categorized correlation coefficients into three categories: less than .1 (insubstantial), .1 – .3 (small); .3 - .5 (moderate); and greater than .5 (large). The Pearson Correlation test showed there to be a large correlation between organizational commitment and the reduced component of job satisfaction - professional status at .540, $p < .001$; autonomy and time for quality care were at small correlation .431, $p < .001$ and .348, $p < .001$ respectively.

The correlation results for reduced components organizational commitment and job dissatisfaction are similar, with pay and administration had a large correlation with .580, $p < .001$, even higher than that of professional status, signifying that the nurses may place a higher importance on remuneration and administration than their professional status. The next is moderately correlated variable is decision making with .416, $p < .001$ and organizational relationship at .366, $p < .001$; and least is a weak correlational relationship with peer relationships at .298, $p < .001$. The correlation between mentoring were nonsubstantial.

The correlation between the two components of mentoring was very strong at .916, $p < .001$. These two components had rather very weak correlations with all other variables including organizational components, except with time for quality care. Strategic guidance and

personal development correlated moderately strongly with time for quality care, but strategic guidance was stronger at .304, $p < .001$.

Table 17

Pearson Intercorrelations for Organizational commitment and Reduced Components of Job Satisfaction, Job Dissatisfaction, and Mentoring

	1	2	3	4	5	6	7	8	9
Job Satisfaction									
1. Professional status	----								
2. Time for quality care	.282*	----							
3. Autonomy	.471**	.556**	----						
Job Dissatisfaction									
4. Pay and administration	.308**	.369**	.402**	----					
5. Peer relationships	.264*	.285*	.479**	.052	----				
6. Organizational relationships	.390**	.345**	.567**	.143	.568**	----			
7. Decision making	.395**	.519**	.643**	.507**	.346**	.434**	----		
Mentoring									
8. Strategic guidance	.012	.304**	-.056	.094	.089	-.050	.144	----	
9. Personal development	.022	.280*	-.024	.082	.138	-.078	.199	.916**	----
Organizational Commitment									
10. Organizational Commitment	.540**	.348**	.431**	.580**	.298**	.366**	.416**	.053	.080

* $p < .05$. ** $p < .001$

Time for quality care was seen to correlate weakly with all the variable of job satisfaction: professional status, strongly with autonomy at .556, $p < .001$; moderately with job dissatisfaction: pay and administration, organizational relationships, decision making; and with organizational commitment. Time for quality care correlates weakly with peer relationships $p < .001$ and personal development $p < .001$ the relationship between mentoring; represented by strategic guidance (predominantly) and time for quality care seems to be the link to mediating job satisfaction, job dissatisfaction, and therefore organizational commitment.

In addition, there was a strong correlation between organizational commitment, professional status, and autonomy ($p < .05$). There was also a strong correlation between organizational commitment, pay and administration, organizational relationships, and decision-making. These variables were used for further inferential analysis.

Research Question 2. Does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

The multiple regression test was carried out to explain the relationships between the dependent variable, organizational commitment, and the independent variables, professional status, autonomy, pay and administration, organizational relationships, and decision-making. The sample size was adequate at 76, which was greater than the required minimum as defined by the formula $n > 50 + 8m$, where $m = 3$ is the number of variables used and n is the sample size. However, the sample size was not adequate to make individual predictors for independent variables (Tabachnick & Fidell, 2012).

Job satisfaction regression. Stepwise multiple regression was carried out with organizational commitment as the dependent variable, and professional status, time for quality of

care, and autonomy as the independent variables. Table 18 show the results of the regression analysis.

Table 18

Regression Analysis Summary for Organizational Commitment, Professional Status and Time for Quality Care Predictors Variables

Variable	<i>B</i>	<i>SEB</i>	
Professional status	6.952	1.466	.481***
Time for quality care	1.901	.873	.221

Note. Adjusted $R^2 = .587$ ($N = 73$, $p < .001$). *** $p < .001$.

At Step 1 of the analysis, professional status entered into the regression equation and was significantly related to organizational commitment, $F(1, 72) = 30.37$, $p < .001$. The multiple correlation coefficient was .54, indicating approximately 7.9% of the variance of organizational commitment could be accounted for by professional status. Autonomy did not enter into the equation at Step 2 of the analysis ($t = 1.229$, $p > .05$).

Job dissatisfaction regression. Stepwise multiple regression was carried out with organizational commitment as the dependent variable and the reduced components of job dissatisfaction that correlated the most—pay and administration, organizational relationships, and decision-making—as independent variables, as seen on Table 19.

Stepwise multiple regression. The final stepwise multiple regression was carried out with as the dependent variable, and professional status and pay and administration as independent variables. These two variables were chosen as they both predicted best pay and administration from job dissatisfaction and professional status from job satisfaction, and were thus used for further regression. Both variables each entered into the first step of their multiple regression analyses.

Table 19

Regression Analysis Summary for Organizational Commitment, Pay and Administration, Decision Making, and Organizational Relationships Predictors Variables

Variable	<i>B</i>	<i>SEB</i>	
Pay and administration	5.508	.925	.527***
Organizational relationships	3.125	.877	.315***

Note. Adjusted $R^2 = .425$. ($N = 74$, $p < .001$). *** $p < .001$.

Table 20

Regression Analysis Summary for Organizational Commitment, Pay and Administration, and Professional Status Predictors Variables

Variable	<i>B</i>	<i>SEB</i>	
Pay and administration	4.736	.923	.455***
Professional status	5.744	1.274	.400***

Note. Adjusted $R^2 = .479$. ($N = 76$, $p < .001$). *** $p < .001$.

A stepwise multiple regression was conducted to evaluate whether the two variables, professional status and pay and administration, would predict organizational commitment. At Step 1 of the analysis, pay and administration entered into the regression equation and was significantly related to organizational commitment, $F(1, 75) = 37.175$, $p < .001$. The multiple correlation coefficient was .58, indicating approximately 6.01% of the variance of organizational commitment could be accounted for by pay and administration. Professional status entered the equation in Step 2, ($t = 4.51$, $p < .05$).

Summary of Findings

The demographical survey indicated a higher percentage of female nurses to male nurses, as it obtains in the field and is supported by research. It also showed that a larger percentage of the respondents were younger (26 to 30 years old) and White (not of Hispanic origin), as is seen in the field. The validity and reliability tests showed that the surveys were both valid and reliable

with the sample. The Cronbach's alphas for all components were moderately strong to strong, all $>.7$, which means they were all strongly reliable. The results showed that strategic guidance and personal development correlated with time for quality care. This variable, time for quality care, in turn, correlated with all the variables, which is noteworthy. The correlation tests reveal that organizational commitment correlates with all the variables correlates moderately with job satisfaction (time for quality care and autonomy) and job dissatisfaction (organizational relationships and decision making), and largely with job satisfaction (professional status) and job dissatisfaction (pay and administration)

Multiple regression analyses were conducted to answer the second research question posed. The results showed that the job satisfaction components of professional status and time for quality care together accounted for 8.8% of variability of organizational commitment. For job dissatisfaction, pay and administration and organizational relationships accounted for 8.6% of variability of organizational commitment.

Chapter 5: Discussion, Implications, Conclusion, and Recommendations

The purpose of this correlational study was to evaluate the influence of mentoring, mediating job satisfaction, job dissatisfaction, and, therefore, organizational commitment, on nurses who completed the nurse residency program between January 2010 and December 2014 in two south Texas healthcare institutions. The two research questions proposed were the following:

1. Is there a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring?
2. Does mentoring influence job satisfaction, job dissatisfaction, and organizational commitment of nurses who have completed a nurse residency program?

This chapter discusses Herzberg's (1976) motivation-hygiene theory and how it relates to organizational commitment, job satisfaction, job dissatisfaction, and mentoring. The chapter also discusses the results, the limitations of the study, and recommendations for further research.

The findings of this study indicate that though mentoring did not correlate directly with organizational commitment, it did have an impact on the variable time for quality care. Interestingly, time for quality care correlated with all the other variables, including organizational commitment. The results of this study show that job satisfaction and job dissatisfaction did impact the nurse's commitment to the organization, which is supported by Herzberg's (2003) motivation-hygiene theory. In addition, this theory that mentoring would mediate both job satisfaction and job dissatisfaction such that it would increase the nurse's commitment to stay with the organization is further supported by other research (Lee et al., 2010; Mariani, 2012; May, 2003; Ramaswami & Dreher, 2010; Weng et al., 2010).

Discussion

Research Question 1. The first research question asked whether there was a relationship between organizational commitment, job satisfaction, job dissatisfaction, and mentoring. Cohen and Steinberg (1992) divided the correlation coefficient into three categories .1 to .3 as small, .3 to .5 as moderate, and greater than .5 as large correlations. The Pearson correlation test revealed that time for quality care was seen to correlate weakly to strongly with all the variables of job satisfaction (professional status and autonomy), job dissatisfaction (pay and administration, peer relationships, organizational relationships, and decision-making), and with organizational commitment. The relationship between mentoring, represented by strategic guidance, and time for quality care seems to be the link with mediating job satisfaction, job dissatisfaction, and organizational commitment. Baron and Kenny (1996) and Miles and Shevlin (2001) described a mediating relationship as one in which the changes in the predictor variables (in this case, job satisfaction and job dissatisfaction) account for changes in the mediator variable (time for quality care) and, thus, accounts for changes in the outcome variable (occupational commitment).

It could be argued from the results that mentors teach their mentees how to manage their time. This then increases the nurses' ability to render quality care to their patients within the time frame while meeting all their treatment goals and regulations. This new time management skill then helps the new nurses know how to care skillfully for their patients, complete all required paperwork in time, relate to others, make wise decisions, be proud of their jobs, know how to stand on their own, and thus commit to the organization. Hill and Sawatzky (2011) stated that mentorship is vital in developing the healthcare professional to be capable of providing "safe and competent care" (p. 166).

In order to better understand mentoring, especially since such a high percentage of respondents (72%) agreed that their experience with their mentors was good, mentoring was reduced to two components: strategic guidance and personal development. Figure 20 shows the relationship between job satisfaction, job dissatisfaction, and organizational commitment.

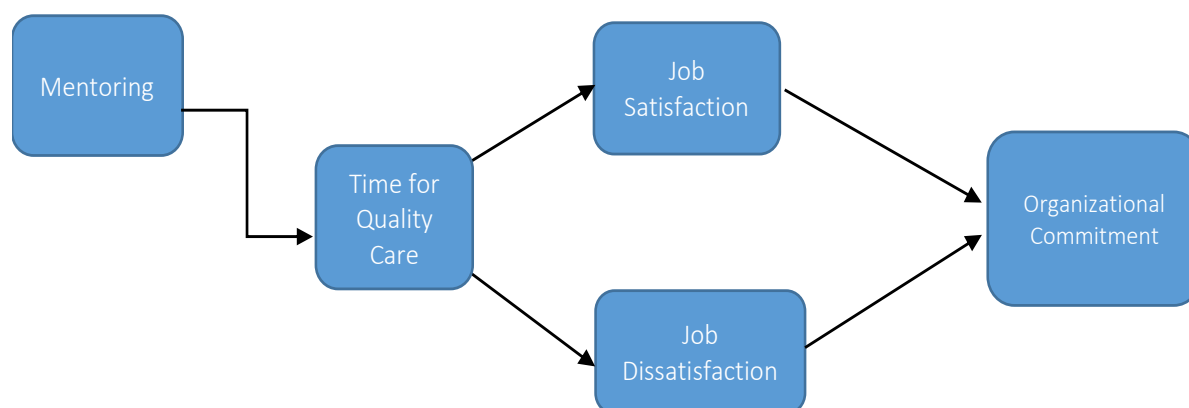


Figure 20. Time for quality care correlates with job satisfaction and job dissatisfaction and, therefore, organizational commitment.

The task then is to better understand how time for quality care interplays with a nurse's transition from the classroom to the bedside, which raises the following question: Should these skills first be taught in nursing school or later in a nurse residency program? If this skill is taught in nursing school, the question is, how is the skill taught to enable a smooth transition to the bedside? Research shows that the efficacy of mentoring positively influences turnover by improving commitment to the organization in graduate nurses (Frost et al., 2013; Rush et al., 2013; Webb & Shakespeare, 2008).

Research Question 2. The second research question asked how mentoring influenced job satisfaction, job dissatisfaction, and organizational commitment of nurses who had completed a nurse residency program. Stepwise multiple regression analyses were conducted to determine how job dissatisfaction and job dissatisfaction contributed towards organizational commitment.

Since mentoring was found not to correlate directly with organizational commitment, it was removed from the multiple regression analysis. The stepwise multiple regression analysis was carried out to quantify the amount of variability that the variables accounted for in organizational commitment and eliminate those variables that did not offer additional variability.

The conclusion drawn from the analyses is that pay and administration, professional status, organizational relationships, and autonomy influenced a nurse's commitment to the organization, supporting Herzberg's (1963) theory. According to his theory, the factors that contribute the highest to job satisfaction and job dissatisfaction are company policy and administration, salary, work conditions, and work itself, which all compare with the variables earlier stated. This study's results also supported by Hayes et al. (2012) who found that lack of interpersonal relationships could be one of the reasons why nurses leave their jobs. Hayes et al. (2012) also found that pay was a greater factor in reducing organizational commitment, though they found this more in male nurses than in female nurses. Similarly, one of the main reasons given why nurses leave their jobs was dissatisfaction with their pay (Kudo et al. 2006, p. 511; Tominaga & Miki, 2011, p. 42).

Pay is one of the reasons that healthcare systems hone in on as the reasons why the new graduate nurses leave. Many resources are poured into empowering the directors to meet more often with the nurses and improve the supervisor–staff relationship, but not as much attention is paid to researching salary differences or how to make new nurses' salaries comparable to the market. The hospital administration should work on increasing the pay of nurses and on factors that could reduce job dissatisfaction.

The conceptual diagram that can be derived as a result of this study is presented in Figure 23. Mentoring mediates job satisfaction, which accounts for 58.7% of variability of

organizational commitment. Mentoring also mediates job dissatisfaction, which accounts for 42.5% of variability of organizational commitment. Healthcare institutions should review the structure of their nurse residency programs, as they are the bedrock to assist the new graduate nurses transition from the classroom to the bedside.

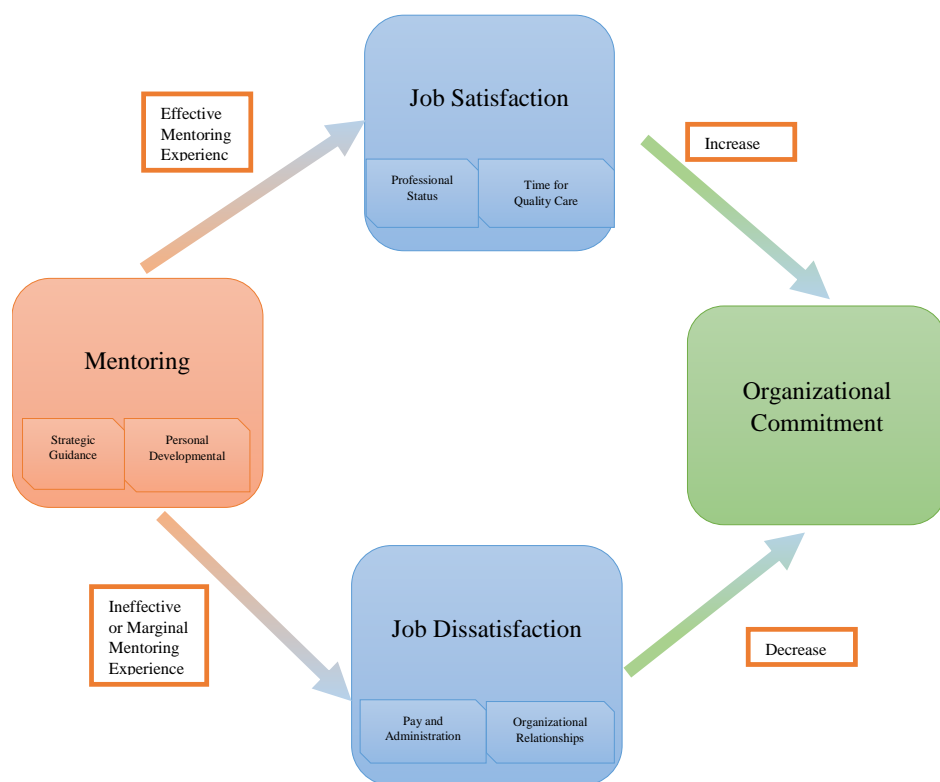


Figure 21. Conceptual diagram of proposed mentoring mediating job satisfaction and job dissatisfaction and, therefore, organizational commitment.

Hansen (2014) described that nursing education was moved from the hospitals to the classroom in order to elevate the status of the nurse and to offer a more robust foundation with inclusion of liberal arts and sciences foundation. This movement to the classrooms then allowed the two bodies to drift apart such that, as he described it, “like two slowly diverging continents, creating a gap between them that newly licensed nurses had to leap” to start their nursing career (p. 47). The NRP was designed to help the nurse bridge this gap. The solidification of the

mentoring process in the NRP could be said to be the link to increasing organizational commitment in the new nurses.

Implications From the Current Study

Research about nurse residency programs has shown that one of the foundations for the program is the availability of a mentor and how the mentor could positively influence the mentee to either stay with the hospital that trained them or stay in the profession. The results of this research show that mentoring influences organizational commitment indirectly by first influencing time for quality care and then organizational commitment. In this section, the variables of job satisfaction, job dissatisfaction, and mentoring are discussed.

Job satisfaction. This research shows that job satisfaction has a big role to play, whether graduate nurses commit to the hospital that trained them or intend to separate and seek employment elsewhere. Earlier in this study's introduction, the reason given by the health system for the nurses' separation was a difference in pay between them and the other competing hospitals. The results of this study show that pay was not the only deciding factor for organizational commitment in the nurses studied, but professional status and time for quality care also played strong roles.

Job dissatisfaction. According to Herzberg (1976), policies and administration is the biggest hygiene factor that contributes toward job dissatisfaction. Pay is the fifth largest factor for dissatisfaction on the job. The implication for this is that the health systems should examine the different factors that encompass job dissatisfaction and focus on improving each one of them. Therefore, effort should be made to not lose sight of reducing job dissatisfaction while improving job satisfaction.

Mentoring. The results of this study show an indirect effect of mentoring on organizational commitment, supporting the response that 72% of the nurses' mentors were good or effective. The results support the view that the new nurses put value into mentoring, and the health systems should do so as well. Of note is the correlation between time for quality care, mentoring, and all the variables, which could mean that the mentees value the mentor's input into their time management so that they, in turn, could provide quality care to their patients. Health systems should pay more attention to the selection and pairing of the mentor/mentee process by setting up rigorous selection/withdrawal process systems. These systems would ensure that the mentor or mentee could withdraw from the relationship if it became unproductive for either party. Once paired, the health systems should offer support systems whereby both the mentor and mentee could seek help and guidance for developing the relationship and offer support during the length of the residency program.

Healthcare organizations that currently utilize an internally designed NRP should consider patterning external companies that run NRPs with proven track records of success rates with reduced turnover, increased organizational commitment, and increased job satisfaction. A study that compares the efficacy of an internal residency program to one run by an external company is also recommended. The issue of teaching time management to new nurses should be further researched as to when it would be more efficacious, whether it is taught in schools or during the NRP, to bridge the gap between the classroom and the bedside.

Limitations. The following were limitations to the study:

1. The sample was selected from nurses that completed the nurse residency programs (NRP) in two south Texas hospitals between 2010 and 2014. This wide timespan created the possibility for a large number of nurses to have separated from hospitals.

Though the possibility existed for separation from the hospitals, the information gleaned from the surveys was rich in nature and supported research.

2. Since it was self-reported data, there are chances of misrepresentation of the events experienced during the NRP and the mentoring aspects of the program. Since a large percentage of respondents were from the 2014 graduating class, it is hoped that their experience with their mentor was more recent, and they gave a better representation of their experiences.
3. The type of nurse residency programs being studied was different between Hospital A and Hospital B. One hospital's NRP was run by a nationally recognized and managed NRP, while the other was run and managed internally by its education department. The internal structure of both NRPs were similar in that they provided similar skill development for their nurse residents, but their approaches toward their goals differed. Hospital A required nurse residents, regardless of the setting, to complete at least 420 hours of residency. In Hospital B, the time spent in residency was guided by the setting in which the nurse was training.
4. Each residency program was of differing lengths, depending on the specialty, thus giving the residents different lengths of time to spend with their mentor.
5. The only means of communicating with the prospective participants permitted was via e-mail, thus limiting recruitment for survey completion. Though the response rate was low, there was sufficient information to share with the two hospitals.

Suggestions for Nurse Residency Programs

1. Conduct exit interviews, by a third party, with nurses that do separate from their organizations or unit to ascertain the reason for separation.

2. Review how students prepared in the skill of managing their time to enable them transition smoother from the classroom to the bedside as skilled clinician.
3. Review training models that teach quality indicators used in healthcare.
4. With NRP that are run internally, consider partnering with national recognized bodies that show sustained results with their NRPs in terms of commitment, turnover and satisfaction of the nurses.

Conclusion

From this study, professional status (a component of job satisfaction) and, pay and administration (a component of job dissatisfaction) had a largest impact on determining the nurses' organizational commitment. The effect of mentoring on organizational commitment was seen indirectly through its mediating effect on time for quality care.

Recommendations for Future Research

1. Expand the population to include more nurses in the South Texas region.
2. Expand the study to focus on mentoring, strategic guidance, and its importance in teaching time management to the nurse residents to improve patients' quality of care.
3. Expand the study to include a survey done at the beginning, middle, and end of the NRP to better predict organizational commitment and to see whether mentoring was a factor.
4. Expand the study to include more participants and include exit interviews from nurses that left their organizations to ascertain their reasons for exiting.
5. Conduct a study with nurses who resigned from their jobs to raise their families but returned to nursing later in life.

6. Conduct a study with nurses who chose to leave the unit where they completed their NRP but stayed in the hospital system.
7. Conduct a study to investigate the impact age has on new graduate nurses' organizational commitment.
8. Conduct a study to explore what role gender plays in determining a nurses' commitment to the organization in new graduate nurses.
9. Study how nursing schools prepare their students in the skill of managing their time to enable them transition smoother from the classroom to the bedside as skilled clinician.
10. Expand the study to review if the educational level of the mentor or the mentee would affect the organizational commitment of the mentee.
11. Conduct a study to investigate if NRP are more effective with nurses that graduated with a bachelors, associate or diploma in nursing.

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Appendices

Appendix A

Survey Instrument

Instructions for Scoring. Please select the number that most closely indicates how you feel about each statement. The *right* set of numbers indicates degrees of *agreement*.

If you strongly agree with the first statement, circle 7, if you strongly disagree circle 1.

Remember: the more strongly you feel about the statement, the further from the center you should circle, with agreement to the right and disagreement to the left.

(1) Strongly Disagree; (2) Moderately Disagree; (3) Slightly Disagree; (4) Neither Disagree nor Agree; (5) Slightly Agree; (6) Moderately Agree; (7) Strongly Agree.

Section A

	Item	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Disagree nor Agree	Slightly Agree	Moderately Agree	Strongly Agree
1	I am willing to put in a great deal of effort beyond that normally expected in order to help this organization be successful.	1	2	3	4	5	6	7
2	I talk up this organization to my friends as a great organization to work for.	1	2	3	4	5	6	7
3	I feel very little loyalty to this organization.	1	2	3	4	5	6	7
4	I would accept almost any type of job assignment in order to keep working for this organization.	1	2	3	4	5	6	7
5	I find that my values and the	1	2	3	4	5	6	7

	organization's values are very similar.							
6	I am proud to tell others that I am part of this organization.	1	2	3	4	5	6	7
7	I could just as well be working for a different organization as long as the type of work was similar.	1	2	3	4	5	6	7
8	This organization really inspires the very best in me in the way of job performance.	1	2	3	4	5	6	7
9	It would take very little change in my present circumstances to cause me to leave this organization.	1	2	3	4	5	6	7
10	I am extremely glad that I chose this organization to work for over others I was considering at the time I joined.	1	2	3	4	5	6	7
11	There's not too much to be gained by sticking with this organization indefinitely.	1	2	3	4	5	6	7
12	Often, I find it difficult to agree with	1	2	3	4	5	6	7

	this organization's policies on important matters relating to its employees.							
13	I really care about the fate of this organization.	1	2	3	4	5	6	7
14	For me this is the best of all possible organizations for which to work.	1	2	3	4	5	6	7
15	Deciding to work for this organization was a definite mistake on my part.	1	2	3	4	5	6	7
16	My present salary is satisfactory	1	2	3	4	5	6	7
17	Nursing is not widely recognized as being an important profession	1	2	3	4	5	6	7
18	The nursing personnel on my service pitch in and help one another out when things get in a rush.	1	2	3	4	5	6	7
19	There is too much clerical and "paperwork" required of nursing personnel in this hospital.	1	2	3	4	5	6	7
20	The nursing staff has sufficient control over	1	2	3	4	5	6	7

	scheduling their own shifts in my hospital							
21	Physicians in general cooperate with nursing staff on my unit.	1	2	3	4	5	6	7
22	I feel that I am supervised more closely that is necessary.	1	2	3	4	5	6	7
23	It is my impression that a lot of nursing personnel at this hospital are dissatisfied with their pay.	1	2	3	4	5	6	7
24	Most people appreciate the importance of nursing care to hospital patients.	1	2	3	4	5	6	7
25	It is hard for new nurses to feel "at home" in my unit	1	2	3	4	5	6	7
26	There is no doubt whatever in my mind that what I do on my job is really important.	1	2	3	4	5	6	7
27	There is a great gap between the administration of this hospital and	1	2	3	4	5	6	7

	the daily problems of the nursing service.							
28	I feel I have sufficient input into the program of care of each of my patients.	1	2	3	4	5	6	7
29	Considering what is expected of nursing service personnel at this hospital, the pay we get is reasonable.	1	2	3	4	5	6	7
30	I think I could do a better job if I did not have so much to do all the time.	1	2	3	4	5	6	7
31	There is a good deal of team work and cooperation between various levels of nursing personnel on my service.	1	2	3	4	5	6	7
32	I have too much responsibility and not enough authority	1	2	3	4	5	6	7
33	There are not enough opportunities for advancement of nursing personnel at this hospital	1	2	3	4	5	6	7

34	There is a lot of teamwork between nurses and doctors on my unit.	1	2	3	4	5	6	7
35	On my service, my supervisors make all the decisions. I have little direct control over my own work.	1	2	3	4	5	6	7
36	The present rate of increase in pay for nursing personnel at this hospital is not satisfactory.	1	2	3	4	5	6	7
37	I am satisfied with the types of activities that I do on my job.	1	2	3	4	5	6	7
38	The nursing personnel on my service are not as friendly and outgoing as I would like.	1	2	3	4	5	6	7
39	I have plenty of time and opportunity to discuss patient care problems with other nursing service personnel.	1	2	3	4	5	6	7
40	There is ample opportunity for nursing staff to participate in the	1	2	3	4	5	6	7

	administrative decision-making process.							
41	A great deal of independence is permitted, if not required, of me.	1	2	3	4	5	6	7
42	What I do on my job does not add up to anything really significant.	1	2	3	4	5	6	7
43	There is a lot of "rank consciousness" on my unit: nurses seldom mingle with those with less experience or different types of educational preparation.	1	2	3	4	5	6	7
44	I have sufficient time for direct patient care.	1	2	3	4	5	6	7
45	I am sometimes frustrated because all of my activities seem programmed for me.	1	2	3	4	5	6	7
46	I am sometimes required to do things on my job that are against my better professional nursing judgment.	1	2	3	4	5	6	7

47	From what I hear about nursing service personnel at other hospitals, we at this hospital are being paid fairly.	1	2	3	4	5	6	7
48	Administrative decisions at this hospital interfere too much with patient care.	1	2	3	4	5	6	7
49	It makes me proud to talk to other people about what I do on my job.	1	2	3	4	5	6	7
50	I wish the physicians here would show more respect for the skill and knowledge of the nursing staff.	1	2	3	4	5	6	7
51	I could deliver much better care if I had more time with each patient.	1	2	3	4	5	6	7
52	Physicians at this hospital generally understand and appreciate what the nursing staff does.	1	2	3	4	5	6	7
53	If I had the decision to make all over again, I would	1	2	3	4	5	6	7

	still go into nursing.							
54	The physicians at this hospitals look down too much on the nursing staff.	1	2	3	4	5	6	7
55	I have all the voice in planning policies and procedures for this hospital and my unit that I want.	1	2	3	4	5	6	7
56	My particular job really doesn't require much skill or "know-how".	1	2	3	4	5	6	7
57	The nursing administrators generally consult with the staff on daily problems and procedures.	1	2	3	4	5	6	7
58	I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.	1	2	3	4	5	6	7
59	An upgrading of pay schedules for nursing personnel is needed at this hospital.	1	2	3	4	5	6	7
60	My mentor was available to talk/meet	1	2	3	4	5	6	7

	with me when I wanted to talk/meet.							
61	My mentor talked with me about my professional development.	1	2	3	4	5	6	7
62	My mentor helped me to strategize activities to meet my professional goals.	1	2	3	4	5	6	7
63	My mentor allowed me to openly express my feelings about my current work environment.	1	2	3	4	5	6	7
64	My mentor was non-judgmental when listening to my evaluation of the workplace.	1	2	3	4	5	6	7
65	My mentor assisted with introductions to people who could help me professionally .	1	2	3	4	5	6	7
66	My mentor expressed confidence in me and my abilities as a nurse.	1	2	3	4	5	6	7
67	My mentor assisted me with long-range career planning.	1	2	3	4	5	6	7
68	My mentor discussed with me ways to handle challenging	1	2	3	4	5	6	7

	patient situations.							
69	My mentor discussed with me ways to handle difficult situations with my co-workers.	1	2	3	4	5	6	7
70	My mentor discussed with me ways to handle difficult situations with a physician.	1	2	3	4	5	6	7
71	My mentor discussed with me ways to handle difficult situations with my unit manager.	1	2	3	4	5	6	7
72	My mentor encouraged me to act as a patient advocate.	1	2	3	4	5	6	7
73	My mentor talked with me about clinical decisions I made.	1	2	3	4	5	6	7
74	My mentor demonstrated that she/he cared about me.	1	2	3	4	5	6	7
75	My mentor advocated for me in the workplace.	1	2	3	4	5	6	7
76	My mentor gave me feedback on my assessment of your performance as a nurse.	1	2	3	4	5	6	7

77	My mentor fostered my independence as a nurse.	1	2	3	4	5	6	7
78	My mentor communicated in such a way as to enhance my self-esteem.	1	2	3	4	5	6	7
79	My mentor guided me in assessing my immediate learning needs.	1	2	3	4	5	6	7
80	My mentor offered me insight into the workings of clinical agencies.	1	2	3	4	5	6	7
81	My mentor offered me insight into human behavior in the workplace.	1	2	3	4	5	6	7
82	My mentor guided me in assessing my future potential.	1	2	3	4	5	6	7
83	My mentor is a role model for me.	1	2	3	4	5	6	7
84	My mentor is supportive of me overall.	1	2	3	4	5	6	7

85	Gender	
	Male	
	Female	

86	Age Group	
	18-20yrs	
	21-25yrs	
	26-30yrs	
	31-35yrs	
	36-40yrs	

	41-45yrs	
	46-50yrs	
	51-55yrs	
	>56yrs	

87	Ethnic Background	
	American Indian or Alaskan Native	
	Asian	
	Black or African American	
	Hispanic or Latino	
	Native Hawaiian or Pacific Islander	
	Other	
	White (not of Hispanic Origin)	

88	Salary range (\$ per hour)	
	\$20 - \$25/hr	
	\$25.01 - \$30/hr	
	> \$30.01/hr	

89	Year of graduation from the nurse residency program	
	2010	
	2011	
	2012	
	2013	

90	How long is your residency program?	
	6 weeks	
	8 weeks	
	6 months	
	9 months	

Appendix B

From: Santos, Abisola A.
Sent: Wednesday, August 6, 2014 8:34 PM
To: Rick Mowday
Subject: RE: Permission to Modify and Use Survey Tool

Hello Dr. Mowday:

Thank you for your response and the clarification on the use of the OCQ.

Sincerely, kind Regards

Bisola Santos

From: Rick Mowday
Sent: Wednesday, August 6, 2014 11:26 AM
To: Santos, Abisola A.
Subject: RE: Permission to Modify and Use Survey Tool

Abisola

The Organizational Commitment Questionnaire (OCQ) was originally developed by Professor Lyman Porter. He decided not to copyright the instrument to encourage its use by others in research. As a consequence, the OCQ legally exists in the public domain and you are free to use it and/or amend it for use in your dissertation research.

The original instrument has not been modified since it was published in 1979.

Good luck on your dissertation.

Rick

Appendix C

Permission From Market Street Research to Use the Index of Work Satisfaction



September 16, 2014

Ms. Abisola Santos

To Whom It May Concern:

This letter gives Abisola Santos permission to use the copyrighted Index of Work Satisfaction. It may be re-published in its original form or a modified form.

Sincerely,

Executive Assistant
Market Street Research

31 Trumbull Rd. Northampton MA 01060 tel 413.582.1200 fax 413.582.1206
www.marketstreetresearch.com contact@marketstreetresearch.com

Appendix D

Permission From Academy Medical-Surgical Nurses (AMSN) to Use Assessment of the Relationship With the Mentor

Sent: Friday, November 7, 2014 10:38 AM
To: Santos, Abisola A.
Subject: Re: Form submission from: Contact Us

Good afternoon Bisola,

Thank you for your interest in utilizing the Mentoring section of the AMSN website!

It is offered in a self-directed format, therefore, you may use and customize the information and tools provided in any manner you deem appropriate for your agency or yourself. There is no need to get permission to use or amend the mentor survey tool. You will also see this noted on the [Mentoring webpage](#) of the AMSN website.

Good luck with your dissertation!

Sincerely,

Association Services Manager
Academy of Medical-Surgical Nurses (AMSN)
Medical-Surgical Nursing Certification Board (MSNCB)

Please consider the environment before printing this e-mail.

Appendix E

Job Satisfaction Component Scores as on IWS

Components	Component Scores	Component Mean Scores
Pay	16.59	2.76
Autonomy	39.31	4.91
Task Requirements	21.34	3.55
Organizational Policies	28.68	4.09
Professional Status	42.47	6.06
Interaction	55.54	5.55
- Nurse to Nurse Interaction	28.99	5.79
- Nurse to Physician Interaction	26.54	5.31

Appendix F

IRB from the University of the Incarnate Word

**Application for Institutional Review Board Approval
University of the Incarnate Word**

Title of Study: Mentoring, Job Satisfaction, and Intent to Stay Among Graduate Nurses

College/School or Division/Discipline: Dreeben School of Education

INVESTIGATORS			
Principal Investigator - A UIW PI must be designated for all projects in which UIW is engaged in research.			
Name: Abisola A. Santos	Phone #: Click here to enter text.	E-mail: Click here to enter text.	Address: Click here to enter text.
Co-Investigator(s) – List all co-investigators and provide contact information (list each on a separate line)			
Name: N/A	Phone #: Click here to enter text.	E-mail: Click here to enter text.	Address: Click here to enter text.
Faculty Supervisor of Student Project, Thesis, or Dissertation			
Name: Dr. Absael Antelo	Phone #:	E-mail:	Address:
CITI TRAINING			
<input checked="" type="checkbox"/> All investigators (including faculty supervisors) have completed CITI training and are currently certified			

RESEARCH INFORMATION		
Research Category: <input checked="" type="checkbox"/> Exempt <input type="checkbox"/> Expedited Review <input type="checkbox"/> Full Board Review		
Number of Subjects: 500	Number of Controls: Click here to enter text.	Duration of Study: Two years

--

FUNDING DISCLOSURES
Funding source: <input checked="" type="checkbox"/> None <input type="checkbox"/> Internal <input type="checkbox"/> External <input type="checkbox"/> Pending
List all external funding sources (pending and awarded): Click here to enter text.
The funding provides for (select all that apply): <input type="checkbox"/> Investigator release time or compensation <input type="checkbox"/> Research materials <input type="checkbox"/> Graduate assistants, student workers, or other project employees <input type="checkbox"/> Travel <input type="checkbox"/> Other: Click here to enter text.
Financial Conflict of Interest
Please describe any financial interest in the funding organization or any similar organization (stocks, board membership, etc): Click here to enter text.

SIGNATURES
Original Signatures are required. This application will not be processed until all signatures are obtained. Ensure the document is finalized BEFORE collecting signatures. Any subsequent edits will remove signature verification and require the collection to begin again.
Signature of the Principal Investigator The undersigned accepts responsibility for the study, including adherence to DHHS, FDA, and UIW policies regarding protections of the rights and welfare of human subjects participating in the study. In the case of student protocols, the faculty supervisor and the student share responsibility for adherence to policies.

X

Signature of Faculty Research Supervisor – Required for student investigators

By signing this form, the faculty research supervisor attests that he/she has read the attached protocol submitted for IRB review, and agrees to provide appropriate education and supervision of the student investigator above.

X

Signature of Co-investigator(s)

For additional signature fields, contact the Office of Research Development.

X

X

X



1/12/2015

Abisola Santos

Dear Abisola:

Your request to conduct the study titled *Mentoring, Job Satisfaction, and Intent to Stay Among Graduate Nurses* was approved as an exempt study on 1/12/2015. Your IRB approval number is 15-01-002. Any written communication with potential subjects or subjects must be approved and include the IRB approval number. Electronic surveys or electronic consent forms, or other material delivered electronically to subjects must have the IRB approval number inserted into the survey or documents before they are used.

Please keep in mind these additional IRB requirements:

- This approval is for one year from the date of the IRB approval.
- Request for continuing review must be completed for projects extending past one year. Use the **IRB Continuation/Completion form**.
- Changes in protocol procedures must be approved by the IRB prior to implementation except when necessary to eliminate apparent immediate hazards to the subjects. Use the **Protocol Revision and Amendment form**.
- Any unanticipated problems involving risks to subjects or others must be reported immediately.

Approved protocols are filed by their number. Please refer to this number when communicating about this protocol.

Approval may be suspended or terminated if there is evidence of a) noncompliance with federal regulations or university policy or b) any aberration from the current, approved protocol.

Congratulations and best wishes for successful completion of your research. If you need any assistance, please contact the UIW IRB representative for your college/school or the Office of Research Development.

Sincerely,

Research Officer
University of the Incarnate Word IRB

Appendix G

Principal Component Matrix of Job Satisfaction

	Component											
	1	2	3	4	5	6	7	8	9	10	11	12
Q48R	.729	.283	-.002	-.149	.069	.015	-.200	.107	-.032	-.119	.008	.147
Q27R	.676	.274	.006	.082	-.128	.157	-.143	-.112	.140	.020	.043	-.351
Q46R	.665	.047	-.282	-.125	-.138	.136	-.017	.186	-.223	.092	-.091	.139
Q54R	.658	-.345	-.114	.172	.314	-.106	-.122	.144	-.258	-.075	.051	-.191
Q32R	.652	-.110	-.135	-.221	-.135	.120	-.211	.088	.008	-.175	-.272	.144
Q28	.621	-.053	.125	.166	.094	-.020	-.105	.023	.064	-.119	-.308	.303
Q52	.604	-.373	-.037	.294	.267	-.208	-.048	-.089	-.144	-.244	.036	-.133
Q45R	.596	-.082	.020	-.138	-.036	.240	-.100	-.343	.024	-.190	-.405	-.089
Q40	.594	.135	-.029	-.200	-.035	-.471	.189	-.016	-.049	.138	.107	-.129
Q50R	.594	-.322	-.265	.198	.318	-.171	-.113	.067	-.063	-.018	-.016	-.276
Q21	.592	-.381	-.126	.205	.356	-.180	-.003	.030	.166	-.193	.039	.184
Q44	.580	.029	-.038	-.487	-.059	.113	.291	-.307	.073	.050	.046	-.093
Q30R	.578	.175	-.073	-.419	.340	-.134	.187	.061	.011	.080	.125	.272
Q51R	.570	.139	-.212	-.497	.194	.099	.103	-.139	.216	.150	-.005	-.034
Q49	.567	.053	.560	-.019	-.108	.121	-.049	.209	-.147	.005	.036	-.001
Q57	.557	.343	.158	.026	-.223	-.117	-.077	-.257	-.384	-.061	.088	-.048
Q39	.555	-.003	-.204	-.397	-.095	-.111	.379	-.059	-.223	.006	.077	-.082
Q37	.544	-.233	.496	-.143	-.086	.222	-.030	-.005	.039	-.165	.075	-.211
Q35R	.536	-.247	-.280	-.059	-.410	-.035	-.234	.335	.176	-.219	.014	.030
Q55	.536	.320	.022	-.039	-.130	-.294	-.093	.005	.283	.246	.080	-.097
Q58	.521	.036	-.154	-.080	-.460	.129	-.285	.226	.072	-.116	.381	-.067
Q31	.517	-.329	-.122	.369	-.141	-.098	.211	-.287	.164	.172	-.085	.061
Q33R	.489	.145	-.355	-.110	-.159	-.267	-.265	.134	.086	.360	-.057	.232
Q25R	.478	-.476	-.254	.155	-.259	.288	.129	.042	-.158	.082	.166	.140
Q41	.456	.024	-.036	-.066	-.415	-.350	-.019	-.093	.037	-.126	-.335	-.006
Q34	.456	-.355	.152	-.097	.314	-.091	.133	.180	.420	-.250	.100	-.043
Q17R	.445	.080	.165	.312	.046	-.270	-.259	-.369	-.058	.094	.267	.095
Q29	.324	.790	-.056	.284	.096	.008	.190	.052	.015	-.072	.015	.005
Q47	.309	.751	.100	.274	-.041	.126	.255	.082	.048	-.080	-.064	-.170
Q16	.365	.646	.008	.385	-.024	.040	.152	.089	-.171	-.006	.108	.289
Q36R	.437	.591	-.118	.234	.107	-.062	.054	.137	-.072	.033	-.095	.079
Q23R	.376	.587	-.063	.332	.019	.173	-.125	-.100	.187	.003	-.020	-.129
Q59R	.473	.576	-.108	.061	.168	.360	.080	-.010	.228	.046	-.138	-.073

Q38R	.489	-.533	-.307	.219	-.008	.151	.257	-.080	.126	.206	.064	.063
Q43R	.495	-.497	-.290	.234	-.198	.199	.112	-.178	-.220	.084	-.047	-.109
Q26	.252	-.132	.750	-.013	.020	-.074	-.016	-.038	.114	.161	-.072	.154
Q24	.438	.066	.589	-.074	-.063	-.272	-.066	-.126	.071	-.126	.194	-.028
Q42R	.463	-.092	.570	-.120	-.044	.188	-.080	.011	-.214	.256	.014	.051
Q56R	.280	-.337	.564	.116	.018	.064	-.037	-.045	.006	.176	-.244	.138
Q22R	.464	-.068	-.068	-.090	.496	.037	-.155	.181	-.224	.307	-.192	-.181
Q20	.221	-.184	.086	.082	.192	.406	-.304	.081	.170	.339	.247	-.033
Q18	.377	-.421	.162	.347	-.241	.041	.433	.068	.198	.007	.091	.125
Q53	.296	-.071	.370	-.027	-.026	-.001	.446	.513	-.115	-.027	-.080	-.148
Q19R	.325	.122	-.059	-.206	.298	.333	.009	-.260	-.126	-.349	.260	.323

Extraction Method: Principal Component Analysis.

a. 12 components extracted.