Mentoring in the workplace: A study of mentoring in allied health and aged care sectors

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SUMMARY

Mentoring is widely used in the health sector and has received a great deal of attention from health management researchers. Much of this research has concentrated on doctors and nurses working in the acute care public health sector at pre-qualification or early stages of their career. However the organisation and industry context in which mentoring occurs influences the effectiveness of different forms of mentoring. While there has been some research into mentoring in acute care health contexts, little attention has been paid to the needs of allied health professionals who are often employed in multiple part time or casual roles in public sector clinics or private practices. Many allied health professionals rely on a professional association to provide mentoring support and training. Further, there has been little research into mentoring in the rapidly growing residential aged care sector. Just as working conditions in the acute care sector are recognised as physically and psychologically demanding, similar conditions are experienced in the non-acute residential aged care sector. Workers are often subject to significant stress levels which can lead to burnout in extreme situations. Little is known about the psychological benefits of mentoring and in particular whether mentoring is an antecedent of psychological capital.

This thesis aims to fill this knowledge gap by investigating the mentoring experiences of allied health professionals and residential aged care workers to discover how these experiences achieve the individual and organisational goals typically associated with career and psychosocial mentoring. Two theoretical frameworks of positive organisational behaviour and the learning perspective underpin the exploration of mentoring in these contexts and the relationship of mentoring and psychological capital. This thesis examines whether mentoring can influence the psychological capital of residential aged care workers.

A three phase mixed method approach is used to investigate the mentoring experiences of allied health professionals and residential aged care workers. Phase 1 is a qualitative study of allied health professionals who rely on a professional association to provide a mentor and continuing professional development. Fifteen semi-structured interviews with mentors and mentees were conducted and template analysis explored three dimensions of mentoring; career, psychosocial and clinical mentoring as well as the method of delivery of a professional association mentoring programme. In phase 2, thirty-two semi-structured interviews were conducted with residential aged care workers where the relationship between existing career, psychosocial and clinical mentoring interventions of four aged care service provider organisations and the psychological capital of aged

care workers was analysed. Phase 3 is a quantitative study involving a survey of the mentoring experiences of aged care workers in relation to psychological capital.

Key findings for Phase 1 highlight the need to develop clinical skills of allied health professionals in the early stage of their careers. Professional associations have a role to play in supporting early career professionals through the delivery of mentoring programmes that need to address the specific needs of the professionals involved. Participants had a preference for one-on-one face-to-face mentoring rather than group mentoring or e-mentoring.

Key findings for Phase 2 highlighted that all career, psychosocial and clinical mentoring behaviours with the exception of four career behaviours were provided in the residential aged care context to a limited extent and often informally by peers. Of concern was that care workers reported being confronted with emotional challenges in the workplace, received inferior training and, little support from senior staff. As highlighted in the literature clinical mentoring is widespread in the health care sector and also in residential aged care. The researcher found that while clinical mentoring referred to psychosocial support, this support was actually the provision of psychosocial support for residents rather than for workers. Clinical mentoring is essentially a training and coaching support process as distinct from traditional mentoring theory. As such, clinical mentoring is an augmentation and not a replacement for other forms of mentoring. Another finding was that professional participants (ie. nurses) were more likely to receive mentoring than the paraprofessionals (ie. care workers) who represent the majority of residential aged care workers in the industry.

Key findings of Phase 3 highlighted a positive relationship between mentoring and hope, optimism, self-efficacy and a marginal relationship with resiliency. Further there was a positive relationship between the mentoring behaviours of coaching, acceptance and confirmation, counselling, friendship, role modelling and psychological capital. From a learning perspective the research has identified that some mentoring behaviours share a positive relationship with positive organisational behaviour and also confirms prior research that psychological capital can be learned.

Implications for academic researchers of these findings are that traditional mentoring relationships are no longer able to meet the learning needs of mentees working in diverse and dynamic organisational contexts. Further research into the relationship of the mentoring functions to personal learning and personal growth will provide new insights into mentoring relationships and of mentoring and psychological capital and positive organisational behaviour.

Implications for management practitioners include the need to recognise that clinical mentoring alone does not provide sufficient psychosocial support for residential aged care workers, particularly paraprofessionals. Further, psychological capital of residential aged care workers can be improved through training and coaching which will increase positive organisational behaviour of employees. Mentoring is a valuable learning and development strategy applicable to the personal development of individuals and personal growth of psychological capital leading to positive organisational behaviour and improved outcomes for organisations.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university, and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed..

Date..

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PUBLICATIONS ASSOCIATED WITH THIS THESIS

The research in Chapters 1, 2, 3, 4 and 7 underpins the following articles:

Coppin, R. and Fisher, G., 2015. An exploratory study of career, psychosocial, and clinical mentoring of podiatrists. *Australian Journal of Career Development*, 24(2), pp. 93-104.

Coppin, R. and Fisher, G., 2016. Professional association group mentoring for allied health professionals. *Qualitative Research in Organizations and Management: An International Journal*, 11(1), pp. 2-21.

CHAPTER 1 : INTRODUCTION

1.1 Introduction

Mentoring is defined as a relationship generally between two people with learning and development as its purpose (Megginson & Garvey, 2004). Mentoring has been widely embraced by managers over the past twenty-five years for its value in helping to transform individuals, groups, organisations and communities (Ragins & Kram, 2007)

However, there is still much to learn about mentoring relationships, the different forms of mentoring support and how mentoring is related to work attitudes and behaviours (Baranik, Roling, & Eby, 2010). Insights into the most beneficial forms of mentoring support will assist organisations in deciding which interventions are most suitable in a particular work environment.

These issues are of particular importance to organisations because of the large quantity of resources consistently invested in establishing, implementing, supporting and maintaining mentoring programmes. The purpose of this research is to contribute to the existing body of knowledge of mentoring relationships and add to the understanding of how mentoring affects workplace behaviours (Baranik et al., 2010; Craig, Allen, Reid, Riemenschneider, & Armstrong, 2012; Hall & Smith, 2009) using the two theoretical frameworks of positive organisational behaviour and learning perspective to examine these relationships. Positive organisational behaviour links the positive strengths and psychological capacities of individuals to achieve performance improvement in the workplace. The learning perspective is about supporting mentee development of knowledge and skills as identified by the mentee rather than directed by the mentor. Both are related to personal development of individuals. As such, the thesis has both theoretical and practical implications.

This chapter provides an introduction to the research by first presenting background regarding the need for this research. A discussion of the research problem, research questions, justification for the research and outline of methodology follows. Then, a glossary of terms and acronyms is provided. The chapter then describes limitations and delimitations that underpin the research and finally presents an overview of the thesis.

1.2 Background to the research

Previous organisational research has investigated the relationship between mentoring and perceived organisational support (Baranik et al., 2010; Hu, Wang, Yang, & Wu, 2014), job satisfaction; (Allen, Eby, Poteet, Lentz, & Lima, 2004; Mathieu & Hamel, 1989), organisational commitment (Cook & Wall, 1980; Craig et al., 2012) and organisational citizenship behaviour (Ghosh, Reio Jr., & Haynes, 2012; Organ, 1997; Spector & Fox, 2002). Further, recent research has established a relationship between psychological capital and positive and negative workplace behaviours (Avey, Luthans, & Youssef, 2010), with psychological capital being an independent variable. Psychological capital is "an individual's positive psychological state of development" (Luthans, Avolio, Avey, & Norman, 2007a) and is characterised by the four components of hope, optimism, self-efficacy and resilience. Other studies have found psychological capital to be a mediating variable with job satisfaction, intention to leave and organisational commitment (Avey et al., 2010; Luthans et al., 2007a; Luthans & Jensen, 2005). Ragins and Kram (2007) and Saks and Gruman (2011) have suggested that mentoring may provide positive psychological capital outcomes. Within the domain of positive organisational behaviour, psychological capital is characterised by its flexibility and openness to modification and development (Luthans & Youssef-Morgan, 2017). Similarly mentoring is about learning and development and creating positive change and outcomes for individuals (Megginson & Garvey, 2004). This is important because mentoring is a learning process that assists individual's to take responsibility for their personal development, and psychological capital is concerned with the current state of personal development of psychological resources. Experimental studies have showed that psychological capital can be developed through short training interventions (Luthans & Youssef-Morgan, 2017). As far as the researcher is aware, a relationship between mentoring and psychological capital has not yet been investigated. However, numerous researchers have suggested that mentoring may be an antecedent of psychological capital (Cameron & Brownie, 2010; Knudson, 2015; Lunsford, 2016; Pineau Stam, Spence Laschinger, Regan, & Wong, 2015; Saks & Gruman, 2011; Toor, 2010). This thesis investigates whether there is a relationship between mentoring behaviours and psychological capital in the context of residential aged care.

Understanding how different types of mentoring affect attitudes and behaviours of individuals and perceptions of their employing organisation are critical for organisations looking to implement a mentoring programme. It is also important to external organisations that create and administer mentoring programmes. This thesis explores the roles of three forms of mentoring: career

mentoring (Kram, 1985), psychosocial mentoring (Kram, 1985), and the newly emerging term of clinical mentoring (Aggett, Shantz, Mair, & Charles, 2008; Clevenbergh et al., 2006; Workneh et al., 2013) in transforming organisations and individuals in two different health care contexts of allied health and residential aged care.

In the health context, the term clinical mentoring first appeared on the internet in the mid-2000s, but a search of the theoretical literature has not yielded a concise definition or explanation. The first use of the term appears to have been by the World Health Organisation in its guidelines for clinical mentoring to support human immunodeficiency virus (HIV) care in resource-poor settings in 2006 (World Health Organisation, 2006). Over the past decade, clinical mentoring has been described in a variety of ways, depending on mentoring context (Boyer, 2011; I-TECH, 2008; Morey, 2015; Nursing Midwifery Council, 2008; World Health Organisation, 2006). Yoder (1990) noted that, in the nursing context, there is much confusion about the meaning of mentoring, preceptorship, clinical supervision and role modelling. Further, Stewart and Kreuger (1996) identified mentoring as a teaching and learning process. On the other hand, Xiao and Morey (2015) identified a model of clinical mentoring that can be embedded into residential and community aged care that differs to a clinical mentoring model in acute care nursing. Thus, there is debate on whether clinical mentoring includes the benefits of psychosocial and career mentoring as mentoring provides in the business context or whether clinical mentoring is, in fact, a form of training (Fisher, 2013) driven by a lack of financial and human resources (Morey, 2015). An extensive search of the literature failed to identify studies that concurrently deal with all three forms of mentoring. Investigating the relative contribution of these forms of mentoring is one of the theoretical contributions made by this thesis.

In the health industry, continual development of clinical skills is paramount. Mentoring is widely used, particularly for early career professionals in the public health system (Bassell, 2010; Block, Claffey, Korrow, & McCaffrey, 2005; Causby, 2003; Eby, 2007; Fleig-Palmer & Rathert, 2015; Leners, Wilson, Connor, & Fenton, 2006; McCloughen, O'Brien, & Jackson, 2006; Mills, Francis, & Bonner, 2005). This has resulted in formal mentoring programmes, preceptorship and clinical supervision programmes being used for transition of new doctors and nurses into health sector professions (Bassell, 2010; Eby, 2007; Jeon, Glasgow, Merlyn, & Sansoni, 2010a; Nolinske, 1995; Omansky, 2010; Rodger et al., 2008).

Considerable mentoring research has concentrated on acute care nurses working in the public hospital system (Bassell, 2010; McCloughen et al., 2006). The type of care provided in the hospital

sector is known as acute care and is short term in duration whereas care provided in residential care is defined as non-acute care and is provided over a longer time period. However, many health sector workers are not acute care nurses working in hospitals. They may be non-acute aged care nurses or paraprofessionals working in aged care or allied health professionals. There is an emerging body of literature on mentoring in other allied health professions, including physiotherapists (Ezzat & Maly, 2012), social workers (Hair, 2012; Webb & Carpenter, 2012), mental health professionals (Lee & del Carmen Montiel, 2011) and physician assistants (Rose, Rukstalis, & Schuckit, 2005). Further, literature on residential aged care services concentrates on nurses rather than paraprofessionals (Block et al., 2005; Cameron & Brownie, 2010; Jeon et al., 2010a; Karantzas et al., 2012; Omansky, 2010; Stack, 2003).

With the perceived need for mentoring support, there are four theoretical and practical reasons for focusing on the health care and social assistance industry. Firstly, it is the fastest growing industry in the Australian economy. In 2014-15, total health expenditure in Australia accounted for 10 percent of gross domestic product (Australian Institute of Health and Welfare, 2016a). As at June 2015, employment in the industry accounted for 11.9 percent of the total Australian workforce. The health care and social assistance workforce is expected to continue to grow at a rate of 3.3 percent per annum over the next five years to 2015-20 (Department of Employment, 2015).

Secondly, the allied health services component of the health care and social assistance industry grew by 25.1 percent in the five years to November 2015. This is followed by the residential care services component which grew at 15.7 percent and Hospitals recorded negative employment growth of -2.7 percent over the same period. The continued strong growth in allied health and residential care services can be attributed to the pressures of Australia's aging population and associated demands on health care services and facilities (Department of Employment, 2015).

Thirdly, previous studies on mentoring have tended to focus on a single profession, for example nursing (Bassell, 2010; Jeon et al., 2010a; Omansky, 2010). However, the aging population in Australia has created a need for multi-disciplinary teams of professionals and paraprofessionals to work together as medical requirements of the elderly become more complex. Members of a multi-disciplinary team often have different levels of educational background and experience ranging from basic certificates to specialist degrees. Therefore, investigating the effectiveness of mentoring for professionals and paraprofessionals is critical to future service delivery in the residential care services industry.

Finally, implementation of professional registration across the allied health sector has led to an increased focus on ongoing professional development and skills-based mentoring. While this is perceived to have a positive impact on organisational performance, career paths, and work-life balance, there is a lack of baseline information about the nature and quality of mentoring for many professions in the health services industry.

As noted earlier, considerable research has been conducted on leadership and management in acute care settings, particularly for nursing (Jeon, Merlyn, & Chenoweth, 2010b). While there are suggestions that more extensive mentoring and support would be beneficial to individuals and organisations in the aged care sector (Karantzas et al., 2012), action in these areas is only now emerging, and the area remains under-researched.

A review of the literature identified a limited number of studies on mentoring of professionals and paraprofessionals working in aged care facilities (Jeon et al., 2010b; Stack, 2003). Some studies have concentrated on mentoring in aged care nursing, (Cameron & Brownie, 2010; Chenoweth, Merlyn, Jeon, Tait, & Duffield, 2014; Nichols, Horner, & Fyfe, 2015) but little attention has been paid to mentoring of paraprofessionals in the aged care sector, particularly in regards to provision of psychosocial support. Thus, this thesis investigates the level of mentoring support provided to paraprofessionals in the residential aged care sector.

Much mentoring research has concentrated on large public organisations (Baranik et al., 2010; Day & Allen, 2004) or mentoring that occurs in a single organisation (Kammeyer-Mueller & Judge, 2008), and some research has focused on mentoring in specific professions (Bassell, 2010; Blickle, Witzki, & Schneider, 2009; Cho, Johanson, & Guchait, 2009) (Hall & Smith, 2009; Omansky, 2010). There has been a strong focus on researching mentoring in health professions, particularly in acute care nursing (Bassell, 2010; Jeon et al., 2010a; Omansky, 2010), but much less research emphasis on mentoring in allied health professions and the residential aged care sector.

Even less research attention has been given to mentoring for regional, remote or sole practitioners in traditional health care professions and other allied health professions who often work alone or with little support (Causby, 2003; Joubert, 2006; Nolinske, 1995; Paul, Stein, Ottenbacher, & Liu, 2002; Struber, 2004). Mentoring in multidisciplinary health practice represents another context that has attracted limited research activity. All of these contexts have a high number of casual and part-time workers and the impact of casualisation on career development and staff turnover is also under-researched. As such, there are many potentially interesting areas of mentoring research,

other than acute care nursing, within the health services sector. For example, the different nature of mentoring and mentoring experiences in residential aged care and allied health professions, and the significance of clinical, career and psychosocial mentoring and their impacts on residential aged care workers and allied health professionals. This thesis explores some of these areas.

Mentoring is particularly important in assisting the transition of new graduates to become professionals in the workplace. Mentoring programmes are in place for some public sector allied health professionals in rural and remote areas (Causby, 2003; Moran et al., 2014; SA Health, 2014; Struber, 2004). However, many allied health professionals, for example, occupational therapists, podiatrists, psychologists, physiotherapists, speech therapists and dieticians, are employed in private practice and do not have access to continuing professional development (CPD), support and/or supervision available to public sector workers (Lincoln et al., 2013; Struber, 2004).

As a result, numerous allied health professionals rely on professional associations for mentoring support and training (French & Dowds, 2008; Friedman & Phillips, 2002). While many professional associations provide mentoring and CPD as a benefit of membership (e.g., (Australian Podiatry Association SA Incorporated, 2015; Dieticians Association of Australia, 2015) (Occupational Therapy of Australia Ltd, 2015; Optometry Australia, 2015; Speech Pathology Australia, 2015), little research has been conducted on provision of mentoring programmes and CPD by professional associations.

Emphasis on mentoring support, particularly for early career professionals, has arisen with the introduction of mandatory requirements for registration of some health care professions with the Australian Health Practitioner Regulation Agency (AHPRA). Allied health professionals registered with AHPRA include occupational therapists, optometrists, osteopaths, pharmacists, podiatrists, physiotherapists and psychologists (Australian Health Practitioners Regulatory Authority, 2015). Allied health professionals who are members of AHPRA are required to undertake CPD for registration purposes (Australian Health Practitioners Regulatory Authority, 2015). Formal mentoring is not a registration requirement, but is a positive, additional benefit provided by professional associations (Australian Health Practitioners Regulatory Authority, 2015).

In the past, much professional development provided to allied health professionals focused on technical skills and latest industry developments, and may have been provided by sales representatives of companies promoting products to a particular profession (Rodger et al., 2008). Some professional associations and employers have also recognised the need to develop a mentoring programme which provides support, particularly to early career professionals, that goes

beyond practical and technical professional skills and gives psychosocial mentoring support (Coppin & Fisher, 2015; Fisher, 2013). Components of career and psychosocial mentoring may occur either explicitly or implicitly in clinical mentoring programmes (Ali & Panther, 2008; Baranik et al., 2010). Alternatively, people may receive career and psychosocial mentoring from other sources within their social network (Higgins, Chandler, & Kram, 2007). There has been little research into the effectiveness of clinical and training based mentoring programmes in achieving career and psychosocial benefits. Thus, investigation of the effectiveness of clinical mentoring programmes is another intellectual contribution made by the thesis.

Typically, professional association mentoring programmes are one-on-one programmes where mentors are matched with mentees (Friedman & Phillips, 2002; Nguyen, Thomson, & Leithhead, 2010; Wilding, Marais-Strydom, & Teo, 2003). However, financial constraints challenge the viability of one-on-one mentoring programmes to support new graduates' transitioning to the workforce (Scott & Smith, 2008). As such, a group mentoring approach may be useful where the availability of mentors is limited and online forums may assist in bringing together geographically dispersed mentors and mentees (Carvin, 2011; Redmond, 2015). Thus, group mentoring can be a viable alternative for providing support in health settings (Scott & Smith, 2008). The first study in this thesis examines a group mentoring programme that is delivered face-to-face and online and is based on a mentoring model using many mentors and mentees within the group. As little is known about the effectiveness of group mentoring, (Carvin, 2011) (Dansky, 1996; Emelo, 2011b; Huizing, 2012; Scott & Smith, 2008) this thesis provides additional insights into this method of delivery and adds to the theory and practice of group mentoring (Coppin & Fisher, 2016).

1.3 Research problem, research issues and contributions

While mentoring programmes have become vital for many organisations seeking to improve work behaviours and attitudes, job satisfaction and reduce turnover, the intended purpose is not always achieved (Baugh & Fagenson-Eland, 2007; Blake-Beard, O'Neill, & McGowan, 2007). In the health care industry context, worker retention is critical because of continued sector growth due to the aging Australian population (Australian Government, 2012; Australian Institute of Health and Welfare, 2016b). This need to retain staff is exacerbated by staff shortages, reductions in government funding, low wages and difficult working conditions, and aged care workers being subject to significant levels of stress which can lead to burnout in extreme situations (Hayes, Douglas, & Bonner, 2015; Laschinger & Fida, 2014).

This research investigates the mentoring experiences and expectations of workers in two different health care contexts. In the first instance a mentoring programme for allied health professionals operated by a professional association is evaluated together with the mentoring experiences and expectations of the podiatrists who participate in the programme. In the second context, the mentoring experiences of aged care workers in the residential care sector are explored. It also investigates whether the mentoring experience influences psychological capital of residential aged care workers. Further, this thesis examines whether a clinical mentoring model is sufficient to achieve the individual and organisational goals associated with career and psychosocial mentoring. Examples of individual goals include performing specific job tasks competently, achieving the required results, learning skills associated with adaptability, flexibility and coping with uncertainty, enhanced sense of identity and feeling emotionally supported. (Lankau & Scandura, 2007). The organisational goals of mentoring may include employee skill development, enhanced communication, new employee support, leadership training, managerial succession, socialisation, increased productivity and reduced turnover (Godshalk & Sosik, 2000).

The research problem addressed in this thesis is:

How is mentoring experienced by allied health professionals and residential aged care workers and how do these experiences achieve the individual and organisational goals usually associated with career and psychosocial mentoring?

Building on previous research in the area of mentoring generally, and mentoring in the health sector more specifically, the researcher explores the following four research questions:

Research Question 1

What are the mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as a result of participating in professional association mentoring programmes?

Research Question 2

What are the mentoring experiences and expectations of residential aged care workers as a result of participating in formal or informal mentoring programmes provided by residential aged care organisations?

Research Question 3

How does provision of mentoring affect the psychological capital of residential aged care workers?

Research Question 4

How does the mentoring experience of aged care workers influence psychological capital in the residential aged care sector?

The research problem and research questions are addressed by examining early conceptualisations of mentoring and the theoretical framework of learning to explore the functions of mentoring developed by Kram (1985). A review of the career and psychosocial functions of mentoring, and the relatively new term of clinical mentoring is then examined, and a variety of conceptualisations are explored. This is followed by discussion of formal and informal mentoring, individual, group, face-to-face and online mentoring and the theoretical framework of positive organisational behaviour and the construct of psychological capital.

1.4 Justification for this research

There are several important reasons to research mentoring in the allied health and residential aged care sectors. The literature review identified that little research has been undertaken on mentoring in allied health professions, especially when practitioners work remotely, for small organisations or as sole practitioners (Causby, 2003; Joubert, 2006; Nolinske, 1995; Paul et al., 2002; Struber, 2004). Likewise, it has been identified that little research has been undertaken regarding mentoring of paraprofessionals in the aged care sector (Jeon et al., 2010b).

Most of the research on mentoring in the health industry has focused on nurses in acute care and there is an underlying implicit assumption that the clinical supervision, preceptorship, mentoring model adopted in the nursing sector applies across the board in the health industry. There are claims made in the professional literature that clinical mentoring provides psychosocial benefits to mentees (I-TECH, 2008; Morey, 2015; Nursing Midwifery Council, 2008; SA Health, 2014). For instance, I-TECH (2008) refers to mentors as teachers and guides who provide psychosocial support through role modelling, workplace behaviour and communication for mentees that is designed to enhance the ability of mentees to provide psychosocial support to patients. However other professional literature on clinical mentoring focuses on the training and professional development aspects in lieu of psychosocial benefits for mentees (Boyer, 2011; World Health Organisation, 2006).

The literature review identified little or no academic research on the psychosocial benefits provided by clinical mentoring. This research investigates whether the application of clinical mentoring provides the career and psychosocial benefits associated with traditional mentoring as recognised in the management literature.

This research may be unique because of the nature of work and high level of part-time and casual work undertaken in the allied health and residential care sectors. It is not unusual for allied health professionals to work part-time or on a multi-employer basis, but much mentoring research has focused on full-time nursing staff (Bassell, 2010; Jeon et al., 2010a; Omansky, 2010). However, the aged care setting has an employment profile where many staff are part-time or casual workers.

Limited research has been conducted using mixed methods and template analysis to build on existing mentoring theory. Qualitative work previously undertaken has tended to be exploratory in nature and not based on existing mentoring theory. Many studies have focused on quantitative analysis and relied on outcomes of job satisfaction, career satisfaction, career success or intention to leave to demonstrate the effectiveness of mentoring (Dougherty & Dreher, 2007). This may be a reason why research has tended to focus on career based functions of mentoring rather than psychosocial functions which are more difficult to quantify.

Some health industry mentoring programmes adopt a learning process based on improving skills of nurses and allied health practitioners through CPD, on-the-job professional development and training activities, and clinical mentoring. However, little or no research has been undertaken into the concept of clinical mentoring and career and psychosocial outcomes for the individual and organisation. Some examples of career and psychosocial outcomes for individuals include psychological career success, continuous learning and relational competence (Lankau & Scandura, 2007). Hall (2002) as cited by (Lankau & Scandura, 2007) reported that personal identity and personal adaptability are competencies that enable individuals to continuously learn and these competencies also increase self-esteem and lead to psychological career success. Fletcher and Ragins (2007) as cited by (Lankau & Scandura, 2007) suggest that relational competence is the ability of an individual to be able to connect effectively with others in any organisational context. Zey (1988) as cited by (Godshalk & Sosik, 2000) found that the career and psychosocial outcomes for organisations include "faster employee integration, reduced turnover, increased communication, management development, succession planning, productivity and socialisation" (Godshalk & Sosik, 2000, p. 163). This thesis examines where professionals and paraprofessionals obtain career and

psychosocial support, and whether the support received is sufficient to provide workers with the psychological capital and positive organisational behaviours necessary to work in high stress allied health and residential care environments.

Review of the literature has identified several gaps in allied health and residential aged care research. These include the size and location of workplaces, the contractual basis of work, the type of mentoring provided, the focus of mentoring research in non-acute care nursing and medical contexts in lieu of paraprofessionals in residential aged care, the lack of theory based research on mentoring and the career and psychosocial benefits of clinical mentoring.

This research addresses gaps in the literature identified above and adds new insights into clinical mentoring and increased casualisation of the allied health and residential care workforce using the learning perspective as a theoretical framework. It also provides valuable insights regarding mentoring experiences and expectations of allied health professionals and residential aged care workers not addressed previously in the acute care nursing literature.

1.5 Methodology

The thesis research questions are investigated using a mixed methods approach involving three phases drawing upon realist ontology and social constructivist epistemology. Collection and analysis of qualitative and quantitative data and connection of observations and results was used in this study (Creswell, 2009). Data was collected from multiple sources, and included open-ended interviews and a survey, providing connection of results. Semi-structured interviews were analysed using template analysis (King, 2012). Interpretation of data was expanded using descriptive and narrative sources to explain statistical results (Tashakkori & Teddlie, 1998), ensuring that common method variance was avoided (Chang, Van Witteloostuijn, & Eden, 2010b).

Research question 1 is addressed in Phase 1, a qualitative study conducted with a group of allied health professionals who are members of a professional association within the allied health sector. The professionals are podiatrists participating in a mentoring programme aimed at providing career, psychosocial and clinical support for early career professionals. Many of these professionals work in small private sector practices, often for several different employers on a part-time or casual basis, while others are employed in public health. Both groups face varying degrees of communication isolation from others within their profession and the professional association mentoring programme aims to provide support to participants.

Phase 1 investigated mentoring expectations and experiences of allied health professionals working in multidisciplinary clinics and private practice. A mix of early career professionals, mentors, senior practitioners and other stakeholders were interviewed. Clients were not interviewed as they are outside the scope of this research. Phase 1 focused on the phenomenon of mentoring more broadly and the findings were used to inform Phase 2 of the research. Phase 2 sought to identify similarities and differences of mentoring experiences in a broader health services context.

Research questions 2 and 3 were addressed in Phase 2 utilising a qualitative study conducted with professionals and paraprofessionals working in the residential aged care sector. Four not-for-profit residential aged care providers agreed to participate in Phase 2. One provider gave access to two sites within metropolitan Adelaide. The remaining three providers gave access to one site each; two in metropolitan Adelaide and one located in country SA.

Phase 2 investigated mentoring experiences and expectations of residential aged care workers. A mix of clinical nurse consultants, registered nurses, enrolled nurses, care workers, allied health professionals, administration and hospitality workers were interviewed. Again, clients were not interviewed as they are outside the scope of the research. Findings from Phase 2 template analysis informed Phase 3 and provided connection of the results.

Research question 4 was addressed using quantitative methods in Phase 3 of this research. A survey was conducted with professionals and paraprofessionals working in the residential aged care sector. Four not-for-profit residential aged care providers and one for-profit provider agreed to participate in Phase 3. One provider gave access to three sites within metropolitan Adelaide and five country sites. Three providers gave access to one site each; two in metropolitan Adelaide and one in country South Australia. The for-profit provider gave email access to workers at sites in Western Australia.

Phase 3 investigated perceived quality of mentoring received by residential aged care workers and relationships that may exist with psychological capital. A mix of clinical nurse consultants, registered nurses, enrolled nurses, care workers, allied health professionals, administration and hospitality workers were surveyed. Hypotheses for Phase 3 were informed and refined based on findings of semi-structured interviews conducted in Phase 2. Details of research hypotheses are listed in Chapter 6. Findings from Phase 3 were combined with results of Phase 2.

1.6 Functional definitions

The following definitions are used throughout the thesis.

Acute care: Defined as short term care provided by the hospital sector.

Allied health professionals: Allied health professionals include audiologists, chiropractors, counsellors, dietitians, exercise physiologists, music therapists, nutritionists, occupational therapists, optometrists, osteopaths, pathologists, physiotherapists, podiatrists, pharmacists, psychologists, social workers, sonographers and speech pathologists (Department of Health, 2013).

Allied health professional association: An allied health professional association is a not-for-profit organisation that seeks to further an allied health profession, the individual practitioners engaged in the profession and promotes the profession in public.

Career mentoring: The career function of mentoring provides mentees with a range of behaviours to assist them in developing their career including sponsorship, coaching, advocacy, challenging assignments, exposure and visibility (Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990).

Clinical mentoring: Clinical mentoring is a collaborative relationship where a highly experienced health care provider guides improvement in quality of care delivered by other health care providers. The components discussed in this thesis are; complicated cases, continuing education, case discussions, psychosocial support, on-site training and quality control (I-TECH, 2008).

E-mentoring: E-mentoring is an online forum where discussions take place between mentors and mentees moderated by an experienced facilitator (Celik, 2013).

Formal mentoring: In formal mentoring relationships mentors and mentees are assigned to a dyad for a fixed period of time (Baugh & Fagenson-Eland, 2007).

Group mentoring: Group mentoring involves mentoring a group in one of four ways. These include peer group mentoring (PGM), one-to-many group mentoring (OTMM), many-to-one mentoring (MTOM), and many-to-many mentoring (MTMM) (Huizing, 2012).

Informal mentoring: Informal mentoring relationships are formed spontaneously between two people based on attraction and sense of connection (Kalbfleisch, 2000).

Mentoring: Defined as a relationship generally between two people with learning and development as its purpose (Megginson & Garvey, 2004).

Multi-disciplinary clinics: Multi-disciplinary clinics are health clinics where a group of health professionals work in one location and provide multiple services from that location.

Non-acute care: Defined as long-term care provided by the residential aged care sector.

Positive organisational behaviour: Defined as "the study and application of positively oriented human resources strengths and psychological capacities that can be measured, developed and effectively managed for performance improvement in today's workplace" (Luthans, 2002, p. 59).

Psychosocial mentoring: Psychosocial support is provided by the mentoring behaviours of friendship, role modelling, counselling, acceptance, and confirmation (Jacobi, 1991; Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990)

Psychological capital: Psychological capital adds a new dimension for developing a sustainable competitive advantage through self-efficacy, optimism, hope and resiliency of individual workers (Luthans, Youssef, & Avolio, 2007b).

Paraprofessionals: The term paraprofessionals has been used to differentiate between CNCs, RNs and ENs and LCs, CWs, AWs and HWs working in residential aged care facilities.

Residential aged care facility: Aged care services within permanent or temporary accommodation settings.

In addition to these terms the following acronyms are used.

AACQA - Australian Aged Care Quality Agency
AHP - Allied health professional
AHPRA - Australian Health Practitioners Regulatory Authority
AIHW - Australian Institute of Health and Welfare
APERF - Australian Podiatry Education Research Fund
AW - Administration worker
CNC - Clinical Nurse Consultant
CPD - Continuing professional development
CW - Care Worker
EN - Enrolled Nurse

HC - Hospitality worker

LC - Lifestyle coordinator

RN - Registered Nurse

RSM - Residential Site Manager

SPSS - Statistical Package for Social Sciences

1.7 Delimitation and justification of scope and key assumptions

The scope of the research was limited to two sectors within the Health Care and Social Assistance industry in Australia. The sectors selected were allied health and residential care, the two fastest growing sectors of the industry (Department of Employment, 2015). Within these two areas, the research concentrated on a single allied health profession for Phase 1, and Phase 2 was limited to six residential care organisations with some providing access to multiple sites.

As with all research, the thesis has some limitations. Data collected was cross-sectional, and therefore causal inferences cannot be made. Samples used in Phases 2 and 3 were different and unlikely to have been subject to common method bias.

From a theoretical perspective, the research is limited to the broad domain of vocational and organisational behaviour research related to mentoring and controlled by variables such as age, gender, and profession. While there are many other influences on individual attitudes, behaviours, and values, for example, leadership style, emotional intelligence, and trust, providing the potential for investigation in future research, the focus of this research was narrowed to the positive organisational behaviour construct of psychological capital.

1.8 Thesis outline

This thesis is divided into seven chapters. The first chapter provides an introduction to the thesis and describes the underlying value of this research. Chapter 2 provides a review of the mentoring literature and context for this investigation. As early research phases inform latter phases, Chapter 2 does not identify all possible research hypotheses. Chapter 3 describes the methodology and method used to examine the research questions. Chapters 4 and 5 provide results of qualitative research, while Chapter 6 outlines research hypotheses developed from earlier phases and combines results of quantitative and qualitative phases. Thesis findings are discussed in Chapter 7

along with theoretical and practical implications of the research. The thesis structure is outlined in Table 1.1.

Table 1.1: Thesis Structure

Description	Chapter Number
Introduction	Chapter 1: Introduction
Literature Review	Chapter 2: Literature Review
Methodology and Methods	Chapter 3: Methodology and Methods
Results	Chapter 4: Qualitative Results – Phase 1
	Chapter 5: Qualitative Results – Phase 2
	Chapter 6: Quantitative Results – Phase 3
Discussion and Conclusion	Chapter 7: Discussion and Conclusion

1.9 Conclusion

This chapter provided research foundations, introduced the research problem and research issues to be addressed. It then justified the research, briefly outlined and justified the methodology, presented functional definitions, provided delimitations and outlined the thesis. The thesis continues with a comprehensive review of the literature and description of the research.

CHAPTER 2 : LITERATURE REVIEW

2.1 Introduction

This chapter reviews theoretical and professional literature connected to the concepts of mentoring, mentoring functions, including clinical mentoring, the mentoring relationship, delivery of mentoring and outcomes of mentoring. Next, the theoretical framework underpinning mentoring is discussed. Then the theoretical lens of positive organisational behaviour provides the background behind the core construct of psychological capital. Positive organisational behaviour is discussed in Section 2.8.

While it is important to discuss historical literature on the development of mentoring, this thesis has viewed the mentor role theory developed by Kram (1985) through the lens of learning as a process. The next section reviews the early mentoring literature and discusses three conceptualisations of mentoring.

Table 2.1: Outline of Perspectives of Mentoring in Different Contexts

Perspectives	Business context	Acute Care context	Allied Health context	Aged Care context
Human Development	✓			
Career Advancement	✓			
Learning Perspective	✓	✓	✓	✓
Career Mentoring Function	✓	✓	✓	✓
Psychosocial Mentoring Function	✓	✓	✓	✓
Clinical Mentoring		✓	✓	✓
Formal mentoring	✓	✓	✓	✓
Informal Mentoring	✓			✓
Individual Mentoring	✓	✓		✓
Group Mentoring	✓		✓	
Face-to-face mentoring	✓	✓	✓	✓
E-mentoring	✓		✓	
Psychological Capital				✓

2.2 Early mentoring literature

There are many definitions and descriptions of mentoring in the organisational behaviour, business, education and acute care nursing literature. Within these disciplines, three main concepts describe mentoring relationships. These concepts include human developmental relationships (Dalton, Thompson, & Price, 1977; Kanter, 1977; Kram, 1985; Levinson, Darrow, Klein, Levinson, & McKee, 1978), career advancement (Noe, 1988; Ragins & Cotton, 1993) (Tharenou, 2005; Whitely,

Dougherty, & Dreher, 1991; Zey, 1984) and a learning approach (Gibb & Megginson, 1993; Hale, 2000; McCarthy, 2014; Zachary, 2011). The common element of these descriptions is a helping relationship between individuals. However, perceptions of the researchers differ according to the purpose, reasons, motivation, criteria or characteristics of the mentoring relationship. Identification of each perspective of mentoring appears in (Table 2.1).

2.2.1 Mentoring from a human development perspective

The origins of mentoring can be traced to Greek mythology and Homer's Odyssey. Ragins and Kram (2007) noted that a "mentor was a wise and faithful advisor entrusted to protect Odysseus's son, Telemachus, while Odysseus sailed against Troy" (p. 3) and that the "archetype embodied both male and female attributes. Mentor was a man, but Athena, the female goddess of wisdom, assumed this form in order to guide, teach and protect young Telemachus" (p.4). The archetype provides an interesting insight into the mentoring relationship as one that transcends time, gender and culture (Ragins & Kram, 2007).

Levinson et al. (1978) explored the impact of mentoring on men's development in the book 'The Seasons of a Man's Life'. The authors described the mentoring relationship "as one of the most complex, and developmentally important, a man can have in early adulthood" (p.97). In particular, the character and functions of the mentoring relationship, such as a teacher, sponsor, guide, role model and counsel in times of stress, were seen as important roles of a mentor (Levinson et al., 1978). A qualitative study of 40 men in middle adulthood, aged 35 to 45 years, concluded that the mentoring relationship between the mentor, a more senior experienced male, supports the transition of the younger man, the mentee, from early to middle adulthood. The study also found that negotiating phases of the mentoring relationship, such as initiation, development, continuation, and termination, was also necessary for the development of young men. For the older man, being a mentor provided the opportunity to enhance middle adulthood and leave a legacy (Levinson et al., 1978). Levinson et al. (1978) viewed mentoring as the psychosocial development of individuals through the stages of life and not necessarily influenced by organisational context.

Other early research recognised mentoring relationships in an organisational context. Kanter (1977) used a career perspective to explore experiences of men and women in organisations. Kanter's (1977) study found that it was necessary for participants to have a sponsor within the organisation. Sponsor functions were to provide advice, advocacy, guidance and self-confidence to navigate a path through the organisation. Further, Kanter (1977) suggested that sponsorship was essential for

the progress of women in organisations, but was not readily available, due to lack of women in key positions in the workplace. From Kanter's (1977) perspective, the purpose of mentoring was to provide career advancement, rather than psychosocial development in the organisational context.

Around the same time, Dalton, Thompson and Price (1977) combined psychosocial development and career perspectives to provide an integrated perspective of mentoring relationships. They developed a career stage model of four stages through which high-performers progress. The career stages were: apprentice, colleague, mentor and sponsor. Each stage involved different tasks, types of relationships and psychological development. Dalton et al. (1977) found that a mentoring relationship focused on two of the four career stages and highlighted the importance of receiving and giving mentoring in an organisation. Further, Dalton et al. (1977) identified that individual needs and organisational requirements affect mentoring relationships.

The research of (Dalton et al., 1977; Kanter, 1977; Levinson et al., 1978) has several common elements. The first is that mentoring is important for the personal and professional development of an individual. That is, while the focus of these studies was not mentoring, it emerged as an important element to individuals and their careers. Secondly, the functions provided by mentors and benefits received by mentees began to explain the nature of mentoring relationships. Thirdly, Kanter (1977) and Dalton et al. (1977) recognised the existence of gender issues in mentoring relationships. The samples used in their studies were male dominated which highlighted gender imbalance in the workforce. Further, it underscored the availability of females to be mentors to other women and the difficulties frequently related in cross-gendered relationships.

In response to common findings of the early researchers, Dalton et al. (1977), Kanter (1977), and Levinson et al. (1978), that mentoring was important to individuals and their careers, Kram (1985) researched the functions of mentors and benefits to mentees. She was particularly interested in the degree that a developmental relationship augments psychosocial development and / or career advancement. As such, Kram (1985) identified nine functions provided by mentors and these were further grouped into two main categories: career functions and psychosocial functions. Kram (Kram, 1985) conceptualised mentoring as a process of adult development in the workplace.

Other models of mentoring have been proposed based on the human development approach. For example, Johnson, Geroy and Griego (1999) developed a model concentrated on the interactive nature of the mentoring relationship. Three dimensions were identified as important in the mentor-mentee relationship, with the first being socialisation. Johnson et al. (1999) suggested that the stage

of socialisation for both mentor and mentee within various groups affects the way parties interact in the mentoring relationship. Secondly, the level of skill development of mentor and mentee in relation to work and family tasks affects mentoring interactions. Thirdly, lifespan development influences the interaction of mentor and mentee. Essentially, Johnson et al. (1999) suggest that the mentoring relationship is a unique combination of the stages of socialisation, work and family task development and lifespan of the mentor and mentee. Finally, this model of mentoring extends the application of mentoring beyond the career and workplace and into the private domain of the individual.

In summary, mentoring from a human development approach begins as a relationship between individuals at different life stages (Levinson et al., 1978) and various career stages (Dalton et al., 1977) who are seeking career advancement in an organisation (Kanter, 1977). From this early work, Kram (1980) identified characteristics of a mentor and benefits for the mentee and developed the functions of career and psychosocial mentoring and describes mentoring as a process of adult development in the workplace. Finally, Johnson et al. (1999) described mentoring as a unique interpersonal relationship between mentor and mentee that continuously changes over the lifespan in the workplace and personal life. All of these mentoring descriptions focus strongly on the developmental stages of individuals.

2.2.2 Mentoring from a career advancement perspective

In contrast to the human development perspective, other researchers emphasised the ability of mentoring to provide career advancement within an organisation (Noe, 1988; Ragins & Cotton, 1993; Tharenou, 2005; Whitely et al., 1991; Zey, 1984). The career advancement perspective viewed mentoring as a method for overcoming gender barriers (Noe, 1988; Ragins & Cotton, 1993; Shapiro, Haseltine, & Rowe, 1978; Tharenou, 2005; Zey, 1984) and socioeconomic disadvantage in the workplace (Whitely et al., 1991).

In the early 1980s, Zey (1984) interviewed some executives in large and small organisations regarding their mentoring experiences and identified a number of mentoring relationship benefits including career advancement, job satisfaction and social mobility (Zey, 1984). Zey (1984) developed a Mutual Benefits Model based on social exchange theory and the assumption that workers enter into, and continue, relationships to meet a particular need. In a mentoring relationship, the mentor and mentee engage with each other because each party perceives they will benefit from the relationship (Zey, 1984). Overtime mentors and mentees are likely to outgrow the relationship.

However, there is no predetermined time for this to occur as may be the case with the career stage theory (Dalton et al., 1977). Zey (1984) suggested a further benefit of the Mutual Benefits Model. That is, not only did the mentor and mentee benefit from the mentoring relationship but so did the organisation. With the development of formal mentoring programmes, organisations were able to reach out and provide a variety of support systems to bring people with similar interests or problems together. This provided a sense of purpose for participants in being able to share knowledge, skills and experiences with others (Zey, 1984). According to Zey (1984), in the corporate world, generally a more senior mentor provides career development in the form of guidance, counselling, protection and promotion to a junior mentee and the mentee may provide information about lower levels of the organisation to the mentor. The mentoring relationship relies upon the compatibility of career needs and goals and the ability of mentor and mentee to work together, rather than emphasising a close interpersonal relationship.

Another supporter of the career advancement perspective is Whitely et al. (1991). For Whitely et al. (1991) mentoring is a shorter, less intense and less inclusive relationship as compared to the mentoring relationship described by Zey (1984). Whitely et al. (1991) focused on external career achievements, such as promotions and compensation, which are considered indicators of career advancement. Thus, mentees could obtain career guidance from multiple mentors as they progressed through their career. Conversely, the human development perspective is more concerned with internal growth and task achievement (Kram, 1985; Levinson et al., 1978).

Shapiro et al. (1978) regarded career advancement as the goal of mentoring. These authors described mentoring as an exclusive, intensely emotional parental-type relationship. Further, they viewed mentors at higher organisational levels as having more power and influence and thus having greatest potential to promote mentee career advancement (Shapiro et al., 1978). As a result, Shapiro et al. (1978) saw mentoring as relatively ineffective for career advancement of professional women.

Eby (1997) viewed mentoring in terms of the changing nature of work and extended interpretation of mentoring to include job-related skill development and career advancement. Mentoring for job-related skill development helps the mentee develop skills, of a technical or personal nature, that assist the organisation. These skills may or may not be transportable to another organisation. On the other hand, career advancement skills are likely to be more broadly based and transferable to

other organisations. Eby (1997) concluded that frequent changes in the organisational environment result in mentoring construct change to reflect current career trends of individuals.

Mentoring, from the perspective of career advancement, can be viewed as a strategic relationship between mentor and mentee to advance the mentee's career. Thus, mentors assist mentee career progress by virtue of their position and relative power within an organisation, rather than because of a particular life stage, as occurs in the human development perspective. Therefore, the career advancement perspective emphasises career needs and goals, rather than mentee emotional development.

2.2.3 Mentoring from a learning perspective

In addition to human development and career advancement perspectives, researchers have also described mentoring as a learning process (Gibb & Megginson, 1993; Hale, 2000; McCarthy, 2014; Zachary, 2011). This is very different to the traditional mentoring model of sponsorship and career advancement (Clutterbuck, 2008). Gibb (1999) regarded mentoring as a type of training intervention, and mentoring relationships as “learning partnerships” (p. 1058) between more experienced mentors and less experienced mentees. The benefit for organisations is the ability to tap into the skills, knowledge and wisdom of existing workers and share this with less experienced workers. In effect “it is a personalised form of development that is low cost for the organisation, in comparison with other types of training intervention” (Gibb, 1999, p. 1058).

Mumford (1995, 1998) considered workplace learning as an outcome of mentoring. In exploring the relationship of mentoring and learning Mumford (1998) examined the purpose of learning. That is transmission of knowledge, skills development or development of insights for the mentee. While mentoring can assist in knowledge development, it is constrained by knowledge of the mentor. In terms of achieving insights, mentoring is seen as a powerful tool in helping the mentee to reflect upon and change their behaviour. The distinction between acquisition of knowledge, skills and insights made by Mumford (1998) provided the basis for Hale (2000) to research the impact of mentoring and learning.

Hale (2000) researched the similarities and differences between mentors and mentees and the influence on learning outcomes. This researcher developed a model to support the matching of mentors and mentees in a formal mentoring programme and found that learning was optimised where the mentor and mentee had similar values, beliefs and life goals and contrasting personal styles, learning styles, strengths and development needs. Further, relationships were developed

more quickly where mentor and mentee had similar interests, profession and personal circumstances (Hale, 2000).

Hale (2000) also recognised that different individuals benefit from a mentoring relationship in various ways. Therefore it was necessary to identify personal objectives of mentees and mentors and consider whether their learning objectives could be met from the relationship. For example, one mentee may wish to acquire specific knowledge, whereas another may wish to gain insights into their role as a practitioner. As noted by Hale (2000) and Lankau and Scandura (2007), research into the benefits of mentoring in terms of learning is relatively new in the mentoring literature. It appears that it has been "assumed that individuals learn from mentoring" (Lankau & Scandura, 2007, p. 95), but the real link is far from obvious (Hale, 2000, p. 224).

Zachary (2011) identified a shift in the purpose of mentoring away from career advancement towards learning and gaining insight, along with a change from mentor directed learning to self-directed learning by the mentee. From this perspective, a mentor is a facilitator of learning, and the mentee is the learner (Zachary, 2011). Bokeno (2009) further identified a split between developmental and relationship mentoring, where relationship mentoring is concerned with helping mentees develop productive relationships. Other researchers also noted a change in the emphasis of mentoring as well as variations in definitions (Chandler, Kram, & Yip, 2011; Haggard, Dougherty, Turban, & Wilbanks, 2011). However, the core elements of reciprocity, regular interaction, and developmental benefits remained unchanged. Zachary (2011) described seven elements of learning, development, mutually set goals, reciprocity, relationship, collaboration and partnership as being critical to learning-centred mentoring.

In summary, mentoring from a learning perspective is a training strategy that can be used to support the development of the mentee's knowledge and skills or complement other training interventions. In this circumstance mentors and mentees are differentiated by expertise. Further, mentor teaching style and mentee learning style must be aligned with the learning task for mentoring to be effective. Also, emphasis on reflective thinking and gaining insights form part of the learning perspective. This is in contrast to the human development perspective that focuses on the achievement of developmental tasks and mentee stage of development and the career advancement perspective where sponsorship and upward mobility are essential. Features of the human development, career advancement and learning perspectives of mentoring are evident in business and management and acute care nursing contexts. The business and management context are reviewed next.

2.3 Mentoring in the business and management context

The core literature on mentoring theory and practice is concerned with the development of relationships and focused on sharing knowledge and experience between mentors and mentees (Kram, 1985; Levinson et al., 1978). Mentoring was traditionally defined as a "relationship between an older more experienced mentor and a younger less experienced mentee for the purpose of helping and developing a mentee's career" (Sanyal, 2017, p. 149). In more recent times as young people have become more educated, a more experienced person will not necessarily be older (Stewart & Krueger, 1996). Thus, the concept of mentoring has changed to incorporate peer mentoring (Kram & Isabella, 1985) and reverse mentoring (Giscombe, 2007), meaning that everyone has the potential to be a mentor.

In this body of literature, there have been changes in the definition of mentoring, and the core feature that distinguishes it from other forms of personal relationships is that mentoring relationships focus on career and personal development (Garvey, Stokes, & Megginson, 2009) (Hall & Chandler, 2007). The mentor may be employed by the same organisation as the mentee or may be in the same profession (Ragins & Kram, 2007). Mentoring has typically been researched as a dyadic relationship (Dansky, 1996). However, if the goals of mentoring are to share the knowledge and wisdom of others' experiences, then it is also possible that delivery of mentoring in a group setting has the potential to multiply the positive effects of mentoring (Higgins & Kram, 2001; Huizing, 2012).

Mentoring in the management context highlights the human development perspective of Kram (1985) and Levinson et al. (1978) and focuses on the development of mentors and mentees in relation to career and psychosocial functions. Other researchers viewed mentoring as a method of promoting career advancement and overcoming gender imbalance within organisations (Noe, 1988; Ragins & Cotton, 1993; Shapiro et al., 1978; Tharenou, 2005; Zey, 1984). Gibb (1999) extended mentoring to include learning in mentoring relationships. Organisations can benefit from sharing knowledge, skills and wisdom of existing workers and develop new workers at a lower cost than other training interventions (Gibb, 1999).

2.4 Mentoring functions

Kram's (1985) mentor role theory identified two functions that mentors may provide in a mentoring relationship, namely career development and psychosocial support roles. The career function of mentoring provides mentees with a range of behaviours to assist them in developing their career including sponsorship, coaching, advocacy, challenging assignments, exposure and visibility (Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990). The second function of mentoring provides psychosocial support through the mentoring behaviours of friendship, role modelling, counselling, acceptance, and confirmation that often provides the mentee with increased competence, effectiveness and belongingness (Jacobi, 1991; Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990). The psychosocial function builds on trust and the strength of emotional bonds of a relationship by using behaviours that develop professional and personal growth, identity, self-worth and self-efficacy (Cherniss, 2007).

As mentoring research has progressed, it has been found that career and psychosocial functions are two relatively independent dimensions of behaviours (Noe, 1988; Ragins & McFarlin, 1990), although some authors suggest that role modelling should be categorised as a separate function (Scandura, 1992; Scandura & Ragins, 1993). The debate on whether role modelling is a behaviour of psychosocial support (Kram, 1985; Ragins & Cotton, 1999) or a behaviour of career support (Noe, 1988) or a separate function (Pellegrini & Scandura, 2005; Scandura, 1992), is ongoing. However, recent research of mentoring functions from a developmental network perspective (Janssen, van Vuuren, & de Jong, 2013; Murphy & Kram, 2010) provides qualitative evidence to support the idea that role modelling is a separate function. Further, a meta-analysis by Ghosh and Reio (2013) established that provision of "career mentoring was most associated with career success; psychosocial mentoring with organisational commitment; and role modelling with job performance" (p. 106). As such the debate continues. Each of the mentoring functions is now reviewed.

2.4.1 Career mentoring function

2.4.1.1 Sponsorship

The first mentor role behaviour is sponsorship (Kram, 1985). Sponsorship involves the provision of public support of the mentee for career advancement. Mentors may provide sponsorship support for mentees through formal recommendations, for example, nominating the mentee for challenging assignments, informal discussions with other influential members of the organisation and by being publicly aligned with the mentee (Dougherty & Dreher, 2007). The level of influence a mentor has

in an organisation determines mentor ability to provide sponsorship to a mentee (Baranik et al., 2010; Fowler, 2002; Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990).

2.4.1.2 Coaching

According to Kram's (1985) mentor role theory, coaching is the second behaviour of the career function. Within the mentoring literature, coaching support is limited to activities that enhance career development through sharing ideas with the mentee on how to navigate an organisation, achieve career goals and provide acknowledgement, feedback and information on completing work tasks (Baranik et al., 2010; Kram, 1985). However, in the wider literature coaching is seen as a learning and development activity applicable to personal and workplace contexts (Clutterbuck, 2008; Garvey et al., 2009; Whitmore, 2002).

Learning and development give a mentee an understanding of the professional world through the mentor's expertise and insight. However, in the broader literature on coaching and mentoring (Clutterbuck, 2008; Garvey et al., 2009), there is much debate on the meaning of coaching and mentoring and it is "very unlikely that there will ever be widespread consensus as to the meaning of coaching and mentoring in any particular context" (Garvey et al., 2009, p. 27). Garvey et al. (2009, p. 27) suggest that while coaching and mentoring have developed from different discourses, in the modern context both "are essentially similar in nature". Fundamentally, coaching and mentoring are learning and development activities (Garvey et al., 2009).

Whitmore (2002) takes a more holistic approach to coaching in the workplace. This author describes coaching as an intervention that aims to build a person's "self-belief regardless of the task or issue" (Whitmore, 2002, p. 18). This is based on the premise that "self-belief is built when we make decisions, take successful actions and recognise our full responsibility for both" (Whitmore, 2002, p. 18). In terms of the workplace, coaching is more than a technique used to solve a problem. It is "a way of managing, a way of treating people, a way of thinking, a way of being" (Whitmore, 2002, p. 18) and is based on authenticity that improves relationships and performance in the workplace. This notion of coaching is far more widely based than the meaning of coaching in the mentoring literature which is focused on task-based activities using an instructional style that dominated sports coaching (Whitmore, 2002). The origins of coaching came from sports coaching and Harvard educationalist and tennis expert Timothy Gallwey. Gallwey (1986) as cited by Whitmore (2002, p. 8) described the essence of coaching as "unlocking a person's potential to maximise their own performance. It is helping them to learn rather than teaching them".

Noe (1988) developed an instrument to measure mentor roles provided to mentees through the two functions of career development and psychosocial support. The nine behaviours identified by Kram (1983) were used as the basis for the instrument. Factor analysis showed that the two functions defined by Kram (1983) were nearly identical. The exception was that mentor coaching behaviour showed more common variance with psychosocial functions. Noe (1988, p. 473) suggested that mentees might "perceive coaching behaviours as more instrumental for work effectiveness and self-identity than for career advancement". This idea is consistent with the opinion of Whitmore (2002) and links with Kram's (1985) observation that the first year of a mentoring relationship is more likely to be characterised by a task focus. Noe's (1988) study also found that psychosocial functions were more prevalent in the first year. As the functions of coaching and role modelling facilitate task completion, it is not surprising that mentees reported receiving more psychosocial functions of mentoring (Noe, 1988). Ragins and McFarlin (1990) also found that coaching, exposure and role modelling behaviours were among the first to develop in a mentoring relationship. Further, the longer the mentoring relationship continued, the less likely it was that coaching and role modelling were required at which time other behaviours became more important in the mentoring relationship (Ragins & McFarlin, 1990). This is in keeping with Kram's (1985) idea that mentors provide different mentoring behaviours to mentees according to their particular career stage.

2.4.1.3 Advocacy

The third mentor role is advocacy. Advocacy is prevention, shielding and protection of mentees from damaging contact with others in the organisation (Cherniss, 2007; Kram, 1985). In relation to this behaviour, the mentor role is to shield the mentee from potentially harmful exposure that could unnecessarily damage a mentee's reputation. This may involve the mentor taking responsibility for uncertain outcomes, limiting mentee contact with others in the organisation until the mentee has gained required knowledge and skills to perform competently, or intervening directly in situations that are beyond the ability of the mentee at that point in time. For example, a career-limiting situation may be where the possibility of failure is high, or the mentee has not yet developed the skills to complete the required task (Ragins & McFarlin, 1990). In this situation, the role of the mentor is to shield the mentee from harmful exposure. The level of advocacy provided by the mentor must be handled carefully to not overly limit exposure and visibility of the mentee within an organisation. Mentee exposure and visibility are essential for growth and establishment of a professional reputation (Allen, 2007; Baranik et al., 2010; Cherniss, 2007; Kram, 1985).

2.4.1.4 Challenging assignments

The fourth career related behaviour is challenging assignments (Kram, 1985). The mentor role is to provide challenging assignments that help the mentee develop specific competencies and a sense of achievement in the professional role. The mentor assigns work to the mentee based on increasing complexity and challenge. At the same time, technical training and performance feedback is provided to ensure the mentee is successful in completing assigned tasks. This provides the mentee with the opportunity to learn and develop new skills and reflect on task outcomes with mentor feedback (Baranik et al., 2010; Kram, 1985; Kram & Isabella, 1985). Provision of challenging assignments supports work-related learning essential for the mentee to take advantage of opportunities provided through sponsorship, coaching, advocacy, exposure and visibility (McManus & Russell, 2007).

2.4.1.5 Exposure and visibility

The final mentor role behaviour is exposure and visibility (Kram, 1985). The mentor deliberately creates opportunities for mentees to develop relationships with other influential people in the organisation. This can increase the mentee's network of organisational supporters and uncover other career opportunities, providing valuable learning experiences that would not otherwise be available. Mentors also promote mentee accomplishments and provide support to become more visible within the organisation (Baranik et al., 2010). As with sponsorship, the mentor is in a position of influence that enables provision of exposure and visibility for the mentee. Sosik and Godshalk (2000) suggest that sponsorship, exposure and visibility may reduce the amount of stress experienced by career-minded mentees because they view additional attention towards their work as contributing to career success.

2.4.1.6 Summary

This review of the literature on career mentoring functions highlights the importance of a mentor being able to exert formal and informal power within an organisation for mentee career advancement. The next section reviews the psychosocial functions of mentoring.

2.4.2 Psychosocial mentoring functions

2.4.2.1 Friendship

The first behaviour of psychosocial mentoring examined here is friendship. Friendship is about creating positive social experiences in the workplace that provide the mentee with a feeling of belongingness and confidence to speak with more senior people in the organisation (Kram, 1985; Ragins & Cotton, 1993; Ragins & McFarlin, 1990). That is, the mentee feels like a peer with a more senior person in the organisation which can positively impact on mentee perceptions of authority figures (Baranik et al., 2010). The mentor may also provide friendship through informal social interactions in the workplace which provides the mentee with a sense of confidence and self-esteem and a feeling of being liked by the mentor (Kram, 1985).

2.4.2.2 Acceptance and confirmation

The second psychosocial role of the mentor is acceptance and confirmation. Acceptance and confirmation occur when the mentor communicates positively with, and has respect for, the mentee. When the mentor provides positive feedback the mentee develops a belief in their ability and this builds trust in a mentoring relationship (Baranik et al., 2010). As a mentee becomes more confident in their ability they are more likely to take risks and suggest or try new ways of doing things without fear of rejection by their mentor if their ideas or actions are unsuccessful (Kram, 1985). Also, in a group setting mentors can help support mentees by accepting and confirming their organisational membership. In these situations, mutual respect between the mentor and mentee can advance the process of socialisation and help the mentee feel welcome in the organisation (Chao, 2007).

2.4.2.3 Counselling

The third psychosocial role of the mentor is counselling. Counselling is the process through which a mentor acts as sounding board and allows the mentee to express anxieties or self-doubt about work related issues, such as relationships with co-workers, ethical dilemmas, career matters or work-life balance issues (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). In this role the mentor helps the mentee explore personal concerns that may hinder their ability to feel content or hinder career progress in the organisation (Noe, 1988). According to Hall and Chandler (2007), personal counselling can be particularly important at times of psychological stress, such as being a newcomer in unfamiliar surroundings, learning a new role, or being exposed to stressful situations not previously experienced. Having a mentor who understands mentee emotional needs and demonstrates warmth, encouragement, trust, rapport and listening skills helps the mentee to cope

with difficult situations in a confident manner. In some instances, it may be appropriate for the mentor to share challenges and difficulties they have faced during their career (Hall & Chandler, 2007; Kram, 1985).

2.4.2.4 Role modelling

The final psychosocial mentoring role behaviour is role modelling and is the most frequently reported psychosocial function by mentees. Role modelling allows the mentee to watch, and potentially imitate, mentor behaviours and over time the mentee admires and respects the mentor (Sosik & Godshalk, 2000). Greenhaus and Singh (2007) suggest that role modelling may reduce a mentee stress levels because they are working with a mentor who is more experienced and successful. This is likely to help the mentee to feel more secure and confident in potentially stressful situations. In terms of the organisation, mentors can model behaviours, attitudes, beliefs and skills valued by the organisation (Kram, 1985). By watching a mentor, mentees may become more comfortable that their own behaviours match and mirror those of the organisation (Hall & Chandler, 2007). Over time, the mentee develops their own professional identity and retains some aspects learnt from their mentor, but differentiate themselves with their own style (Kram, 1985).

2.4.2.5 Summary

Essentially, psychosocial behaviours assist mentees to develop a sense of professional identity, competence and confidence brought about by development of an intimate, trusting interpersonal relationship between mentor and mentee. The next section reviews the clinical function of mentoring.

2.5 Mentoring in the health care context

The evolution of mentoring in the acute care nursing context is examined next in relation to the three conceptualisations of mentoring discussed in the early mentoring literature. This is followed by a review of the literature on mentoring for allied health professionals and, lastly, mentoring in the residential aged care context is reviewed.

2.5.1 Acute care nursing

The concept of mentoring first appeared in the acute care nursing literature in the late 1970s (Vance, 1977) and proliferated over the next ten years (Stewart & Krueger, 1996; Yoder, 1990). However, Yoder (1990) was concerned that the acute care nursing literature had not defined the concept of mentoring and confused it with other terminologies such as role modelling, sponsorship,

preceptorship, clinical supervision and peer strategising. This led Yoder (1990) to seek a definition for mentoring in the acute care nursing context. Thus, this author engaged an interdisciplinary approach and reviewed business management, education and acute care nursing literature (Stewart & Krueger, 1996).

Within the business and management literature, mentoring is often described as an organisational occurrence with a career advancement focus (Yoder, 1990). Yoder (1990) saw similarities between mentoring in business and management and the concept of mentoring in the acute care nursing context. She adopted a definition of mentoring by Bowen (1985), presented below, because it most clearly described mentoring programme participants and the purpose of mentoring (Yoder, 1990, p. 11).

> "Mentoring occurs when a senior person (the mentor) in terms of age and experience undertakes to provide information, advice, and emotional support for a junior person (the protege) in a relationship lasting over an extended period of time and marked by a substantial emotional commitment by both parties. If the opportunity presents itself, the mentor also uses both formal and informal forms of influence to further the career of the protégé" (Yoder, 1990, p. 11).

Yoder (1990) acknowledged an issue with the above definition related to age and experience of the senior person being one and the same, as this archetype is not always valid in our changing world. Further, by using this definition Yoder (1990) viewed the concept of mentoring through human development (Kram, 1985; Levinson et al., 1978) and career advancement (Zey, 1984) perspectives. Yoder (1990) also suggested that organisational contexts of hospitals and allied health agencies may not allow for some interpersonal functions of mentoring to be used in the same way as in a business management or educational context.

A subsequent analysis of the literature by Stewart and Kreuger (1996) identified six further attributes of mentoring in acute care nursing, namely:

> "(1) a teaching-learning process, (2) a reciprocal role, (3) a career development relationship, (4) a knowledge or competence differential between participants, (5) a duration of several years, and (6) a resonating phenomenon"(Stewart & Krueger, 1996, p. 312).

The above additional six attributes of mentoring represented a move away from viewing mentoring from human development and career advancement perspectives, highlighting the importance of the teaching and learning perspective. Comparing the studies of Yoder (1990) and Stewart and Kreuger (1996) both agreed on the majority of attributes including dyadic relationship, career development, experience differential of mentor and mentee, duration of relationship and opportunity to mentor others. However, Stewart and Kreuger (1996) identified mentoring primarily

as a teaching and learning process. Of interest is that Stewart and Kreuger's (1996) research was based on doctoral education in acute care nursing. In this context, mentoring and transmission of knowledge may contribute to collaborative professional knowledge development (Stewart & Krueger, 1996, p. 313). In terms of career development, Ardery (1990) cited in (Stewart & Krueger, 1996, p. 314) suggests that mentoring relationships should move away from the personal notion of career advancement and strive for development of a professional body of acute care nursing knowledge. That is, the focus of the mentoring relationship is professional success, not personal success. This means that the content of the relationship, that is, knowledge shared or jointly created between mentors and mentees, is more important than mentoring relationship outcomes. This is a major shift in the concept of mentoring as compared to business and management disciplines (Stewart & Krueger, 1996).

Adoption of a teaching and learning process in acute care nursing is consistent with the learning perspective advanced by Gibb and Megginson (1993), Hale (2000), McCarthy (2014) and Zachary (2011). The shift away from career advancement towards learning and gaining insight means that a mentor is a facilitator of learning and learning is directed by the mentee, not the mentor (Zachary, 2011). In the acute care nursing context, mentoring focuses on the development of the profession, rather than growth of the individual.

As noted previously, much confusion surrounds the cross-over between mentoring, preceptorship, supervision and role modelling in the acute care nursing context (Yoder, 1990). This confusion continues with the relatively recent introduction of the term clinical mentoring, as referred to in the allied health and aged care sectors.

2.5.2 Allied Health Professions

In Australia, allied health professions account for 28.1 percent of growth in the health care and social assistance industry since November 2007 (Australian Government, 2012). Allied health professions registered with AHPRA include physiotherapists, occupational therapists, optometrists, osteopaths, pharmacists, podiatrists and psychologists (Australian Health Practitioners Regulatory Authority, 2015). However, there are a number of other long established allied health professions excluded from the scheme, including dietetics, exercise physiology, speech pathology, audiology, orthodontists/prosthetists, social work and sonography (Solomon, Graves, & Catherwood, 2015). Thus, many practitioners work outside of the regulatory framework concerned with provider accountability and patient safety (Solomon et al., 2015).

One of the many AHPRA requirements is that allied health professionals undertake a minimum number of hours of continuing professional development each year to maintain professional registration (Australian Health Practitioners Regulatory Authority, 2015). To meet these requirements allied health professionals may undertake training programmes provided by employers. However, many allied health professionals are employed in private practice and do not have access to continuing professional development, support and/or supervision available to public sector workers (Lincoln et al., 2013; Struber, 2004). Instead, allied health professionals in private practice often rely on a professional association for clinical training (French & Dowds, 2008; Friedman & Phillips, 2002).

Mentoring is particularly important in supporting transition of new graduates to become professionals in the workplace. Within the public sector, some allied health professionals in rural and remote areas have access to mentoring programmes provided largely in response to past difficulties in retaining staff (Causby, 2003; Moran et al., 2014) (SA Health, 2014; Struber, 2004). In addition to training, many professional associations provide mentoring as an additional benefit of membership, particularly for early career professionals (e.g., (Australian Podiatry Association SA Incorporated, 2015; Dieticians Association of Australia, 2015; Occupational Therapy of Australia Ltd, 2015; Optometry Australia, 2015) (Speech Pathology Australia, 2015).

A review of the literature revealed minimal studies on the allied health professions, especially when practitioners work remotely, for small organisations or as sole practitioners (Causby, 2003; Joubert, 2006; Nolinske, 1995; Paul et al., 2002; Struber, 2004), although more studies have become evident since the inception of AHPRA in 2010. Some of the more recent literature focuses on the areas of retention (Campbell, McAllister, & Eley, 2012; Keane, Lincoln, Rolfe, & Smith, 2013; Keane, Lincoln, & Smith, 2012; O'Brien, Byrne, Mitchell, & Ferguson, 2013), regional services (Buykx et al., 2012; Whitford, Smith, & Newbury, 2012), clinical supervision policy (Dawson, Phillips, & Leggat, 2013; Fitzpatrick, Smith, & Wilding, 2012; Gonsalvez & Milne, 2010) and clinical education (Gillieatt, Martin, Marchant, Fielding, & Duncanson, 2014). As recently as 2015, Solomon et al. (2015) described data available on the Australian allied health workforce as inadequate and insufficient for workforce planning making it difficult to manage the workforce and provide appropriate support services.

Just as there is limited research on the allied health professions, there is even less literature on mentoring in the allied health professions. Some of the literature relates to specific professions,

while other literature is more general and covers many occupations. For example, there is literature involving mentoring and physiotherapy (Ezzat & Maly, 2012; Sanders, Nio Ong, Sowden, & Foster, 2014), social work (Hair, 2012; Webb & Carpenter, 2012), podiatry (Coppin & Fisher, 2015; Coppin & Fisher, 2016), mental health (Lee & del Carmen Montiel, 2011) and physician assistants (Rose et al., 2005). A recent study by Bell et al. (2014) suggests a move away from in-service professional support, which is generally considered as supervision, to more reflective professional supervision, peer group supervision and mentoring. Another study, by Moran et al. (2014) reviewed forty-three articles from across the world and evaluated a variety of support strategies used by health professionals working in rural and remote areas. Of these support strategies, two relate specifically to mentoring programmes and the interventions used were predominantly training and education programmes. Further, Moran et al. (2014) reported an absence of literature on the evaluation of support, supervision and mentoring interventions used by health professionals. The researcher also found it difficult to review the mentoring process in allied health, however with the emphasis placed on training and education, mentoring is likely to be conceptualised as a learning process.

2.5.3 Residential aged care

According to a 2016 Aged Care Workforce Census and Survey, over 153,000 workers were employed in direct care roles in residential aged care facilities in Australia. Of these, 15 percent were registered nurses, 10 percent enrolled nurses, 70 percent personal care attendants and 5 percent allied health professionals. Of the total direct care staff, 11.9 percent were employed on a permanent full-time basis, 78.1 percent on a permanent part time basis and 10 percent on a casual or contract basis (National Aged Care Workforce Census and Survey, 2016). Further, nearly 52.2 percent of the direct care workforce were 45 years of age or older, which was higher than the average age of Australian workers which was 39.5 years in 2014 (Australian Bureau of Statistics, 2014). The aged care sector is associated with lower pay and status than other areas (King, Wei, & Howe, 2013a) and working conditions within residential aged care are recognised as physically and psychologically demanding. Workers are often subject to significant stress levels which can lead to burnout in extreme situations (Hayes et al., 2015; Laschinger & Fida, 2014).

Until recently, literature on residential aged care was limited and concentrated on nurses rather than paraprofessionals working at these facilities (Block et al., 2005; Cameron & Brownie, 2010; Chenoweth et al., 2014; Jeon et al., 2010a; Karantzas et al., 2012; Omansky, 2010; Stack, 2003). In the last few years research into residential aged care and experiences of care workers has increased with a number of articles being published in various areas including occupational status of care

workers (Ostaszkiewicz, O'Connell, & Dunning, 2016), psychological health (McCaughey, Turner, Kim, DelliFraine, & McGhan, 2015), paramedics and dementia (Lucas et al., 2013a; Lucas et al., 2013b), leadership (Jeon, Simpson, Chenoweth, Cunich, & Kendig, 2013; Jeon et al., 2015b) and aged care generally (Australian Government, 2012; Fedele, 2015; King et al., 2013b).

Although research on residential aged care has increased in the last few years, research on mentoring in the residential aged care context remains limited. A recent study by Jamieson and Grealish (2016) refers to academic mentoring with the purpose of providing teaching, learning and research in aged care. Another study by Meissner and Radford (2015) examined the capability of middle managers in aged care to provide leadership and undertake on-going training in management and leadership. Meissner and Radford (2015) identified a need for training of middle managers to go beyond clinical skills development and include communication skills, self-awareness, change management, conflict resolution and leadership skills to improve organisational performance.

Annear, Lea and Robinson (2014) and Lea, Marlow, Bramble, Andrews, Crisp, Eccleston, Mason and Robinson (2014) studied mentoring of nursing students completing placements in residential aged care facilities and the appropriateness of care workers mentoring student nurses. These studies found that it was important for student nurses to learn the basics of hygiene and dementia care that are typically performed by care workers in residential aged care facilities. Therefore care workers contribute to the mentoring process for student nurses. However, with so few studies on mentoring in the residential aged care context, it is difficult to conceptualise the mentoring process for student nurses. As with allied health, emphasis is placed on training and education, therefore mentoring is likely to be conceptualised as a learning process.

Recent research for the Australian Government, Department of Social Services by Resthaven Incorporated (Morey, 2015) focused on developing a model for residential aged care that provides clinical mentors and site champions at residential aged care facilities. Development of clinical mentoring is discussed in the next section.

2.5.4 Clinical mentoring

In the mid 2000's the term clinical mentoring emerged in the literature. However, as with the term 'mentoring' in general, there are several descriptions of 'clinical mentoring' and differences in support a clinical mentor provides. The literature on this topic has only appeared in the last ten years or so, and descriptions provided thus far are from the professional literature. Six perspectives of clinical mentoring are discussed in this section.

2.5.4.1 Clinical mentoring perspectives

One of the first uses of the term clinical mentoring was by the World Health Organisation in recommendations for clinical mentoring to support HIV care in resource-constrained areas (World Health Organisation, 2006). The World Health Organisation (2006, p. 8) defined clinical mentoring as "a system of practical training and consultation that fosters ongoing professional development to yield sustainable, high-quality clinical care outcomes". This description relates specifically to training and professional development in clinical practice, but does not include other mentoring functions of career and psychosocial support. In the antiretroviral therapy context, a clinical mentor is an experienced clinician with substantial expertise who provides ongoing mentoring to less experienced HIV clinical providers. "Support is provided by answering questions, reviewing clinical cases, providing feedback and assisting case management" (World Health Organisation, 2006, p. 4). Mentoring is delivered during site visits, by telephone or e-mail consultation (World Health Organisation, 2006). World Health Organisation guidelines specifically exclude some activities from the explanation of clinical mentoring, namely, shadowing or clinical rotation, referral care, process improvements and counselling mentoring (World Health Organisation, 2006).

A second perspective of clinical mentoring in the professional literature is provided by the International Training and Education Center on HIV (I-TECH), a global network providing health care providers working in the infectious diseases with clinical mentor training. I-TECH (2008, p. 3) defines clinical mentoring as "a sustained, collaborative relationship in which a highly experienced health care provider guides improvement in the quality of care delivered by other providers and the healthcare systems in which they work". I-TECH clinical mentors are experienced clinician-trainers providing onsite training and consultation on complex cases, supporting high-level problem-solving, diagnostic and decision-making skills. Clinical mentors also lead case discussions and address issues of quality assurance and continuing education (I-TECH, 2008).

A third perspective of clinical mentoring in the professional literature is provided by the Vermont Nurses in Partnership (VNIP) in the United States (Boyer, 2011). This organisation suggests that early career nurses and allied health professionals need additional transitional support beyond the 'preceptorship' period. They identified this stage as clinical mentoring. Clinical mentoring differs from traditional mentoring in that it uses a framework of clinical expertise, known as the Benner model (Boyer, 2011). The Benner model of nursing outlines five stages of proficiency for nurse development from novice to advanced beginner, to competent, to proficient and finally, expert and is based on the Dreyfus model of skill acquisition (Benner, 1982). In the acute care nursing context, experience, in terms of acquiring expertise, is more than the "passage of time or longevity as it includes refinement of preconceived ideas and theory by facing many practical situations that add nuances or shades of differences in past experiences"(Benner, 1982, p. 407). Accumulation of these experiences takes a number of years, far beyond the 'preceptorship' period. Hence, the need for clinical mentoring as described by the VNIP (Boyer, 2011). Clinical mentoring provided through the VNIP mentoring programme gives continued support to early career nurses where clinical mentors to act as a sounding board, support development of critical thinking and validate mentee clinical judgment. Over time, clinical mentoring may transition to professional mentoring where an off-site mentor may assist the mentee to develop interests in other areas, such as education, leadership or specialty nursing (Boyer, 2011).

A further description of an acute care nursing mentor is provided in the Nursing and Midwifery Council's Standards to Support Learning and Assessment in Practice (Nursing Midwifery Council, 2008) which relates to the United Kingdom (UK). The Nursing Midwifery Council (2008) standards state that the mentor's role is to "facilitate learning for a range of students, within a particular area of practice where appropriate, encouraging self-management of learning opportunities and providing support to maximise individual potential" (Nursing Midwifery Council, 2008, p. 51). In this description, the mentor is a facilitator of learning and a teacher. There is scope for the mentor to decide on the level of supervision provided to the mentee and how much supervision is delegated to the nurses on duty, but overall mentors are responsible for the student experience. Under UK standards, a mentor requires additional training to be a sign-off mentor and undertake student assessments (Craig & Smith, 2014).

A fifth perspective of clinical mentoring from the professional literature on allied health professionals is provided by the SA Health Allied Health Clinical Supervision Framework (SA Health,

2014). The framework clearly differentiates clinical supervision, line management and mentoring, as detailed in Table 2.2 below.

The clinical supervision framework acknowledges that "it is preferable to separate clinical supervision and mentoring from line management due to the inherent power imbalances that exist within a line management relationship (Smith, 2005)" (SA Health, 2014, p. 8). However, this is not always possible within team structures in the public health sector. Also, the large number of allied health professionals who work as the sole representative of a profession in the public sector context provides a challenge for clinical supervision and mentoring.

Table 2.2: SA Health Allied Health Clinical Supervision Framework 2014

Clinical Supervision	Operational Line Management	Mentoring
Driven by clinical development needs of the clinician	Driven by service delivery, team and individual development needs and requirements.	Deliberate matching of two clinicians, one generally with more experience than the other.
Targeted to promote enhanced client outcomes and safety	Manages performance	Focuses on growth and career development of the mentee through supporting, guiding, advising
Teaches and facilitates best practice knowledge and skills acquisition in clinical practice and guides professional development needs	Manages human resource issues, such as staff development, mandatory training and annual leave	Supports skill and knowledge acquisition through reflection and assistance to develop plans to achieve goals
Provides a forum for discussion of ethical practice issues	Allocates and monitors workload or caseload proactively in collaboration with clinician and supervisor	Regular dialogue on a range of issues selected by the mentee
Promotes reflective practice	May promote reflective practice in context of service delivery needs	Promotes reflective practice and personal appraisal
Supervisor typically involved in day-to-day work of clinician	Manager involved in day-to-day work of the clinician	The mentor not involved in day-to-day work of the clinician
Formal process	Formal process	Voluntary process

Source: SA Health (2014, p. 8).

According to the framework, mentoring of allied health professionals takes place between two clinicians and involves regular discussions on a range of issues with the goal of having the lesser "skilled clinician grow, develop and address career development where desired" (SA Health, 2014, p. 8). The focus of mentoring is on the needs and issues of the mentee. The role of the mentor is to encourage conversation and reflective practice, as well as broaden the mentee knowledge base.

Importantly, the mentee should choose the type of mentor who may work best for them (SA Health, 2014).

The last perspective of clinical mentoring reviewed for this thesis is a contemporaneous study undertaken for the Australian Government Department of Social Services by Resthaven Incorporated (Morey, 2015). This study provided a definition of an aged care clinical mentor as "a leader who facilitates improved quality of care for older people using best practice by providing and encouraging professional development in colleagues through communication, education and peer support" (Morey, 2015, p. 14). The role of the aged care clinical mentor is to implement best practice within aged care services in order to achieve continuous improvement in clinical services. The clinical mentor identifies an area of clinical priority, for example wound management, dementia, pain management or manual handling that requires improvement and then identifies a site champion or clinical coach to implement an up-skilling programme for direct care staff at a particular site. The study suggests there should be one clinical mentor for an organisation and a site champion or clinical coach at each aged care location (Morey, 2015).

As outlined above, there are many interpretations and perspectives of clinical mentoring within the medical, acute care nursing, allied health and aged care contexts, but two areas are common to all of these descriptions: professional development and training. Some descriptions are broader than others. For example, the I-TECH description includes quality control and psychosocial support, in the form of role modelling whereas the tightest description is that of the aged care clinical mentor that revolves around maintaining quality control and continuous improvement of processes.

2.5.4.2 Integration and operationalisation of clinical mentoring used in this thesis

The theoretical and professional literature on clinical mentoring provides limited information on the components of clinical mentoring. In fact there appears to be an implicit assumption that the meaning of clinical mentoring is widely understood. From the six perceptions of clinical mentoring outlined above, the researcher based this research on the six components outlined in the I-TECH description (I-TECH, 2008). The components include; complicated cases, continuing education, case discussions, psychosocial support, on-site training and quality control. The researcher has drawn from the wider literature to explain the components of clinical mentoring in greater depth and describe the differences to career and psychosocial mentoring.

Complicated cases

The first component of clinical mentoring is complicated cases. In a clinical acute care setting, complicated cases require diagnosis and problem-solving skills (I-TECH, 2008; World Health Organisation, 2006). In diagnosis of a medical condition a standard process is followed according to presenting symptoms of the patient. It follows that if certain symptoms lead to diagnosis of a particular condition, there is an increased probability that another patient with the same symptoms is likely to receive the same diagnosis, for example influenza (Glouberman & Zimmerman, 2002). However, cases can be complicated by additional medical illnesses such as human immunodeficiency virus (HIV) care and the support and guidance of clinical mentors in the field provides support to health care workers (I-TECH, 2008; World Health Organisation, 2006).

Continuing education

The second clinical mentoring component is continuing education. The World Health Organisation (2006) states that continuing education needs to be emphasised as part of a clinical mentoring programme because very few countries have a system of continuing education and ongoing clinical training. Clinical mentoring is extremely important in slowing "the spread of HIV drug resistance" (World Health Organisation, 2006, p. 7). In the developed world, however, continuing medical education, or continuing professional development, is a requirement for membership of professional associations and practice registration with AHPRA. Continuing education is provided in a variety of ways and does not have to be a regulated under the Australian Qualifications Framework (Australian Qualifications Framework, 2013). As detailed by Davis, O'Brien, Freemantle, Wolf, Mazmanian, Taylor and Vaisey (1999) there are many activities that provide formal continuing medical education professional development, such as conferences, workshops, lectures, small group tutorials, discussions, teleconferences and practical teaching with videotaped patients and educational materials. Davis et al. (1999) concluded that didactic sessions, such as conferences and lectures, did not provide a change in physician performance, whereas interactive sessions with a clinical mentor provide an opportunity to practice skills and were more likely to effect change on professional practice and health outcomes.

Case discussions

The third function of clinical mentoring is case discussions. Case discussions allow "participants to discuss and learn about cases or approaches that they would otherwise not have been exposed to,

hear about a range of perspectives, get feedback from others and feel comfortable to ask questions and express concerns" (SA Health, 2014, p. 25). A clinical mentor may facilitate case discussions between clinicians to ensure sharing and learning. Case discussions in health care teams are also used routinely to review individual cases (Robinson, Stacy, Spencer, & Bhopal, 1995). These cases may represent effective or ineffective practice and are used to improve quality of care. The aim is to use case discussions to identify specific events without assigning blame or self-criticism (Robinson et al., 1995). Case discussions can also be used as an audit process for improving quality of care.

Psychosocial support

The fourth component of clinical mentoring is psychosocial support, comprising of three elements: role modelling, workplace behaviour and communication (I-TECH, 2008). Psychosocial support in clinical mentoring is different to the underlying behaviours of psychosocial mentoring. Psychosocial behaviours include acceptance and confirmation, friendship, counselling and role modelling. The only behaviour that overlaps is role modelling. Another difference is that counselling is not an activity provided by clinical mentoring (World Health Organisation, 2006). Interestingly, evidence is building in acute care nursing literature "to suggest that the psychological demands of nursing are pivotal factors in promoting the development of symptoms of stress" (Kravits, McAllister-Black, Grant, & Kirk, 2010, p. 131) and this is considered a risk factor for burnout in the profession. Environmental stressors for nurses include pain, suffering, death, continually changing technology and challenging institutional and ethical issues (Kravits et al., 2010). As such, there is a need to develop intervention programmes to assist nurses in developing stress management plans and appropriate coping strategies which may include resilience training, communication, bereavement workshops, career development and stress management (Barnard, Street, & Love, 2006; Kravits et al., 2010; Sherman, Edwards, Simonton, & Mehta, 2006). Psychosocial support in clinical mentoring is very much about mentors teaching and guiding mentees (I-TECH, 2008). This is in contrast to psychosocial mentoring generally that includes emotional support for mentees (Kram, 1985).

On-site training

The fifth function of clinical mentoring is on-site training. The literature refers to on-site training as practical training that follows theory learned in the classroom (Andrews & Wallis, 1999), such as bedside teaching in a clinical setting (World Health Organisation, 2006), clinical work placement for an allied health professional (SA Health, 2014) or work placement in a residential aged care facility (Australian Qualifications Framework, 2013). The World Health Organisation clinical mentoring

guidelines refer to overlap of clinical mentoring and supportive supervision and in the context of the World Health Organisation HIV programme "clinical mentors need to be experienced practising clinicians in their own right" (World Health Organisation, 2006, p. 10). Further, in this context, managers at the district level do not have time to be clinical mentors, therefore the system relies on clinical mentors visiting a variety of locations. As such, clinical mentors tend to incorporate supportive supervision activities in relation to clinic management and clinician mentoring activities (World Health Organisation, 2006). Another aspect relevant to on-site training is the ability of clinical mentors to guide reflective practice for clinicians. Reflective practice is also relevant for acute care nursing and allied health professionals (SA Health, 2014).

Quality control

The sixth function of clinical mentoring is quality control. Quality control in the World Health Organisation HIV programme context is concerned with improving the clinical environment, rather than an audit of care quality provided (World Health Organisation, 2006). In the allied health and nursing contexts, professionals are required to be registered with AHPRA and meet the requirements of their particular professional body to gain professional registration to practice in their field (Australian Health Practitioners Regulatory Authority, 2015). The Australian Government relies on the Australian Aged Care Quality Agency (AACQA) to manage performance of the residential aged care industry. Residential aged care services must achieve and maintain the minimum standards necessary to receive an Australian Government subsidy towards resident care (Baldwin, Chenoweth, dela Rama, & Liu, 2015). AACQA conducts site audits on a regular basis and where the AACQA identifies serious issues sanctions may be imposed on residential aged care providers who have breached their responsibilities under the Australian Aged Care Quality Agency Act 2013, or who have failed to implement necessary improvements as determined by AACQA (Baldwin et al., 2015). As such, AACQA requires residential aged care facilities to maintain detailed documentation in terms of the Australian Aged Care Quality Agency Accreditation Standards (Australian Aged Care Quality Agency, 2014). Therefore, quality control is an important component of clinical mentoring in the health industry.

In conclusion, clinical mentoring assists in development of a mentee's professional and clinical skills, by providing continuing education, on-site training, reflective practice, teaching and guidance within a quality control process.

2.6 Forms of mentoring

Mentoring can be provided informally or formally through an organisation based mentoring programme. While a review of the wider literature shows that limited research has been undertaken on formal mentoring in comparison to research on informal mentoring (Baugh & Fagenson-Eland, 2007), some research on both formal and informal mentoring programmes has been undertaken in the nursing literature (Dorsey & Baker, 2004; Ehrich, Tennent, & Hansford, 2002; Stewart & Krueger, 1996; Tourigny & Pulich, 2005; Yoder, 1990). Identifying the nature of mentoring provided by organisations is sometimes difficult because much of the literature does not comment on the nature of the mentoring relationship or fails to distinguish between formal and informal mentoring dyads (Baugh & Fagenson-Eland, 2007; Blake-Beard et al., 2007). In the following section, formal and informal mentoring is discussed based on the wider mentoring literature.

2.6.1 Informal mentoring

An informal mentoring relationship differs in structure to formal relationships and this is evident from the beginning of the mentoring relationship (Chao, Walz, & Gardner, 1992; Ragins & Cotton, 1999; Underhill, 2006). Kram identified four phases in an informal mentoring relationship, namely initiation, cultivation, separation and redefinition. The initiation phase is where the mentor and mentee get to know each other (Kram, 1983). With informal mentoring, relationships are formed with between pairs based on attraction and sense of connection (Kalbfleisch, 2000). Thus, by the time they might think of themselves as a mentoring pair the developmental relationship is well underway (McGowan, Stone, & Kegan, 2007).

Informal mentoring relationships are different due to the purpose, strengths, needs and desires of the mentor and mentee (Allen, Day, & Lentz, 2005). The duration of the informal relationship is not restricted to a given period of time and will, therefore, continue as long as both parties remain in contact. However, as noted by Kram (1983), the nature of the relationship may change over time. The research sample of Kram (1983) had an average of five years in a mentoring relationship. Therefore, there was ample time for the mentoring relationship to pass through the four phases of initiation, cultivation, separation and redefinition. The time duration is shorter in formal mentoring programmes.

In informal mentoring the developmental needs of the mentee are likely to have been agreed with the mentor prior to the relationship being recognised as a mentoring relationship (Allen & Eby, 2003). Higgins and Kram (2001) suggest that these developmental needs have a career or

psychosocial focus. As mentors and mentees select each other based on perceptions of similarity, Blake-Beard O'Neill and McGowan (2007) further suggest that informal mentoring pairs share the same approach to development. As such, these informal mentoring pairs are already in agreement on the relationship focus which makes it easier to have a relationship based on similar goals and expectations (Blake-Beard et al., 2007).

Informal mentoring relationships do not have to follow formal processes in relation to the frequency, length or context of meetings. Thus, meetings can be casual, although it is likely that the dyad establishes its own norms. A lack of formality provides the informal relationship with an element of anonymity not always available in formal relationships or group mentoring (Baugh & Fagenson-Eland, 2007).

2.6.2 Formal mentoring

Formal mentoring relationships are developed through organisational mentoring programmes where mentors and mentees are assigned to a dyad for a fixed period (Baugh & Fagenson-Eland, 2007). Formal mentoring programmes may take on the appearance of traditional, hierarchical, one-on-one mentoring approach. However, over the past two decades formal mentoring has taken on peer relationships, team mentoring, mentoring circles and structures networks as well as a variety of electronic mediums for delivery. Research on formal mentoring is limited, relative to research on informal mentoring. However, the professional literature abounds with anecdotal evidence of successful formal mentoring programmes. Nevertheless, without proof of formal mentoring programme effectiveness organisations are committing management time and financial resources without knowing what outcomes to expect. This is a real problem for organisations and mentoring programme developers (Baugh & Fagenson-Eland, 2007).

There are structural differences between formal and informal mentoring which need to be discussed. Formal mentoring programmes may be created by organisations to address specific needs, for example for new workers entering a profession or industry such as health (Causby, 2003; Moran et al., 2014; SA Health, 2014; Struber, 2004). On the other hand, informal mentoring occurs spontaneously. The majority of research has been conducted on informal mentoring relationships (Baugh & Fagenson-Eland, 2007). Organisations quickly recognised that workers who had informal mentors were more productive and successful (Baugh & Fagenson-Eland, 2007). As such, organisations wanted to replicate the perceived benefits of mentoring and developed formal mentoring programmes. However, essential structural features of formal mentoring programmes

impact on formal relationships created and as such cannot fully replicate the informal mentoring relationship (Baugh & Fagenson-Eland, 2007).

Formal mentoring programmes vary considerably in structural aspects of programme establishment. In particular, initiation and duration of a mentoring relationship are determined by the organisation according to programme purpose. Formal mentoring programmes are generally run for a maximum of twelve months (Baugh & Fagenson-Eland, 2007). In the initiation phase, formal mentoring programmes use a variety of mechanisms to match mentors and mentees. The selection of dyads may be random, or mentors and mentees may be carefully selected "according to the unique needs they can fulfill for one another" ((Baugh & Fagenson-Eland, 2007, p. 251). Thus, formal mentoring relationships are usually set up to meet specific organisation goals. In formal mentoring programmes, there are limits on time available for the four stages of the mentoring relationship that has implications for progress of a formal mentoring relationship (Kram, 1983). If the relationship survives the timeframe of the programme, the mentor and mentee may continue an informal mentoring relationship.

Formal mentoring relationships begin differently to informal relationships and go through a stage of orientation, or setting the future direction of the mentoring relationship (McGowan et al., 2007). The orientation phase is the initial process of negotiating the relationship between mentor and mentee and mentoring functions to be provided. Further, because formal mentoring programmes are sponsored by an organisation there are additional structural elements, such as number of meetings and programme length that may impede on the mentoring relationship (Blake-Beard et al., 2007).

In formal mentoring programmes there is training usually takes place for mentors or mentees, or both. This training may be extensive depending on organisation requirements. Often in organisational programmes mentors and mentees may be known to each other and work within group situations. This provides potential for information sharing, but has the downside of confidentiality issues. Formal mentoring programmes do have risks. For instance, a poorly performing mentee may reflect badly on a mentor, or mentee performance may be rated on the mentee-mentor relationship rather than on work undertaken. (Baugh & Fagenson-Eland, 2007).

While the literature on success of formal mentoring programmes is limited, the health sector uses a variety of formal programmes for new graduates and early career professionals to assist transition

from theory to practice, such as preceptorship, clinical supervision, clinical mentoring and elements of psychosocial and career mentoring.

2.7 Programme delivery methods

2.7.1 Individual mentoring

Mentoring is a relationship between two individuals and from a learning outcomes perspective there is always an individual or personal learning outcome. That is, each person learns something different from the relationship, either positive or negative. Early career development researchers recognised that both mentors and mentees benefited from mentoring relationships (Clawson, 1980; Dalton et al., 1977; Hunt & Michael, 1983). This was followed by Kram's (1985) research on developmental mentoring relationships which highlighted the "mutuality and reciprocity of mentoring relationships" (Allen, 2007, p. 123). Even so, much of the early research focused on the mentee experience rather than that of the mentor (Allen, 2007). In the nursing context, mentoring is a personal teaching-learning process between two individuals of diverse experience and background (Mills, Francis, & Bonner, 2008).

In a mentoring relationship, the mentor and mentee take on different roles and responsibilities in the relationship and success of the relationship depends on behaviours of both parties. In an organisational sense, a mentor has a key role in facilitating the transfer of knowledge to new workers and to prepare less experienced workers for career advancement within the organisation, or another organisation (Kram & Hall, 1996). Further, the mentor may also support the mentee to develop psychosocial skills important in personal learning. Lankau and Scandura (2007) suggest that individuals experience learning through their own past experiences and this type of personal learning has the ability to change how an individual sees themselves in the broader context. In other words, an individual requires self-awareness and the ability to reflect, but the quality of the developmental experience can be increased with support of a mentor who can provide "feedback, empathy, social support and real-time reflection" (Lankau & Scandura, 2007, p. 117).

2.7.2 Group mentoring

The majority of mentoring research deals with dyadic relationships (Kram, 1985; Ragins & Scandura, 1997). However, Eby (1997) expanded the term mentoring to include alternative forms of group mentoring, including team-based mentoring and professional association mentoring. Dansky (1996) identified four components of group mentoring as networking, inclusion, role modelling and psychosocial support, and found that professional associations could function as a team and provide

mentoring functions. Some research of group mentoring has been undertaken in the nursing context (Kostovich & Thurn, 2013; Scott & Smith, 2008).

Group mentoring is distinctive because mentoring "emerges from the dynamics of the group as a whole rather than the relationships with any one person" (Dansky, 1996, p. 6). The development of group mentoring theory is centered on using strengths of previously developed one-to-one mentoring relationships combined with the benefits of group learning (Carvin, 2011; Emelo, 2011a; Huizing, 2012; Johns & McNamara, 2014; Scott & Smith, 2008).

In many respects, group mentoring may take on the appearance of classroom training. However, classroom training is different to mentoring. Trainers deliver pre-prepared material, and each learner receives the same set of knowledge (Carvin, 2011). On the other hand, group mentoring provides a safe and confidential environment to explore and share personal challenges. It also offers a forum for reflection on particular actions and allows the mentor to guide rather than train. Usually, topics of discussion fall outside of formal training. The main advantages of group mentoring are that mentors and mentees can share experiences and reflect on better ways of doing things in a non-threatening environment. Each mentee can apply the knowledge gained to their circumstances. Group mentoring also provides a forum where mentors and mentees can socialise and build networks with other like-minded individuals (Carvin, 2011). Further, group mentoring promotes greater coverage for a professional association or organisation, allowing fewer mentors to mentor more mentees (Dansky, 1996).

Within the scope of group mentoring Huizing (2012) described four different models of group mentoring. These include peer group mentoring (PGM), one-to-many group mentoring (OTMM), many-to-one mentoring (MTOM), and many-to-many mentoring (MTMM). The distinction between the types is helpful in understanding the best type of group mentoring to use in a particular situation. Throughout this thesis, group mentoring is used as a general term to represent the four different types of group mentoring described above.

Most of the group mentoring literature has focused on the two models of PGM and OTMM (Huizing, 2012; Johns & McNamara, 2014; Redmond, 2015; Skaniakos, Penttinen, & Lairio, 2014). In a recent literature review on group mentoring theory and practice, Huizing (2012, p. 51) identified only five previous studies using the MTMM model and suggested "MTMM has the most promise for further research".

MTMM goes beyond a networking group as it involves a group of people who interact for the purpose of personal and professional development (Holbeche, 1996). Benefits of MMTM include "collaboration of ideas, mutual understanding, and the development of lifelong learning" (Huizing, 2012, p. 35). Further, it provides a safe place to share experiences, an opportunity to meet others, build relationships and networks (Dansky, 1996; Scott & Smith, 2008). It also promotes feelings of inclusion and belonging and provides an opportunity for role modelling and psychosocial support (Dansky, 1996; Huizing, 2012).

An advantage of MTMM is that there are two or more people in the mentoring relationship clearly identified as mentors, thereby providing the group with experienced individuals to guide mentees (Huizing, 2012). Saarnivaara and Sarja (2007) found that by encouraging exploration, experimentation and risk-taking through MTMM, participants had the opportunity to engage and build networks within their profession. That is, mentees gained a broad range of ideas from several mentors within the profession in a non-threatening environment.

Inclusion is an important role of group mentoring (Dansky, 1996). The shared identity of belonging to a group provides opportunities to strengthen social and professional networks that may lead to further career advancement. Also, for reasons of self-efficacy, some individuals have a stronger need to 'belong' than others (Dansky, 1996).

Another role of group mentoring identified by Dansky (1996) is role modelling. The group mentoring environment provides the opportunity for mentees to observe and model behaviours of mentors and learn successful behaviours. Role modelling can create "changes in attitudes, values, and styles of operation" Dansky (1996, p. 16).

Group mentoring also provides psychosocial support (Dansky, 1996). In a group setting the exchange of information and feelings of friendship are communicated through the social network (Dansky, 1996). Further, the psychological benefits of being included in a group promote self-esteem and self-confidence, as well as a place to share anxieties and show empathy for others. The sharing of emotions in a safe environment is one of the strengths of group mentoring (Saarnivaara & Sarja, 2007).

In a study of a professional association group mentoring programme, Dansky (1996) found that networking, role modelling and psychosocial support were more important than skill development typically undertaken in professional association continuing professional development programmes.

Thus, Dansky (1996) concluded that "professional groups may serve their members better by teaching less and nurturing more" (Dansky, 1996, p. 17). The literature also raises some concerns about inclusion in group mentoring, in particular, the "suspicion of peers, the need for training, and the argument that peers cannot help each other get beyond their own professional or personal level" (Huizing, 2012, p. 34). Other issues, such as lack of confidentiality, facilitation and dominating personalities within the group, can also create concerns for participants. These are more apparent in some types of group mentoring than others.

Effective organisation and facilitation can ameliorate difficulties in face-to-face and online group mentoring (Carvin, 2011; Moran et al., 2014; Scott & Smith, 2008). The role of a facilitator is to introduce the group, provide moderating instructions for online groups, encourage participation, clarify expectations and ensure the mentoring group remains focused (Carvin, 2011). Further, access to mentoring training for mentors, mentees and facilitators is essential to the success of a mentoring programme (Clutterbuck, 2004; Moran et al., 2014). Also, an understanding of the roles and responsibilities, qualities of a good mentor, phases of the mentoring relationship and limitations of mentoring provide the basis for improved attitudes to mentoring and increased confidence in practice, skills and knowledge of mentees (Moran et al., 2014).

2.7.3 Face-to-face mentoring

Mentoring has traditionally been delivered in a face-to-face environment. However, with the advent of digital technologies the way that mentoring is delivered has changed to include electronic mentoring (e-mentoring). Some research has compared face-to-face and e-mentoring delivery in the wider mentoring literature (Ensher & Murphy, 2007; Johnson, Aragon, Shaik, & Palma-Rivas, 2000; Shrestha, May, Edirisingha, Burke, & Linsey, 2009; Smith-Jentsch, Scielzo, Yarbrough, & Rosopa, 2008). The nursing literature also includes research into mentoring delivery methods (Byrne & Keefe, 2002) (Dorsey & Baker, 2004; Gibson & Heartfield, 2005; Mills et al., 2008). Online learning can be an effective platform for learning and teaching in the health industry particularly for continuing professional development. However, mentees often prefer face-to-face delivery where questions can be asked and feedback provided immediately and related to the specific circumstance (Mills et al., 2008). Other advantages of face-to-face mentoring include being able to engage with body language, build trust and rapport more quickly, feel more confident about privacy and confidentiality and be able to correct misunderstandings immediately (Ensher & Murphy, 2007).

2.7.4 E-mentoring

Group mentoring may take place using forms of delivery other than the traditional face-to-face method. For example, online forums provide mentees with the opportunity to appreciate many different viewpoints and see the discussion unfold (Meskill & Anthony, 2005). Another advantage of an online forum is that geographically dispersed mentors and mentees can interact directly, with information shared quickly and efficiently to a broad audience. Equally, information can be challenged, meaning that an online forum requires an experienced facilitator/moderator to work effectively (Celik, 2013). Further, Richardson and Ice (2010) as cited by (Celik, 2013, p. 666) suggest that "online forums stimulate collaborative learning, as users bring their own prior experiences and individual perspectives to an ongoing exchange of ideas". In the health context, online programmes and simulations are often used to enhance learning and provide training for workers in individual or group situations (Mills et al., 2008).

While there are benefits to collaborative learning, not all online programmes are successful. The literature suggests several reasons for this, including structure and content of online groups, facilitation and competence of users in using web-based communications (Celik, 2013). Further, relationships between group members can significantly influence the overall group learning experience (Swan, 2004). The effect of social interaction and group unity applies to all group situations whether face-to-face or online. In particular, attitudes of members participating in an online forum affect willingness to engage in discussions (Celik, 2013).

Previous research (Clouder et al., 2006; Meskill & Anthony, 2005) has noted several issues with online discussion forums. For example, some participants may be overly negative and critical of others; there may be a predisposition for a small number of participants to dominate conversation; the forum may create a competitive atmosphere, and fear of criticism may minimise the benefits of online interaction (Celik, 2013). In this type of forum, it is easy for comments to be misinterpreted and seen as criticism when this is not the intention (Celik, 2013). A missing link for online communication is lack of facial expressions, hand gestures and other non-verbal cues. Other issues raised in the online group mentoring literature include time constraints, compatibility of participants, lack of motivational material, no defined theme and discomfort with the group environment (Huizing, 2012).

In this chapter, the researcher reviewed the mentoring literature from the three perspectives of human development, career advancement and learning processes, and linked these to business

management and health care contexts. This was followed by a discussion of career, psychosocial and clinical mentoring and mentor role behaviours and the different forms of mentoring and process of mentoring delivery were discussed. Review of the literature provides a backdrop for addressing the research problem and research questions through examination of experiences and expectations of allied health professionals and residential aged care workers in a variety of contexts and formats measured against psychological capital.

2.8 Positive organisational behaviour and Psychological capital

While it is important to discuss the overall phenomenon of mentoring in the allied health and residential aged care settings, it is also important to consider organisational outcomes achieved through delivery of mentoring programmes. However, little is known about psychological benefits of mentoring and their relationship to positive organisational behaviour. If mentoring provides career and psychosocial benefits and, arguably, clinical mentoring has an added training outcome, mentoring should impact on some aspects of psychological capital. As such, psychological capital was chosen to measure the psychological benefits of mentoring.

Underpinning the core construct of psychological capital is positive organisational behaviour. Positive organisational behaviour is defined as "the study and application of positively oriented human resources strengths and psychological capacities that can be measured, developed and effectively managed for performance improvement in today's workplace" (Luthans, 2002, p. 59). According to Bakker and Schaufeli (2008) positive organisational behaviour has similarities to positive organisational scholarship, a conceptual framework which draws from the positive psychology movement (Luthans & Youssef-Morgan, 2017). Positive organisational scholarship is defined as ''the study of that which is positive, flourishing, and life-giving in organisations. Positive refers to the elevating processes and outcomes in organisations. Organisational refers to the interpersonal and structural dynamics activated in and through organizations, specifically taking into account the context in which positive phenomena occur. Scholarship refers to the scientific, theoretically derived, and rigorous investigation of that which is positive in organisational settings' (Cameron & Caza, 2003, p. 731). The definition of positive organisational scholarship emphasises the positive aspects of organisations whereas positive organisational behaviour is concerned with individual psychological states and human strengths that influence employee performance (Bakker & Schaufeli, 2008, p. 149).

Within the positive organisational scholarship framework Cameron & Spreitzer (2012) as cited by (Luthans & Youssef-Morgan, 2017, p. 340) identified four characteristics of positive approaches. The first positive approach is to "adopt a unique or alternative lens that alters the interpretation of phenomena which by themselves may or may not be positive" (Luthans & Youssef-Morgan, 2017, p. 340). That is, viewing a problem as an opportunity for learning and growth rather than as an obstacle that cannot be overcome. The second approach is to channel a negative deviance into a positive deviance characterised by extraordinary positive outcomes. A third positive approach is positively biased towards placing a higher weight on positive concepts and outcomes rather than negative ones. The fourth positive approach emphasises the best of human condition where positivity is practised for its own sake and not as a means to other ends. While the positive organisational scholarship framework focuses on positive outcomes it also values negative constructs and negativity and the purpose they serve. For example, negativity may be a response to a perceived threat that requires immediate action whereas positivity implies there is no need to change. Thus within organisations this may limit motivation for change (Luthans & Youssef-Morgan, 2017).

Within the positive organisational scholarship framework, positive organisational behaviour focuses more on specific positive psychological constructs of an individual that have the ability to increase employee outcomes. Through the lens provided by positive organisational behaviour researchers have found that positive employee behaviours can be advanced in the workplace. Luthans, (2002) as cited by (Luthans & Youssef-Morgan, 2017) identified the need for a psychological construct to be included in positive organisational behaviour that was evidence-based, consistent with positive psychology, with valid and reliable measurement, open to development and management and "related to desirable and measureable work attitudes, behaviours and performance criteria" (Luthans & Youssef-Morgan, 2017, p. 342). The constructs of hope, efficacy, resilience and optimism were determined to best fit the positive organisational behaviour inclusion criteria (Luthans & Youssef-Morgan, 2017) and once empirically supported (Luthans et al., 2007b) became known as psychological capital.

Psychological capital is a relatively new construct that has gained traction in the business management literature over the last ten years (Avey, Reichard, Luthans, & Mhatre, 2011; Huang & Luthans, 2014; Larson & Luthans, 2006; Luthans, Luthans, & Avey, 2014; Luthans, Luthans, & Jensen, 2012). There has been growing interest on positivity in the workplace fuelled by the positive psychology movement. This has led to a broadened view of human resources which looks beyond

what is wrong with people and moves towards optimising human potential. Managing contemporary organisations requires a new paradigm where competitive advantage can no longer rely on traditional physical, financial and technological resources. The constructs of human capital (Becker, 1962) and social capital (Tzanakis, 2013) have already been developed by researchers and the latest construct of psychological capital adds a new dimension for developing a sustainable competitive advantage through self-efficacy, optimism, hope and resiliency of individual workers (Luthans et al., 2007b).

The construct of psychological capital was advanced by (Luthans et al., 2007b) as an approach for organisations to gain a competitive advantage with their workers. The meta-analysis of Avey, Reichard, Luthans and Mhatre (2011) found that psychological capital was strongly related to desirable employee attitudes such as job satisfaction, organisational commitment, psychological capital and behaviours, for instance, citizenship and performance. Further, a significant negative relationship between psychological capital and undesirable employee attitudes, for instance, cynicism, turnover intentions, job stress and anxiety; and behaviours, for example, deviance was also found (Avey et al., 2011). Other researchers (Cameron & Brownie, 2010; Fletcher & Sarkar, 2013; Jackson, Firtko, & Edenborough, 2007; McAllister & McKinnon, 2009; Sabo, 2011) also concluded that development of personal resilience and provision of professional support through mentoring programmes provided positive outcomes for workers working in adverse work environments, such as nursing. Some studies have been undertaken on the effect of psychological capital in the nursing context (Boamah & Laschinger, 2015; Brunetto et al., 2016; Laschinger, Nosko, & Wong, 2013; Liu, Zhao, Tian, Zou, & Li, 2015; Sun, Zhao, Yang, & Fan, 2012), but this remains an under-researched area as is the residential aged care context.

Avey et al. (2011) noted that little research had been conducted on antecedents to psychological capital. Avey et al. (2011) suggested that leadership may play a vital role in development of psychological capital in followers. This is supported by other researchers who suggest that psychological capital can be enhanced with training and development interventions, such as mentoring and coaching (Knudson, 2015; Lunsford, 2016; Pineau Stam et al., 2015; Saks & Gruman, 2011; Toor, 2010). A further study by Cameron et al. (2010) highlights the importance of mentors, teams and colleagues providing psychosocial support in developing resiliency in registered aged care nurses. There is evidence that each component of psychological capital can be taught and developed through on-going support which can best be achieved through teaching reflective communication

skills and teaching managers and workers how to coach, mentor and support each other in the workplace (Luthans, Youssef-Morgan, & Avolio, 2015).

Psychological capital consists of the positive psychological resources of hope, efficacy, resiliency and optimism (Luthans et al., 2007b). It is defined as:

> "an individual's positive psychological state of development and is characterised by 1) having confidence (self-efficacy) to take on and put in the necessary effort to succeed at challenging tasks; 2) making a positive attribution (optimism) about succeeding now and in the future; 3) persevering towards goals and, when necessary, redirecting paths to goals (hope) in order to succeed; and 4) when beset by problems and adversity, sustaining and bouncing back and even beyond (resiliency) to attain success" (Luthans et al., 2007b, p. 3).

The first construct of psychological capital is self-efficacy. Self-efficacy relates to a person's belief about themselves. That is, who they are, what they can do and whom they can become in the future (Bandura, 1997). A person with self-efficacy is motivated to choose challenges that allow development over time and has awareness that positive change is possible. All individuals have a comfort zone, and a confident person is able to overcome fears or resistance to change. The five characteristics of individuals with self-efficacy are a) high self-motivation, b) set high goals and choose difficult tasks, c) thrive on challenge, d) invest the effort required to accomplish goals, and e) persevere when faced with obstacles (Luthans et al., 2007b).

The second psychological capital construct is hope which comes from the positive psychology movement. Snyder, Irving and Anderson (1991) as cited by (Luthans et al., 2007b) defined hope as:

> "a positive motivational state that is based on an interactively derived sense of successful (1) agency (goal-directed energy) and (2) pathways (planning to meet goals)" (Luthans et al., 2007b, p. 66).

In everyday language, hope is often confused with wishful thinking, an emotional high or an unsubstantiated positive attitude. However, as noted in the definition above, hope has two components: agency and pathways. The agency component provides an individual with the ability to set realistic and challenging goals which are achieved through self-directed determination, energy and perceived internal control. The second component of hope is pathways, which allows an individual to create an alternative path to realise their goals should the original path become blocked. The ability to create new pathways in response to adverse situations is an important aspect of hope which differentiates it from other psychological capital states of self-efficacy, optimism and resiliency. Some research suggests there is a relationship between hope and improved work performance and it has been established in the areas of academic and athletic achievement that a relationship between hope and performance exists (Luthans et al., 2007b, p. 67).

The third construct of psychological capital is optimism. Seligman (1998) as cited by (Luthans et al., 2007b) defined optimism as:

> “an explanatory style that attributes positive events to personal, permanent and pervasive causes and interprets events in terms of external, temporary and situation–specific factors” (Luthans et al., 2007b, p. 91).

Characteristics of an optimistic person include the ability to accept recognition for positive events that occur in their life and see these “events as being within their control” (Luthans et al., 2007b, p. 91). They expect that these positive events will continue and view the past, present and future in a positive way and are able to externalise their feelings. Counselling, coaching and mentoring can provide effective techniques for improving cognitive, social and behavioural attitudes in the workplace. Having effective social networks can reduce pessimism and increase optimism (Luthans et al., 2007b). Workplaces with optimistic leaders are able to accept the past, appreciate the present and look for opportunities to improve in the future. Development of interventions to grow optimistic leaders who share their optimism with followers is an essential element for creating a competitive advantage in organisations.

The fourth construct within psychological capital is resiliency. (Luthans et al., 2007b) defined resilience as:

> “the capability to rebound or bounce back from adversity, conflict, failure, or even positive events, progress and increased responsibility” (Luthans et al., 2007b, p. 112).

The above definition acknowledges that resiliency is affected by positive and negative events and positive psychology has identified three factors that contribute to or hinder development of resiliency. These factors are classified as assets, risk factors and values (Luthans et al., 2007b).

The first factor is resiliency assets which include personal insights, faith, positive outlook on life, emotional stability, self-regulation, sense of humour, independence, relationships, initiative and creativity (Masten & Reed, 2002). These assets have been found to enhance resiliency (Luthans et al., 2007b).

Secondly, resiliency risk factors include negative and dysfunctional factors, such as alcohol and drug abuse, exposure to trauma or experiencing violence, stress and burnout, poor health, education and unemployment (Luthans et al., 2007b). The presence of risk factors does not necessarily mean that an individual lacks resilience. However, when a person is repeatedly subject to extreme undesirable

events there is a higher probability of reduced resilience (Cowan, Cowan, & Schulz, 1996; Luthans et al., 2007b; Masten, 2001).

In compiling psychological capital resiliency, it is necessary to take a cumulative view of an individual's assets and risk factors and recognise that the assets and risk factors are interactive by nature. The sequence of desirable or undesirable events can be a significant predictor of an individual's resiliency level. Further, psychological capital resiliency views "adversities and setbacks as both risk factors and challenging opportunities for growth and success beyond the normal state" (Luthans et al., 2007b), p. 118).

Thirdly, psychological capital resiliency is the underlying value system that provides consistency and meaning to an individual's thoughts, emotions and behaviours. Values and beliefs allow individuals to cope with challenging and overwhelming present events by linking them to a more pleasant future. Avolio and Luthans (2006) cited in (Luthans et al., 2007b) noted that in times of failure, resilient, authentic leaders were able to see themselves in the future while also able to consider themselves in the present. The ability to maintain a long-term view and remain in the present can result in leaders being motivated to achieve higher performance in themselves and others. This also suggests that individuals who are more motivated to learn and develop are prepared to spend more effort on achieving challenging goals and expectations. Further motivation to learn and develop can be taught, just as resiliency can be taught. The reason is that individuals with a strongly held belief in a cause, purpose or mission will extend themselves to achieve their goal and this enhances their resiliency level (Luthans et al., 2007b).

In the workplace, organisations are seeking top performers who thrive on chaos and learn and grow through difficult situations no matter how severe the setbacks. Therefore, viewing psychological capital resiliency as proactive and not just reactive, that is coping in difficult times (Bonanno, 2004), may provide substantial gains for human resource development.

Table 2.3: Characteristics of Psychological Capital

Construct of Psychological capital	Meaning/Factors	Characteristics	Sub - Characteristics
Self-efficacy	Beliefs about self.	Motivated to choose challenges that allow development over time. Awareness that positive change is possible. Able to overcome fears or resistance to change.	High self-motivation Set high goals and choose difficult tasks. Thrive on challenge. Invest effort to accomplish goals. Persevere when faced with obstacles.
Hope	Agency (goal-directed energy).	Ability to set realistic and challenging goals.	Self-directed determination, Energy Perceived internal control.
	Pathways (planning to meet goals).	Create alternative path to achieve goals if original path is blocked.	Ability to create new pathways in response to adverse situations.
Optimism	Sees positive events to personal, permanent and pervasive causes Interprets events in terms of external, temporary and situation specific.	Ability to take credit for positive events that occur.	Expect these events to continue. Able to view the past, present and future in a positive way. Able to externalize feelings.
Resiliency	Capability to rebound from adversity. Failure, conflict or positive events, progress and increased responsibility.	Resiliency assets.	Personal insights, faith, Positive outlook on life, Emotional stability, Self-regulation, Sense of humour, Independence. Relationships, initiative, creativity.
		Resiliency risk factors.	Alcohol & drug abuse, exposure to trauma, experience violence, stress & burnout, poor health, poor education, unemployment.
		Values and beliefs.	Provide consistency and meaning to thoughts, emotions & behaviours. Maintain long term view but remain in the present. Experience difficulties but know they can achieve goals in the future.

Source: Luthans et al. (2007)

Allowing individual’s time to reflect on adversities, whether in the workplace or their personal life, can result in substantial growth and development as well as self-reflection and self-assessment. By tapping into this growth perspective of resiliency, organisations can expect to achieve improved performance and gains to profitability. Additional potential outcomes are likely to include increased job satisfaction, greater organisational commitment and improved social capital, as well as the positive effect of increased resiliency (Luthans et al., 2007b). A summary of the characteristics of psychological capital is detailed in Table 2.3.

2.9 Summary of discussion

This literature review identified three conceptual theories of human development, career advancement and learning perspectives to explain the functions of mentoring. Based on these concepts, mentoring theory and practice is concerned with development of relationships focused on sharing of knowledge and experience, career success, professional development, life or career transitions and work-related learning experiences. Within a mentoring relationship, the mentor provides a variety of psychosocial and career functions for the mentee (Kram & Isabella, 1985). While these features are generally provided in a one-on-one relationship, mentoring can also be offered in a group setting (Huizing, 2012; Johns & McNamara, 2014). Past research has found group mentoring to be an effective career development tool (Johns & McNamara, 2014).

In the broader health professions, continual development of clinical skills is paramount. For the transition of new graduates, preceptorship and clinical supervision programmes are often used (Eby, 2007; Nolinske, 1995; Rodger et al., 2008). Considerable research has concentrated on nurses working in the public hospital system (Bassell, 2010; McCloughen et al., 2006). However, there is an emerging body of literature on other allied health professions, including physiotherapists (Ezzat & Maly, 2012), social workers (Hair, 2012; Webb & Carpenter, 2012), mental health professionals (Lee & del Carmen Montiel, 2011), and physician assistants (Rose et al., 2005). The health literature separates preceptorship, clinical supervision and mentoring (Firtko, Stewart, & Knox, 2005) as distinctly different roles.

Mentoring is particularly important in assisting transition of new graduates to become professionals in the workplace. Mentoring programmes are in place for some public sector allied health professionals in rural and remote areas (Causby, 2003; Moran et al., 2014; SA Health, 2014; Struber, 2004). However, many allied health professionals do not have access to these programmes as they work for small organisations in the private sector where isolation is a factor. Some allied health

professional associations have introduced mentoring programmes in an effort to address this shortfall. For example, the occupational therapy Mentorlink programme (Occupational Therapy of Australia Ltd, 2015).

A large number of podiatrists work in rural and remote areas or small private sector organisations where mentoring is not provided. The professional association recognised the need to provide new graduates, mainly working in the private sector, with clinical, career and psychosocial support. As a result, a single integrated mentoring programme including face-to-face and online group mentoring was developed to support new graduates. Further, in line with national reforms in the allied health sector, the professional association has expanded and formalised its continuing professional development programme.

There are many interpretations and explanations of clinical mentoring within the medical, acute care nursing, allied health and aged care contexts. The literature review examined the functions of clinical mentoring in detail in an effort to provide some clarity of meaning. When compared to the concepts of mentoring, clinical mentoring is dominated by the learning perspective, but does include elements of human development and career advancement perspectives.

A review of the literature on mentoring and psychological capital provides support for the idea that mentoring may be an antecedent of psychological capital. The literature also provides support for design of training and development interventions, such as mentoring and coaching, to develop psychological capital in workers who work in stress related environments, such as acute care nursing, allied health, policing and aged care. Little research has been undertaken to establish whether there is a relationship between mentoring and psychological capital in the residential aged care sector.

2.10 Emerging themes, research questions and objectives

The literature review identified that the allied health and residential aged care sectors are under-researched contexts within the health care industry. Moreover, both of these areas are projected to grow considerably in the next few years as a result of Australia's aging population. There is also a shortage of workers within the health workforce. Further, in 2016 nearly 52.2 percent of the residential aged care workforce was over the age of 45 years (National Aged Care Workforce Census and Survey, 2016). These findings reflect an aging workforce and may have implications for future workforce planning as workers reduce the number of hours worked and retire from the workforce.

Another implication of changing workforce demographics is that younger workers in allied health and aged care need assistance in transitioning from university to the workplace. One method that can be used for transitioning early career professionals or new workers is provision of mentoring. Another area of importance for registered health practitioners is continuing professional development (CPD) which may be provided by professional associations or the workplace. Another theme emerging from the literature is the lack of research on the psychosocial effects on care workers of caring for the elderly in residential aged care facilities. The themes identified in the literature lead to the problem addressed in this research:

Are the mentoring practices identified in the predominately acute care nursing environment transferable to the allied health and aged care environments and sufficient to achieve the individual and organisational goals usually associated with career and psychosocial mentoring?

This research investigates the mentoring experiences and expectations of allied health professionals who work in multi-disciplinary clinics and small private clinics and the experiences and expectations of aged care workers in the residential care sector. It also investigates whether the nature of the mentoring experience influences psychological capital of residential aged care workers.

2.10.1 Research questions, propositions and objectives

Four research questions were developed based on the gaps in the literature.

2.10.1.1 Research Question 1

What are the mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as a result of participating in professional association mentoring programmes?

2.10.1.2 Research Question 2

What are the mentoring experiences and expectations of residential aged care workers as a result of participating in formal or informal mentoring programmes provided by residential aged care organisations?

2.10.1.3 Research Question 3

How does the provision of mentoring affect the psychological capital of residential aged care workers?

2.10.1.4 Research Question 4

How does the mentoring experience of aged care workers influence psychological capital in the residential aged care sector?

This section identified the research questions and objectives. The hypotheses for Research Question 4 were informed by results of research Phases 1 and 2 and are detailed in Chapter 6. The research questions and objectives are summarised in Table 2.4.

Table 2.4: Summary of Research Questions and Objectives

Research question	Objective
What are the mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as a result of participating in professional association mentoring programmes?	a) Identify the mentoring experiences and expectations of allied health professionals participating in the professional association programme b) consider the effectiveness of the delivery of professional association programme
What are the mentoring experiences and expectations of residential aged care workers as a result of participating in formal or informal mentoring programmes provided by residential aged care organisations?	a) Identify the mentoring experiences and expectations of residential care workers participating in the organisation's mentoring programme b) Consider the effectiveness of the delivery of the organisation's mentoring programme
How does the provision of mentoring affect the psychological capital of residential aged care workers?	c) Identify if mentoring affects psychological capital in the aged care context
How does the mentoring experience of aged care workers influence psychological capital in the residential aged care sector?	a) Identify the quality of mentoring received by residential aged care workers b) Identify the level of influence the quality of mentoring has on psychological capital

2.11 Conclusion

This chapter discussed a selection of the mentoring literature in relation to allied health professions, nursing and residential aged care. The discussion identified a number of gaps in the literature with emerging themes and research questions. The literature was used to develop four research questions with propositions to guide the research. The theoretical model developed from results of Phase 1 and Phase 2 of the research and existing literature is detailed in Chapter 6. Findings from the literature review were used to inform Phase 1 of the mixed method research explained in the following chapter.

CHAPTER 3 : METHODOLOGY AND METHODS

3.1 Introduction

The purpose of this research was to evaluate the experiences and expectations of healthcare workers regarding mentoring provided by their organisations. Chapter 1 provided an overview of the research problem. Chapter 2 outlined the theoretical framework underpinning the research and provided a discussion of mentoring in the management and health care literature to date. The research is then contextualised within the Australian allied health and residential aged care sectors in chapter 2. Chapter 3 describes the methodology and methods used to investigate the research problem.

The chapter begins with an outline of the philosophical foundation for the methodology. This is followed by a description and justification of methods used to collect data and a discussion on how interview questions and survey tools were developed. Details of samples, measures, procedures and data analysis for each phase of the research are outlined. This is followed by discussion of validity, reliability and measurement of the data and an overview of how data was connected. The chapter concludes with a discussion of ethical considerations associated with the research.

3.2 Philosophical foundation

This research was driven by a philosophical worldview, or paradigm, of pragmatism. Pragmatists "believe that multiple paradigms can be used to address a research problem" (Creswell, 2003, p. 15) and is arguably seen as "the best philosophical foundation for mixed methods research" (Creswell, 2003, p. 15; Tashakkori & Teddlie, 2010). The pragmatic approach allows the researcher to focus on the research problem, situation and consequences, rather than the past, as is the case with positivism. Pragmatist researchers are interested in 'what' and 'how' questions based on likely consequences of the research. They are interested in the values and visions of human action and interaction that can then be applied to existing theories and explanations to provide new knowledge and interpretation to the research problem (Cherryholmes, 1992). The process of collecting data is very much an inductive approach followed by a phase of theoretical reflection which may involve further data collection to establish whether the theoretical conditions hold for a particular context (Bryman, 2015).

A pragmatist approach was chosen in preference to other methodological approaches of post-positivism, constructivism and participatory action as it provides scope to apply more than one

approach to understand the research problem and provides opportunity to use a variety of methods and techniques for collecting and analysing data (Creswell, 2009). That is, this research uses 'what' questions to investigate mentoring experiences of health workers and then investigates 'how' the mentoring experience influences psychological capital. The next section discusses the ontological and epistemological approaches that support this research.

3.2.1 Ontology

Ontology is a branch of philosophy concerned with the nature of existence and structure of reality (Crotty, 1998). In other words, the phenomenon being researched exists independently of our knowing and perceiving it, or be taken to be real and an outcome of knowing and observation (Duberley, Johnson, & Cassell, 2012). In this research, it is helpful to differentiate between realist and subjectivist assumptions. Subjectivism assumes that the mind experiences its own reality whereas realism is the notion that reality can exist outside of the mind waiting to be discovered (Crotty, 1998). It has been a dominant approach in the social sciences for more than thirty years (Maxwell & Mittapalli, 2010).

Some major proponents of pragmatism have been ontological realists (Maxwell & Mittapalli, 2010). However, pragmatic realism has its critics. Smith and Deemer (2000), as cited by Maxwell and Mittapalli (2010), asserted that the concept of reality being independent of the theory is not useful because reality cannot be separated from relativist epistemology. In response, Maxwell and Mittapalli (2010) demonstrated that realism ontology can be helpful in the methodology and practice of mixed methods research. By adopting a realist perspective, it is possible to develop new ways of approaching problems and also obtain new insights into social phenomena. As noted by Maxwell and Mittapalli (2010), "realism is pragmatic in that it does not discard a priori those approaches that have shown some ability to increase our understanding of the world" (p. 153). Realism provides the capacity to design research to study real entities, not just models of the concept. In other words, it enables research of real world practical issues. From the perspective of pragmatism, researchers can adopt more than one lens for viewing the world, and this provides the ability for new phenomena and insights to be revealed (Maxwell & Mittapalli, 2010).

3.2.2 Epistemology

The epistemological view of the researcher underpins how they research the social world and surroundings and what knowledge is adequate knowledge in a discipline (Bryman, 2015). Epistemology is concerned with the nature of knowledge, kinds of knowledge possible and how we

know that knowledge is adequate and legitimate (Crotty, 1998). A range of epistemologies explain truth and meaning in our engagement with the realities of our world. For example, an objectivist epistemology holds that meaningful reality exists in objects independently of consciousness (Crotty, 1998). On the other hand, a constructivist epistemology states that "meaning is not discovered but constructed" (Crotty, 1998, p. 8). Thus, human beings faced with the same phenomenon construct meaning in different ways (Crotty, 1998). As a pragmatist researcher adopting a realist ontology, the approach of this study was that knowledge and truth of reality are constructed through interaction of human beings in their world and conveyed within an essential social context. A social constructivist epistemology was adopted for this research which gathered information through personal interviews with healthcare workers for the purpose of understanding the reality of the workplace context.

Social constructivism emphasises "the idea that society is actively and creatively produced by human beings" (Crotty, 1998, p. 54). Social realities are constructed from shared meanings of a social group or organisation. In fact, all reality is socially constructed (Crotty, 1998). As such, reality and social constructivism are inextricably linked. Realism in ontology and social constructivism in epistemology are compatible with mixed methods research (Maxwell & Mittapalli, 2010, p. 146).

The pragmatist approach is grounded in the values and visions of human action which is then applied to existing theories to provide new interpretations to how things occur (Cherryholmes, 1992). This type of research aims to discover the experiences of individuals and then explain how these experiences influence human behaviour. The role of the researcher is that of external observer who seeks to identify the reality of participants using an inductive approach to interpret and generate meaning from data collected in the field. Interpretation is shaped by the personal experiences and background of the researcher (Creswell, 2014). The next section explores how the philosophical foundations of this research influenced study methods and research questions.

3.3 Method

3.3.1 Research design and justification

Adoption of a pragmatic worldview provides the opportunity to use a diverse research approach that values subjective and objective knowledge (Creswell & Plano Clark, 2011). Pragmatism is not committed to a particular philosophy (Creswell, 2014), values diverse viewpoints and explanations within personal value systems (Teddlie & Tashakkori, 2009) and views the role of values as important in interpretation of results (Teddlie & Tashakkori, 2009). This philosophical view enables researchers

to use mixed methods design to address a research problem (Creswell, 2014; Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2010; Teddlie & Tashakkori, 2009).

Mixed methods research involves collection and analysis of qualitative and quantitative data using a variety of methods and informed by a philosophical worldview or theory. Data obtained from qualitative and quantitative methods is integrated into research design by merging, connecting or embedding the data. Timing of data collection (concurrent or sequential) and equality of each data set (equal or unequal) also needs to be incorporated into research design (Creswell, 2014). Research design helps guide the research process and interpret data based on the philosophical and theoretical foundations of the research. Creswell and Plano Clark (2011) identified six basic designs suitable for mixed methods research that vary according to complexity and nature of the research problem and research questions. The six designs are convergent, explanatory, exploratory, embedded, transformative and multiphase design (Table 3. 1).

Table 3.1: Types of Mixed Methods Research Designs

Designs	Characteristics
Convergent	Concurrent or sequential qualitative and quantitative data collection, with merging of the two sets of data
Explanatory	Sequential collection of quantitative data in Phase 1 followed by qualitative data collection in Phase 2, which builds on Phase 1
Exploratory	Sequential collection of qualitative data in Phase 1 followed by quantitative data collection in Phase 2, which builds on Phase 1
Embedded	Either concurrent of sequential data collection with separate data analysis, using supporting data throughout the data collection process
Transformative	Framing concurrent or sequential collection and analysis of quantitative and qualitative data sets within a transformative, theoretical framework that guides the methods and decisions
Multiphase	Combining concurrent and/or sequential collection of quantitative and qualitative data sets over multiple phases of a programme of study

Source: Adapted from Creswell & Plano Clark (2011, p.73)

The research design selected for this thesis was a multiphase sequential exploratory mixed methods design (Creswell, 2014; Creswell & Plano Clark, 2011; Teddlie & Tashakkori, 2009). (Figure 3.1).

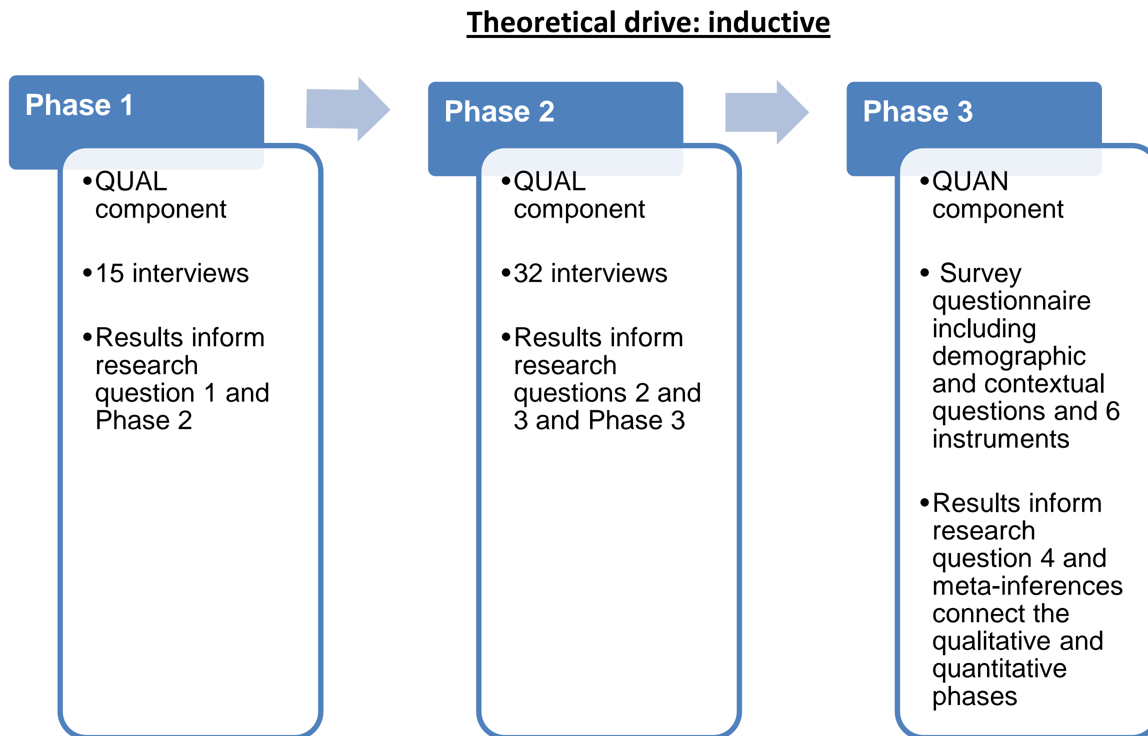

Figure 3.1: Multiphase Sequential Connected Mixed Methods Design

The first phase (Phase 1) of this research was a sequential qualitative study of mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as relevant to delivery of a professional association formal mentoring programme. Results of the first phase informed the second phase. The second phase (Phase 2) was a qualitative study addressing mentoring experiences and expectations of workers in the residential aged care sector in terms of delivery of formal or informal mentoring. Phase 2 also considered the relationship between mentoring and psychological capital following results of Phase 1. These phases were exploratory by nature and qualitative methods were chosen to facilitate thematic analysis of data gathered from semi-structured interviews with a variety of stakeholders. Results of the second phase informed the third phase. The final phase (Phase 3) of this research was a quantitative study

that explored the influence of the mentoring experience on psychological capital of aged care workers in the residential aged care sector.

Data was collected from multiple sources, including open-ended interviews and surveys, multiple locations and at different points of time ensuring common method variance is avoided (Chang et al., 2010b). Interpretation of data is expanded by using descriptive and narrative sources to explain statistical results (Tashakkori & Teddlie, 1998). The qualitative and quantitative components of Phase 2 and Phase 3, respectively, provide connection of the quantitative results to the qualitative results in Phase 2. Discussion of the sampling strategy, data collection process and data analysis techniques for the multiphase mixed methods design follows.

3.3.2 Sampling strategy

In line with the multiphase sequential mixed methods design chosen for this study, a sequential mixed methods sampling strategy was adopted using purposeful and stratified purposeful samples. Phases 1 and 2 used purposeful samples to obtain detailed information from a small number of cases about the phenomena being researched. Phase 3 used a stratified purposeful sampling procedure where the researcher uncovered similarities and differences of experiences over several subgroups (Teddlie & Tashakkori, 2009). Samples investigated in Phases 1, 2 and 3 were selected to answer the research questions under investigation. The sampling strategy for each phase is discussed next.

3.3.2.1 Phase 1

Phase 1 addresses the first research question regarding the mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as a result of participating in professional association mentoring programmes. Phase 1 adopted a stratified purposeful sampling procedure (Cohen & Crabtree, 2006) where the researcher selected participants able to identify the common characteristics of the phenomenon (Teddlie & Tashakkori, 2009). A mix of mentors and mentees were selected to participate in Phase 1.

The sample for Phase 1 was provided by a state-based podiatry professional association who acknowledged the need to provide new graduates, mainly working in the private sector, with mentoring support to assist transition from university to the workforce. Membership of the association is open to all registered podiatrists and podiatry students and a majority of the 250 members are in private practice or a mix of private and public practice. Membership of this professional association is not a requirement for Australian Health Practitioner Regulation Agency

registration. Many public sector podiatrists are not members of the professional association because they have access to continuing professional development programmes and formal mentoring within the public sector.

The professional association provided a group mentoring programme comprising two components. The first component comprises a face-to-face mentoring group specifically for new graduates in first year of podiatry practice and the second component is an online group mentoring forum, available to all members of the professional association. The sample, except one senior mentor, drew from a list of current financial members who had joined the professional association in the past five years. An invitation email was sent to forty-eight practitioners on the list and the email was followed up with telephone calls. Eighteen practitioners accepted the request for an interview, but subsequently, three withdrew due to scheduling conflict. Thus, fifteen podiatrists were interviewed providing a broad range of views on the group mentoring programme.

Teddlie and Tashakkori (2009) state that there are no rules regarding sample size in qualitative research and that thirty or fewer is satisfactory. It is recognised that the results of Phase 1 are not generalizable due to small sample size. However, the intention of Phase 1 was to explore the phenomena present in the professional association mentoring programme to inform Phase 2 of the research to be undertaken in a larger health-related context.

3.3.2.2 Phase 2

Phase 2 addresses the second research question regarding mentoring experiences and expectations of workers in the residential aged care sector as related to delivery of formal or informal mentoring. This phase also addresses the third research question about whether provision of mentoring affects the psychological capital of aged care workers. As with Phase 1, Phase 2 adopted a stratified purposeful sampling procedure (Cohen & Crabtree, 2006) to identify the common characteristics across multiple organisations and job roles.

For Phase 2, four not-for-profit residential aged care organisations agreed to participate in the research. One organisation provided access to two sites within metropolitan Adelaide. Each location employed between 100 and 200 workers who were a mix of full-time, part-time and casual workers.

Following approval by an authorised person from each organisation, the residential site manager at each facility was contacted by email and asked to participate in the research. Information about the research was provided including ethics approval from the University. Five RSMs agreed to take part

in Phase 2 of the research. A meeting was arranged with each RSM to discuss where and how interviews would be conducted. While there were some slight differences in procedure between sites, essentially the same steps were followed. Flyers were posted on staff noticeboards, and workers were invited to participate in the interview process. In consultation with RSMs, interviews were conducted at each site and five interviews were conducted in an allocated block of time. Participants were a cross-section of staff, generally selected by RSMs based on who was available at the time. Thirty-two participants agreed to be interviewed. Three organisations provided ten participants each for interview, and the fourth organisation provided two participants. As noted above, one organisation provided access to several sites, and in that case, five interviews were undertaken at two separate locations.

In line with Phase 1, Phase 2 was an exploratory study designed to investigate the experiences and expectations of mentoring programmes in the residential aged care context. RSMs were asked to provide up to ten participants for interview resulting in thirty-two interviews. As noted by Teddlie and Tashakkori (2009) the size of the sample is not important in qualitative research with interviews continuing until data saturation is achieved. Results of Phase 1 guided and informed Phase 2 of the research. Again, Phase 2 was an exploratory study of the mentoring experiences and expectations of residential aged care workers. Phase 2 identified similarities and differences in mentoring of residential aged care workers, the majority of whom are non-professional care workers. Also, the results of Phase 1 identified a lack of self-confidence and psychosocial support among newly graduated allied health professionals. Therefore, Phase 2 interviews also explored whether mentoring could be an antecedent to psychological capital.

3.3.2.3 Phase 3

Phase 3 addressed the fourth research question by exploring the impact of the mentoring experience on the psychological capital of residential aged care workers. Phase 3 adopted a stratified purposeful sampling procedure where the researcher identified subgroups of residential aged care facilities to approach for the study. Specific organisations were then selected in a purposeful manner (Teddlie & Tashakkori, 2009).

For Phase 3, four not-for-profit and one for-profit residential aged care organisations agreed to participate in the research. The initial sample size was around 1,900 workers from five different residential aged care organisations located in two states of Australia. One organisation gave access to eight sites within metropolitan Adelaide and country South Australia and an interstate

organisation provided access to 800 workers. Each location employed around 100 workers who were a mix of full-time, part-time and casual workers.

Information about the research was provided to the organisations, including details of ethics approval from the University and a consent form for signature of the authorised representative. Following approval by authorised representatives, the human resource manager from each organisation introduced the researcher to the RSMs at each facility nominated to participate in the study. The researcher then contacted the RSM by email and a meeting was arranged with each RSM to discuss the best method for distribution of surveys. The method of distribution varied between facilities because of the nature of the work and lack of access to computers at some sites. The use of different distribution methods was necessary for practical reasons and is consistent with other studies (Gaskin, Georgiou, Barton, & Westbrook, 2012; Kaplowitz, Hadlock, & Levine, 2004).

The questionnaire was distributed in two ways: by hand and via the internet. Two facilities agreed to forward a survey link directing workers to the anonymous survey produced using Survey Monkey. The remaining sites distributed paper surveys to workers through their internal mail systems. A letter of introduction was attached, and an envelope addressed to the researcher was provided for confidential return of the survey. After three weeks and weekly follow-ups, surveys were collected from each site by the researcher or posted to the researcher. Participants from the organisation located in Western Australia were invited to complete the questionnaire via a Survey Monkey link. The organisation provided a list of email addresses, and an introductory email and invitation to participate in the survey were sent to all workers. Two follow-up emails were sent to participants and then data was coded for each organisation and input into IBM SPSS.

3.3.3 Data collection strategy

Data collection for the multiphase sequential mixed methods design was selected from the six mixed methods data collection strategies outlined in Table 3.1. Of the six strategies available, two were chosen for this research. Interviews were used in Phases 1 and 2 and a questionnaire in Phase 3. Details of the data collection strategy for each research phase follows.

Table 3.2: Mixed Methods Data Collection Strategies

Strategy	Strengths	Weaknesses
Observation	Allows for direct observation without relying on what participants say they do Can be used with participants with weak verbal skills. Good for description	Reasons for behaviour may be unclear More expensive to conduct than questionnaires Data analysis can be time-consuming
Unobtrusive measures	Unobtrusive, making reactive and investigator effects very unlikely. Can be collected for time periods in the past (e.g., Historical data). Archived research data are available on a wide variety of topics.	May be incomplete because of selective reporting or recording. Data possibly dated. Access to some types content may be difficult
Focus Groups	Useful for exploring ideas Allows study of how participants react to each other. Allows probing.	Sometimes inexpensive. May be dominated by one or two participants Focus group moderator possibly biased.
Interviews	Good for measuring attitudes and most other content of interest. Allows probing by the interviewer. Can provide in-depth information.	In-person interviews are expensive and time-consuming. Reactive and investigator effects may occur. Data analysis is sometimes time-consuming for open-ended items.
Questionnaires	Good for measuring attitudes and eliciting other content from research participants Inexpensive Quick turnaround.	Must be kept short Might have missing data Response rate may be low for mail questionnaires
Tests	Can provide useful measures of many characteristics of people. Instruments usually already developed Wide range of tests is available	Can be expensive Possibly reactive effects may occur. Sometimes biased against certain groups of people

Source: Teddlie and Tashakkori (2009, p. 239)

A qualitative descriptive approach (Sandelowski, 2000; Sandelowski, 2010; Vaismoradi, Turunen, & Bondas, 2013) was used for in-depth exploration of participant experiences of allied health and residential aged care mentoring programmes. This method is commonly used in health science research (Appleton, Fowler, & Brown, 2014; Karatuna, 2015) and "is the method of choice when straight descriptions of phenomena are desired" (Sandelowski, 2000, p. 339). Qualitative interviews were undertaken using a semi-structured approach. This method allows for flexibility with an emphasis on what the interviewee views as important and how they understand events and particular forms of behaviour (Bryman, 2012). It allows for data to be induced and deduced concurrently and is consistent with the Eisenhardt (1989) method of building a theory based on data collected. This approach is widely used in core management and business research (Perry & Jensen, 2001).

The semi-structured interview approach allows the researcher to be guided by a list of issues for discussion in each interview without using a list of fixed pre-determined questions. Interviewees have the ability to raise additional views which form part of the findings. The open-ended, flexible nature of interviews provides an iterative process of modification where the thoughts of previous interviewees can be explored further with later interviewees (Bryman, 2012). As with most qualitative methods, there are some limitations to semi-structured interviewing, including the potential for interviewer bias, the need for participants to be knowledgeable about the research subject matter, and results are not generalisable to the wider population (Doody & Noonan, 2013; Rao & Perry, 2003).

3.3.3.1 Phase 1

Phase 1 addressed Research Question 1 by undertaking a mix of face-to-face and telephone interviews depending on location and availability of the participant. Each interview took around forty-five minutes to complete. Open-ended questions addressed participant background and mentoring experiences. Interviews were audiotaped, transcribed and confirmed with participants for correctness. Participants were invited to share their perceptions and experiences of the current face-to-face and online professional association group mentoring programme (Coppin & Fisher, 2015). Theoretical saturation was reached when the researchers were unable to identify new themes in participant responses. The interview guide developed for the Phase 1 is provided in Appendix A.

3.3.3.2 Phase 2

Phase 2 addressed Research Questions 2 and 3 by undertaking semi-structured interviews using a general interview guide approach with participants. Each interview took around thirty to forty-five minutes to complete. Participants were asked to describe the mentoring they received, what behaviours and attitudes are needed to work in aged care and what type of mentoring support they would prefer, if any. Experiences and expectations regarding the quality of mentoring currently available in residential aged care facilities were gathered. The initial questions provided demographic data about the participant and background information about the work setting. Theoretical saturation was reached when the researchers were unable to identify new themes in participant responses. The interview guide developed for Phase 2 is provided in Appendix B.

3.3.3.3 Phase 3

Research Question 4 was investigated using a quantitative survey instrument in Phase 3. A cross-section of workers working in aged care, including registered nurses and personal carers, were surveyed to establish the types of mentoring received by residential aged care workers and identify any relationship with psychological capital. The questionnaire included some additional variables not reported on in this thesis. A total of 1,900 questionnaires were distributed to the residential aged care facilities participating in the study. 191 questionnaires were returned from participants representing a 10% response rate. Of the 191 questionnaires, 155 were useable due to missing data or incomplete surveys. The initial questions provided demographic and background information about the respondents and the workplace, followed by several survey instruments discussed in the following section.

3.3.4 Survey instrument and measures

The survey instrument used in this research required respondents to express their experiences of mentoring, attitudes and behaviours in the workplace. The initial demographic questions were developed to understand the background of the residential aged care respondents followed by the use of several instruments that measured mentoring, psychological capital, organisational citizenship behaviour, counterproductive workplace behaviour, perceived organisational support, organisational commitment, job satisfaction and intention to leave. All of these instruments are valid and reliable measures which “is a crucial component to research quality” (Kimberlin & Winetrstein, 2008, p. 2276). A discussion of the measures used in the survey instrument follows.

Measures

This section outlines the measures used, beginning with demographic data, and followed by the instruments used. See Appendix C for a complete copy of the questionnaire used in the research.

Part 1 - Demographic data

Gender

Respondents were asked to provide information on gender by answering the question "Are you male or female?" and selecting male or female for their response.

Age range

Respondents were asked to provide information on their age by answering the question "How old are you?" by selecting one of five options for their response: under 25, 25-34 years, 35-44 years, 45-54 years, 55 + years.

Current position within the organisation

The questionnaire captured information on the current position of respondents in the organisation by answering the question "Are you a registered nurse, allied health professional, personal care worker, administration worker, kitchen, laundry or other worker". Respondents were provided with the five options for their response.

Level of experience

Respondents were asked to provide information on their level of experience in the industry by answering the question "How many years have you been working in aged care?" by selecting one of six options for their response: less than one year, 1-2 years, 3-5 years, 6-10 years, 10+ years, 20+ years.

Work status

Respondents were asked to provide information on their employment status by answering the question "Which of these best describes your work status?" by selecting one of four options for their response: full time, part time, casual, work placement.

Education level

Respondents were asked to provide information on their level of education by answering the question "What is your highest qualification?" by selecting one of nine options for their response: Certificate III, Certificate IV, Diploma, Undergraduate Degree, Honours Degree, Graduate Certificate/Graduate Diploma, Masters Degree, Doctoral Degree, other.

Work preference

Respondents were asked to provide information on their work preferences by answering the question "Are you currently working in your preferred job?" by selecting one of two options for their response: yes and no.

Part 2 - Information on mentoring

Mentor support

Respondents were asked to state whether they had mentor support by answering the question "Do you currently have a mentor?" by selecting one of two options for their response were: yes and no.

Respondents were then asked "If yes, is this person a supervisor or senior professional, peer (a colleague who is not your supervisor), family member, friend, an independent person outside of the organisation or not applicable".

Then respondents were asked "If you do not have a mentor, who supports you when difficult situations arise?" Space was provided for a written answer.

Provision of mentoring

Respondents were asked to provide information on how mentoring was provided by answering the question "How would you describe the mentoring you receive?" by selecting one of four options: formal, informal, a combination of both, or not applicable.

Mentoring provided

Respondents were asked to provide information on the types of mentoring provided by answering the question "Does your mentor provide you with clinical training only, clinical supervision only,

career support only, emotional support only, none of the above" by selecting as many responses as applicable.

Selection of mentors

Respondents were asked to provide information on selection of their mentor by answering the question "How was your mentor chosen?" by selecting one of two options: provided by the organisation and identified by yourself.

Number of mentors

Respondents were asked to provide information on whether they had more than one mentor by answering the question "Do you or have you had more than one mentor at any one time?" by selecting one of two options: yes or no.

Part 3 - Mentoring experiences

The Quality of Mentoring Provided

The quality of mentoring provided was measured using the Ragins and McFarlin (1990) measure of mentoring. This scale consists of 33 questions relating to the individual mentoring functions of sponsorship, coaching, protection, challenging assignments, exposure and visibility, friendship, role modelling, counselling, acceptance and confirmation, social and parent roles. While data on the social and parent roles was collected, these two behaviours have not been reported on in Chapter 6 as they were not included in the original mentor role theory as proposed by Kram (1985) which is the foundation of this thesis. The Noe (1988) mentor role scale was considered. However, the instrument measures mentoring more broadly as career and psychosocial functions and does not provide detail on the complexities of the nine mentoring behaviours outlined in Kram's (1985) mentor role theory. Further, the Ragins and McFarlin (1990) mentor role scale is widely used in nursing research (Blastorah, 2009). Respondents indicated extent agreement with each item on a seven-point Likert scale (1= strongly disagree to 7= strongly agree).

Sample questions included in the mentor role scale are 'My mentor suggests specific strategies for achieving career aspirations' 'My mentor is someone I can confide in' 'My mentor accepts me as a competent professional' and 'My mentor serves a role model for me'.

Psychological Capital

Psychological capital was assessed using the 24 item psychological capital questionnaire (PCQ) developed by Luthans, Youssef and Avolio (2007b). This questionnaire measures levels of resilience, hope, optimism and efficacy of an individual. Respondents indicated extent agreement with each item on a six-point Likert scale (1= strongly disagree to 6= strongly agree).

Sample questions included in the psychological capital questionnaire are 'I feel confident analysing a long-term problem to find a solution' 'At the present time, I am energetically pursuing my work goals' 'I usually take stressful things at work in my stride' 'When things are uncertain for me at work, I usually expect the best'

3.3.5 Data analysis techniques

In line with the multiphase sequential mixed methods design chosen for this study, an iterative sequential mixed methods data analysis strategy was adopted (Teddlie & Tashakkori, 2009). Iterative sequential mixed data analysis involves two separate processes. Qualitative analysis used thematic analysis related to the narrative data, and quantitative analysis used descriptive and inferential statistics for appropriate variables. The two sets of analyses are independent of each other but "each provides an understanding of the phenomenon under investigation" (Teddlie & Tashakkori, 2009, p. 266). While the two sets of analyses are independent in practice, it is likely that researcher knowledge of one may shape the other in a semi-iterative manner. Further, convergent or divergent results may occur. Analysis of data collected in Phase 1 generated inferences for the second qualitative phase (Phase 2), and this generated further inferences for the quantitative Phase 3. Inferences from each research phase were integrated into meta-inferences or conclusions at the end of the study (Teddlie & Tashakkori, 2009). Discussion of the data analysis strategy for each of the phases follows.

3.3.5.1 Phase 1

Interviews with allied health professionals were transcribed and then analysed using template analysis (King, 2012). Template analysis is a technique for thematically organising and analysing qualitative data (King, 2012) applicable to business and management research in the healthcare setting (Waring & Wainwright, 2008). It is an iterative process in which codes are refined and revised, and the template is modified (Collins, Cartwright, & Hislop, 2013). Template analysis is appropriate to a range of epistemological positions including social constructivism (Brooks & King, 2012; Waring & Wainwright, 2008).

The initial thematic template was based on literature and expanded using data obtained in interviews. The open-ended nature of the interview questions allowed exploration of existing and emergent themes. The transcripts were coded into various hierarchies, with similar text placed together, and connections made through induction of the material (King, 2012). Based on this data coding process, we revised the themes and modified the template (Coppin & Fisher, 2015). Results of data analysis of the first phase were used to inform the approach to Phases 2 and 3.

3.3.5.2 Phase 2

The interviews with residential aged care workers were transcribed and then analysed using template analysis (King, 2012). The literature and practical concerns identified some potential a priori themes that formed the initial template. The use of open-ended interview questions provided an opportunity to explore the existing themes and analyse the data using an iterative process where themes and codes are refined and revised, and the template is modified (King, 2012).

3.3.5.3. Phase 3

Survey data was transferred into IBM SPSS version 23 software package and analysed using confirmatory factor analysis and canonical correlation analysis. Confirmatory factor analysis was undertaken to confirm that the data set for residential aged care workers was robust, valid and reliable in line with the previously validated use of the instruments. This was followed by a canonical correlation analysis which is considered to be the most appropriate method for examining relationships between two sets of variables (Sherry & Henson, 2005). It is particularly useful for explaining variable sets that contain several interrelated variables. In this research, the researcher examined the relationship between five behaviours of mentoring identified as relevant to residential aged care and four constructs of psychological capital.

3.4 Validity and reliability considerations

Mixed methods research presents a number of challenges associated with collection and analysis of data, in part due to the many mixed method designs available and the complexity of those designs (Creswell, 2010). It is important for mixed methods researchers to address the validity, reliability and connection of the qualitative and quantitative strands of the research. Validity refers to potential issues that might arise in data collection, data analysis, interpretations that might compromise connecting the two strands and conclusions that may be drawn (Creswell & Plano Clark, 2011). Validity and reliability issues for the research and the steps taken to mitigate these concerns are discussed below.

3.4.1 Construct validity

Possible data collection issues include selecting inappropriate participants for the qualitative and quantitative research phases, using inappropriate sample sizes and not designing an instrument with sound psychometric properties (Creswell & Plano Clark, 2011). This was mitigated for all three phases by collecting data from a wide range of participants that allowed building and testing of new phenomena. The sample size for each phase was appropriate for the particular data collection. The survey instrument was designed using measurement scales previously evidenced as valid and reliable.

Another possible data analysis issue is that qualitative results may be weak and unable to support quantitative results (Creswell & Plano Clark, 2011). In this research, this was mitigated by using major themes from the literature to support each of the qualitative and quantitative research phases.

Possible issues with interpretation of data include comparing or merging the two data sets when they are intended to build on each other. Another concern is not interpreting mixed methods results through the lens used at the beginning of the research and not relating phases of a multiphase study to each other (Creswell & Plano Clark, 2011). These issues were mitigated by interpreting results based on the major themes related to mentoring, as previously identified in the literature. Thus, each phase provided new information that built on the previous phase. In this research, each of the qualitative and quantitative phases answers separate research questions with the findings provided in Chapters 4, 5 and 6. The findings are then connected in Chapter 7.

3.4.2 External validity

External validity is concerned about whether study results can be generalised beyond the specific context in which the study was conducted (Bryman, 2008). This was addressed in this research by gathering data from six different organisations over three research phases. In this research, the two qualitative studies each informed the next phase, with Phase 3 being a quantitative study of a larger section of the residential aged care sector across two states of Australia. The overall connection of findings may be generalisable to the Australian residential aged care sector.

3.4.3 Measurement reliability

Measurement reliability is defined as "the degree to which a measure of a concept is stable" (Bryman, 2008). In this research, measurement reliability was ensured by using measures demonstrated as reliable in previous studies. Reliability tests were also completed to verify results in the context of this research. Further, data was entered and screened for human error before completing analysis. The results of these tests are presented in Chapter 6.

3.5 Connection of the data

The final stage of the multiphase sequential mixed methods design is to connect data analysis from the research phases to answer the research question. Each phase informs the next phase and provides the opportunity for the conclusions to be generalisable. In this study, Phase 1 identified themes of interest included in the second phase. Phase 2 expanded on some of these themes and allowed development of a table that facilitated creation of an instrument for Phase 3 of the research. Data analysis for each of these three phases is recorded separately in Chapters 4, 5 and 6.

Inferences drawn from the three phases are recorded in Chapter 7. Meta-inferences connecting the qualitative and quantitative phases are made at the end of the discussion section. They provide a more generalised understanding of the research problem than qualitative analysis alone (Creswell & Plano Clark, 2011). By using this methodology, the researcher was able to view the research problem from many directions and critically examine the results.

3.6 Ethical considerations

3.6.1 Phase 1

Formal ethics approval for Phase 1 of the research was obtained from the Flinders University Social and Behavioural Research Ethics Committee before commencing data collection (Project Number 5598). Upon approval, the researcher approached the Australian Podiatry Association South Australia to participate in the research which was funded by the Australian Podiatry Education Research Fund (APERF). The participating organisation received a final report of the findings at the conclusion of the research as well as copies of the two publications that arose from the research to inform their practices.

3.6.2 Phases 2 and 3

Formal ethics approval for Phases 2 and 3 was obtained from the Flinders University Social and Behavioural Research Ethics Committee before commencing data collection (Project Number 6262).

Upon approval, the researcher approached seven large not-for-profit residential aged care organisations to participate in the research. Three organisations were unable to take part in the research, but the remaining four agreed after receiving approval from their internal ethics committees. The four not-for-profit organisations provided access to undertake interviews at sites nominated by them for the qualitative study.

For the quantitative study (Phase 3), questionnaires were distributed to sites visited for qualitative interviews and one organisation provided access to staff at eight sites. A further organisation was recruited after the initial response rate was not considered high enough. This organisation was a for-profit residential aged care organisation located interstate. To participate in the project the organisation obtained internal ethics approval before email distribution of the questionnaire link to all workers. Participating organisations received a final report of the findings at the conclusion of the research to inform their practices.

3.7 Procedure for the research

Procedures for each phase are shown in Table 3.2 below.

3.7.1 Phase 1

Following ethics approval, exploratory semi-structured interviews were undertaken with fifteen allied health professionals to answer Research Question 1. The data collected was analysed based on the mentoring theory for career, psychosocial, clinical and group mentoring and results are detailed in Chapter 4. The results of this research were then used to inform Phase 2 of the mentoring experiences and expectations of residential aged care workers.

3.7.2 Phase 2

Phase 2 involved semi-structured interviews with thirty-two residential aged workers from four different organisations. Interviews were undertaken following ethics approval from both the University ethics committee and ethics committees of participating organisations. Data was collected and analysed using template analysis and mentoring theory for the career, psychosocial and clinical mentoring functions. Also, the effect of mentoring on psychological capital was analysed as an additional factor identified as important in Phase 1. Results of Phase 2 were then used to inform Phase 3.

Table 3.3: Details of Research Procedure

	Theory Ch2	Phase 1 Allied Health Ch4 RQ1	Results Ch4 RQ1	Phase 2 Aged Care Ch5 RQ2 & RQ3	Results Ch5 RQ2	Results Ch5 RQ3	Phase 3 Aged Care Ch6 RQ4	Results Ch6 RQ4
Career mentoring								✓
Sponsorship	✓	✓		✓	✓		✓	
Coaching	✓	✓		✓	✓	✓	✓	
Advocacy	✓	✓		✓	✓		✓	
Challenging assignments	✓	✓	✓	✓			✓	
Exposure & Visibility	✓	✓	✓	✓			✓	
Psychosocial mentoring								✓
Friendship	✓	✓	✓	✓		✓	✓	
Acceptance & confirmation	✓	✓		✓		✓	✓	
Counselling	✓	✓		✓		✓	✓	
Role Modelling	✓	✓		✓	✓	✓	✓	
Clinical mentoring								
Complicated cases	✓	✓	✓	✓	✓			
Continuing Education	✓	✓	✓	✓	✓	✓		
Case discussions	✓	✓	✓	✓	✓			
Psychosocial support	✓	✓	×	✓	✓	✓		
Onsite training				✓	✓	✓		
Quality control				✓	✓			

	Theory Ch2	Phase 1 Allied Health Ch4 RQ1	Results Ch4 RQ1	Phase 2 Aged Care Ch5 RQ2 & RQ3	Results Ch5 RQ2	Results Ch5 RQ3	Phase 3 Aged Care Ch6 RQ4	Results Ch6 RQ4
Group Mentoring								
Networking	✓	✓	✓					
Inclusion	✓	✓						
Role modelling	✓	✓	✓					
Psychosocial support	✓	✓						
Structural & operational issues	✓	✓	✓					
Psychological capital						✓		✓
Self-efficacy	✓					✓	✓	
Hope	✓					✓	✓	
Optimism	✓					✓	✓	
Resiliency	✓					✓	✓	

3.7.3 Phase 3

Phase 3 of the research involved a quantitative survey of 155 residential aged care workers from five different organisations. Surveys were undertaken following ethics approval from the University ethics committee and ethics committees of the participating organisations. Data was collected and analysed using IBM SPSS and AMOS version 23 with results reflecting the relationship between mentoring and psychological capital. The results of Phase 3 were then used to connect to qualitative results of Phase 2.

3.8 Conclusion

The purpose of this research was to examine the mentoring experiences and expectations of allied health professionals and residential aged care workers and how mentoring influences psychological capital and perceived organisational support. This chapter described the methodology and methods used to carry out this research. It began with an outline of the philosophical foundation of the methodology employed. This was followed by description and justification of methods used, including data collection methods, development of the survey instrument and data analysis techniques. A description how data was connected and study validity and reliability was provided. The chapter then discussed ethical issues identified and how they were minimised and detailed the research procedure. The next chapter presents results of Phase 1 qualitative analysis and addresses Research Question 1. Chapter 5 provides results of Phase 2 qualitative analysis, followed by results of quantitative analysis in Chapter 6.

CHAPTER 4 : RESULTS OF ALLIED HEALTH INTERVIEWS

4.1 Introduction

This chapter presents findings of the first research phase. The purpose of Phase 1 was twofold. Firstly, to gain an understanding of what factors were important for developing a mentoring relationship with allied health professionals working in multidisciplinary clinics and private practice. Secondly, to examine whether there are additional or unique contextual factors that influence the mentoring experience of a professional association mentoring programme. Interviews were conducted with a small sample of members of a professional association. Findings were analysed using a template analysis framework (King, 2012). A description of the sample and interview questions is provided to give an understanding of the allied health context.

4.2 Description of the sample

4.2.1 Organisation background

A state-based podiatry professional association acknowledged the need to provide new graduates, mainly working in the private sector, with mentoring support to assist transition from university to the workforce. The professional association held concerns that poor job satisfaction and an intention to leave the profession were problems. In response, the professional association implemented a mentoring programme to provide support to early career professionals.

Association membership is open to all South Australian registered podiatrists and podiatry students, and a majority of the 250 members are in private practice or a mix of private and public practice. Membership of the professional association is not a requirement for Australian Health Practitioner Regulation Agency registration. Many public sector podiatrists are not members of the professional association because they have access to continuing professional development programmes and formal mentoring within the public sector.

4.2.2 Description of the existing mentoring programme

The professional association developed a group mentoring programme to meet perceived needs of participants. The programme was delivered face-to-face and online. Access to the online group mentoring forum was available to all members of the professional association, while participation in the face-to-face mentoring group was specifically for new graduates in their first year of podiatry practice. The face-to-face programme was organised by a volunteer facilitator who was also a

mentor. The number of active participants in the face-to-face group mentoring programme varied between fifteen and twenty-five. Likewise, the online forum was managed by a volunteer moderator who was also a mentor. The role of the facilitator was to organise and facilitate face-to-face meetings while the role of the moderator of the online forum was to ensure conversation was conducted in a courteous manner.

4.2.3 Participant demographics

The sample, except one senior mentor, was drawn from a list of current members who had joined the professional association in the past five years. An invitation email was sent to forty-eight practitioners and followed up with phone calls. Eighteen practitioners accepted the request for an interview, but three subsequently withdrew due to scheduling conflicts. Thus, fifteen podiatrists were interviewed, providing a broad range of views on the existing group mentoring programme. All members could participate in the online group mentoring programme (Table 4.1).

Table 4.1: Composition of Sample

Interviews	Years of Experience	Gender	Participant in face-to-face group mentoring programme	Participant in online group mentoring forum
PD01	10+	M	Mentor	Mentor
PD02	8.5	F	Mentor	Mentor
PD03	1.5	F	Mentor	Mentor
PD04	2.5	F	Mentee	Mentee
PD05	1.5	F	Mentee	Mentee
PD06	5.5	F	No	Mentee
PD07	4	F	No	Mentee
PD08	1.5	F	No	Mentee
PD09	10	M	No	Mentee
PD10	0.5	M	No	Mentee
PD11	0.5	F	No	Mentee
PD12	4	M	No	Mentee
PD13	1.5	F	Mentee	Mentee
PD14	0.5	F	No	Mentee
PD15	5	F	No	Mentee

Source: Podiatry interviews

Experience level of participants ranged from six months to over ten years in the profession. Eighty percent of participants worked in the private sector and 20 percent in the public sector. Regarding employment status, 40 percent were full-time workers, 13 percent part-time and 20 percent casual. Casual workers reported working with up to three small businesses. Twenty-seven percent were owner-operators who worked self-determined hours at multiple sites. The gender profile of

participants was 73 percent female and 27 percent male, in line with membership distribution (Table 4.2).

Table 4.2: Characteristics of Participants (N=15)

Characteristics	Percentage
Gender:	
Male	27
Female	73
Experience:	
0.5-4 years	67
>4 years	33
Participation in group mentoring:	
Mentors	20
Mentees	80
Face-to-face	40
Online	100
Employment sector:	
Public	20
Private	80
Employment status:	
Full time	40
Part time	13
Casual	20
Owner operator	27

Source: Podiatry interviews

The sample included both mentors and mentees. All fifteen participants had taken part in the online group mentoring forum, and six had participated in the face-to-face group programme. Reasons cited for not participating in the face-to-face programme included being past the early career stage, working in country locations and unable to attend meetings, and having other established networks outside of the professional association. However, these participants provided valuable feedback on what they would like to see in a professional association mentoring programme. While hard data is not available from the professional association, these proportions appear relatively consistent with participation levels in the face-to-face group mentoring programme and online group mentoring forum in recent years.

4.2.4 Data Collection

A mix of face-to-face and telephone interviews were used subject to participant location and availability. Interviews took forty-five minutes to one hour to complete. Open-ended questions addressed participant background and mentoring experiences. Participants were invited to share their experiences and opinions of the face-to-face and online professional association group mentoring programme.

Table 4.3: Initial Template of Mentoring Functions

1	**Career mentoring**	
1.1	Sponsorship	
	1.1.1	Support for advancement
1.2	Coaching	
	1.2.1	Task-based work provision
	1.2.2	Recognition
	1.2.3	Career aspirations
1.3	Advocacy	
	1.3.1	Prevention of damaging contact
	1.3.2	Shielding from harmful contact
	1.3.3	Protection from career limiting situations
1.4	Challenging assignments	
	1.4.1	Learn and develop new skills
	1.4.2	Mentor feedback
1.5	Exposure and visibility	
	1.5.1	Impress new people
	1.5.2	Promote accomplishments
	1.5.3	Visibility in organization
2	**Psychosocial mentoring**	
2.1	Friendship	
	2.1.1	Social experiences
	2.1.2	Belongingness
	2.1.3	Confidence to speak
2.2	Acceptance and confirmation	
	2.2.1	Belief in a personal ability
	2.2.2	Trust
2.3	Counselling	
	2.3.1	Personal concerns
	2.3.2	Contentment in organization
2.4	Role modelling	
	2.4.1	Model behaviours of mentor
	2.4.2	Admire and respect mentor
3	**Clinical mentoring**	
3.1	Complicated cases	
	3.1.1	Diagnosis
	3.1.2	Decision making
3.2	Continuing education	
3.3	Case discussions	
3.4	Psychosocial	
	3.4.1	Role modelling
	3.4.2	Behaviour
	3.4.3	Communication
3.5	On-site training	
3.6	Quality control	

Source: Developed from Kram (1985) and SA Health (2014) policy document and representatives of the professional association

An initial thematic template was created based on the career and psychosocial functions identified by Kram (1985), clinical functions outlined by SA Health (SA Health, 2014), and discussions with representatives of the professional association (Table 4.3). It is important to emphasise that the programme developed by the professional association drew from other allied health resources and intended to provide career, psychosocial and clinical mentoring and this is reflected in the template. The open-ended nature of the interview questions allowed exploration of existing and emergent themes.

Further, the interview questions were driven by the practical aims of the professional body and linked back to the literature on group mentoring. Due to the relatively small number of studies specifically about the Many-to-many mentoring model, the themes drawn from the literature relate to group mentoring as a whole. The literature and practical concerns identified some potential *a priori* themes that formed the initial template (Table 4.4). Use of open-ended interview questions provided an opportunity to explore the existing themes and new themes resulting in a modified template.

Table 4.4: Initial Template of Many-to-Many Group Mentoring

1	**Group mentoring**		
	1.1	Networking	
		1.1.1	Develop networks
		1.1.2	Transfer of knowledge
	1.2	Inclusion	
		1.2.1	Confidential environment
		1.2.2	Mutual understanding
	1.3	Role Modelling	
	1.4	Psychosocial support	
		1.4.1	Friendship
		1.4.2	Reflection on practice
		1.4.3	Sharing personal challenges

Source: Developed from Dansky, (1996)

4.3 Results

Phase 1 of this study focused on whether the professional association achieved its aim to provide clinical, career and psychosocial mentoring for members through a many-to-many group mentoring programme. Using the three functions of career, psychosocial and clinical mentoring as a framework, the researcher analysed experiences and expectations of participants regarding the professional association online and face-to-face group mentoring programmes. All fifteen

participants considered mentoring support as vital in their professional work. In the interviews, participants were asked to describe the mentoring they received and how they preferred it to be delivered. Regarding delivery, all participants stated a preference for one-on-one mentoring if available. Findings are detailed below using a template analysis framework.

4.3.1 Career mentoring

To begin this section both the initial template (Table 4.5) and final template (Table 4.6) for career mentoring are presented to demonstrate the analysis process. Findings are reported based on the final template. Career mentoring includes the support behaviours of sponsorship, coaching, advocacy, challenging assignments, exposure and visibility (Kram, 1985).

Table 4.5: Initial Template of the Career Mentoring Function

1	Career mentoring	
1.1	Sponsorship	
	1.1.1	Support for advancement
1.2	Coaching	
	1.2.1	Task-based work provision
	1.2.2	Recognition
	1.2.3	Career aspirations
1.3	Advocacy	
	1.3.1	Prevention of damaging contact
	1.3.2	Shielding from harmful contact
	1.3.3	Protection from career limiting situations
1.4	Challenging assignments	
	1.4.1	Learn and develop new skills
	1.4.2	Mentor feedback
1.5	Exposure and visibility	
	1.5.1	Impress new people
	1.5.2	Promote accomplishments
	1.5.3	Visibility in organization

Source: Developed from Kram (1985)

Table 4.6: Final Template of Career Mentoring Function

1	Career mentoring	
1.1	Sponsorship	
	1.1.1	Support for advancement
1.2	Coaching	
	1.2.1	Career aspirations
1.3	Advocacy	
	1.3.1	Prevention of damaging contact
1.4	Challenging assignments	
	1.4.1	Learn and develop new skills
1.5	Exposure and visibility	
	1.5.3	Visibility in organization

Source: Developed from Kram (1985) and podiatry interviews

4.3.1.1 Sponsorship

There was only one participant who purported receiving any form of sponsorship for career advancement, this person worked in the public sector and commented:

> I have been asked to think about what I am interested in,…..working with kids, and I would like to visit kids in schools, and there is some talk of doing some work shadowing. (PD11)

One possible reason for this is that the majority of podiatrists work for small to medium size private practices where they are required to complete their job competently, and there is little scope for progression. Those in the public sector may have some scope for career progression to a senior podiatrist or management role, but hospital jobs are relatively scarce.

4.3.1.2 Coaching

A minority of participants reported receiving coaching for deciding on future career directions, for example:

> Previous mentoring…..did help with future career planning particularly with specialisations. (PD12)

However, this coaching was provided outside of the association.

Another reported that:

> The owners provide $2,000 towards professional development for each podiatrist that includes the conference each year. (PD15)

Again this was provided outside of the professional association programme. The mentoring programme does have mentors from different specialisations and provides information about a variety of specialisations, such as surgery, sports injuries, biomechanics, orthotics, diabetes and palliative care. The programme provided by the professional association did not substantially meet the career direction needs of participants.

4.3.1.3 Advocacy

Participants spoke about advocacy provided by the mentoring group, for example:

> I think there is a fairly good structure for people, you know, we do have a real sense of looking out for our new grads. (PD03)

Others felt that there was potential for new graduates to feel inferior, either in a face-to-face situation or on the online forum. One participant commented:

> The negativities and patrolling and the putting down of others or making people feel uneducated perhaps in terms of their knowledge – that could be a factor. (PD06)

Almost all participants indicated an underlying concern about being made to feel stupid while one responded that fear of being wrong stopped her from contributing. For example:

> The fear of being wrong – no one will directly say no that's wrong – because there's an etiquette as well. But you don't want to come off looking stupid so I think for me that will stop me from contributing or if I just don't know. (PD05)

Even though the mentoring programme was structured to be independent of the workplace, the ability to consistently provide an advocacy outcome was limited by these concerns.

4.3.1.4 Challenging assignments

Provision of challenging assignments was difficult to identify in the profession. However, all participants were attuned to the notion of learning and developing new skills, whether they are technical, administrative or communication skills. A participant commented:

> I don't know everything, and there's going to be a student who's going to ask a question, and I'm going to think actually I don't know that, and I'm going to look it up. So it's a reciprocal learning thing. (PD04)

This comment highlighted the ability of mentoring to provide skill based career development.

4.3.1.5 Exposure and visibility

Exposure and visibility are about developing networks and creating credibility in the profession. The majority of participants reported building networks of contacts through the professional association (PD01, PD02, PD03, PD04, PD05, PD10, PD12, PD13). Some of more experienced participants, particularly those in private practice, reported building their networks outside of the profession. One participant commented:

> I have started to build up my network of where I know I can send people to. But it's taken a year and a half. (PD05)

Another participant stated:

> There's a need – for a single podiatrist particularly in their own business, to have a better contact group, better peer group, and be able to help others to achieve their goals and improve their careers down the track. (PD02)

Another participant stated:

> I've got a number of different mentors that I can sort of pull out of the ether as I need certain information or need a sounding board. So I think you start to develop a bit of network in that sense of mentors of who you know as a slant towards certain aspects of either professional advice or general advice for life. (PD01)

Exposure and visibility were considered essential to career advancement in the profession. On balance, the mentoring programme provided this to participants.

Table 4.7: Summary of Career Mentoring as Perceived by Participants

Career mentoring	Provided Yes/no
Sponsorship	No
Coaching	No
Advocacy	No
Challenging assignments	Yes – in part
Exposure and visibility	Yes

Source: Podiatry interviews

In summary, participants considered career-related support to be necessary, particularly exposure and visibility and challenging assignments. Sponsorship was only evident in one case, but this may be due to a lack of promotional structure available in the profession. Advocacy was limited by the concerns and fear expressed by participants. Coaching was provided outside of the professional association mentoring programme. However, those who participated in the mentoring programme had the opportunity to develop networks and reflect on areas of specialisation, skill development, further study and progression in their personal and professional growth (Table 4.7).

4.3.2 Psychosocial mentoring

To begin this section on psychosocial mentoring the initial template (Table 4.8) and final template (Table 4.9) are presented to demonstrate the process of analysis. Findings are reported based on the final template. Psychosocial mentoring includes the support functions of friendship, counselling, acceptance and confirmation and role modelling (Kram, 1985).

Table 4.8: Initial Template of Psychosocial Mentoring

1	Psychosocial mentoring	
1.1	Friendship	
	1.1.1	Social experiences
	1.1.2	Belongingness
	1.1.3	Confidence to speak
1.2	Acceptance and confirmation	
	1.2.1	Belief in a personal ability
	1.2.2	Trust
1.3	Counselling	
	1.3.1	Personal concerns
	1.3.2	Contentment in organization
1.4	Role modelling	
	1.4.1	Model behaviours of mentor
	1.4.2	Admire and respect mentor

Source: Developed from Kram (1985)

Table 4.9: Final Template of Psychosocial Mentoring

1	Psychosocial mentoring	
1.1	Friendship	
	1.1.1	Social experiences
	1.1.2	Belongingness
1.2	Acceptance and confirmation	
	1.2.1	Belief in a personal ability
	1.2.2	Trust
1.3	Counselling	
	1.3.1	Personal concerns
1.4	Role modelling	
	1.4.1	Admire and respect mentor

Source: Developed from Kram (1985) and podiatry interviews

4.3.2.1 Friendship

All participants reported receiving friendship and positive social experiences from a variety of sources. One mentor commented:

> We try and support socialisation and getting people to know other podiatrists and setting up support networks, and what to do if you're not happy in your job, and things like that. (PD03)

A mentee, who is a sole practitioner, commented:

> I've made some good friends with colleagues in that I feel comfortable to approach them. (PD04)

This demonstrates the feeling of belongingness that is part of the concept of friendliness. Several participants expressed the view that friendship was more likely to be provided by peers than more experienced mentors. For instance:

> Psychosocial support - probably my peers…. that probably comes down to being able to say more, because I'm more comfortable with my peers and I'd be able to tell them more. (PD08)

Friendship, social support and a sense of belongingness were important to all respondents. If support was not available in the workplace, participants sought social support from other sources, for example, the professional association, family, or friends who were often peers from university. The mentoring programme was seen as a source of friendship.

4.3.2.2 Counselling

Counselling support is about being able to share personal concerns about work. Regarding the group mentoring programme, counselling support does not feature strongly, summed up by the following comments:

> There's certainly a little bit of it, certainly not something that's done a lot. (PD03)
>
> Interestingly enough for me, I go home and often off load onto my husband who is a health professional….. he mentored me through it at home. (PD05)

Another participant commented that she:

> Faced some difficult situations with patients in the first 12 months that psychologically changed me. (PD06)

In this case, the counselling support received from group meetings in the workplace helped her through the stressful time. The mentoring programme did not provide counselling support.

4.3.2.3 Acceptance and confirmation

Acceptance and confirmation evoked some interesting comments, both positive and negative, from participants, for instance:

> They're all approachable; they're all very helpful I have never seen anyone made to feel…… that they've asked a silly question. There's no belittling, humiliation or intimidation. (PD04)

> I don't know a whole lot of the mentors that well, so I guess I'd feel more comfortable in a group setting where there's other people to throw some questions up as well. (PD08)

> It's a bit intimidating because you don't often feel like you know how to answer the question properly. (PD02)

Several participants raised concerns about confidentiality and trust, complicated by the small size of the profession. For instance:

> In a group situation, many people are scared and shy and don't want to look silly. A number of the mentors are employers in the profession and older and might be friends of your boss – so people feel they can't say what they are thinking. (PD13)

Finally, another participant commented:

> For mentoring programmes to work.... I have learned that there must be trust between a mentor and a mentee. (PD10)

This statement exemplifies the core meaning of acceptance and confirmation. Overall, the mentoring programme did not provide this.

4.3.2.4 Role modelling

While participants did not comment specifically about role modelling, there was an underlying respect for mentors who gave their time to develop and support others. This comment captures that feeling:

> They're so willing to give their expertise. There's nothing – no barriers there, so that's really important. (PD05)

Role modelling was not a feature of the mentoring programme.

In summary, participants considered psychosocial support essential but perceived that the mentoring programme did not provide this. The mentoring programme provided friendship, but not counselling, acceptance and confirmation or role modelling. As a result, participants sought social and emotional support from other sources such as family, friends and university peer networks (Table 4.10).

Table 4.10: Summary of Psychosocial Mentoring as Perceived by Participants

Psychosocial mentoring	Provided Yes/no
Friendship	Yes
Acceptance and confirmation	No
Counselling	No
Role modelling	No

Source: Podiatry interviews

4.3.3 Clinical mentoring

To begin this section on clinical mentoring the initial template (Table 4.11) and final template (Table 4.12) are presented to demonstrate the process of analysis. Findings are reported based on the final template. Clinical mentoring includes developing diagnosis and decision-making skills, case discussions, continuing education, psychosocial, behavioural and communication skills, quality assurance and onsite training (I-TECH, 2008). Quality assurance and onsite training were not included as goals or activities of the mentoring programme. Therefore, the researcher concentrated on the other aspects of clinical mentoring.

Table 4.11: Initial Template of Clinical Mentoring

1	Clinical mentoring	
1.1	Complicated cases	
	1.1.1	Diagnosis
	1.1.2	Decision making
1.2	Continuing education	
1.3	Case discussions	
1.4	Psychosocial	
	1.4.1	Role modelling
	1.4.2	Behaviour
	1.4.3	Communication
1.5	On-site training	
1.6	Quality control	

Source: Developed from SA Health 2014 policy document and representatives of the professional association

Table 4.12: Final Template of Clinical Mentoring

1	Clinical mentoring	
1.1	Complicated cases	
	1.1.1	Diagnosis
	1.1.2	Decision making
1.2	Continuing education	
1.3	Case discussions	
1.4	Psychosocial	
	1.4.1	Role modelling
	1.4.2	Behaviour
	1.4.3	Communication

Source: Developed from SA Health 2014 policy document podiatry interviews

4.3.3.1 Complicated cases

All participants were seeking support and guidance around the diagnosis of issues, for example:

> Personally, it's been professional stuff. Advice on patients that sort of thing. (PD04)
>
> I suppose for me having just graduated it's about mentoring... clinical skills. As a new grad you think at the end of university that you know a lot, and then the first day of work you realise you know nothing. (PD03)

The mentoring programme provided support in this area. However, participants would have preferred one-to-one mentoring about specific cases.

4.3.3.2 Continuing education

Continuing education was important to all participants, and there was a general view that they needed to remain current with knowledge and latest techniques. One participant made the following comment:

> Specifically, I would like to build my biomechanics skills - biomechanics that includes adult and paediatric because that's where I'm lacking, and that's where I fall down in private work. And in a sense, it's good because the mentoring actually has a strong focus on biomechanics, so that's good for me. (PD05)

The mentoring programme provided support in this area.

4.3.3.3 Case discussions

Participants emphasised the value of discussion of clinical cases. For example:

> When I first started – the senior podiatrist would mentor me with say devices – what works best – troubleshooting mostly. So whenever I needed, I would give him a call. So that's the kind of mentoring I got. (PD06)
>
> The mentoring programme provided two forums for this, online and face-to-face which operated with mixed success due to the fear of being made to look stupid. (PD05).

4.3.3.4 Psychosocial support

Further, participants saw psychosocial, behavioural and communication skills as essential to their development as a practitioner. For example:

> I'll go and get one of my bosses to come in and see a client with me, or I'll ask them a question about a client I had earlier in the day if it's not urgent. Asking… your friends and other colleagues…. questions and bouncing ideas off of each other. (PD08)
>
> I was sitting next to a neurosurgeon on a plane and we were talking about business and he said to me "The biggest thing that is missing in all of those medical professions is that communication, business running, all of that sort of stuff" which got me thinking about the mentoring programme and what it could do, because a lot of people are great at what they do but they're not great at running their business or liaising with people or communicating. (PD02)

Development of these skills was considered important. However, the mentoring programme did not provide them.

In summary, professionals working in private practices are seeking clinical skills development and support with communicating with patients, particularly in the early stages of their career. They want to be able to discuss various diagnoses and treatments with more experienced professionals, and the mentoring programme provided this. This support is in addition to continuing professional

development required for registration purposes. Psychosocial support was supplied by the workplace, peers, friends or family, not the mentoring programme. Finally, development of professional communication and behavioural skills were not provided by the professional association or the workplace. There was an underlying assumption that these skills were innate (Table 4.13).

Table 4.13: Summary of Clinical Mentoring as Perceived by Participants

Clinical mentoring	Provided Yes/no
Complicated cases	Yes
Continuing education	Yes
Case discussions	Yes
Psychosocial	No

Source: Podiatry interviews

4.3.4 Group mentoring

To begin this section on group mentoring the initial template (Table 4.4) has been modified and the findings are reported based on the final template (Table 4.14). The themes identified are networking, inclusion, role modelling, psychosocial support and a new theme of structural and operational issues. To provide additional clarity, where quotations are used, participants are identified as a mentor or mentee and participating in either the face-to-face or online group.

4.3.4.1 Networking

Development of networks was considered crucial to all participants in the face-to-face mentoring group. Participants welcomed the opportunity to meet other podiatry professionals and saw the establishment of networks as an important step in developing their career. For example, one participant commented:

> There's a need for a single podiatrist particularly in their own business, to have a better contact group, better peer group and be able to help others to achieve their goals as well (PD02 - mentor – face-to-face and online).

Moreover, another participant commented on the length of time it takes to establish relationships with other podiatrists and to create a referral list of like-minded professionals:

> I have started to build up my own network of where I know I can send people to. But it's taken a year and a half (PD05 – mentee – face-to-face and online).

In contrast, participants used the online forum to post clinical cases and seek advice on appropriate treatment methods rather than for networking. The online group forum was perceived to be:

> Important for learning about new treatments and the latest techniques (PD12 – mentee – online only).

Findings suggest that the network component of group mentoring was achieved in the face-to-face group, but not in the online forum.

The second aspect of networking is transfer of knowledge. This aspect was considered highly relevant to participants in face-to-face and online components of the group mentoring programme. In particular, mentors and mentees of the face-to-face group found value in sharing different views and advice from mentors. For instance:

> In a group, you've got a number of different mentors giving different points of view, so the audience is getting differences of opinion as opposed to a smaller group with one mentor because you get one view (PD01 - mentor - face-to-face and online).

The ability to share clinical experiences, diagnoses, treatments and methods is essential to ongoing development of the profession and practitioner. The following comment reflects this:

> One of the major benefits of the mentoring programme was the ability to share and get new ideas on how to treat a case not seen before (PD04- mentee – face-to-face and online).

All participants stated that sharing of ideas, experiences and techniques between mentors and mentees was a major benefit of a group mentoring programme. A majority of participants who attended the face-to-face group felt those expectations were met.

All participants considered the online forum useful and an excellent resource, for example:

> The online discussion board has been good to see what everyone else is seeing as well and getting some ideas of particularly the mentors, the ones that have had lots of experience (PD08 – mentee – online only).

However, the majority of participants mentioned a reluctance to contribute because they perceived that other clinicians had far more experience, which in some way invalidated any suggestions or input they may have considered contributing.

Table 4.14: Final Template of Many-to-Many Group Mentoring

Code	Theme
1	**Group mentoring**
1.1	Networking
1.1.1	Develop networks
1.1.1.1	Opportunity to meet others
1.1.1.2	Establish relationships
1.1.2	Transfer of knowledge
1.1.2.1	Sharing views and advice
1.2	Inclusion
1.2.1	Confidential environment
1.2.2	Mutual understanding
1.2.3	Concerns
1.2.3.1	Trust
1.2.3.2	Intimidation
1.2.3.3	Lack of confidence
1.3	Role Modelling
1.3.1	None evident
1.4	Psychosocial support
1.4.1	Friendship
1.4.1.1	Socialisation to group
1.4.2	Reflection on practice
1.4.3	Sharing personal challenges
1.5	Structural and operational issues
1.5.1	Lack of structure
1.5.1.1	Facilitation
1.5.2	Use of technology
1.5.3	Training
1.5.3.1	Mentor/mentee training
1.5.3.2	Online programme
1.5.4	Mentoring preferences
1.5.4.1	Individual mentoring

Source: Developed from Dansky (1996) and podiatry interviews

4.3.4.2 Inclusion

The second theme outlined in the template is inclusion. Participants raised some concerns about the group environment in face-to-face and online components. These concerns were around confidentiality, trust, intimidation and lack of confidence. Regarding confidentiality, there was a general belief that confidentiality could not be guaranteed in the group setting. For example:

> You can't keep anything confidential in the respect that you've got a group (PD02 – mentor – face-to-face and online).

Reasons cited for this belief include small size of the profession, competitiveness between small business owners and the fact that everyone knows each other or of each other. Similarly, all participants were concerned about trust and mutual respect. One online participant commented:

> Making sure that you've got mutual respect and trust and all those sorts of things that any group situation encounters [is important] (PD07 – mentee – online only).

This finding is significant and may explain why some interview participants chose not to participate in the face-to-face component of the group mentoring programme and only passively in the online forum.

Further, two-thirds of participants in face-to-face and online environments were concerned about intimidation. One participant in the face-to-face group reflected:

> The problem is you could have somebody who perhaps might think that they're a bit more superior and intimidate the younger inexperienced podiatrist or mentees (PD04- mentee – face-to-face and online).

Regarding the online forum, one participant spoke about the volume of information required when posting a question online, reflected in the following comment:

> They require lots of information on cases, everyone wants to know all the observations and all the medical history, and it gets a little bit technical, and I actually find that a little bit intimidating (PD02-mentor-online).

This mentor (PDO2) explicitly stated that feelings of intimidation deterred participation. This view was also implicit in the responses of the majority of participants (PD02, PD04, PD05, PD06, PD07, PD08, PD09, PD10, PD11, PD12, PD13, PD14). There were several reasons for this perception. Firstly, the process required that whole cases be reviewed, in part as a safeguard against misdiagnosis. However, frequently questions that mentees needed to ask were simple questions that in a face-to-face situation may have been dealt with in a more casual and informal way between mentor and mentee. Some mentees felt intimidated by the need to provide the entire case, with the potential to reveal other shortcomings in their case assessment to other group participants (PD04, PD07, PD14). Secondly, as the online forum was in writing and perceived as a permanent record, participants felt under pressure to ensure the information provided was correct. This formal permanent record is different to informal interactions with a mentor that may occur in a face-to-face mentoring process. As such, some participants felt intimidated (PD02, PD05, PD07, PD13). Over two-thirds of participants expressed unease with the online group process and were concerned about being challenged in front of their peers and potential employers (PD02, PD04, PD05, PD06,

PD07, PD08, PD09, PD10, PD11, PD12, PD13). Subsequent feelings of intimidation led to passive participation in the group online forum.

Lack of confidence was an issue that resonated strongly with two-thirds of participants taking part in the group mentoring programme. Participants most affected by confidence issues were early in their career, particularly recent graduates who were comfortable with their university peer group and in the process of adjusting to life as a professional podiatrist. As such, these participants cited a lack of confidence in their knowledge and ability to be a podiatrist and sought support from their peers in managing transition from student to professional. For example:

> I'd feel more comfortable in a (face-to-face) group setting where there're other people to throw some questions up as well (PD08 – mentee – online only).

On the other hand, mentors perceived their role as to support and build confidence in the new career podiatrists. As such, mentors were willing to give their time, share knowledge and experience and promote inclusion. During interviews, mentors stated their disappointment that mentees did not ask more questions and contribute to discussions. This was reflected in a comment made by a mentor:

> People are reluctant to give or contribute (PD01- mentor – face-to-face and online).

These findings are of interest because they reflect a purpose of the professional association establishing the group mentoring programme in the first place and is elaborated on further in the discussion section.

4.3.4.3 Role Modelling

The third theme outlined in the template is role modelling. Role modelling in group mentoring provides mentees with the opportunity to learn and model successful behaviours of mentors. From the interviews with mentors (PD01, PD02, PD03), it was evident that role modelling was occurring. Knowledge was conveyed in a positive, constructive manner and mentees were encouraged to participate in group mentoring. The willingness of mentors to share their knowledge was acknowledged by one participant:

> They're so willing to give of their expertise (PD05 – mentee – face-to-face and online).

While the majority of participants were 'silent participators' in the online forum, mentors consistently modelled positive behaviours and attitudes through contribution and responses in the

online forum. Other than the comment above, mentees did not specifically comment on role modelling.

4.3.4.4 Psychosocial Support

All participants in the group mentoring programme considered psychosocial support necessary. However, it was not a feature of the online forum and the majority perceived that the face-to-face group mentoring programme did not provide this support. One mentor commented:

> The group settings are really important both for social and support networks, and we can learn a lot in group settings and learn from each other, and create a bit of camaraderie and all of that sort of thing that I think is important (PD03 - mentor - face-to-face and online).

In particular, mentees in the face-to-face group were reluctant to share personal challenges (PD02, PD05, PD13), and to some extent reflect on practice, because of a perceived lack of mutual respect, trust, feeling of intimidation and concerns around confidentiality (PD02, PD04, PD05). As such, participants felt more comfortable receiving this support from family, friends and peers in their workplace.

4.3.4.5 Structural and Operational Issues

Throughout interviews participants raised concerns about the structure and operation of the group mentoring programme that led to development of an additional theme. These concerns included the lack of organisation of the face-to-face programme, use of technology and need for training of mentors and mentees. The face-to-face programme was organised by a volunteer facilitator who was also a mentor. Likewise, the online forum was managed by a volunteer moderator who was also a mentor. The role of the facilitator was to organise and facilitate face-to-face meetings, while the role of online forum moderator was to ensure conversation was conducted in a civil manner.

All participants commented on the need for structure, direction and organisation of the group mentoring programme, for example:

> For me, they're not quite structured enough. I think there needs to be more of a defined topic for each one [session] (PD05 – mentee – face-to-face and online).

To elaborate further, mentees expressed that they were attending a meeting with no purpose other than socialisation and networking, rather than group mentoring.

Regarding use of technology in the online forum, few mentees were active. However, the majority were passive participants following content online. Some participants suggested that the amount of case specific information required in the online forum created unnecessary feelings of doubt and

insecurity for new career podiatrists. The moderator spoke about the time and effort involved in organising and running the online forum and frustrations experienced in encouraging individuals to participate, for example:

> Having time to organise it and get people involved…but actually not a lot of people are actually participating in it, and getting involved and asking questions…it seems a lot quieter than it could be, it could be a great tool, but I feel like it's not being utilised as much as it certainly could be (PD03 - mentor – face-to-face and online).

With regard to training, both mentors and mentees wanted training in how to use the online technology efficiently and mentors sought mentor training. Participants also suggested that mentees be trained to understand the process of mentoring to improve quality and trust of relationships.

Mentors and mentees were asked how they would prefer mentoring to be delivered. All participants preferred individual mentoring, citing confidentiality and communication quality as drivers of this preference. They also indicated that face-to-face communication provided additional non-verbal cues that mentees highlighted as essential for interpretation of messages. Further, individual mentoring provides opportunity for role modelling without the confusion of having several mentors providing ideas, as in an MMTM group situation. Indicative comments on the usefulness of individual mentoring are noted below. The first relates to the time involved in individual mentoring:

> I always find that individual one to one, or a face-to-face, is always better – it is just more time consuming (PD02 – mentor – face-to-face and online).

The second notes the difficulty in teaching hands-on skills in a group environment:

> I think individual mentoring, I think for something like a podiatrist, where there are very hands-on clinical skills that need to be learned, that's certainly harder to do in a group (PD03 – mentor – face-to-face and online).

Moreover, the third mentions another added benefit of face-to-face communication as the ability to demonstrate a technique:

> I think in a face-to-face interaction, or if someone draws something for you or demonstrates something to you then perhaps you can visualize via the written word perhaps or the internet (PD05 – mentee – face-to-face and online).

Further, a non-participant in the face-to-face programme agreed:

> If I'm going to talk to someone or have a group meeting, I'd prefer to see people (PD08 – mentee – online only).

Overwhelmingly, all mentors and mentees preferred one-on-one, face-to-face mentoring with a trusted mentor because it allowed them to discuss cases in detail without feeling inadequate or lacking in knowledge. This aspect is explored further in the discussion section.

4.4 Summary of results

This chapter investigated the three mentoring functions of career, psychosocial and clinical mentoring in an allied health professional association. It also explored two methods of delivery, face-to-face and online forum of a many-to-many group mentoring programme.

Findings highlight the importance of developing clinical skills, specifically diagnostic skills, in the early stages of an allied health professionals' career. Professional associations have a role to play in this, particularly in professions where the majority of professionals work in the private sector. As to how professional associations meet this need highlights the value evaluation of delivery of mentoring programmes and purported aims. Understanding needs and fears of early career professionals provides a new perspective regarding developing mentoring programmes for professional associations. Evidence gathered suggests that clinical mentoring may be sufficient in initial stages of a podiatrists' career, especially when the programme is provided by a professional association. However, clinical mentoring may not provide career and psychosocial benefits necessary for long-term development and progression.

The importance of coordination, facilitation and training of mentors and mentees is critical to successful functioning of a group mentoring programme. Without these behind the scenes functions group mentoring is unlikely to provide networking, inclusion, role modelling and psychosocial support. Moreover, reflection skills are required to facilitate face-to-face mentoring and manage and moderate the online forum. Professional associations have a role to play in providing members with the opportunity to reflect on professional practice, particularly in professions where the majority of professionals work in the private sector. Awareness of mentors regarding needs and fears of early career professionals may provide a new perspective for development of mentoring programmes by professional associations. Evidence gathered suggests that facilitation and organisation of the MTMM group programme are likely to promote inclusiveness and may over time see the confidence and active participation of mentees increase.

Study 1 provided preliminary support for the notion that clinical mentoring alone may be sufficient for early career allied health professionals, certainly when provided in the professional association

context. In Chapter 5, Study 2 examines provision of the three mentoring functions in the residential aged care context.

CHAPTER 5 : RESULTS OF RESIDENTIAL AGED CARE INTERVIEWS

5.1 Introduction

This chapter presents findings of the second research phase. The purpose of the second phase was twofold. Firstly, to gain understanding of mentoring in the residential aged care sector using the three functions of career, psychosocial and clinical mentoring as a framework, and secondly, to identify a possible relationship with psychological capital. Interviews were undertaken at five residential aged care sites owned by four different organisations. Findings are detailed in this chapter as analysed using a template analysis framework (King, 2012). A description of the sample and interview questions is presented to provide understanding of the residential aged care context.

5.2 Description of the sample

5.2.1 Organisational background

All aged care organisations are required to operate within the Australian Government Quality of Care Principles of 2014. Accreditation standards cover four areas of residential aged care, detailed in Table 5.1.

Table 5.1: Australian Government Quality of Care Principles of 2014

Accreditation Standards	
Part 1	Management systems, staffing and organizational development
Part 2	Health and personal care
Part 3	Care recipient lifestyle
Part 4	Physical environment and safe systems

Source: Australian Government, 2014

This study addresses management issues most strongly aligned with Part 1 of the Australian Government Quality of Care Principles. In particular, the personal support and training provided for residential aged care workers. The staffing structure of each residential aged care facility is similar, although titles of job roles may differ between organisations. To provide conformity throughout this thesis, the following titles were used for aged care job roles. The residential site manager (RSM) is at the top of the organisational structure, followed by the clinical nurse consultant (CNC), then registered nurses (RN), lifestyle coordinator or assistant (LC), enrolled nurses(EN), care workers (CW), administration workers (AW), hospitality workers (HW) and buddy. A brief description of each role is provided in Table 5.2.

Table 5.2: Brief Explanation of Aged Care Job Roles

Job role	Brief explanation of role
Residential site manager	Oversee day to day management of the facility, including engaging with residents and their family, ensuring that care expectations are achieved
Clinical nurse consultant	Coordinate and lead clinical services
Registered nurse	Coordinate resident care and supervise staff to ensure effective functioning of the team.
Lifestyle coordinator or assistant	Organisation and delivery of lifestyle programme for residents
Enrolled nurse	Assess and evaluate individual resident care
Care worker	Delivers care and services to residents in all activities of daily care
Administration worker	Reception and administration support
Hospitality worker	Provision of food and beverages to residents
Buddy	Orientate new employee or student to the specific requirements of a job role.

Source: Various position descriptions from participating organisations

5.2.2 Description of existing mentoring programmes

All organisations involved in the study purported to provide mentoring to its workers either on a formal or informal basis. Each site perceived mentoring differently and provided varying levels of support. A description of each site's mentoring activities is detailed below.

5.2.2.1 Site 1

Site 1 provided informal mentoring to all workers. For new workers, an orientation day and two ‘buddy shifts’ were provided to enable workers to become accustomed to the workplace. Students on work placement were provided with orientation and onsite training with a ‘buddy’ for duration of the placement. The duration of a work placement can be up to 120 hours of on-site training. No formal mentor was assigned to a new employee or student. Rather, a new employee or student was placed with an available CW. The ‘buddy’ or CW could be different each day of placement. At this site, new workers could approach their ‘buddy’, RN or EN for assistance. Similarly, existing workers could approach more senior staff if they required support or training. As such, mentoring provided at site 1 was clinical training only, and in the case of existing workers, the organisation was reliant on individuals recognising and acknowledging that they needed training or support. External support was available through the Employee Assistance Program.

5.2.2.2 Site 2

Site 2 provided informal mentoring to all workers. New workers were provided with orientation and two ‘buddy’ shifts, while students on placement received orientation and on-site training with a ‘buddy’ for the duration of placement. While there was no formal mentor coordinator at site 2, the CNC selected an appropriate CW ‘buddy’ to train the new employee or student. Generally, the ‘buddy’ remained the person same throughout a placement where possible. Further, new workers could approach their ‘buddy’, EN, RN or CNC for assistance. Essentially, mentoring provided at site 2 was clinical training only. Existing workers were required to identify their own training and support needs and were referred to the Employee Assistance Programme as required.

5.2.2.3 Site 3

Site 3 provided a formal mentoring programme for new workers and students on placement. The purpose of the mentoring programme was to provide orientation to the residential care facility, ‘buddy shifts’ and onsite training for students on placement. The formal programme had a trained mentor who was assigned to mentor new workers for the period of their probation and students on placement for the period of their placement. In this programme, the mentor was separate to the ‘buddy’ or person training new workers or students. The role of the mentor was: a) to resolve issues between staff in relation to the new employee or student; b) assess the skills and ability of the new employee or student; c) coach them where necessary; d) sign off their placement paperwork and; e) provide emotional support as required.

At site 3 clinical training was provided by ‘buddies’ and psychosocial mentoring was available to new workers and students on work placement from the work placement coordinator. Existing workers also received informal mentoring from the RSM and CNC for psychosocial issues and were aware of the availability of counselling through the Employee Assistance Programme. Pastoral care was also available through the site’s Chaplain. Clinical training was encouraged and supported by the RSM and CNC.

5.2.2.4 Site 4

Site 4 was trialling a mentoring programme where several CW team leaders were appointed to act as mentors for less experienced CWs. The CW team leader role was essentially that of supervisor or reference point and was necessarily directive due to time constraints. Further, the CW team leaders had not been trained as mentors. The organisation also ran an informal mentoring programme for new workers and students on placement. Effort was made by the CNC on site to appoint a CW team leader to ‘buddy’ new workers and students. ‘Buddy’ support was provided for a maximum of two

days to new workers and for the duration of student placement. Mentoring provided at site 4 was clinical training and peer supervision by more experienced CWs. Existing workers were required to seek their own support and clinical training. Counselling was available through an Employee Assistance Programme.

5.2.2.5 Site 5

Site 5 provided a formal mentoring programme for new workers and students on placement. The mentoring programme provided orientation, coordination of the 'buddy' system and psychosocial support in addition to onsite training provided by 'buddies'. Mentors were trained in mentoring and one was also a counsellor. The formal programme ran for the period of a new employee's probation or the period of a student's placement. The role of the mentor was: a) to resolve issues between staff in relation to the new employee or student; b) assess the skills and ability of the new employee or student; c) coach them where necessary; d) sign off their placement paperwork and; e) provide emotional support as required. Site 5 provided mentoring through clinical training and psychosocial support for new workers and students on work placement. Existing workers could also obtain support from the mentors, CNC or RSM on an informal basis. Clinical training was provided on-site and encouraged by the RSM. Counselling was available through an Employee Assistance Programme if required.

Table 5.3: Mentoring Functions Received at each Site as a Percentage

	Clinical Mentoring (%)	Career Mentoring (%)	Psychosocial Mentoring (%)	No mentoring (%)
Site 1 (n=10)	50	0	30	30
Site 2 (n=10)	50	20	10	50
Site 3 (n=5)	100	20	20	0
Site 4 (n=5)	100	40	20	0
Site 5 (n=2)	100	100	100	0

Source: Participant interviews

5.2.2.6 Mentoring functions received by participants by site

Table 5.3 shows the percentage of participants at each site who said they received a particular mentoring function. Sites 1 and 2 provided informal mentoring only and did not provide a formal mentoring programme for new workers or students on placement. 50 percent of participants indicated that they received clinical mentoring at sites 1 and 2 and 30 percent and fifty percent, respectively, said they received no mentoring. In contrast, sites 3, 4 and 5, where a formal mentoring programme was provided for new workers and students on placement, one hundred percent of participants received clinical mentoring. This suggests there may be a flow on effect from the formal mentoring programme to existing workers, although the sample size for sites 3 and 4 is half the

number of sites 1 and 2. Further, the sample for site 5 may be biased as only two mentors were interviewed.

Table 5.4: Composition of Sample

Name	Organisation	Age	Job role	Qualifications	Full time (F/T), Part time (P/T), Casual/ work placement (W/P)	Years in industry
LC1	1	45-55	LC	Cert III	F/T	10
RN2	1	25-35	RN	Degree	F/T	8
CW3	1	55+	CW	Cert III	P/T	17
CW4	1	35-45	CW	Cert III	W/P	0
CW5	1	55+	CW	Cert III	P/T	34
EN6	1	25-35	EN	Diploma	F/T	3
LC7	1	45-55	LC	Cert III	P/T	12
CW8	1	45-55	CW	Cert III & Reiki	P/T	1.5
CW9	1	45-55	CW	Cert III	P/T	20
CW10	1	35-45	CW	Cert III	P/T	11
AW11	2	55+	AW	Diploma	P/T	30
LC12	2	25-35	LC	Degree	F/T	4
HW13	2	35-45	HW	None	P/T	6
CNC14	2	45-55	CNC	Degree	F/T	19
CW15	2	25-35	CW	Cert III	P/T	2
CW16	2	18-25	CW	Cert III	Casual	4
CW17	2	35-45	CW	Cert III	P/T	8
EN18	2	25-35	EN	Diploma	W/P	3
CW19	2	25-35	CW	Cert III	Casual	3
CW20	2	25-35	CW	Cert III	F/T	6
CNC21	3	35-45	CNC	Degree	F/T	12
EN22	3	35-45	EN	Diploma	F/T	16
CW23	3	35-45	CW	Diploma	P/T	4
CW24	3	55+	CW	Cert III	P/T	20
CW25	3	25-35	CW	Cert III	P/T	2
CW26	4	25-35	CW	Cert III	P/T	8
CW27	4	45-55	CW	Cert III	P/T	20
EN28	4	25-35	EN	Diploma	Casual	2
CW29	4	35-45	CW	Cert III	P/T	5
RN30	4	25-35	RN	Degree	F/T	5
M31	5	45-55	CW	Cert III & Counsellor	F/T	4
M32	5	55+	CW	Cert III	F/T	10

Source: Participant interviews

5.2.3 Participant demographics

The sample was drawn from workers at the five sites detailed in Section 5.2.2. Workers were invited to participate in an interview and participants were ultimately selected by RSMs based on staff available at the time. In total, thirty-two participants were interviewed. Three organisations provided ten participants for an interview, and the fourth organisation provided two participants. As noted above, one organisation provided access to two sites, and in that case, five interviews were undertaken at two separate locations. The sample comprised two CNCs, two RNs, four ENs, nineteen CWs, three LCs, one AW and one HW. Table 5.4 provides a detailed list of all participants.

Table 5.5: Characteristics of Participants (N=32)

Characteristics	Percentage
Gender:	
- Male	3
- Female	97
Industry Experience:	
- <1 year	3
- 1-2 years	12
- 3-5 years	28
- 6-10 years	22
- 11-19 years	19
- 20+ years	16
Age:	
- Under 25 years	3
- 25-34 years	34
- 35-44 years	25
- 45-54 years	22
- 55+ years	16
Job role:	
- Clinical Nurse Coordinator	6
- Registered nurse	6
- Enrolled nurse	6
- Allied health professional	10
- Care worker	60
- Enrolled Nurse on placement	3
- Care worker o placement	3
- Administration worker	3
- Kitchen, laundry or other worker	3
Qualification level:	
- Degree	16
- Diploma	19
- Certificate III	62
- None	3
Employment status:	
- Full time	34
- Part time	50
- Casual	10

- Work placement	6

Source: Interviews of residential aged care workers

Gender characteristics of participants in the residential aged care interviews show that 97 percent are female. This is slightly higher than the 2012 workforce survey published by King et al. (2013b) where it was reported that 89 percent of direct care workers in residential facilities were women (Table 5.5). Age distribution of the participants was representative of the workforce report King et al. (2013b) with 34 percent of participants under 34 years of age, 25 percent between 35-54 years old, 22 percent between 35-54 years and 16 percent over 55 years old. A range of occupations was included in the sample. Eighteen percent of the participants were CNCs, RNs or ENs, 10 percent allied health professionals, 60 percent personal care workers, 3 percent administration and 9 percent hospitality, laundry or other workers (Table 5.5).

Employment status of the sample was 34 percent full-time staff, 50 percent part-time, 10 percent casual and 6 percent on work placement (Table 5.5). Participant level of experience was 3 percent for less than one year experience, 12 percent for 1-2 years' experience, 28 percent for 3-5 years' experience, 22 percent for 6-10 years' experience, 19 percent for 11-19 years' experience and 16 percent for over 20 years' experience (Table 5.5). The sample is skewed towards inexperience in comparison to 2012 national census figures (King et al., 2013b). Qualifications of participants interviewed reflected participant job roles. The only person with no qualification was a participant working in hospitality (Table 5.5).

5.2.4 Mentoring experience of participants

Mentoring provided by residential aged care organisations was classified as a formal or informal programme based on the information provided by each organisational site. The mentoring experience of participants was classified as clinical, career or psychosocial mentoring based on responses provided during the interviews. Participants were then asked to describe the person who provided them with emotional support. The researcher categorised the person providing the support as being inside or outside the organisation. Supporters inside the organisation were RSM, CNC, or peers and those outside included friends outside of work, family and the employee assistance programme (EAP). In some cases participants reported no-one available to provide emotional support. Table 5.6 details the mentoring received by participants interviewed.

Two participants were students on work placement, who both received informal clinical mentoring (CW4, EN18). The remaining thirty participants were existing workers who according to management at the five locations received either formal or informal mentoring in the workplace.

Table 5.6: Mentoring Received by Participants (N=32)

Name	Site	Mentoring programme	Clinical Mentoring	Career Mentoring	Psychosocial Mentoring	Who provides emotional support?
LC1	1	Informal	No	No	Yes	RSM
RN2	1	Informal	Yes	No	No	RSM
CW3	1	Informal	No	No	No	No-one
CW4	1	Informal	Yes	No	No	Peers
CW5	1	Informal	No	No	Yes	EAP
EN6	1	Informal	Yes	No	Yes	Peers
LC7	1	Informal	Yes	No	No	Peers
CW8	1	Informal	No	No	No	Friends outside
CW9	1	Informal	No	No	No	Peers
CW10	1	Informal	Yes	No	No	Peers
AW11	2	Informal	No	No	No	Friends outside
LC12	2	Informal	Yes	Yes	Yes	RSM
HW13	2	Informal	No	No	No	No-one
CNC14	2	Informal	No	No	No	No-one
CW15	2	Informal	Yes	Yes	No	Peers
CW16	2	Informal	Yes	No	No	Peers
CW17	2	Informal	Yes	No	No	Peers
EN18	2	Informal	Yes	No	No	Family
CW19	2	Informal	No	No	No	No-one
CW20	2	Informal	No	No	No	No-one
CNC21	3	Formal	Yes	No	Yes	RSM
EN22	3	Formal	Yes	No	No	CNC
CW23	3	Formal	Yes	No	No	No-one
CW24	3	Formal	Yes	Yes	No	No-one
CW25	3	Formal	Yes	No	No	No-one
CW26	4	Formal	Yes	Yes	No	Peers
CW27	4	Formal	Yes	Yes	No	Peers
EN28	4	Formal	Yes	No	No	No-one
CW29	4	Formal	Yes	No	No	Peers
RN30	4	Formal	Yes	No	Yes	CNC
M31	5	Formal	Yes	Yes	Yes	RSM
M32	5	Formal	Yes	Yes	Yes	RSM

Source: Participant interviews

Table 5.7 below provides a description of the mentoring experiences of interview participants. All sites that provided participants for interview purported to provide either a formal mentoring programme (62 percent) or informal mentoring (38 percent).

Participants were asked whether they currently had a mentor. Sixty percent reported that they had a mentor in the workplace and 12 percent reported that they received emotional support from a family member, friend or independent person outside of the organisation. A further 28 percent reported having no one available to support them (Table 5.7).

Participants were asked about the nature of the mentoring received and to identify clinical, career and psychosocial mentoring as relevant. Sixty-nine percent of participants reported receiving clinical mentoring (either training or supervision), 22 percent received career support, 25 percent received psychosocial support and 28 percent received no mentor support other than clinical training (Table 5.7).

Table 5.7: Mentoring Experience of Participants (N=32)

Characteristics	Percentage
Have Mentor in workplace:	
- Yes	60
- No	40
Who is the mentor?	
- Supervisor or senior professional	25
- Peer	35
- Family member	3
- Friend	6
- Independent person outside organisation	3
- No mentor	28
Structure of mentoring provided by organisation:	
- Formal	62
- Informal	38
Mentoring function received*:	
- Clinical mentoring	69
- Career mentoring	19
- Psychosocial mentoring	25
- None of the above	16

Source: Interviews of residential aged care workers

*Participants could report receiving more than one mentoring function

5.2.5 Data collection

Phase 2 interviews were completed in the same manner as for Phase 1 and analysed using the initial template of mentoring functions (Table 4.3). As interviews progressed the researcher identified

that training was the main function received by participants and a minority of participants received psychosocial support in the workplace. The researcher proceeded to probe participants about the elements of psychological capital and their relationship to residential aged care workers. The initial themes of psychological capital were drawn from the literature (Table 5.8) and the use of open-ended interview questions enabled existing themes to be explored in the residential aged care context.

Table 5.8: Initial Template of Psychological Capital

1	**Psychological Capital**		
	1.1 Self-efficacy		
		1.1.1 Beliefs about self	
			1.1.1.1 Motivated
			1.1.1.2 Awareness of ability to change
	1.2 Hope		
		1.2.1 Goal-directed energy	
			1.2.1.1 Self-directed determination
		1.2.2 Planning	
			1.2.3.1 Create alternative pathways
	1.3 Optimism		
		1.3.1 Positive view of events	
		1.3.2 Externalise feelings	
		1.3.3 Accept praise	
	1.4 Resiliency		
		1.4.1 Ability to rebound from adversity	
			1.4.1.1 Personal insights
			1.4.1.2 Values and beliefs
			1.4.1.3 Consistency of thoughts
			1.4.1.4 Long-term view but present focused

Source: Luthans et al. (2007)

5.3 Results

Interview data was analysed using template analysis (King, 2012) and the results recorded through the theoretical themes of career, psychosocial and clinical mentoring.

5.3.1 Career mentoring

Career mentoring includes the support behaviours of sponsorship, coaching, advocacy, challenging assignments, exposure and visibility (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). These behaviours are below discussed in the context of residential aged care.

Table 5.9: Final Template of Career Mentoring

1	**Career mentoring**				
	1.1	Sponsorship			
		1.1.1	Support for advancement		
			1.1.1.1	Not evident	
	1.2	Coaching			
		1.2.1	Task-based work provision		
			1.2.3.1	Reference point for questions	
			1.2.3.3	Conflict resolution support person	
				Provide advice	
		1.2.2	Recognition		
		1.2.3	Career aspirations		
			1.2.3.1	Not evident	
	1.3	Advocacy			
		1.3.1	Prevention of damaging contact		
			1.3.1.1	Over-directive co-workers	
		1.3.2	Shielding from harmful contact		
			1.3.2.1	Negative attitudes of co-workers	
	1.4	Challenging assignments			
		1.4.1	Learn and develop new skills		
			1.4.1.1		
		1.4.2	Good knowledge of environment		
		1.4.3	Mentor feedback		
	1.5	Exposure and visibility			
		1.5.1	Not evident		

Source: Developed from Kram (1985) and residential aged care interviews

5.3.1.1 Sponsorship

In the literature, sponsorship is described as the active nomination and public support for career advancement of a mentee within an organisation (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). The capacity of a mentor to provide sponsorship is dependent on their level of influence within an organisation. When sponsorship was discussed with participant CNCs, it was seen as a way to encourage workers to undertake further study for the purpose of career advancement. However, the expectation was that further study be completed in the employee's own time and at their cost. There was minimal sponsorship about recommending workers for promotion. At the participating organisations, sponsorship was limited to encouraging workers to participate in further study with the possibility of further advancement, but opportunities to actively nominate or promote workers was not evident.

5.3.1.2 Coaching

The second aspect of career mentoring is coaching. In the mentoring literature (Baranik et al., 2010; Kram, 1985) coaching support is limited to activities that enhance career development. For example, teaching mentees how to navigate the organisation by providing them with information on how to accomplish work tasks, gain recognition and achieve their career aspirations. However, in the wider literature, coaching is seen as a learning and development activity and includes reflection and intrinsic feedback (Clutterbuck, 2008; Garvey et al., 2009).

Based on the wider notion that coaching is a learning and development activity (Garvey et al., 2009), participants reported that new workers received coaching and training support in the workplace. That is, new workers are matched with a 'buddy' for up to two shifts to learn about role expectations and orientation to the particular facility. For example:

> I get the buddy shifts, so when people first start here, they come and do a shift with me and in that span of time of 8 hours I try to instil in them how I do what I do; why I do what I do. Once they're on the floor on their own, it's going back and making sure that they're doing the way we do things - just correcting them when they need to be corrected; lending an ear when they need to talk about something. Showing them the paths that they need to get to and to get what they need at the time. Making sure that they're happy in what they're doing (CW29).

A similar 'buddy' process is in place for students on placement who are also assigned a 'buddy' for placement duration. At two participating organisations this was recognised as a mentoring programme and trained mentors coordinated the programme.

Another aspect of coaching is task-based work provision. That is, teaching someone how to do the job. Some participants (CW9, CW10, EN18, CNC21, EN22, CW24, CW29) reported providing coaching for a variety of tasks on a regular basis. The interviews highlighted two methods of task-based work provision. The first was being a reference point for answering questions. One mentor described the way she mentored others as:

> Just being there if they need you and be prepared to listen and to give advice, not to take over completely (CW24).

The second method was encouraging mentees to find their own solution to a problem by assisting them to consider all possibilities and reflect on which solution will provide the best outcome. In other words, encouraging self-belief and self-confidence in mentees (Whitmore, 2002). One mentor said she preferred to use the second method when answering questions because she found it provided better results over time. For example:

> There's nothing worse than people thinking that they can't approach you – because you're seen as like the person that just tells them what to do….it's quicker to delegate. It's quicker to sort of have that attitude, but I wouldn't feel comfortable (EN18).

Depending on new workers' previous experience as a CW, additional coaching, buddying or mentoring may be required. Several participants thought it was important that new workers be nurtured and allowed to grow at their pace in their new role or environment. As one mentor said:

> We all have different talents, and I've had complete newbies come in and just blow me away with their – just natural ability to relate to the residents, and that's just fantastic, and they can teach me a thing or two by just doing that (CW24).

However, as noted above, not all new workers adapt and relate as easily with aged care residents and may require additional mentoring in how to communicate with residents.

In the residential aged care context, coaching was limited to learning and development activities related to task-based work provision. The use of coaching to gain recognition or achieve career expectations was not evident.

5.3.1.3 Advocacy

Advocacy refers to the prevention, shielding and protection of mentees from damaging contact within the organisation (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). Some participants (CW5, CW9, CW10, CW17, CW25, CW27) spoke about the need to place new workers with CWs who displayed a positive attitude on the job. For example:

> They'll look at the roster to see who's working and decide then to put the new staff member with anyone that's on the floor that's been here for a while, that knows that they'll look after the person that's just started. I wouldn't put a buddy with [some] people though because they come across aggressive. We had one girl complained about another one for bullying and that girl got spoken to about bullying (CW9).

In the participating organisations, advocacy appears to be restricted to moving new workers around to prevent them from being exposed to co-workers with poor attitudes and behaviours in the workplace. In the context of the sites visited, there appears to be limited enthusiasm to performance manage poor performers.

5.3.1.4 Challenging assignments

The literature refers to challenging assignments as providing opportunities for new learning, particularly when feedback is provided. A mentor can assist the mentee to develop specific competencies as well as provide them with the knowledge that they can achieve a difficult assignment (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). In the context of aged care, this study identified no opportunities for mentors to provide challenging assignments.

5.3.1.5. Exposure and visibility

The literature refers to exposure and visibility as the ability of the mentor to introduce the mentee to influential senior members of the organisation and exposing them to career opportunities (Kram, 1985). There was no evidence of mentors providing exposure and visibility in this study.

In conclusion, career mentoring in the aged care context was limited. Coaching was used for individual work tasks for new workers and placement workers and a reference point for other workers. Sponsorship was limited to mentees being encouraged to undertake further training at their cost and in their own time, and advocacy was limited to preventing damaging contact by protecting new workers and placement workers from co-workers with poor attitudes and behaviours. There was no opportunity in aged care for mentors to provide challenging assignments and exposure and visibility was not a feature in this context. A summary of the results reported above is provided in Table 5.10.

Table 5.10: Summary of Career Mentoring as Perceived by Participants

Career mentoring	Provided Yes/No	Activity
Sponsorship	No	Limited to encouraging participation in further training.
Coaching	Yes	Limited to learning and development activities related to task-based work provision. Not for future career aspirations.
Advocacy	No	Limited to prevention of damaging contact by placing new workers with positive co-workers.
Challenging assignments	No	Not evident
Exposure and visibility	No	Not evident

Source: Residential aged care interviews

5.3.2 Psychosocial Mentoring

Psychosocial mentoring includes the support behaviours of friendship, counselling, acceptance and confirmation and role modelling (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). These behaviours are discussed next in the context of residential aged care.

Table 5.11: Final Template of Psychosocial Mentoring

1	**Psychosocial mentoring**		
	1.1	Friendship	
		1.1.1 Social experiences	
			1.1.1.1 Not evident
		1.1.2 Belongingness	
			1.1.2.1 Self-selected friends
		1.1.3 Confidence to speak	
	1.2	Acceptance and confirmation	
		1.2.1 Belief in a personal ability	
			1.2.1.1 Provide praise
			1.2.1.2 Allow growth at own pace
		1.2.2 Trust	
	1.3	Counselling	
		1.3.1 Personal concerns	
		1.3.2 Contentment in organisation	
			1.3.2.1 Not evident
	1.4	Role modelling	
		1.4.1 Model behaviours of mentor	
			1.4.1.1 Support and guidance
		1.4.2 Admire and respect mentor	
			1.4.2.1 Positive attitude
			1.4.2.2 Knowledge and experience
			1.4.2.3 Ability to listen, hope, optimism

Source: Developed from Kram (1985) and residential aged care interviews

5.3.2.1 Friendship

The mentoring literature says that friendship is about belonging in the workplace, feeling confident to speak out in work situations and social experiences between mentors and mentees (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). Eighty percent of participants interviewed reported having a sense of belonging in the workplace that was achieved by self-selecting friends within the work group. One participant commented:

> So, we're more like a family than we are work mates because we spend most of our time together (CW29).

However, there was one participant who stated that belongingness in aged care was an issue. The participant commented:

> There's one thing called belongingness; you know belongingness. It is something which is a little bit of a concern in aged care (RN30).

This participant also reported being bullied at another residential aged care workplace which may have informed this view on belongingness.

Another aspect of friendship is confidence to speak out in the workplace. CW participants were reluctant to speak out about workplace concerns, such as the level of care given to residents, poor attitudes and behaviours of other workers, working conditions or staff not following rules. Their concerns were based on a lack of trust and fear of not being taken seriously at some levels. As illustrated in the following quote, a CW spoke to their friend about work concerns before speaking to a mentor or manager (RSM or CNC). For example:

> You can go to any of the care managers [RSM, CNC] if you feel that you need to express anything. I tend just to see what she [friend] thinks and then if we feel that we need to say something we'll go together. Because it's more meaningful to me if I've got a backup support and that you're saying what you need to say (CW5).

This participant's response was fairly typical of CWs interviewed. There was a definite feeling of 'safety in numbers' at the CW level of organisational hierarchy, due to a lack of approachability and lack of desire for change in some RNs that was acknowledged as a concern for management. As such, RSMs and CNCs at all work sites had reported an 'open door policy' for all workers and this was confirmed by the staff interviewed.

The last aspect of friendship is social experiences outside the workplace. There was only one site of the five visited where participants engaged in social experiences outside of the work arena. At this location, participants spoke about staff farewells, Christmas parties and employee barbeques as a way of fostering team building within the workplace (CNC21, EN22).

For the remaining four work sites visited, the friendship aspect of mentoring was provided to a limited extent. Belongingness was provided through team work and self-selection of friends in the workplace. However, confidence to speak out about work practices was limited, and workers tended to seek counsel from friends before discussing concerns at the RSM and CNC level. Furthermore, only one organisation provided social experiences outside the workplace.

5.3.2.2 Acceptance and confirmation

The second aspect of psychosocial mentoring is acceptance and confirmation. This aspect is concerned with mentee belief in their personal ability and building of trust in the mentoring relationship (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). In the two organisations with a mentoring programme, mentors sought to develop mentee belief in themselves by coaching and encouraging them using positive reinforcement.

One trained mentor described this aspect of mentoring as:

> Providing a support …for people who are training or people who are coming in as new carers to assist them to assimilate to this home or to assist them to learn how to care, and just to be a go-to person that they can speak to confidentially if the need to and to support them in all aspects of care work, whether it be things they need to know physically, or it's an emotional thing they need support with, or just so they can function properly in the workplace and that they enjoy their work, are valued and appreciated in the workplace (M32).

A further aspect of acceptance and confirmation is trust. Several participants (CW10, CW15, CW16, EN18, CW19, CW20, EN22, CW27, CW29) spoke about the type of person with whom they shared their thoughts and feelings. Sometimes this was trusted co-workers, but often it was family and friends. One participant commented on the need to build rapport and be comfortable with a colleague before sharing feelings about work related matters. An exemplar of this view is:

> Carers that you've built a rapport with and you know you can trust and that you can sit down with and debrief with. Same with the nurses, some nurses that you've built a rapport with that you can trust and you feel comfortable sharing things with, and quite often once you go home you debrief with your partner or – I did (EN18).

Overall, participants were cautious about sharing their emotions and feelings regarding difficult situations at work. Further, participants stated that the 'buddy system' for new workers did not provide sufficient nurturing and support for CWs in a new work environment. Exceptions were two sites that provided a mentoring programme.

5.3.2.3 Counselling

The mentoring literature describes counselling as a process where the mentor acts as a confidante for the mentee. Counselling allows the mentee to express anxieties or self-doubts about work issues, such as relationships with co-workers, ethical dilemmas, career matters and work-life balance issues, with a trusted mentor (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). At all organisations involved in this study, counselling was not seen as a part of mentoring, but as a formal process provided by off-site professional counsellors. There was evidence of counselling being provided in a manner consistent with the mentoring literature. However, participants did not describe their experiences as such. Participants reported access to the RSM or CNC to discuss personal concerns as required. If professional counselling were considered necessary, they were referred to the Employee Assistance Programme (EAP). Several participants took advantage of the EAP and found it extremely helpful. For example, one participant shared her story:

> I lost one of my children…They (EAP counsellor) were absolutely phenomenal, they were brilliant, and still, my son passed in 2005, and still I get letters asking if I'm doing okay. When I came here the staff continued the support that I had when I lost my son at [another aged care home]. So, I get lots of

> support at a personal level. So, I can't fault that, I've got friends, colleagues that are all very supportive, if I get a bad day, because you can't predict them days, and they're there straightaway (CW10).

This participant's story above illustrates the complexity of issues that arise in caring professions when an employee's personal circumstances impact on their emotional health, particularly in a work environment engaging with grief and loss on a daily basis.

Another finding of interest provided by the two CNCs interviewed was that they considered performance management as a mentoring duty (CNC14, CNC21). Further, all mentees were aware that EAP counselling was available for a crisis. Mentees did not see counselling as a service provided by a mentor.

All participants were asked how they coped with two difficult areas: managing difficult behaviours and death of residents. Firstly, they spoke about difficult behaviours of residents, such as verbal abuse, hitting and biting that are a common everyday occurrence in residential care facilities. One participant said:

> They could be nasty to other people; they'll bite or say things that they shouldn't. It's not just because of your skin colour (CW20).

This view was also supported by the comment of one CNC, who said:

> What some of the staff have to deal with on a day to day basis, some of them deserve medals, to be honest, I've been there done it myself, so I know what they're having to deal with. I think the most important thing is just having the open door policy (CNC14).

Secondly, all participants were asked how they coped with death of residents and what emotional support was available, as this is an inevitable part of working in residential aged care. Responses to this question varied from participants who accepted it as a normal part of the life-cycle to those who were emotionally challenged by the death of some residents.

One residential facility had prepared a booklet explaining the process of dying. The booklet is given to all workers at induction so they have a basic understanding of what may happen. For example:

> We give it to the girls when they come in on placement so that they don't get a shock. Some people will die suddenly, but others will go through a process, and sometimes the dying process can be a bit overwhelming and a bit daunting to someone who has not been through that. Sometimes they get the death rattles, and when you roll them over they stop breathing, especially for some of the young girls, there are a lot of young carers coming out now. For some of the older women that doesn't really bother them because of their life experiences, but the young one's can find it very confronting (M32).

In contrast to the information intervention provided at one residential facility (mentioned above), other participants reported being expected to 'deal' with the dying process. A long-term carer reflected that:

> It would probably be a good idea to have maybe somebody come out and talk to people about the dying process. You're just expected to know because you work in aged care (CW9).

All CWs reported that there were no formal processes in place for staff to mourn the death of a resident. However, all were aware that EAP counselling services were available in a crisis. The most commonly reported method of dealing with aged care resident death was to share feelings and experiences with trusted work colleagues or at home with family. One participant commented:

> I guess between us carers, we act between us, and I guess we support each other in that regard as to how we're feeling about the situation and I guess you try and take under your wing those that aren't dealing with it quite as well as the next person (CW3).

The same participant also reflected that there could be more direct emotional support provided surrounding death of a resident:

> I do think there could be, you know it maybe just a session that everybody can sit down and just talk about how they're feeling about the situation and how we could not necessarily deal with it better, cause I don't think that's necessarily it, just somebody to talk to, just somebody for support (CW3).

Overall, mentors and mentees did not see counselling as a support provided by mentoring, except for the purpose of performance management or direct emotional support in a difficult situation. Mentors saw the role of counselling as limited to a crisis and mentees were referred to EAP counselling. No emotional support was provided for day-to-day events, such as difficult behaviours, or death and dying, as these are part of the job in residential aged care.

5.3.2.4 Role modelling

Role modelling is concerned with modelling of mentor behaviours, and admiration and respect for the mentor (Baranik et al., 2010; Kram, 1985). All participants spoke highly of attitudes and behaviours of their respective RSMs and CNCs who were seen to be open, compassionate, patient, non-judgmental and supportive. For example:

> She's a very good leader. She's tough but fair which is always a good thing. I admire that about her because she can still be tough and everybody still respects her which is a really good thing… She makes time for you. Sometimes people are always in a bit of a rush. Well, she will stop and actually go come and have a chat with me, or she will make a meeting with you, and you can come and have a chat with her, and she will always follow back up with you. If she says she will do something, she will do it which is good (EN22).

All participants considered role modelling was important. However, not all participants saw role modelling as positive (RN2, LC7, CW9, CW17). Some CW participants (CW5, CW15, CW17) were at times disparaging towards the attitudes and behaviours of some RNs, viewing them as negative and unapproachable to CWs and residents. One CW explained this as follows:

> Just because you're an RN doesn't make you a mentor. You know the communication thing. You would want that person… to be qualified as far as I'm concerned, that's just me personally, you wouldn't just want an RN because I've met RNs whom you wouldn't speak to because they wouldn't listen. It's the same as any industry, and what we're getting down to, there are people who are good at it, and there are people who are just in it for a reason. I had a resident today who's only new, who said about how funny the hospital system was, you meet the nicest nurses, and then you meet other ones that you think, she said to me "I don't know why they become nurses (CW17).

Overall, participants agreed that role modelling was an important aspect of mentoring, but only some participants (LC1, HW13, EN18, CNC21, EN22, EN28, M31, M32) considered that they received role modelling from their mentors. Others were more forthcoming about negative role models present at residential facilities visited.

In summary, psychosocial mentoring in the aged care context was limited. Friendship was restricted to belongingness and self-selection of friends in the workplace. There was a reluctance to speak out about work practices, and social experiences outside of the workplace were almost non-existent. Acceptance and confirmation were only evident at two sites providing mentoring programmes. Counselling was not recognised as provided by mentoring, except regarding performance management or direct emotional support before referral to EAP counselling. Emotional support for challenging behaviours and mourning of residents was not formally provided in the organisations visited. As a result, participants sought social and emotional support from other sources, such as family, friends and selected peers. Further, while role modelling was regarded as important, participants identified the presence both positive and negative role modelling. A summary of the results is outlined in Table 5.12.

Table 5.12: Summary of Psychosocial Mentoring as Perceived by Participants

Psychosocial mentoring	Provided Yes/No	Activity
Friendship	Yes	Limited to self-selection of work friends.
Acceptance & Confirmation	Yes	Limited to sites with mentoring programmes.
Counselling	Yes	Limited to performance management and immediate emotional support before referral to EAP.
Role modelling	Yes	Both positive and negative role modelling

Source: Residential aged care interviews

5.3.3 Clinical Mentoring

Clinical mentoring relates specifically to training in the health professions and care sectors. The functions of clinical mentoring are detailed in the template analysis and include complicated cases; continuing education; case discussions, psychosocial support, on-site training; and quality control (I-TECH, 2008; World Health Organisation, 2006). These functions are discussed in the context of residential aged care.

5.3.3.1 Complicated cases

The first theme of clinical mentoring is complicated cases (I-TECH, 2008; World Health Organisation, 2006). The literature on clinical mentoring does not provide a definition of complicated or complex cases. However, each resident in residential aged care has a different combination of non-acute difficulties, either physical or cognitive, that requires them to be in long-term residential care. As such, each resident has a varying level of complexity.

The first sub-theme of complicated cases is diagnosis. All participants sought advice, guidance and direction around diagnosis. CWs referred to an EN or RN regarding concern about a resident. For example:

> Before ADLs (activities of daily living) going in to shower someone, I'll go in and say 'Good morning, let them know who I am and then explain to them what I'm going to be doing and then assist them in getting up and doing everything we need to do and then if a problem were to occur I'd ring the nurse, the RN, straight away and wait for the RNs assistance (CW16).

This example explains the protocol or policy and procedures followed by CWs. It is a straightforward referral to a senior who has authority to make decisions. These decisions are based on the care plan and advanced care directive provided by the resident.

The second sub-theme of complicated cases is decision making and is about ensuring the policies and procedures are followed in the residential aged care context. All participants were aware of the importance of following the residents care plan and the policies and procedures of the organisation where they worked.

Table 5.13: Final Template of Clinical Mentoring

1	**Clinical mentoring**
1.1	Complicated cases
1.1.1	Diagnosis
1.1.1.1	Guidance/advice/direction
1.1.1.2	Policies and procedures
1.1.1.3	Reference point
1.1.2	Decision making
1.1.2.1	Directions given by RN, CNC, RSM
1.2	Continuing education
1.2.1	Formal education
1.2.2	Learn new skills
1.2.3	Provide training and development
1.2.3.1	On-the-job training
1.2.3.2	Poor continuous training
1.2.3.3	Organisations not training according to needs of carers
1.3	Case discussions
1.3.1	Effective Relationships
1.3.1.1	Effective communication
1.3.1.2	Observation
1.3.1.3	Teamwork
1.4	Psychosocial
1.4.1	Role modelling
1.4.1.1	Support, guidance
1.4.2	Behaviour
1.4.2.1	Managing behaviours
1.4.3	Communication
1.4.3.1	Reference point for questions
1.4.3.2	Death
1.4.3.3	Difficult behaviours
1.4.3.4	Burnout
1.4.3.5	Managing emotions
1.5	On-site training
1.5.1	On-job training
1.5.1.1	Mandatory
1.5.1.2	E-learning done out of hours
1.5.2	Availability of training
1.5.2.1	For EN's & RN's not carers
1.5.3	New employees – development
1.5.3.1	Induction
1.5.3.2	Buddy shifts
1.5.4	Work placements
1.6	Quality control
1.6.1	Policies and procedures
1.6.2	Government regulations/ audits

Source: Developed from SA Health 2014 policy document and residential aged care interviews

5.3.3.2 Continuing education

The second theme of clinical mentoring is continuing education. The World Health Organisation (2006) refers to continuing education as ongoing clinical training with mentoring being an integral part of the process. Participant interviews informed the theme of continuing education in the context of residential aged care. Two sub-themes were identified: formal education and training and development (professional development).

All participants reported being encouraged to undertake formal education, particularly diploma and bachelor qualifications. However, some participants (CW5, CW10, CW13, CW19, CW29) decided to remain CWs because they enjoyed the personal contact with residents. For example:

> When you go to the next level (EN) you lose that because you're giving out medications, you lose that personal (understanding) of what's actually happening with that resident (CW5).

Alternatively, personal issues or work life balance were cited as reasons for not seeking further qualifications. For example:

> Oh, they did ask me if I was going to do it, and I said "Yes" at the time, but because of things that have happened in my life I can't really study at the moment, but I do want to; I want to definitely (CW16).

On the other hand, another participant (CW24) was interested in learning as much as possible about dementia and was encouraged by the site manager to undertake a Bachelor in Dementia Care.

Training and development are the second sub-theme of continuing education. All participants reported undertaking mandatory training, such as manual handling or food safety preparation. However, training in other areas, such as dementia, palliative care, communication with residents and teamwork, some CW participants reported that little training was provided (CW3, CW8, CW12, CW19). Further, some CW participants commented that training was available to ENs and above, but not themselves (CW3, CW8). Two CW participants (CW10, CW27) reported that training was available via e-learning platforms, but to undertake the training they needed to complete it at home in their own time (CW10, CW27). Other participants (CW8, CW10, CW12) commented that they undertook self-learning online and purchased material to assist in their understanding of residents behaviours and illnesses.

Overall, participants reported being encouraged to undertake formal training and e-learning courses. However, CWs stated that to further their knowledge on dementia or difficult behaviours they are required to complete online training in their own time at home.

5.3.3.3 Case discussions

The third theme of clinical mentoring is case discussions. In the acute care sector, case discussions are regarded as an important part of on-going care while in the hospital setting (Robinson et al., 1995; SA Health, 2014). In the residential aged care sector, each resident has a documented plan developed and tailored to their needs. These plans serve two main purposes: 1) to ensure each resident is taken care of to the highest standards; and 2) for compliance and accreditation purposes (Australian Aged Care Quality Agency, 2014). Each residential facility participating in this study conducted handovers at the end / beginning of each shift. The format of handovers differs for each residential facility. At some facilities, handover is tape recorded. At others, information is shared between RN and EN only, or CWs are included in the handover. One CW described handover as:

> The thing that happens is like if we have a palliative care, like the residents at that stage, we get that information during our handover. So, it's not like particular training, we just get, you just need to do this, this, this and this in a care plan, as well. So, we have to read the plan or ask the RN. So, what happens is we get in handover that's how we know what to do with palliative care and need of the resident (CW19).

Overall, all participants considered that the handover process essential to provision of quality care.

5.3.3.4 Psychosocial support

Clinical mentoring also includes a theme of psychosocial support. In the clinical mentoring sense, psychosocial support has three sub-themes being role modelling, work behaviour and communication (I-TECH, 2008). The meaning of psychosocial support in clinical mentoring differs from the underlying themes of psychosocial mentoring. The only sub-theme that overlaps is role modelling.

The second sub-theme of psychosocial support is behaviour. In this context, the focus is on the way staff respond to resident needs. This is closely aligned to role modelling and the third sub-theme of communication. Psychosocial support in clinical mentoring concerns mentors teaching and guiding mentees in appropriate methods for dealing with difficult behaviours of residents. The meaning of psychosocial support in clinical mentoring is different to the meaning adopted in mainstream mentoring. That is, psychosocial mentoring includes emotional support for mentees.

No participant reported receiving specific training in communication skills or methods for managing behaviours to assist them in their work with physically and cognitively impaired residents. Further, some participants (CW5, EN6, CW9, CNC14, CNC21, EN22, CW24, RN30, M32) discussed the verbal and physical violence they face on a daily basis. For example:

> Especially I find the residents that have been in low care, ageing in place, suddenly they have more behaviours etcetera, and the staff sometimes take it personally. That person used to always smile at them, and (now) they're yelling at them to get out. So, a lot of the time I have to mentor about cognitive impairment and someone with dementia is not; they don't have that link to think, you know, if I say to this person, get out of my room, you think it's going to affect them emotionally. They want to tell you to get out of their room, they've lost the link of how to do it properly. So, you know, I think that happens a lot in aged care because some staff do, especially carers, I find. You know, carers get a small amount of training, even though we only take from Certificate III, a small amount of training, out they go, and then they're confronted with some pretty big things, and that's what they need a lot of the mentoring for (CNC21).

Overall, psychosocial support was limited to role modelling for RN and EN participants. Training in communication and behaviour skills was not provided. Overall, all participants considered that more emotional and psychosocial support would be beneficial.

5.3.3.5 On-site training

The fifth theme of clinical mentoring is on-site training. The literature refers to on-site training as practical training that follows theory learned in the classroom (Andrews & Wallis, 1999). In the residential aged care context, this is limited to on-the-job training, mandatory training and online training.

A majority of participants (RN2, CW5, EN6, LC7, CW8, AW11, LC12, CNC14, CW17, EN18, CW19, CNC21, EN22, CW23, CW26, RN30, M31, M32) reported having access to online training courses and videos on a variety of topics such as dementia, palliative care, wound management, incontinence, food handling, respecting patient choices and medication accreditation. Participants commented that the courses were useful, but they preferred on-the-job training. For example:

> I think mentoring is more personal so if you've got somebody physically with you and showing you what to do and sharing their experiences and their ways and things like that, I personally learn better that way than reading it (EN18).

Overall, on-site training in the residential aged care facilities visited was limited to on-the-job learning for new workers and mandatory training undertaken at regular intervals. All sites provided online training courses, but workers were not required to use them.

5.3.3.6 Quality control

Quality control is the sixth theme of clinical mentoring (I-TECH, 2008; World Health Organisation, 2006). Interviews highlighted that, in the context of residential aged care, the two sub-themes of policies and procedures and accreditation standards are high priority. For example, a lifestyle co-ordinator commented:

> There's the paperwork that we need to do as well, which is essential to make sure that we're compliant with the regulations the government put down upon us. And that can be challenging at times because

> of the policies and procedures around what we want, what the residents want and then delivering it to meet their needs, we've got to work within those policies, which makes it very challenging. And making sure that everyone is safe in the whole process of delivering and putting activities and programmes together (LC1).

Further, a CNC commented on the differences between acute care and aged care regarding policies and procedures and monitoring of expectations of care within the aged care sector. The following quote outlines some challenges faced in aged care and emphasis placed on quality control for accreditation purposes:

> It’s managing staff, managing resources, but mainly ensuring that the care is up to standard and looking at all the different expected outcomes from the accreditation agency and how we meet those and how we can improve on those. So, my focus this month has been very much on nutrition, hydration, because we do audits regularly and some of the things we’ve noticed, we’re not meeting the standards that we would like to meet, so anything from how the meals are served to how the residents receiving them, how we’re monitoring their food and nutrition and things like that, so that’s … focuses have become. We’re having an education topic each month and bringing in dieticians to do education with staff, to myself rewriting, well not rewriting, writing from scratch our nutrition, hydration guide for staff and a workbook that goes with that. So, I mean that’s about twenty pages of something that (organisation) unfortunately doesn’t have that I’ve just had to write myself, which I’ve done similarly for the medication manual also (CNC14).

Overall, all participants agreed that quality control and following policies and procedures of the organisation was an essential part of their work and was also a major focus of management teams in all of residential facilities visited.

In summary, clinical mentoring in the aged care context was limited. Treatment of complicated cases was restricted to following organisational policies and procedures, and quality of care provided was reliant on CWs being observant and reporting changes in a resident’s condition. Diagnosis and treatment of a resident’s condition were considered high priority. Continuing education was limited to being encouraged to undertake formal training courses and e-learning courses. RNs and ENs were able to access professional development courses which is a requirement of APHRA registration. CWs seeking to further their knowledge were required to complete training in their own time at home. Participation in case discussions and handover was considered necessary for provision of quality care. Psychosocial support was limited to role modelling for RN and EN participants. Communication and behaviour skills training were not provided. More emphasis on the psychosocial support was considered necessary. On-site training was limited to on-the-job learning for new workers and mandatory training. Finally, quality control is important because organisations are reliant on government subsidised funding and must comply with the Accreditation Standards for Residential Aged Care Facilities (Australian Aged Care Quality Agency, 2014). A summary of results is outlined in Table 5.14.

Table 5.14: Summary of Clinical Mentoring as Perceived by Participants

Clinical mentoring	Provided Yes/No	Activity
Complicated cases	No	Required to following organisations policies and procedures.
Continuing education	No	Limited to encouragement to undertake formal courses and professional development for APHRA registration purposes.
Case discussions	Yes	Handovers completed at all facilities – those who attended differs from site to site.
Psychosocial support	No	Limited to role modelling only for RNs & ENs only.
On-site training	Yes	For new workers, RNs & ENs and mandatory training.
Quality control	Yes	Required to meet accreditation standards.

Source: Residential aged care interviews

5.3.4 Psychological Capital

Psychological capital is comprised of the positive psychological resources of self-efficacy, hope, optimism and resiliency (Luthans et al., 2007b). A relationship between mentoring and psychological capital has recently been established in the literature (Duke & Palmer-Schuyler, 2014; Nigah, Davis, & Hurrell, 2012; Ragins & Kram, 2007). However, the relationship between mentoring functions and constructs of psychological capital has not been investigated. The findings of this study identify specific behaviours of each of the mentoring functions of career, psychosocial and clinical mentoring that provide the psychological resources of self-efficacy, hope, optimism and resilience.

Table 5.15: Final Template of Psychological Capital

1	**Psychological Capital**
1.1	Self-efficacy
1.1.1	Confidence of self
1.1.1.1	Motivated
1.1.1.2	Good communication
1.1.1.3	Ability to deal with difficult behaviours
1.2	Hope
1.2.1	Goal-directed energy
1.2.1.1	Ability to listen
1.2.1.2	Show patience, empathy and compassion
1.3	Optimism
1.3.1	Positive view of events
1.3.2	Externalise feelings
1.4	Resiliency
1.4.1	Ability to rebound from adversity
1.4.1.1	Personal insights
1.4.1.2	Values and beliefs
1.4.1.3	Consistency of thoughts

Source: Luthans et al. (2007) and residential aged care interviews

5.3.4.1 Self-efficacy

The first construct of psychological capital is self-efficacy. Individuals with self-efficacy display five characteristics, namely: high self-motivation, high goals, thrive on challenge, invest effort into achieving goals and perseverance in difficult situations (Bandura, 1997; Luthans et al., 2007b).

In this study, coaching was the only career mentoring behaviour that increased self-efficacy based on coaching being a learning and development activity (Garvey et al., 2009). Some participants (LC1, RN2, CW5, CW9, CW10, CNC14, EN18, CW20, CNC21, CW23, CW24, CW27, CW29, M31, M32) reported that care workers require confidence to work with residents. For example:

> Starting was quite a confidence crusher for a while, and it made you evaluate yourself. I was second guessing myself a lot and not sure that I was doing things correctly. I think that's why we are both really passionate about helping people from the first day to not go through that process of feeling that I'm not going to measure up. I know now that I am quite capable of doing the job and doing it well, but I didn't feel like that to start with (M32).

Along with lack of confidence when first becoming a CW, some other factors that influence self-efficacy were provided. For example, some participants (LC1, RN2, CW8, CNC14, CW15, CW16, CW19, CW20, CNC21, CW23, CW24, CW25, CW27, EN28) reported difficult behaviours of residents as a result of a variety of progressive diseases including dementia, mental illness and physical disabilities. For example;

> You've got to have confidence, you go down to a secure unit, and you start, they [the residents] all know you don't know anything, and you come in telling them what to do. You've got to be very confident…they are insecure, and you've got to know what you're saying. And even if you're not confident you've got to say, I'm confident, you know you can do it - it's pretty hard (CW20).

Being able to overcome fears and work in difficult situations requires self-efficacy, and this can be supported by coaching workers through difficult experiences.

The psychosocial mentoring behaviours of friendship and acceptance and confirmation contributed to increased self-efficacy. Some participants (CW4, CW9, CW10, LC12, CW15, CW20, CNC21, EN22, CW25, CW27) developed confidence through making trusted friendships in the workplace. For example, one participant commented:

> We're such a close-knit family here, and I think that's what I like about working here that we do help each other out whether it be work related or personal related. So, to me that – that's a very good thing it just…being able to mentor each other. We're all on that level, and I think that's what brings us back to being a closer knit as well (CW27).

Acceptance and confirmation may increase self-efficacy. For example:

> Some students have been told about me and have requested me to be with them as a mentor when they're on the placement. So that's a good feeling (RN2).

This study found that the continuing education component of clinical mentoring contributed to self-efficacy. Some participants (RN2, CW5, CW8, LC12, CW24, RN30, M31) undertook professional development which provided them with increased self-efficacy in the workplace.

5.3.4.2 Hope

The second construct of psychological capital is hope. Individuals who display hope are described as having the ability to set realistic and challenging goals that are achieved through determination and energy. Further, should the original path be blocked, individuals with hope have the ability to create an alternative path to success. It is the ability of individuals to create alternatives which sets hope apart from other psychological capital resources (Luthans et al., 2007b).

In this study, the researcher identified that coaching was the only career mentoring behaviour that provided participants with hope. One participant commented on how she encouraged the development of hope in others:

> I like to push them a little bit and challenge them a bit and let them make decisions on their own (RN2).

On the other hand, the acceptance and confirmation and role modelling behaviours of psychosocial mentoring facilitated development of hope in some participants (LC12, CW15, CW16, CW23, CW24, CW25, CW26). These individuals displayed genuine understanding, compassion, empathy, respect and patience for residents. They recognised emotional distress in residents and were willing to spend additional time to listen and interpret the behaviours of each resident and find alternative solutions. For example, one participant commented:

> I've just got a passion for dementia. I don't know I just love it. I find it very rewarding – I feel I'm their voice and doing everything for them – the other day we got biscuits, and we iced them and decorated them, and it stopped behaviours for nearly 3 hours in that area. And it was just icing a packet of arrowroot biscuits (CW23).

An example of role modelling is:

> The skills of my – [mentor] – effective listener, non-judgemental, trying to seek an answer from myself, rather than just giving me an answer, she wants me to come up with a few things of how to fix things, rather than going this is how I think we can do it (CNC21).

The only connection of clinical mentoring to hope was through the sub-theme of role modelling.

5.3.4.3 Optimism

The third construct of psychological capital is optimism. Optimism is based on an individual's ability to externalise feelings and take credit for positive experiences in their life, along with an expectation that further similar experiences will happen in the future (Luthans et al., 2007b).

Coaching was the only career behaviour related to the psychological resource of optimism. In this example, the coaching sub-theme of gaining recognition and ability to take credit for positive experiences combined to create optimism. One participant's experience was:

> I was lucky enough to be nominated to receive a Pride of Australia Medal for working with people with dementia and also with their families as well (CW24).

Psychosocial mentoring was characterised by behaviours of acceptance and confirmation and role modelling. Approximately half of the participants (LC1, LC7, CW8, CNC14, CW10, CW16, CW17, EN18, CNC21, CW24, CW26, CW29, RN30, M31, M32) were optimistic about their work. An example of acceptance and confirmation is:

> It's very rewarding knowing that you're helping these people in the last part of their life. I really love it (CW16).

And role for modelling:

> I came into this job because I wanted to be here, I enjoy listening to people and in listening and watching and observing you can learn (CW17).

The only relationship found between clinical mentoring and optimism was through the psychosocial support sub-theme of role modelling.

5.3.4.4 Resiliency

The final construct of psychological capital is resiliency. Resiliency is the ability to bounce back in the face of adversity, conflict or failure, as well as cope with change or increased responsibility (Luthans et al., 2007b). As with all caring roles, for example, social workers, counsellors, paramedics, doctors, nurses, police and defence force personnel, residential aged care workers witness traumatic and challenging situations.

Career mentoring, through the coaching behaviour, can assist in building resilience by helping co-workers to learn from situations they encounter. For example:

> Having someone that you can talk to about any issues that you have or just debriefing to them or getting guidance from them as well, so when you're asking and seeking support from them and them giving you some, I guess, wisdom or information or how you can sort of tackle things (LC12).

The findings of this study indicate that all behaviours of psychosocial mentoring have a relationship with building resiliency. Some participants (LC1, RN2, CW5, CW9, CW10, EN18, CW20, CNC21, CW23, CW24, CW27, CW29) reported that they had developed friendships in the workplace and it was 'like a family'. Acceptance and confirmation through belief in their ability to cope were evident in over half of the participants (LC1, RN2, CW8, CW10, CNC14, CW15, CW16, CW17, EN18, CNC21, CW23, CW24, CW27, CW29, RN30, M31, M32). These participants reported gaining personal insights through a traumatic event at some point in their lives. Having faith, emotional stability, a sense of humour, initiative and creativity provided them with the strength to work in an environment that they described as challenging, particularly regarding stress, violence and dying. One participant commented:

> I [have] probably felt the worst you could ever feel. [Now] I appreciate everybody. I look at every day as a nice day. Because…anything can happen, it happens within split seconds (CW10).

Another participant commented on how she used counselling skills to help her staff deal with changes in resident health and discussions with resident families. Using counselling skills allowed her to be resilient through difficult conversations. For example:

> For my staff to be able to sort of share a little bit of what I know in terms of counselling if I can remember all of the bits and pieces, to be able to then pass it on to them so that they are more equipped for what you do because you do face that a lot, you do come into those conversations a lot (LC12).

Further, the modelling of difficult conversations by mentors can build resilience in mentees (LC1, CNC21, M31, M32).

Findings of this study show three components of clinical mentoring have a relationship to resilience: case discussions, psychosocial support and on-site training. Continuing education provides participants with additional knowledge and confidence to deal with difficult situations, such as the end of life. For example:

> I actually did a course earlier in the year, in palliative care...and that was like an extra mentoring thing, so that is professional development (M31).

On-site training and role modelling also provided opportunities for some participants to show resilience (CW5, CW8, CW15, CW16, CW17, EN18, CNC21, M32). One participant commented:

> Aged care is a funny thing, you're dealing with people, and there's no book that can tell you everything, that just everybody is as individual as their fingerprints. The nurses will do dementia courses; we don't actually do anything like that here. If we wanted to do it, we'd have to do it our self and offsite and pay for it. Many times it is experience, this job you need to have a certain amount of people here that have experience because they'll say 'Oh look such and such is doing this, how will we appease him, what do we do?' Then might talk to a nurse and maybe another carer, say 'Look I know, I've tried this

with him, it works' or 'I've been somewhere else, and this works'. So, it's just the knowledge is in here, and the knowledge takes years as I say, and you're still learning (CW17).

In summary, strong relationships were identified between career, psychosocial and clinical mentoring and psychological capital. Specifically, the coaching behaviour of career mentoring as a driver, along with the psychosocial mentoring behaviours of friendship, acceptance and confirmation, counselling and role modelling were related to psychological capital. Clinical mentoring behaviours of continuing education, role modelling, case discussions and on-site training also provided psychological capital. The relationships are summarised in Table 5.16.

Table 5.16: Psychological Capital

Mentoring function	Behaviour exhibited	Psychological Capital
Career mentoring	Coaching	Self-efficacy, Hope, Optimism, Resiliency
Psychosocial mentoring	Friendship	Self-efficacy, Resiliency
	Acceptance and	Self-efficacy, Hope, Optimism, Resiliency
	confirmation	Resiliency
	Counselling	Hope, Optimism, Resiliency
	Role modelling	
Clinical mentoring	Continuing education	Self-efficacy, Resiliency
	Role modelling	Hope, Optimism, Resiliency
	Case discussions	Resiliency
	On-site training	Resiliency

Source: Residential aged care interviews

5.4 Summary of the results

This chapter investigated the three mentoring functions of career, psychosocial and clinical mentoring in the residential aged care sector and identified specific behaviours. The findings of this study suggest that career mentoring was limited to behaviours of coaching, sponsorship and advocacy. For psychosocial mentoring, behaviours of friendship, acceptance and confirmation, counselling and role modelling were provided, but to a limited extent. All clinical mentoring components of complicated cases, continuing education, case discussions, psychosocial support, on-site training and quality control, were provided to a limited extent.

Importantly, this study identified that aged care workers, who are low paid and not highly trained, were confronted with some of the most difficult tasks and emotional challenges in caring for residents. Further, care workers specifically reported receiving inferior training and often little support from senior staff. This led the researcher to consider where workers gain self-efficacy, optimism, hope and resiliency to continue working in the residential aged care sector. The semi-structured nature of the interviews allowed the researcher to probe this area further which resulted

in the proposition that there may be a relationship between mentoring and psychological capital. Specifically, coaching, friendship, acceptance and confirmation, counselling, role modelling, continuing education and on-site training contributed to psychological capital. Based on the qualitative results, the researcher completed a quantitative study with a wider sample of participants to investigate the possible relationship between mentoring and psychological capital. Chapter 6 reports the quantitative results of the relationship of some of the mentoring behaviours with psychological capital.

CHAPTER 6 : RESULTS OF RESIDENTIAL AGED CARE SURVEY

6.1 Introduction

This chapter presents the findings of the third phase of the research. The purpose of the third study was to understand how the mentoring experience influences psychological capital of residential aged care workers. To complete Phase 3, results of Phase 2 were analysed and the researcher identified a potential relationship between some mentoring functions and elements of psychological capital. To investigate the relationship further, a preliminary conceptual framework with hypotheses was developed. A quantitative survey was undertaken at five organisations and results were analysed using canonical correlation analysis (CCA) which is considered a suitable method for analysing complex relationships between two variable sets (Sherry & Henson, 2005).

6.2 Preliminary conceptual framework

In Phase 2 of the qualitative research, a potential relationship between mentoring and psychological capital was identified. However, it was not clear whether the holistic relationship between mentoring behaviours contributed to psychological capital. Further, it was even less clear whether it was possible to identify individual relationships between mentoring behaviours and the four psychological capital construct of hope, optimism, self-efficacy and resiliency.

The researcher developed a conceptual model based on findings of Phase 2 of the research. The qualitative results of Phase 2 showed that, for career and psychosocial mentoring functions, the behaviours of coaching, acceptance and confirmation, friendship, role modelling and counselling were the most commonly provided mentoring behaviours in residential aged care. According to qualitative interviews, the most commonly exhibited mentoring behaviours of clinical mentoring were case discussions, on-site training and quality control.

In the Phase 3 quantitative study, mentoring was measured using the Ragins and McFarlin (1990) scale which does not include a measure for clinical mentoring. Therefore, consideration was given to where clinical mentoring behaviours fit with existing mentoring behaviours detailed by Ragins and McFarlin (1990). Findings from Phase 2 showed that clinical mentoring was limited to case discussions, onsite training, role modelling and quality control. As training and role modelling were already identified as key mentoring behaviours provided in the residential care sector, the researcher adopted five behaviours of the Ragins and McFarlin (1990) scale of mentoring as most representative of mentoring for this study. From the five mentoring behaviours of coaching,

acceptance and confirmation, friendship, role modelling and counselling a theoretical model was conceptualised between mentoring and psychological capital using CCA. Canonical correlation analysis was chosen rather than multiple regression because it can analyse several dependent variables at a time. Using CCA has several advantages. Firstly, it limits the probability of committing a Type 1 error within a study (Sherry & Henson, 2005). Secondly, it is robust to the assumption of normality (Hair, Black, Babin, & Anderson, 2010) and thirdly it respects the fact that most human behaviour research investigates variables that may have multiple causes and multiple effects. CCA is a method that is technically able to analyse complex realities and is theoretically consistent with the research purpose (Hair et al., 2010; Sherry & Henson, 2005).

6.2.1 Theoretical framework

Figure 6.1 illustrates the theoretical framework of the variable relationships in CCA with the five predictor variables of mentoring and four criterion variables of psychological capital. The CCA examines correlation between the synthetic predictor and synthetic criterion variable, weighted according to relationships between variables within each set. Effectively, the CCA can be considered a simple bivariate correlation (Pearson r) between two synthetic variables (Sherry & Henson, 2005).

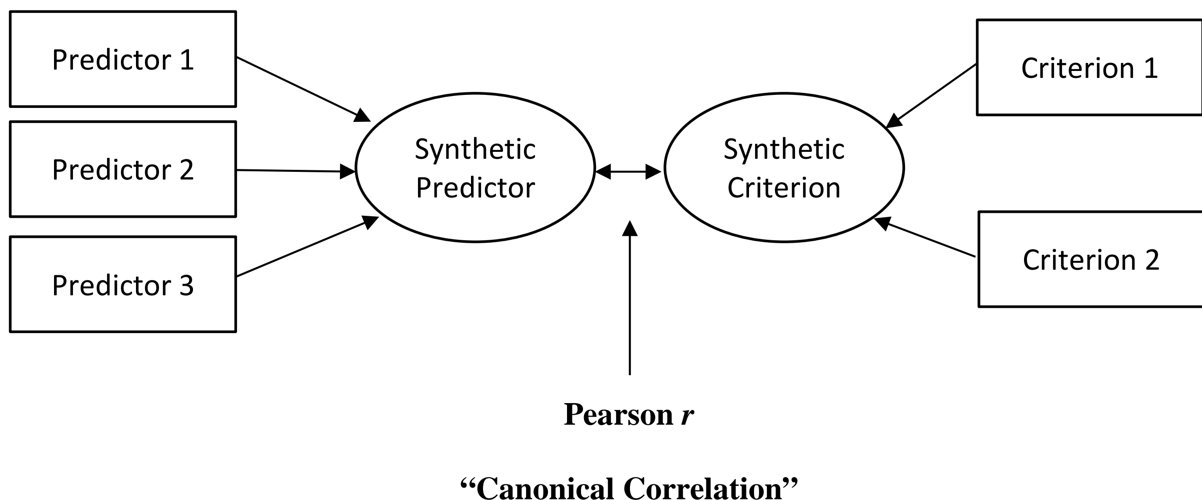

Figure 6.1: Generic Canonical Correlation Analysis Framework
Source: (Sherry & Henson, 2005 p.39)

The CCA theoretical framework was applied to the relationship between five behaviours of mentoring (Mentoringx5) and psychological capital. The framework for the first canonical correlation is presented in Figure 6.2, below.

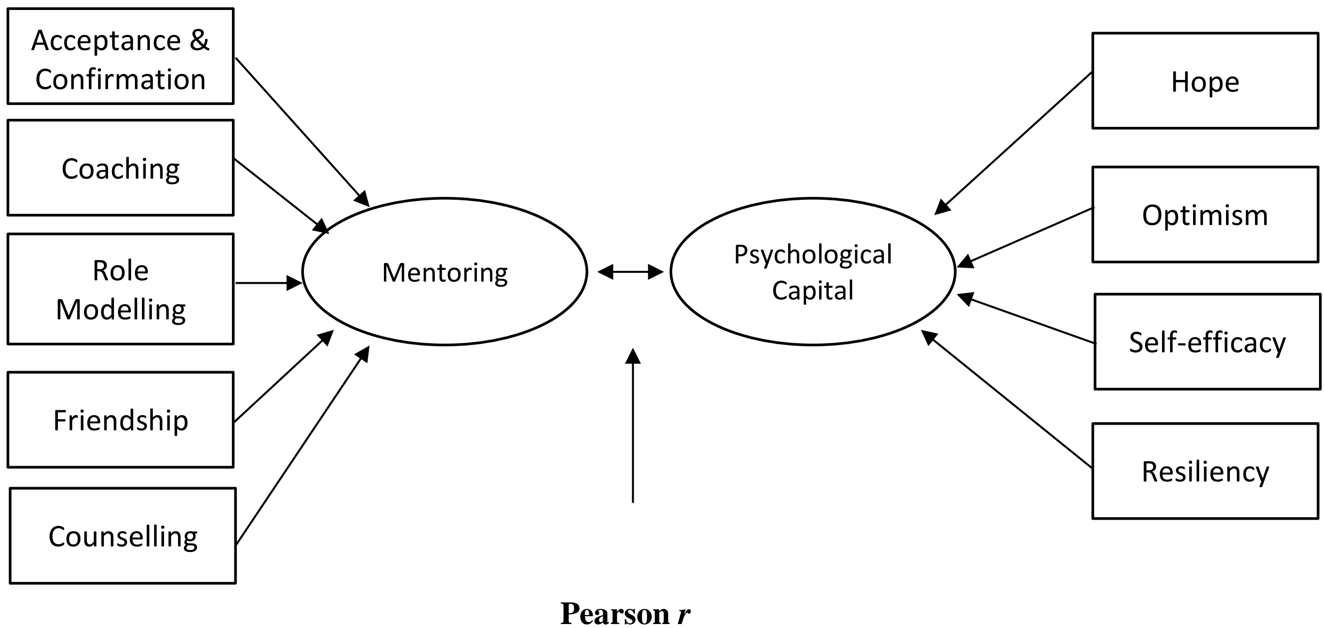

Figure 6.2: First Function Canonical Correlation Analysis between Mentoring and Psychological Capital

6.2.2 Hypotheses

The current study contributes to the literature by examining the relationship between mentoring and psychological capital. Phase 3 tested this finding with a larger population of residential aged care workers to establish whether mentoring is an antecedent of psychological capital (Figure 6.3).

The following hypotheses for residential aged care workers were made:

Hypothesis 1: There is a positive relationship between mentoring and psychological capital.

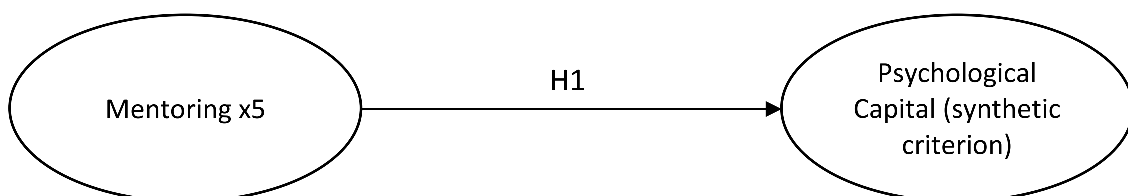

Figure 6.3: Hypothesis 1

The second group of hypotheses are related to the relationship between five mentoring behaviours, identified in Phase 2, and psychological capital as reported in the literature. Avey et al. (2011) noted

that little research had been conducted on antecedents to psychological capital and suggested that leadership may play a vital role in development of psychological capital in followers. Other researchers suggested that psychological capital can be enhanced with training and development interventions, such as mentoring and coaching (Knudson, 2015; Lunsford, 2016; Pineau Stam et al., 2015; Saks & Gruman, 2011; Toor, 2010).

The five hypotheses in the second group of hypotheses are:

Hypothesis 2a: There is a positive relationship between coaching and psychological capital.

Hypothesis 2b: There is a positive relationship between acceptance & confirmation and psychological capital.

Hypothesis 2c: There is a positive relationship between role modelling and psychological capital.

Hypothesis 2d: There is a positive relationship between counselling and psychological capital.

Hypothesis 2e: There is a positive relationship between friendship and psychological capital.

These hypotheses are illustrated in Figure 6.4, below.

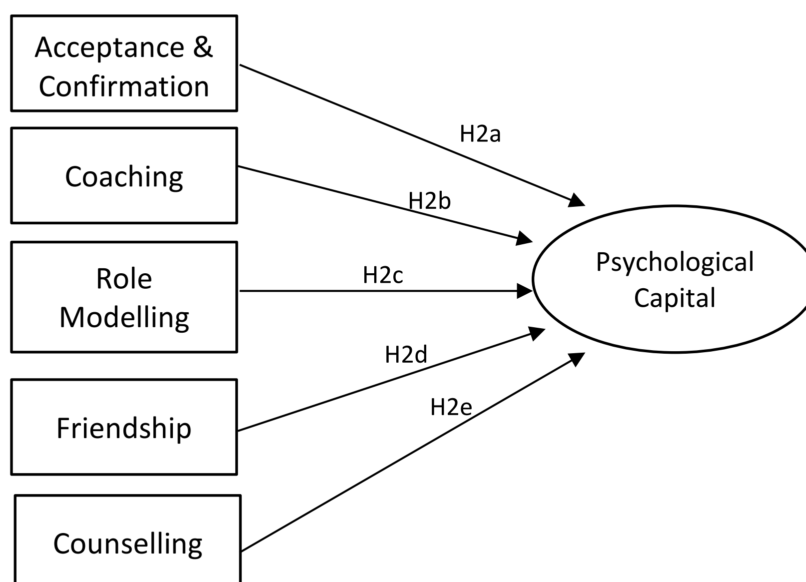

Figure 6.4: Hypotheses 2a to 2e

The third group of hypotheses deals with the relationship between individual constructs of psychological capital drawn from the literature (Luthans et al., 2007b) and relevant mentoring

behaviours identified in Phase 2. The literature supports the need to develop and strengthen personal resilience and professional support through mentoring programmes, particularly for workers who work in adverse work environments, such as nursing. (Cameron & Brownie, 2010; Fletcher & Sarkar, 2013; Jackson et al., 2007; McAllister & McKinnon, 2009; Sabo, 2011). Cameron et al. (2010) highlight the importance of mentors, teams and colleagues providing psychosocial support to develop resilience in registered aged care nurses.

There is evidence that each component of psychological capital can be taught and developed through on-going support which can best be achieved through teaching reflective communication skills and teaching managers and workers how to coach, mentor and support each other in the workplace (Luthans et al., 2015). Therefore, this research sought to confirm whether there is a positive relationship between mentoring and the psychological capital constructs of hope, optimism, self-efficacy and resiliency.

The following hypotheses for residential aged care workers were made:

Hypothesis 3a: There is a positive relationship between mentoring and hope.

Hypothesis 3b: There is a positive relationship between mentoring and optimism.

Hypothesis 3c: There is a positive relationship between mentoring and self-efficacy.

Hypothesis 3d: There is a positive relationship between mentoring and resiliency.

The above hypotheses are illustrated in Figure 6.5, below.

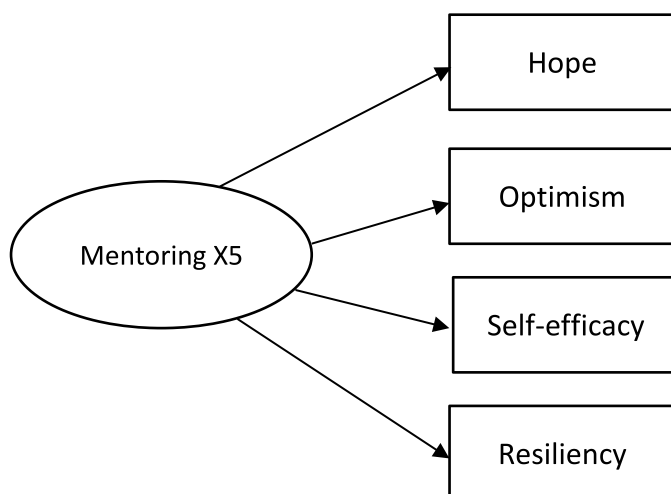

Figure 6.5: Hypotheses 3a to 3d

6.3 Description of the sample

6.3.1 Organisation background

For the quantitative phase (Phase 3), four not-for-profit and one for-profit residential aged care organisation agreed to participate in the research. The initial sample size was around 1,900 workers from five different residential aged care organisations located in two states of Australia. One organisation gave access to eight sites within metropolitan Adelaide and country SA, an interstate organisation provided access to 800 workers. Each South Australian site employed around 100 workers who were a mix of full-time, part-time and casual workers. Employee job roles varied and included Residential Site Manager (RSM), Clinical Nurse Consultant (CNC), Registered Nurse (RN), Enrolled Nurse (EN), Care Worker (CW), Lifestyle Coordinator, Allied Health Professional (AHP), Hospitality Staff, and Administration Staff. It was not a requirement for organisations or individual sites to have a current mentoring programme.

Initial approach was made by electronic mail to the Human Resource Manager at each organisation who facilitated the process of gaining access to various sites. Approval for employee participation in the research was provided by an authorised person from each organisation following an internal ethics clearance. The Human Resource Manager then facilitated a meeting or telephone call between the RSM at each site and researcher to discuss how surveys should be administered. The use of different distribution methods was necessary for practical reasons and is consistent with other studies (Gaskin et al., 2012; Kaplowitz et al., 2004). Two organisations agreed to forward a survey link directing workers to the anonymous survey on Survey Monkey. The remaining three organisations distributed paper surveys to workers through the internal mail system. All respondents had the choice of returning the completed questionnaire directly via mail to the researcher or placing it in a sealed envelope and into a centrally located box for later collection by the researcher. In this way, confidentiality and anonymity were preserved to improve honesty of responses.

6.3.2 Participant demographics

A total of 191 questionnaires were received from participants representing a 10% response rate. Of the 191 questionnaires, 155 were useable. A summary of respondent demographics is detailed in Table 6.1.

Table 6.1: Characteristics of Respondents (N=155)

Characteristics	Percentage
Gender:	
- Male	13
- Female	87
Age distribution:	
- Under 25 years	12
- 25-34 years	14
- 35-44 years	22
- 45-54 years	27
- 55+ years	25
Occupation:	
- Registered nurse	24
- Allied health professional	10
- Personal care attendant	50
- Administration	4
- Hospitality, laundry or other	12
Employment status:	
- Full time	36
- Part time	43
- Casual	19
- Work placement	2
Industry Experience:	
- <1 year	11
- 1-2 years	17
- 3-5 years	25
- 6-10 years	18
- 11-19 years	21
- 20+ years	8
Working in preferred job	
- Yes	74
- No	26

Source: Surveys of residential aged care workers

The survey conducted for this research reported that 87 percent of respondents were female and 13 percent were male which is line with the workforce report (King et al., 2013b) (Table 6.1).

Age distribution of the workforce was representative of the residential care sector in general (King et al., 2013b). For this sample, 25 percent of respondents were over 55+ years old, 49 percent between 35 and 54 years of age and 26 percent were aged 34 years or younger (Table 6.1).

A range of occupations was included in the sample. Twenty-four percent of respondents were RNs, 10 percent allied health professionals (AHP), 50 percent CWs, 4 percent AWs and 12 percent HWs (Table 6.1).

The employment status of the sample was 36 percent full-time staff, 43 percent part-time, 19 percent casual and 2 percent on work placement (Table 6.1). Within the residential care industry, there has been a shift towards permanent part-time employment with census statistics (King et al., 2013b) confirming 9 percent full-time, 72 percent part-time and 19 percent casual employment in 2012. This sample provides a higher proportion of full-time workers, but casual workers are the same as census figures.

The level of respondent experience in the aged care industry was heavily skewed towards inexperience with 11 percent of workers having worked in residential aged care for less than one year. The number of respondents with 1-5 years experience was 42 percent, 6-9 years experience was 18 percent, 10-19 years experience was 21 percent and over 20 years experience was 8 percent (Table 6.1). In comparison to census figures (King et al., 2013b), the level of inexperience in this sample is much higher. National figures show experience of one year or less at 8 percent, 1-9 years experience is 34 percent, 10-19 years is 34 percent and over two decades is 24 percent.

Overall, 76 percent of respondents indicated that they were working in their preferred job (Table 6.1). This suggests that 24 percent may consider alternative employment in the future based on job preference. No conclusions are drawn from these sample profile statistics regarding qualifications for alternative employment or job satisfaction.

6.3.3 Mentoring experience of the respondents

Table 6.2, below, provides a description of the respondent mentoring experience for those who participated in the survey. Respondents were asked whether they currently had a mentor. Of 155 respondents, 83 percent reported that they had a mentor and 67 percent reported that their mentor was a supervisor, senior professional or peer in the workplace. Sixteen percent reported that their mentor was outside the organisation and 17 percent reported not having a support person. Due to question wording it was not possible to determine whether or not these respondents had been mentored previously and had completed the survey based on previous experiences of mentoring.

The majority of mentoring was provided on an informal basis with 38 percent of respondents reporting that mentoring received was informal. A further 6 percent said they received only formal mentoring and a further 39 percent received a combination of both. Further, 17 percent of respondents reported no form of mentoring.

Respondents were asked to identify the nature of mentoring received and could identify as many categories as relevant. The categories included clinical training and supervision, career support and emotional support. Seventy percent of respondents reported receiving clinical training and supervision, 37 percent received career support, 50 percent received psychosocial support and 17 percent received no mentoring.

Forty-one percent of respondents reported that the organisation provided a mentor and 42 percent chose their mentor, with 16 percent of those supporters being outside of the workplace, while the remaining 17 percent reported no support person. Thus, for this group of respondents two-thirds received mentoring support from the workplace and the majority of this support was provided informally.

Table 6.2: Mentoring Characteristics of Respondents (N=155)

Characteristics	Percentage
Currently have a mentor	
- Yes	83
- No	17
Who is the mentor?:	
- Supervisor or senior professional	53
- Peer	14
- Family member	9
- Friend	4
- Independent person outside organisation	3
- Not applicable	17
Structure of mentoring received:	
- Formal	6
- Informal	38
- Combination of both	39
- Not applicable	17
Mentoring functions received*:	
- Clinical training	34
- Clinical supervision	36
- Career support	37
- Psychosocial support	50
- None of the above	17
How was mentor chosen?	
- Provided by organisation	41
- Identified by self	42
- Not applicable	17

Source: Survey of residential aged care workers
*Respondents could report receiving more than one type of mentoring

6.4 Data analysis

Hypotheses developed (Section 6.2) were tested using canonical correlation analysis (CCA) produced with IBM SPSS version 23. The researcher selected CCA for this study because of the large number of independent and dependent variables to be tested and the lack of a priori knowledge about relationships between sets of variables (Hair et al., 2010; Humphries-Wadsworth, 1998; Sherry & Henson, 2005; Tabachnick & Fidell, 2007). This provides a rich picture of the relationships between variables and factors not available through multiple regression. Further, because the CCA technique does not require variables to be defined as dependent or independent synthetic variables, there is no difference in weightings of the synthetic variables in maximising the correlation (Hair et al., 2010, p. 259). In this instance, both sets of factors came from pre-existing measurement scales and provided high scores on the correlation matrix. Canonical correlation is the most generalised multivariate model and is less demanding in meeting the underlying statistical assumptions of other methods. However, interpretability of results is improved if assumptions are satisfied (Hair et al., 2010; Sherry & Henson, 2005; Tabachnick & Fidell, 2007). Before conducting canonical correlation to test various hypotheses, normality and multicollinearity tests were undertaken and results are presented below.

6.4.1 Test for normality

Prior to testing for normality, data was proofread for accuracy. Cases with substantial missing data were deleted from the dataset. Where missing values were considered minor, values were estimated using mean substitution (Tabachnick & Fidell, 2007).

Each variable was examined for skewness and kurtosis using the Kolmogorov-Smirnov and Shapiro-Wilk tests, as well as Q-Q plot of residuals to determine whether data met assumptions of normality (Table 6.3).

Table 6.3: Skewness and Kurtosis Statistics

Variable	Skewness	Std. error	Kurtosis	Std. error
Coaching2	-.695	.195	.482	.387
Role Modelling2	-.393	.195	.176	.387
Friendship	-.865	.195	1.216	.387
Counselling	-.546	.195	.308	.387
Acceptance	-.909	.195	1.240	.387
Self efficacy	-.968	.195	1.468	.387
Hope	-.921	.195	2.223	.387
Optimism2	-.717	.195	1.556	.387
Resiliency	-1.365	.195	4.864	.387

Several variables showed moderate negative skewness. Data was then transformed by applying reflected square root, natural log and logarithmic transformations (Tabachnick & Fidell, 2007). Analyses were conducted on transformed and non-transformed data. When solutions were compared, level of significance for transformed data did not change at p = .000. Therefore, normality at significance level p >.05 could not be achieved. (Table 6.4). Reasons include the method of respondent self-reporting and social desirability biases, often found in health care research (Kimberlin & Winetrstein, 2008; Podsakoff, MacKenzie, & Podsakoff, 2012). Further, pairwise linearity was assessed using residual plots and the distribution showed no evidence of violation of the assumptions of linearity. Two cases were identified as multivariate outliers using Mahalanobis distance (p < .001). Again, there were no differences between results of analyses conducted on data sets that included multivariate outliers and those that did not. Therefore, statistical analysis was completed on non-transformed data, as there was no improvement in level of robustness of transformed data (Hair et al., 2010; Tabachnick & Fidell, 2007).

Table 6.4: Tests of Normality

	Kolmogorov-Smirnov (a)			**Shapiro-Wilk**		
	Statistic	**df**	**Sig.**	**Statistic**	**df**	**Sig.**
Coaching2	.182	155	.000	.928	155	.000
Role Modelling2	.175	155	.000	.950	155	.000
Friendship	.138	155	.000	.914	155	.000
Counselling	.128	155	.000	.953	155	.000
Acceptance	.132	155	.000	.924	155	.000
Self efficacy	.114	155	.000	.933	155	.000
Hope	.133	155	.000	.938	155	.000
Optimism2	.109	155	.000	.953	155	.000
Resiliency	.111	155	.000	.915	155	.000

a. Lilliefors Significance Correction

6.4.2 Test for Reliability

Data was then tested for reliability based on an acceptable Cronbach's alpha of .70 or above (Field, 2013). Reliability tests were conducted on constructs and Cronbach's alpha values were observed. The revised mentoring scale comprising coaching, friendship, role modelling, acceptance and confirmation and counselling provided high reliability with a Cronbach's alpha of .94. The psychological capital scale also provided high reliability with a Cronbach's alpha of .84. All individual independent and dependent variables also showed high reliability (Table 6.5). As the Cronbach's alpha for the constructs was above .70, the data was suitable for further analysis.

Table 6.5: Reliability Statistics

Variable	Cronbach's Alpha
Selfeff_SUM	.90
Hope_SUM	.89
Resil_SUM	.83
Optimism_2	.76
Overall Psychological Capital	.84
Coach_2	.76
Rolemodel_2	.83
Friend_SUM	.92
Counsel_SUM	.89
Accept_SUM	.93
Overall mentoring (x5)	.94

6.4.3 Confirmatory Factor Analysis

Confirmatory factor analysis (CFA) was completed to assess the factor structure of independent and dependent variables reported in this thesis. Although the constructs of mentoring (Ragins & McFarlin, 1990) and psychological capital (Luthans et al., 2007b) have been confirmed previously in the literature as reliable and valid, CFA was utilised to validate the scales in the context of this study. Further, as a result of Phase 2 findings, only some unobserved variables of the mentoring construct were included in Phase 3. As such, use of CFA is suitable for confirming reliability and validity of the five unobserved variables focused on in Phase 3.

The CFA was conducted using IBM SPSS and AMOS version 23. CFA assumes that the variables measured are continuous (Beauducel & Herzberg, 2006). The observed variables of the hypothesised model were examined to confirm whether the model was a good fit to the observed data. For this research, separate CFA was conducted on each unobserved variable. That is, the hypothesised mentoring model adopted from Phase 2 of this research and the psychological capital variable.

6.4.3.1 Mentoring model

An initial analysis of the hypothesised mentoring model (MentoringX5), as shown in Figure 6.4, provided the following fit indices. The chi square goodness-of-fit test was significant, $\chi^2 = 215.2$, df = 80, $p<.001$ suggesting a lack of fit between the hypothesised model and the data. While the χ^2 test is the most commonly reported measure, other measures are also used to confirm fit (Jackson, Gillaspy Jr, & Purc-Stephenson, 2009). The χ^2/df ratio = 2.69, the comparative fit index (CFI) = 0.94 and the parsimony-adjusted comparative fit index (PCFI) = 0.72 indicate a good fit between the

model and the observed data. However, the root mean-square error approximation (RMSEA) = 0.105 indicating a poor fit. The researcher proceeded to modify the model to achieve a better fit.

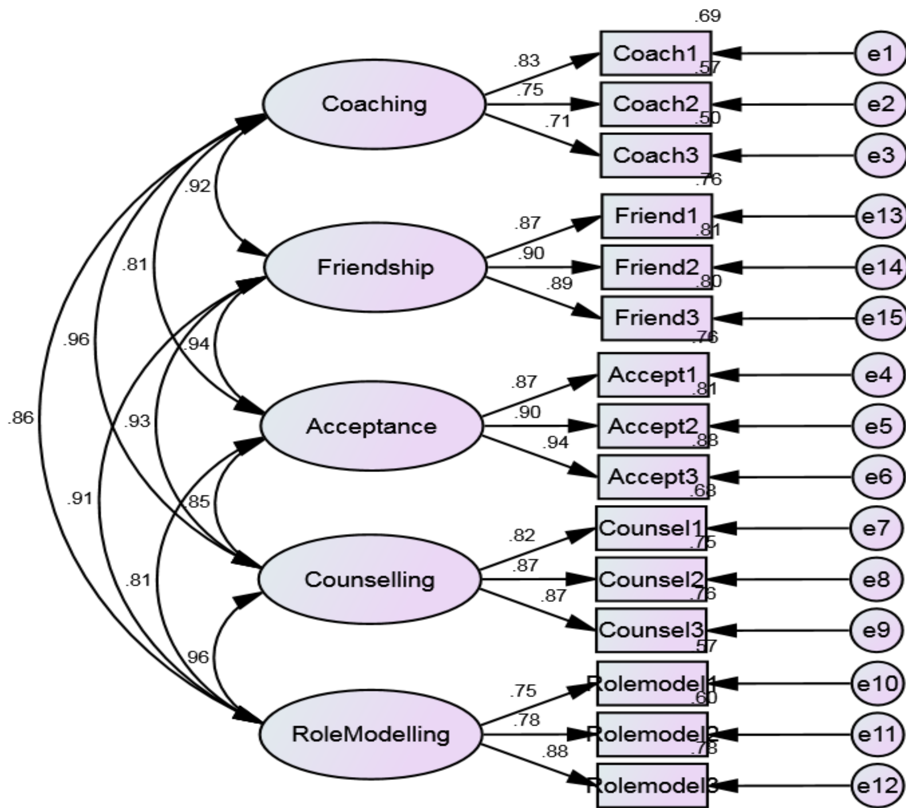

Figure 6.6: Hypothesised Mentoring Model (MentoringX5)

Modifications to the MentoringX5 model were made to assess whether a better model fit could be achieved. The two observed variables with the lowest coefficients, Coach3 = .71 and Rolemodel1 = .75, were removed from the MentoringX5 model. The result was a statistically superior model fit. The chi square goodness-of-fit test remained significant, χ^2 =119.2, df = 55, p<.001. However, the χ^2/df ratio = 2.2, the comparative fit index (CFI) = 0.97 and the parsimony-adjusted comparative fit index (PCFI) = 0.68 and root mean-square error approximation (RMSEA) = 0.087 indicating a good fit between the model and the observed data (Table 6.6). The modified model was renamed a hierarchical Mentoringx5 model (Figure 6.5), in line with recommended terminology of Schreiber, Nora, Stage, Barlow & King (2006).

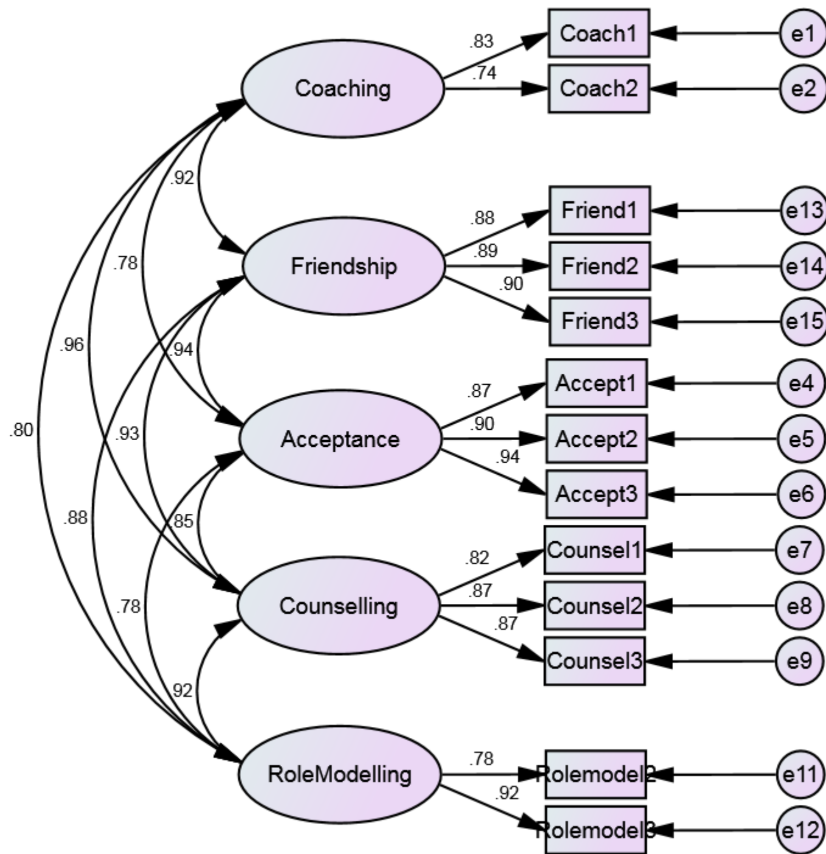

Figure 6.7: Hierarchical MentoringX5 Model

6.4.3.2 Psychological capital model

An initial analysis of the hypothesised psychological capital model (Psycap) as shown in Figure 6.7, provided the following fit indices. The chi square goodness-of-fit test was significant, $\chi^2 = 567.22$, df = 246, $p<.001$ suggesting a lack of fit between the hypothesised model and the data. The χ^2/df ratio = 2.31, the comparative fit index (CFI) = 0.86 and the parsimony-adjusted comparative fit index (PCFI) = 0.76 indicate a good fit between the model and the observed data. However, the root mean-square error approximation (RMSEA) = 0.09 indicating an average fit. The researcher proceeded to modify the model to achieve a better fit.

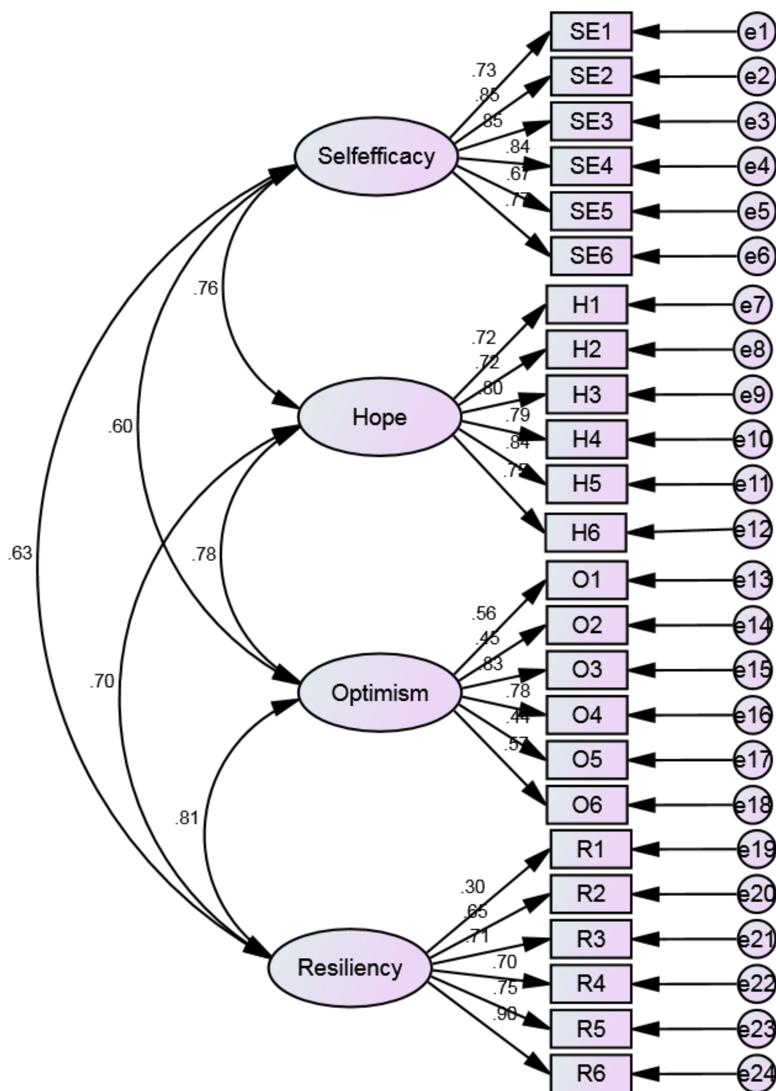

Figure 6.8: Hypothesised Psychological Capital Model (Psycap)

Several modifications to the Psycap model were made to assess whether a better model fit could be achieved. Modifications were made to the observed variables with the lowest coefficients; that is, O2, O4 and R1. Several combinations were applied and the model of best fit was achieved when the two observed variables with coefficients, O2 = .45 and O5 = .44, were removed from the Psycap model. Further, two error covariance modifications were made e11 and e12 =.38 and e21 and e23 = -.36 (Brown, 2014; Gaskin, 2016). The result was a statistically superior model fit. The chi square goodness-of-fit test was significant, χ^2 = 387.5, df = 201, p<.001 suggesting a lack of fit between the hypothesised model and the data. The χ^2/df ratio = 1.9, the comparative fit index (CFI) = 0.91 and the parsimony-adjusted comparative fit index (PCFI) = 0.79 and the root mean-square error approximation (RMSEA) = 0.078 indicate a good fit between the model and the observed data (Table 6.6). The modified model was renamed a hierarchical Psycap1 model (Figure 6.8), in line with the recommended terminology of Schreiber, Nora, Stage, Barlow & King (2006).

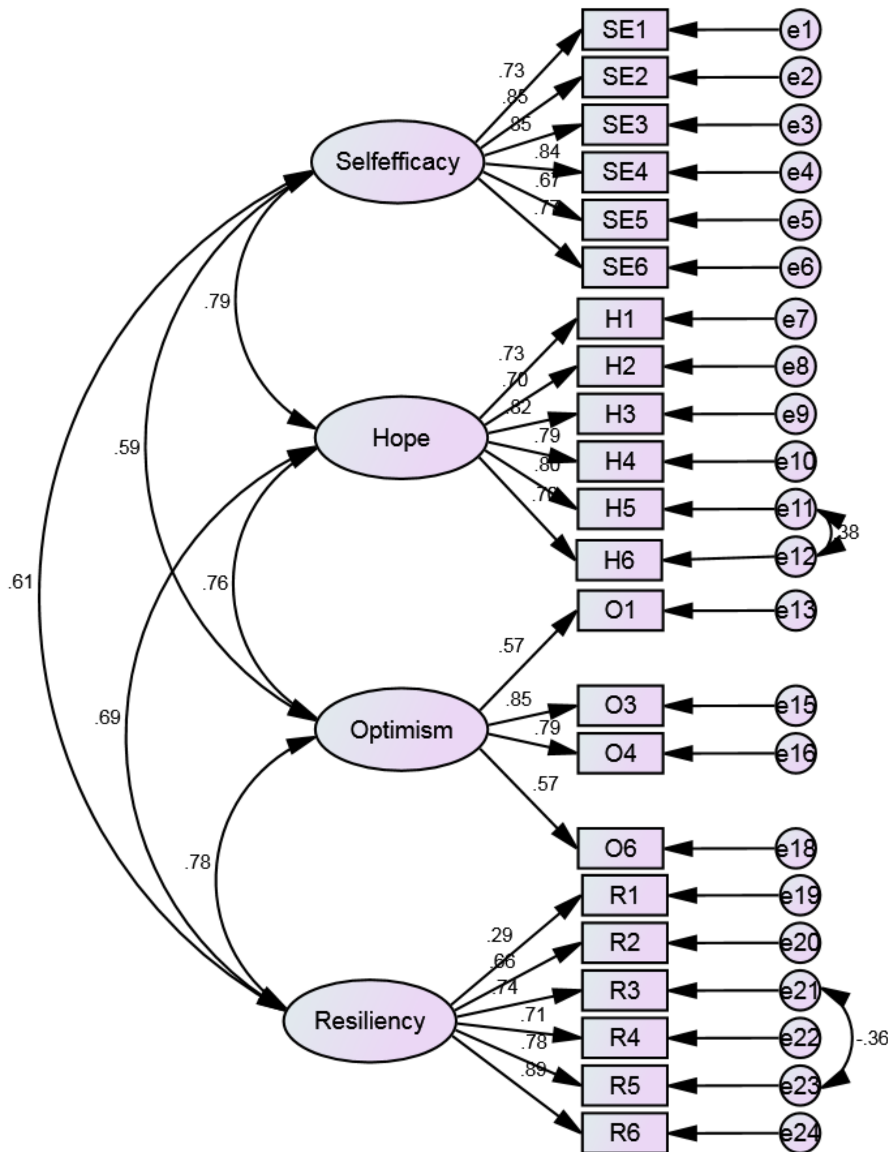

Figure 6.9: Hierarchical Psycap Model

6.4.3.3 Summary of CFA Findings

An overview of measurement model findings based on CFA is outlined in Table 6.6. The determination of model fit was based on comparison of fit indices obtained from CFA with the suggested cut-off values frequently cited in the literature for the AGFI, CFI, PCFI and RMSEA indices (Gaskin, 2016; James, Mulaik, & Brett, 1982; Jöreskog & Sörbom, 1978; Pearson, 1990; Wheaton, Muthen, Alwin, & Summers, 1977). A model was determined to exhibit good, marginal, or poor fit based on comparisons. Both CFA scales were regarded as having good model-data fit based on at least three indices for each model achieving a minimum threshold for fit (Odom, 2008).

Table 6.6: Results Summary for the Mentoringx5 and Psychological Capital Scales

	Acceptable level**	Mentoringx5 Model	Model fit decision	Psycap1 Model	Model fit decision
Cronbach's α	>.7	.94	Good fit	.84	Good fit
χ^2	$p > .05$	119.21* $p = .000$	Poor fit	387.46* $p = .000$	Poor fit
χ^2/df	< 3	2.17	Good fit	1.93	Good fit
AGFI	>.75	.823	Good fit	.775	Good fit
CFI	>.95	.968	Good fit	.910	Marginal fit
PCFI	>.5	.682	Good fit	.792	Good fit
RMSEA	<.06 -.1	.087	Good fit	.078	Good fit

*p <.001 Note CFI = comparative fit index, RMSEA = root mean-square error
**Acceptable levels based on (Gaskin, 2016)

6.4.4 Correlation analysis

Linearity and correlation of the five mentoring variables and four psychological capital variables used in this research was established prior to performing canonical correlation analysis. Results of the Pearson correlation coefficients for each of the variables are detailed in Table 6.7. Examination of correlations indicate that a relationship exists between all variables, therefore use of canonical correlation provides additional insight into the contribution of each of the predictor and criterion variables to the synthetic variables.

Table 6.7: Pearson's Correlation Coefficient (r) Matrix (N = 155)

	Hope _SUM	Selfeff _SUM	Resil _SUM	Optimis m _2	Role model_2	Coach _2	Friend _SUM	Counsel _SUM	Accept _SUM
Hope_SUM	1								
Selfeff_SUM	.693**	1							
Resil_SUM	.569**	.511**	1						
Optimism_2	.632**	.542**	.688**	1					
Rolemodel_2	.388**	.344**	.222**	.365**	1				
Coach_2	.399**	.328**	.291**	.412**	.671**	1			
Friend_SUM	.453**	.353**	.335**	.361**	.757**	.777**	1		
Counsel_SUM	.425**	.353**	.275**	.374**	.814**	.806**	.844**	1	
Accept_SUM	.478**	.448**	.347**	.337**	.675**	.667**	.871**	.775**	1

** Correlation is significant at the 0.01 level (2-tailed)

6.4.5 Canonical correlation

Canonical correlation was performed between a set of mentoring variables and a set of psychological capital variables using IBM SPSS MANOVA version 23 and syntax for canonical correlation. The researcher chose this method because of the large number of independent and dependent variables to be tested and a lack of previous research about relationships between the sets of variables (Hair et al., 2010; Humphries-Wadsworth, 1998; Sherry & Henson, 2005; Tabachnick & Fidell, 2007). Predictor variables for mentoring were coaching, friendship, acceptance and confirmation, counselling and role modelling. Criterion variables for psychological capital were self-efficacy, optimism, hope and resiliency.

The first stage of canonical correlation analysis was to assess general fit of the model. The most commonly used test is Wilks' lambda with significance of $p < 0.05$. The model provided a Wilks' lambda of .614 criterion ($F20, 485.18) = 3.837$, $p < .001$ suggesting that the full model across all functions was statistically significant. Thus, there was a relationship between mentoring variables and psychological capital variables. Wilks' lambda represents unexplained variance of the model. By taking 1 – Wilks' lambda, the overall effect of the full model was calculated. That is, 1 - .614 = .386 equals the squared structured coefficient for the full model. Thus, the full model explained approximately 39 percent of variance shared between the variable sets, thereby supporting Hypothesis 1.

Examination of the canonical correlation coefficients and eigenvalues of canonical roots indicated the hypothesis that mentoring and psychological capital are positively correlated is correct. Table 6.8 shows the first canonical correlation coefficient is .523 with an explained correlation variance of 68.35 percent and an eigenvalue of .377.

Table 6.8: Eigenvalues and Canonical Correlations

Root No.	Eigenvalue	Percentage	Cumulative Percentage	Canonical Correlation	Squared Correlation
1	.37684	68.34778	68.34778	.52316	.27370
2	.11104	20.13925	88.48703	.31614	.09994
3	.05610	10.17416	98.66119	.23047	.05312
4	.00738	1.33881	100.00000	.08560	.00733

The output demonstrated overall model fit and dimension reduction analysis was used to examine significance of roots. As shown in Table 6.8, four possible roots were extracted. The first test of significance tested all four canonical roots of significance ($f = 3.837$ $p < 0.001$), the second test excluded the first root and tested roots two to four ($f = 2.116$ $p = .015$), the third test excluded the

first and second roots and tested roots three and four and lastly root four alone was tested. Results show that the first and second roots are significant $p < 0.05$.

Table 6.9: Dimension Reduction Analysis

Roots	Wilks lambda	F	Hypoth. DF	Error DF	Sig. of F
1 TO 4	.61445	3.83705	20.00	485.18	.000
2 TO 4	.84601	2.11627	12.00	389.22	.015
3 TO 4	.93995	1.55159	6.00	296.00	.161
4 TO 4	.99267	.54993	2.00	149.00	.578

The first and second roots were chosen for interpretation as they explained 27.3 percent and 10 percent of shared variance within their functions, respectively. The third and fourth roots each explained less than 6 percent of shared variance in their functions (5.3 percent and 0.73 percent, respectively) and were sufficiently weak as to not warrant interpretation (Table 6.9).

The next stage of canonical correlation analysis involved interpretation of the two synthetic variables on a given canonical function. Function 1 refers to the whole model (roots 1 to 4) and Function 2 relates to the section model (roots 2 to 4). Having established a relationship between mentoring variables and psychological capital variables, the researcher sought to determine the degree and directionality of connection in multivariate analysis.

Table 6.10: Canonical Solution for Mentoring Predicting Psychological Capital

	Function 1			*Function 2*			
Variable	***Coef***	***Stru Coef***	***Stru r^2 (%)***	***Coef***	***Stru Coef***	***Stru r^2 (%)***	***h^2 (%)***
Optimism	.209	.759	57.60	1.465	.504	25.40	83.00
Self-efficacy	.401	.878	77.09	-.320	-.169	2.85	79.94
Hope	.520	.934	87.24	-.258	-.070	0.49	87.73
Resiliency	.006	.651	42.38	-.907	-.209	4.37	46.75
Coaching	.348	.816	66.59	.842	.415	17.22	83.81
Role modelling	.256	.797	63.52	.768	.390	15.21	78.73
Friendship	-.271	.869	75.52	-.373	-.016	00.02	75.54
Counselling	-.064	.846	71.57	.126	.239	5.71	77.28
Acceptance & confirmation	.838	.957	91.58	-1.130	-.279	7.78	99.36

Table 6.10 presents the standardised canonical function coefficients and structure coefficients for Functions 1 and 2. Further, squared structured coefficients and communalities are provided for the

two functions and two variables. The structural coefficient is critical for deciding which variables are useful in the model (Sherry & Henson, 2005). In canonical correlation analysis, interpretation of both standardised weights and structured coefficients is necessary to understand the importance of a variable. Structured coefficients above .45 are underlined (following convention in factor analyses) (Sherry & Henson, 2005). Communalities above 45 percent are also underlined to show variables with highest usefulness in the model. Criterion variables are listed first in the table followed by predictor variables. The coefficient (Coef) column lists canonical correlation, followed by the structured coefficient (Stru Coef) and then the squared structured coefficient (Stru r^2 (%)). The last column in the Table 6.10 shows the communality statistic (h^2 (%)).

Examination of Function 1 coefficients, shown in Table 6.10, confirms that relevant criterion variables of optimism, self-efficacy, hope and resiliency make contributions to the synthetic criterion variable. Resiliency provided the least contribution to the synthetic criterion variable as indicated by the squared structured coefficient of 42.38 and canonical coefficient of .006.

The other side of the equation on Function 1 involves the predictor set of variables: coaching, role modelling, friendship, counselling and acceptance and confirmation. Results shown in Table 6.10 confirm that all mentoring variables are primary contributors to the synthetic predictor variable. All structured coefficients are positive and all structured coefficients of the criterion variable are positive. There is a positive relationship between all predictors and all criterion variables. These results support the hypothesised relationships between mentoring and psychological capital.

For Function 2, the canonical coefficients, shown in Table 6.10, suggest that the only criterion variable of relevance is optimism at .504. No predictor variables were relevant to this function. The first Function of the canonical correlation analysis model demonstrated theoretically consistent relationships among all variables that contributed to the function. The second Function yielded one theoretical relationship with optimism, which is expected as Function 2 explained only 10 percent of variance in the model.

The communality statistic provided insight into the extent that variables contribute to the mentoring / psychological capital relationship. Table 6.11 shows communality statistics for predictor and criterion variables.

Table 6.11: Contribution of Predictor and Criterion Variables

Mentoring Predictor variables		Psychological Capital Criterion Variables	
Acceptance & Confirmation	99.36%	Hope	87.73%
Coaching	83.81%	Optimism	83.00%
Role Modelling	78.73%	Self-efficacy	79.94%
Counselling	77.28%	Resiliency	46.75%
Friendship	75.54%		

Note: communalities above 45% are considered useful to the model

Results support the second group of five hypotheses 2a, 2b, 2c, 2d and 2e. Of predictor variables, acceptance and confirmation at 99.36 percent and coaching at 83.81 percent are highly significant in their contribution to psychological capital. Role modelling (78.73 percent), counselling (77.28 percent) and friendship (75.54 percent) also contribute significantly to psychological capital.

Results support the four hypotheses of 3a, 3b, 3c and 3d. All criterion variables of hope, optimism, self-efficacy and resiliency are influenced by the five mentoring predictors. Three of the criterion variables, hope (87.73 percent), optimism (83 percent) and self-efficacy (79.94 percent), are significantly influenced by mentoring, while resiliency at 46.75 percent is marginally influenced being just above the cutoff of 45 percent for being useful to a model (Sherry & Henson, 2005). Table 6.12 summarises the hypothesis testing.

Table 6.12: Summary Results of Hypothesis Testing

Hypothesis	Relationship	Finding
Hypothesis 1	Mentoring → psychological capital	Supported
Hypothesis 2a	Coaching → psychological capital	Supported
Hypothesis 2b	Acceptance & confirmation → psychological capital	Supported
Hypothesis 2c	Role modelling → psychological capital	Supported
Hypothesis 2d	Counselling → psychological capital	Supported
Hypothesis 2e	Friendship → psychological capital	Supported
Hypothesis 3a	Mentoring → hope	Supported
Hypothesis 3b	Mentoring → optimism	Supported
Hypothesis 3c	Mentoring → self-efficacy	Supported
Hypothesis 3d	Mentoring → resiliency	Supported

This is the third stage of a three stage study. The first two stages, reported in chapters 4 and 5 were qualitative studies. In section 5.3.4 of Chapter 5 the qualitative findings on the relationship between mentoring and psychological capital were reported. These findings informed the quantitative cross-sectional survey reported in this chapter.

In the business and management literature there is a debate about the potential influence of common method variance and common method bias (Fuller, Simmering, Atinc, Atinc, & Babin, 2016). However, Fuller et al. (2016) suggests that the concern with common method bias may be overstated and that data from the same respondent does not automatically assume common method bias.

However, usual practice is to address common method bias as it is an issue of concern when conducting a cross-sectional study using a self-reported, scale based questionnaire (Chang, McDonald, & Burton, 2010a; Conway & Lance, 2010; Podsakoff, 2003). Conway and Lance (2010) recommend addressing four areas of common method bias including why using self reports is appropriate, evidence of using valid constructs, items in different constructs not overlapping, and use of a research design to mitigate the threats of common method bias. The research design addresses but does not eliminate the likelihood of the main sources of common method bias. Chang et al. (2010b) note that common method bias can be reduced ex ante in the research design phase, or ex post, through statistical analysis. However, Conway and Lance (2010, p. 325) "specifically do not recommend using post hoc statistical control strategies" and place greater emphasis on research design.

Spector (2006) notes that concerns regarding common method bias are most frequently expressed in relation to mono-method cross-sectional self report surveys. Shalley, Gilson, and Blum (2009) argue that in some circumstances employees are best suited to report on the subtle behaviours applicable to their jobs. The research focuses on the perceptions of the respondents and uses a mixed method research design. A second criticism (Spector, 2006) is the reliance on data from a single group of respondents at a single time. Again, this is in part addressed by the use of the mixed method approach, with different sampling frames. A third concern expressed is that the apparent relationships between items would be transparent to respondents, and that this would create a correlation between the items. As the construct was complex and not easily transparent to respondents, the likelihood of common method bias arising from correlation is reduced. The survey used existing measurement scales with different Likert scale end points which can assist with common method variance. Social desirability is another source of bias identified by (Podsakoff, 2003). The ex-ante research design solution to this is ensuring that the respondents feel confident of their anonymity. The research design addressed this through the nature of the information provided to potential participants, and the autonomous data collection method. The researcher

also attempted to reduce evaluation apprehension by ensuring respondents that there were no right or wrong answers.

6.5 Summary

This chapter investigated the relationship between selected mentoring functions and elements of psychological capital. Findings confirm a positive correlation between mentoring and psychological capital. Specifically, acceptance and confirmation, coaching, role modelling, counselling and friendship contribute to psychological capital. Of the four elements of psychological capital, hope, optimism and self-efficacy are significantly influenced by mentoring variables and resiliency is influenced marginally.

Chapter 7 discusses theoretical and practical findings of each research phase individually, and then as a whole. It concludes with a discussion of research questions, implications of results and future directions for further study.

CHAPTER 7 : DISCUSSION AND CONCLUSION

7.1 Introduction

The aim of this research was to examine how mentoring affects workplace behaviours in the allied health and residential aged care sectors. The researcher employed a multiphase sequential exploratory mixed methods design (Creswell & Plano Clark, 2011). The first phase addressed the mentoring experiences of allied health professionals regarding delivery of a professional association mentoring programme. The second phase addressed the mentoring experiences of workers in the residential aged care sector. The third phase explored the influence of mentoring experience on psychological capital in the residential aged care sector. Two theoretical frameworks were used to underpin the research. Kram's mentor role theory (Baranik et al., 2010; Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990) was viewed through the lens of learning (Gibb, 1999; Hale, 2000) and psychological capital through the lens of positive organisational behaviour (Luthans, 2002).

According to mentor role theory (Kram, 1985), there are two distinct functions of mentoring and a number of behaviours that form each of these functions. The theory posits that mentors adopt certain behaviours when providing career and psychosocial mentoring. Mentor functions and behaviours are determined by the nature and purpose of the mentoring programme used by an organisation (Chao, 2007; Lankau & Scandura, 2007). Consequently, it is important for organisations to understand the purpose of a mentoring programme and identify what is to be achieved before deciding on mentoring methods to be used. This research investigated mentoring functions and behaviours present in the allied health and residential aged care programmes, as well as how these behaviours influence psychological capital.

This final thesis chapter integrates research findings and discusses their application to the allied health professional association and residential aged care sector within the framework of the three research questions posed. Available literature is used to support or refute research results. Further, theoretical and practical contributions of this research are described, as well as implications for the allied health professional association and residential aged care organisations. Strengths and weaknesses of the research are outlined, followed by a discussion of future research needed into clinical mentoring and the influence of mentoring on psychological capital in the residential aged care sector and management research field. This chapter concludes by presenting the overall research conclusions.

7.2 Mentoring experiences of allied health professionals (RQ1)

The first research question asked: 'What are the mentoring experiences and expectations of allied health professionals working in multidisciplinary clinics and private practice as a result of participating in professional association mentoring programmes?' To examine this question, the researcher investigated factors important to developing a mentoring relationship for allied health professionals and their experience of a professional association mentoring programme through the lens of learning. This section discusses findings and links findings to relevant literature.

The researcher first investigated a mentoring programme that intended to provide all three functions of mentoring for podiatrists, particularly those in the early stages of their career. Secondly, the researcher obtained feedback on programme delivery. Results show that the group mentoring programme did not fully meet the mentoring aim of the professional association, nor did it fully meet participant expectations. Participants in this study considered clinical support of greatest importance, followed by career and psychosocial support, respectively. This is divergent from the main body of mentoring literature which focuses on career and psychosocial support (Baranik et al., 2010; Jacobi, 1991; Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990).

Research findings support emphasis on clinical mentoring in health professions. However, at least for this group of participants, delivery of the group clinical mentoring programme did not provide career and psychosocial mentoring outcomes. As such, it is an augmentation and not a replacement for other forms of mentoring. Importantly, this suggests that clinical mentoring may not provide all that it purports to provide in the group setting. While it may be sufficient in early career stages, participants acknowledged that career and psychosocial support were also important. Due to concerns around confidentiality and career opportunities, participants were reluctant to seek psychosocial support from the group mentoring programme. Therefore, the professional association may consider providing one-on-one mentors for psychosocial support to support early career professionals. Another key issue was coordination and follow up to maintain and provide support for programme involvement. Therefore, it may be beneficial to engage a coordinator or administrator to actively manage the online and face-to-face mentoring programme.

7.2.1 Career mentoring

The literature on career-related support identifies specific mentor behaviours of sponsorship, coaching, advocacy, challenging assignments, exposure and visibility. Whilst sponsorship was identified as important in the literature (Baranik et al., 2010; Kram, 1985) participants stated this mentoring behaviour was not provided. The reason may be a lack of career progression available to people working in small to medium-sized private practice, limited roles available in the public sector and workforce casualisation. Broader sponsorship from the profession was not evident due to distrust of mentees.

As defined in mentoring literature, coaching support (Baranik et al., 2010) is limited to career development within an organisation and teaching specific skills for career advancement. In contrast, the wider literature on coaching (Garvey et al., 2009) focuses on performance and intervention for managing work relationships. The professional association mentoring programme did not provide much coaching, other than information about areas of specialisation available to podiatrists.

The literature states that exposure and visibility create opportunities for mentees to impress influential people and may assist mentees to become more visible within an organisation (Baranik et al., 2010). Findings support the importance of building networks for future career advancement or building a private practice as the professional association mentoring programme was an important link for building contacts and professional credibility.

Advocacy provides shielding and protection of mentees (Baranik et al., 2010). Findings show that support and protection of new graduates is a high priority for the professional association and relevant to programme participants. However, participants were concerned about being placed in a career limiting situation where there was a perceived risk of not obtaining employment.

Challenging assignments may provide mentees with the opportunity to learn and develop new skills (Baranik et al., 2010). Whilst it was difficult to identify specific challenging assignments offered by the mentoring programme, findings support continuous learning and development in all areas including administration, communication, marketing, business and clinical skills. The mentoring programme provided opportunities for mentees to extend and develop their skills and challenge personal boundaries.

7.2.2 Psychosocial mentoring

Psychosocial support behaviours are friendship, counselling, acceptance and confirmation and role modelling (Baranik et al., 2010; Jacobi, 1991; Kram, 1985). The literature states that friendship is about creating positive social experiences, feelings of belongingness and confidence to speak with more senior people in an organisation (Baranik et al., 2010). Research findings confirm the importance of friendship and social support in the allied health workplace. In situations where friendship and social support were not available in the workplace, due to location or working alone, participants developed their own support networks through the professional association, family, friends or university peer groups.

Counselling support helps mentees explore personal concerns and may improve mentee contentedness regarding their place within an organisation (Baranik et al., 2010). This study found that participants did not receive counselling support around personal concerns from the professional association mentoring programme. Participants discussed concern and reluctance sharing personal concerns in a group environment for confidentiality, lack of trust and future employability reasons.

The mentoring behaviour of acceptance and confirmation builds mentee self-belief and confidence in the mentoring relationship (Baranik et al., 2010). Research findings regarding this mentoring behaviour were variable, with some participants stating they felt validated and accepted into the group mentoring programme and others voiced concerns regarding confidentiality, trust and fear of looking silly in front of potential prospective employers. Such concerns are not unusual in group situations. However, in this case these concerns may be exacerbated due to the small size of the profession.

The last behaviour of psychosocial support is role modelling where the mentee models mentor behaviours and over time the mentee admires and respects the mentor (Baranik et al., 2010). This study found high regard and respect for mentors in the professional association mentoring programme. However, the group setting was not conducive to role modelling of behaviours that participants were seeking to emulate, that is, clinical skills.

While friendship and creation of networks provided a direct benefit to participants, other aspects of psychosocial support were not provided in the face-to-face or online group programme. As such, further investigation is needed to examine the nature of the group programme and how psychosocial support can be improved.

7.2.3 Clinical mentoring

Clinical mentoring involves components such as role modelling, consultation on difficult cases, high level problem solving, diagnosis and decision making. Also, continued development of knowledge and skills, including communication and behavioural skills, is important (I-TECH, 2008; SA Health, 2014). Results of this study found that all participants considered each of the clinical mentoring components crucial to development of clinical skills, particularly for diagnosis and appropriate treatments. In private practice, it is important for new graduates and practitioners to have access to continuing education to ensure knowledge and skills remain current.

Participants working in private practice stated that there was no workplace support for new graduates. Preceptorship and clinical support were only available to those who worked in the public hospital system. The profession provides a mentoring programme for early career professionals. Study findings confirm that the professional association mentoring program provided clinical support, particularly around diagnosis and problem-solving of complicated cases. In addition to the mentoring programme, the professional association is active in providing continuing professional development sessions for members.

Findings support overlap of clinical mentoring with the career-related behaviour of challenging assignments that provides mentees with the opportunity to learn and develop new skills. There is also an overlap with role modelling, a behaviour of psychosocial support. Other than those two behaviours, clinical mentoring is a separate construct in relation to established mentoring functions of career and psychosocial support (Kram, 1985). Clinical mentoring presented in the group setting was also impacted by perceived risks of confidentiality and career outcomes.

This research has also shown that the group mentoring programme, designed to provide career, psychosocial and clinical support, provided career support in relation to skill development and review of challenging cases and exposure and visibility, but did not provide sponsorship, advocacy or coaching behaviours. In terms of psychosocial support, the mentoring programme was successful in delivering friendship, but not counselling, acceptance and confirmation or role modelling. Participants working in the public sector received mentoring and clinical support stated that they would not be working in the public sector without career and psychosocial support. Other participants received psychosocial support from the practice manager or in regular work meetings and sole practitioners tended to rely on family and friends. Based on research findings, it is suggested that allied health sector professional associations should consider providing a forum for

clinical mentoring, including communication and behavioural skills training, for early career professionals rather than trying to provide all mentoring functions, particularly when mentoring is delivered in a group setting.

7.2.4 Group Mentoring

This research also examined the delivery method of the group mentoring programme provided by a professional association, specifically the under-researched format of many-to-many mentoring (MTMM) (Huizing, 2012). The aim of the MTMM model is to provide collaborative input into the personal and professional needs of mentees. By having multiple mentors, mentees can draw on a variety of experiences and ideas to assist their development. As noted by Huizing (2012), having access to several mentors in one group is the major difference of the MTMM model when compared to other group mentoring models, such as peer group mentoring or one-to-many mentoring. The MTMM model is also beneficial for professional associations that rely on volunteer mentors to support early career professionals. In this study, the professional association utilised face-to-face and online delivery to implement MTMM initiatives.

This study revealed concerns about the MTMM model. The only theme positively reported in research findings was networking that includes transfer of knowledge. Findings identified issues around the remaining themes of inclusion, role modelling, psychosocial support and structural and operational matters that are discussed below.

The literature states that group mentoring provides an opportunity for mentors and mentees to build networks (Carvin, 2011; Huizing, 2012). In this study, networking was identified as a primary requirement for working in the podiatry profession. The face-to-face group mentoring programme met the networking needs of participants and provided opportunity for early career podiatrists to develop networks with other podiatrists.

The other major theme included in networking is knowledge sharing. The transfer of knowledge was prominent in the literature and provided the opportunity for peer interaction and reverse mentoring between mentors and mentees (Carvin, 2011; Huizing, 2012). Findings suggest strong emphasis on ideas generation and sharing of knowledge on latest advances in the field. The study identified that exchange of knowledge and ideas is considered a strength of the face-to-face group mentoring programme. When the face-to-face mentoring group was first established, a topic was presented that provided structure for group discussion. However, as the composition of the group changed over time and volunteer organisers became busy with other commitments, meetings became less

focused on mentee needs and more on social interaction. This outcome is not unusual and highlights the need for organisation, leadership and commitment to group mentoring for it to be meaningful (Carvin, 2011).

The second theme of inclusion was a major issue for the face-to-face group mentoring programme. The literature refers to group mentoring as providing a safe and confidential environment and mutual understanding by both mentors and mentees (Carvin, 2011; Dansky, 1996; Scott & Smith, 2008). The group setting also allows mentors and mentees to share and reflect on experiences in a non-threatening environment (Carvin, 2011). Prior research on group mentoring explicitly or implicitly assumes that the process is confidential (Carvin, 2011; Dansky, 1996). By contrast, this research identified participant concerns around confidentiality that impeded programme success. Trust and mutual respect are essential to mentoring group functionality, and when these are not present the group will not function effectively. This research underscores the importance of providing a safe and confidential environment for group mentoring programme participants. Without mutual understanding, trust and confidentiality, participants are unlikely to participate fully or share and reflect on experiences in a positive manner.

The third theme noted in the group mentoring literature is role modelling. Role modelling involves mentees modelling mentor behaviours (Godshalk & Sosik, 2000). Findings of this study are inconclusive as mentors provided role modelling behaviours to mentees in the face-to-face programme and online forum, but participants did not recognise those behaviours as role modelling. However, "there was an underlying respect for the mentors who gave their time to develop and support others" (Coppin & Fisher, 2015, p. 99). The reason that role modelling was not recognised maybe that both forms of mentoring programme delivery did not provide authentic workplace experiences to participants and, therefore, mentees perceived there was nothing 'real' to model. Capacity for role modelling to occur in a professional association mentoring programme context requires further investigation.

Psychosocial support is the fourth theme in the group mentoring literature. In particular, the psychosocial support aspects of friendship, sharing of personal challenges and reflection on practice (Carvin, 2011; Dansky, 1996; Scott & Smith, 2008) are considered important. In the traditional mentoring literature, psychosocial mentoring is delivered by friendship, acceptance and confirmation, counselling and role modelling (Kram, 1985; Ragins & Cotton, 1993). The first aspect,

friendship, is concerned with creating positive social experiences, belongingness and developing confidence (Ragins & Cotton, 1993).

Contrary to the literature (Carvin, 2011; Huizing, 2012) and aspirations of the professional association, the face-to-face mentoring group did not successfully provide psychosocial support. As a result, participants sought psychosocial support from other sources, such as family, friends and peers in the workplace. Further, there was a lack of confidence about asking questions for fear of being seen as incompetent in front of potential employers. Also, mentees were confused by mentors providing different views and ideas for treating clinical issues. Participants saw this open debate as intimidating. Confidentiality was also as a concern due to the small size of the profession.

A fifth theme of group mentoring that emerged from this research is structural and operational issues, with three main matters identified as important in the face-to-face group programme and online group mentoring forum. The first was a lack of programme structure clarity. As noted in the literature (Carvin, 2011; Clutterbuck, 2004), a facilitator is required for a mentoring group to operate successfully. The literature does not specifically deal with structural details of an MTMM group, other than to specify that there are several mentors(Carvin, 2011; Huizing, 2012). Findings of this research suggest that the MTMM model requires a mentor to act as facilitator to ensure meetings have purpose and meaning for participants. In a professional association context, appointment of a coordinator may also be useful to arrange and structure meetings and establish participation rules. Further research could confirm whether a coordinator is appointed in other MTMM situations.

The second operational issue identified in this study is a need for training in how to be a mentor and mentee, as well as how to use the online group forum. Understanding the basic skills required to participate in a group mentoring programme would provide mutual understanding and build confidence in mentors and mentees.

Thirdly, study participants overwhelmingly preferred mentoring individually and face-to-face, rather than group mentoring face-to-face or online. However, participants sought clinical mentoring, specifically support in developing diagnostic skills, which lends itself to one-on-one mentoring. Further, due to a wide range of specialisations in podiatry, mentees preferred to discuss specific cases with a mentor from the same specialisation.

The online group forum provided a platform for association members to post questions, generally about patient diagnosis and treatment, with responses open to members of the professional

association. All participants found the online group forum beneficial, although some concerns were identified. Mentees stated that mentors should be open-minded to ensure an open, healthy discussion of new techniques and 'experimental' treatments.

The literature states that structure and content of online discussion boards is important to the online learning experience (Celik, 2013). Participants in this research found online discussion material useful and the forum was an excellent resource for generating new ideas, assisting diagnoses and selecting appropriate treatment techniques. However, some participants found the process of asking clinical questions intimidating due to the level of detailed information requested by mentors and an underlying fear of saying the wrong thing.

The literature notes issues regarding online discussion forums (Clouder et al., 2006; Meskill & Anthony, 2005). These issues include a tendency for some participants to dominate the discussion board, fear of criticism, especially in a competitive environment, and potential for negative comments and overly critical attitudes (Celik, 2013). Findings of this research support the literature in that participants were reluctant to participate in online discussions, but read the comments of experienced clinicians who were held in high regard. Again organisation, structure and encouragement by an enthusiastic moderator may promote inclusion and increased confidence of mentees.

7.3 Mentoring experiences of residential aged care workers (RQ2)

The second research question asked: 'What are the mentoring experiences and expectations of residential aged care workers as a result of participating in formal or informal mentoring programmes provided by residential aged care organisations?' To examine this question, the researcher investigated factors important to developing a mentoring relationship for residential aged care workers and their experience of a formal or informal mentoring programme. This section discusses findings and links results to relevant literature.

The researcher first investigated the formal and informal mentoring programmes provided by the five residential aged care facilities that took part in Phase 2. Generally the mentoring programmes were designed to provide support for new employees or professional staff. Feedback on the mentoring process in place for all employees was gathered. Results show that the mentoring programmes did not meet the mentoring needs of the majority of aged care workers who were generally paraprofessionals. Participants in this study considered clinical, career and psychosocial

support provided to existing paraprofessionals was minimal and tended to focus on on-site training, quality control and case discussions rather than the emotional needs of care workers. This is consistent with the teaching and learning process adopted by Stewart and Krueger (1996) and used in the acute care nursing context which focuses on the development of the profession rather than individual learning.

In the residential aged care context, clinical mentoring is the predominant form of mentoring. However, for this group of participants, clinical mentoring did not provide the learning or psychosocial mentoring outcomes required by paraprofessionals. Further, the findings support the view that traditional mentoring relationships are no longer able to meet the learning needs of employees who work in diverse and dynamic organisational contexts and continually changing careers.

7.3.1 Career Mentoring

The study of residential aged care workers found that four behaviours of career mentoring were provided to a limited extent: sponsorship, coaching, advocacy and challenging assignments, and one behaviour of career mentoring was not provided: exposure and visibility.

In the residential aged care context, sponsorship was limited to encouraging workers to undertake additional qualifications to gain career advancement. There was no guarantee that organisations would promote workers on completion of the qualification, nor would organisations support workers with financial sponsorship. As such, workers undertook further training and courses for personal development reasons and potential career advancement.

In the residential aged care context, coaching was interpreted as teaching skills for day-to-day performance, rather than for career advancement. Some senior management, in particular RSMs, CNCs and LCs, had completed leadership training and these participants incorporated a coaching approach to management of employee issues. At lower employee levels, however, a coaching approach to conversations was not used unless workers had completed mentor training. Therefore, while managers recognised the need for new workers to be ‘buddied’ by positive mentors or role models at employment commencement, implementation of this strategy was difficult due to some staff being over–directive and lacking compassion and empathy. Other factors include accreditation standards and government funding received for each resident that impact on clinical mentoring. Overall, findings show that coaching philosophy was emergent at each residential facility in this study, but training of all workers in coaching would result in change occurring more quickly.

Advocacy is the third behaviour of career mentoring and was actively used at the residential facilities visited. The literature refers to advocacy as the prevention, shielding and protection of workers from damaging contact with others in the organisation (Cherniss, 2007; Kram, 1985). A major issue identified in the residential aged care context was attitudes and behaviours of some staff who were over-directive and lacked compassion and empathy for other staff, particularly new workers. These behaviours and attitudes resulted in a need to shield and protect new workers from negative staff. This was a common theme in the study and occurred at all organisational levels, particularly from RN level downwards.

Challenging assignments is the fourth behaviour of career mentoring. In the literature, challenging assignments refers to complex work tasks being given to mentees to challenge their ability to apply skills and make appropriate decisions in a difficult environment (Baranik et al., 2010). In the residential aged care context, there were few opportunities for mentors to provide challenging assignments. However, each resident provides some level of challenge due to cognitive or physical impairment. As such, workers are expected to learn and develop new skills in response to environmental factors prevailing at a particular point in time. Following exposure to challenging situations mentees were keen to receive feedback from mentors. Mentees sought to share their thoughts and ideas and receive constructive feedback as this provides them with greater self-efficacy. Overall, if the right mentor/mentee 'buddy' relationships are established at employee induction and job orientation, and constructive feedback is provided by mentors, mentees felt accepted and part of the team. Sites that operated formal mentoring programmes had more workers willing to share ideas in a team environment than sites that operated informal mentoring programmes.

The final behaviour of career mentoring is exposure and visibility and relates to development of networks and credibility in the profession (Baranik et al., 2010). No evidence was found to support provision of exposure and visibility in the residential aged care context. This was the same for all sites.

7.3.2 Psychosocial mentoring

Study findings show that all behaviours of psychosocial mentoring were provided to a limited extent in the residential aged care context. Friendship was limited to social interactions with peers in the workplace, rather than social experiences between mentors and mentees outside the workplace. Further, a majority of workers felt they belonged in the workplace. However, there was a reluctance

to speak out in work situations as a result of negative attitudes of some workers in the workplace. Management in all residential aged care facilities acknowledged that this is an area requiring improvement.

The second psychosocial mentoring behaviour of acceptance and confirmation relates to mentee self-efficacy and trust in the mentor to provide advice and encouragement. Many participants found it difficult to build rapport with supervisors or mentors and chose to discuss concerns with their peers. This was common to all residential aged care facilities and is an area that requires improvement.

The third psychosocial mentoring behaviour is counselling. All participating residential aged care facilities outsource employee counselling when the reason for seeking counselling is personal in nature. However, participants reported that no on-site counselling assistance or emotional support was provided to workers experiencing difficulty coping with death of a resident or challenging behaviours. Participants stated that emotional support and counselling would be useful in the first few months of employment while learning the job. Further, training regarding different types of dementia and the dying process in early employment stages of employment would improve understanding of the feelings of residents and increase employee confidence and self-efficacy in the workplace. Findings of this study show that provision of greater emotional support would be welcomed by residential aged care workers.

The final behaviour of psychosocial mentoring is role modelling. The literature refers to role modelling as mentees respecting and modelling mentor behaviours (Baranik et al., 2010). In residential aged care facilities visited there was limited role modelling of mentors. Findings show that positive role modelling was evident at the senior level of each residential aged care facility, but did not occur at levels below CNC. Participants discussed negative role modelling and actively took steps to avoid workers displaying negative behaviours. As such, there is considerable scope for this area of psychosocial mentoring to improve.

7.3.3 Clinical mentoring

Study findings show that case discussions and quality control received high priority at all residential care sites visited. However, the clinical mentoring components of complicated cases, continuing education, on-site training and psychosocial support received limited mentoring support. In the residential aged care sector, case discussions occur at handover and are reliant on good documentation on a shift by shift basis. Each residential facility in the study held handovers at the

end of each shift. However, the way in which these handovers were conducted, and workers required to take part, differed between facilities. In some cases, handover was audio taped and available for all staff on a shift, in others handover was face-to-face between RN and RN or face-to face with RN and all staff rostered on a shift. As CWs are the first point of contact for residents, their inclusion in handover could provide CWs with self-efficacy, ownership and belongingness within the team. Overall, case discussions and communication of resident needs are important in managing a residential aged care facility. From a practical perspective, some methods of handover are more inclusive than others. From a management perspective, issues of time and cost influence the method of handover.

Quality control is of utmost importance for residential facilities for accreditation and funding purposes (Australian Aged Care Quality Agency, 2014; Baldwin et al., 2015). All participants commented on the need to follow organisational policy and procedures and volume of paperwork involved. Audits and spot checks are made by the Australian Aged Care Quality Agency on a regular basis and compliance is essential to maintain accreditation. As such, this aspect of clinical mentoring is strictly monitored by all residential facilities included in this study and their overriding organisations.

The third function of clinical mentoring is complicated cases. Findings suggest there is limited clinical support for complicated cases at all participating residential aged care facilities. This may be due to the hierarchical organisational structure where process is very procedural. Policies and procedures require that CWs report unusual behaviours to RNs, CNCs or RSMs who then refer to a doctor for diagnosis. The process is necessarily procedural to meet Australian Aged Care Quality Agency guidelines.

Study results found that participants from all residential facilities reported some support for continuing education. Participants reported that formal education, that is, completion of degrees or diplomas in nursing, is encouraged by management. However, informal training such as management or leadership courses or effective communication skills for interacting with residents is not generally provided by aged care organisations. Workers who wanted to learn more about specific topics were required to pay for and complete courses in their own time. Therefore, continuing education is only partially provided by residential facilities included in this research. In many respects, the behaviour of continuing education in clinical mentoring was similar to behaviours of sponsorship and coaching in career mentoring. That is, encouragement was provided

but no monetary support or work time was provided for workers to learn new skills. Education may involve formal qualifications under the Australian Qualifications Framework (Australian Qualifications Framework, 2013) or may be professional development training to fulfil AHPRA registration requirements (Australian Health Practitioners Regulatory Authority, 2015).

On-site training is particularly important when new workers begin work. This research found that all facilities provide some form of induction and 'buddy shift' to facilitate orientation of new workers. Another important feature in the residential aged care sector is the requirement that all trainee CWs, ENs and RNs undertake work placement to complete their qualification. Individuals undertaking placement are placed with a 'buddy' who may be the same or different person for each shift worked. The research found that placement quality is reliant on attitude of the 'buddy' towards supporting prospective workers or new workers and teaching the job role. A further aspect of on-site training is provision of online training or e-learning. Participants reported that provision of short courses was useful, but they preferred on-the-job training. One concern with online training was that it could not be completed during work hours, due to work demands. As a result, workers needed to complete on-line training in their own time. Therefore, only those really keen to learn about particular topics would undertake training available. Overall, on-site training was only partially provided in residential facilities included in this study.

In the context of clinical mentoring, psychosocial support is concerned with role modelling, behaviour and communication skills (I-TECH, 2008). That is, mentors teach and guide mentees. This research found that role modelling was only evident at the management level in each of the residential facilities visited. Further, participants spoke openly about negative behaviours and lack of communication skills of some co-workers. As a result, participants did not perceive that they received psychosocial support. Emotional support was limited to RNs and ENs and did not filter down to CWs. This finding highlights an important issue in the residential aged care sector where CWs do not receive emotional support in the workplace despite being the first responder to assist a resident and the least qualified and trained. The literature specifically states that counselling mentoring is not provided in clinical mentoring (World Health Organisation, 2006). However, there is evidence in the nursing literature that the psychological demands of nursing cause stress and burnout in nurses (Kravits et al., 2010). These findings support previous calls for intervention programmes to develop stress management plans and coping strategies for nurses (Barnard et al., 2006; Kravits et al., 2010; Sherman et al., 2006) and, in the context of this research, it can be strongly argued that such interventions are required for all aged care workers.

7.4 Relationship of mentoring and psychological capital (RQ3)

Based on findings of research questions one and two, the researcher was interested to explore whether mentoring improves self-efficacy, hope, optimism and resiliency. Allied health professionals in the first research phase identified that these constructs were important, but the professional association mentoring programme did not deliver on these constructs through psychosocial mentoring. Phase 2, of the research explored the mentoring experience and enhancement of psychological capital. The third research question was 'How does the provision of mentoring affect the psychological capital of residential aged care workers?' This section discusses qualitative findings in relation to psychological capital.

By using the lens of positive organisational behaviour the researcher was able to examine whether positive employee behaviours could be advanced in the workplace (Luthans & Youssef-Morgan, 2017), in this case through any of the mentoring behaviours. The findings from the application of mentor role theory (Kram, 1985) to residential aged care workers suggest that mentoring may be a learning method (Hale, 2000) for developing psychological capital.

In the residential aged care context, some of mentoring behaviours, i.e. coaching, acceptance and confirmation, role modelling, friendship and counselling, may be related to psychological capital. The remaining mentoring behaviours of sponsorship, advocacy, challenging assignments and exposure and visibility did not impact on psychological capital in this research and are not discussed in this section.

Findings of residential aged care interviews suggest that self-efficacy is important in relation to confidence and perseverance, particularly when dealing with difficult behaviours of residents. The support of co-workers and working as a team are also important factors in self-efficacy (Luthans et al., 2007b). The construct of hope was identified as an important attribute for aged care workers due to the long-term nature of residential aged care work (McCaughey et al., 2015). Participants reported that resident's behaviour changes as they deteriorate. Therefore, workers need alternative strategies to cope with changes in behaviour (Chenoweth et al., 2014). The qualitative study provided evidence that the mentoring behaviours of coaching, acceptance and confirmation, and role modelling provided hope in the workplace. Further, the construct of optimism is an important attribute for aged care workers due to the nature of caring for long-term residents with chronic health conditions (McCaughey et al., 2015). The mentoring behaviours of coaching, acceptance and confirmation and role modelling improved optimism. This research also found that resilience is an

important attribute for residential aged care workers (Masten & Reed, 2002; McAllister & McKinnon, 2009). Participants reported that being resilient helped deal with traumatic and challenging situations. In terms of mentoring behaviours, qualitative interview results suggest that coaching, acceptance and confirmation, role modelling, friendship and counselling were important to establishing resiliency.

Findings identify the five mentoring behaviours most likely to provide the constructs of psychological capital and confirm previous studies indicating that psychological capital can be taught (Brunetto et al., 2016). In terms of mentoring, teaching can occur through the coaching mechanism by delivering training sessions on the constructs of psychological capital and follow up individual coaching sessions to improve employee awareness of the importance of developing psychological capital abilities.

7.5 Mentoring experience and psychological capital (RQ4)

The second phase of the research and research question 3 identified potential relationships between some behaviours of mentoring and psychological capital in residential aged care workers. The strength of this relationship was tested further using quantitative surveys to answer the fourth research question: 'How does the mentoring experience of aged care workers influence psychological capital in the residential aged care sector?' This section discusses quantitative findings referring to the individual hypotheses tested.

A positive relationship between mentoring and psychological capital supported hypothesis 1. Quantitative research results confirmed that all five mentoring behaviours, coaching, acceptance and confirmation, role modelling, friendship and counselling, contributed to an increase in the psychological capital constructs of hope, optimism, self-efficacy and resiliency. This supports the hypotheses proposed following qualitative research undertaken in Phase 2. Further, quantitative results provided new insights regarding the contribution of mentoring behaviours to psychological capital and the constructs of psychological capital to mentoring.

A positive relationship between coaching and psychological capital supported hypothesis 2a. The finding that coaching contributes 83.81 percent to development of psychological capital is highly significant and supported by the concept of mentoring as a learning and development process (Gibb & Megginson, 1993; Hale, 2000; McCarthy, 2014; Zachary, 2011). Further, the literature supports the notion that psychological capital is trainable (Brunetto et al., 2016). In addition, findings of Phase

2 place a heavy emphasis on coaching to increase mentees confidence in difficult work situations, provide encouragement and challenge mentees to make decisions, provide recognition and allow mentees to take credit for good work and learn from past situations.

A positive relationship between acceptance and confirmation and psychological capital supported hypothesis 2b. The researcher identified that the contribution of acceptance and commitment at 99.36 percent is highly significant in achievement of psychological capital. The Phase 3 results confirm Phase 2 findings that acceptance and confirmation of mentees is built through trusted relationships in the workplace that facilitates mentee compassion and understanding of distressed residents, provides intrinsic rewards to mentees, and assists in building the ability to cope in a challenging work environment (Baranik et al., 2010).

A positive relationship between role modelling and psychological capital supported hypothesis 2c. Role modelling contributed 78.73 percent to provision of psychological capital which again is a significant contribution. The Phase 3 results confirm Phase 2 findings that role modelling through listening and observation can provide mentees with the ability to find alternative solutions. However, some participants in Phase 2 stated that they learned more from negative role modelling experiences. Moreover, according to Lankau and Scandura (2007) role modelling is positively related to personal skill development and there is evidence that personal learning matters for employees and organisations. It is through the learning process that personal learning provides personal growth and the opportunity to develop positive organisational behaviours through training of psychological capital (Brunetto et al., 2016; Lankau & Scandura, 2007).

A positive relationship between counselling and psychological capital supported hypothesis 2d. The contribution of counselling at 77.28 percent is significant to achievement of psychological capital. This is in contrast to the findings in Phase 2 where participants reported not receiving on-site counselling assistance or emotional support for work related matters. Kram (1985) as cited by (Lankau & Scandura, 2007) noted that counselling behaviours such as sharing personal experiences, acting as a sounding board, helping resolve problems through feedback, gave mentees the ability to cope with personal issues more effectively. These behaviours are closely aligned to the construct of psychological capital (Luthans et al., 2007b).

A positive relationship between friendship and psychological capital supported hypothesis 2e. The contribution of friendship at 75.54 percent is significant to achievement of psychological capital. The Phase 3 findings are supported by Phase 2 of the research where the majority of workers felt

they belonged in the workplace. Other factors discussed in the literature included socialisation with mentors outside of the workplace, being confident to speak to mentors or those in authority about workplace concerns (Baranik et al., 2010; Kram, 1985; Ragins & McFarlin, 1990). Participants reported that it was difficult to speak out to mentors or more senior employees about work practices with peers tending to provide the support. As such the organisations that promoted team work tended to have a close group of care workers who supported each other through difficult times and encouraged positive psychological capital.

A positive relationship between mentoring and hope supported hypothesis 3a. The contribution of hope at 87.73 percent is significant to achievement of mentoring. Hope is about having the determination and energy to create realistic but challenging goals and being able to find alternatives when the original plan fails (Luthans et al., 2007b). The Phase 3 findings are supported by Phase 2 of the research where participants were able to create alternative strategies to cope with the changes in the workplace. Through the lens of positive organisational behaviour it is significant that aged care workers were willing to try alternative approaches to care for residents who were not necessarily cognizant of the effect of their behaviour on care workers.

A positive relationship between mentoring and optimism supported Hypothesis 3b. The contribution of optimism at 83.00 percent is significant in the achievement of mentoring. Optimism is about an individual being able to externalise feelings and take credit for positive experiences in the knowledge that they will happen again (Luthans et al., 2007b). The Phase 3 findings are supported by Phase 2 of the research where participants were able to care for long-term residents with chronic health conditions. The lens of positive organisational behaviour shows that aged care workers are able to externalise their feelings when they have role models and feel accepted and supported in their work.

A positive relationship between mentoring and self-efficacy supported hypothesis 3c. The contribution of self-efficacy at 79.94 percent is significant to achievement of mentoring. Individuals with self-efficacy are highly motivated, goal driven, enjoy challenges and are willing to persevere in difficult situations (Bandura, 1997; Luthans et al., 2007b). The Phase 3 findings are supported by Phase 2 of the research where participants reported the need to have confidence and perseverance in dealing with difficult behaviours of residents. Through the lens of positive organisational behaviour it is evident that having the support of co-workers and working as a team were important factors in developing and maintaining self-efficacy in a difficult and stressful work environment.

A positive relationship between mentoring and resiliency supported Hypothesis 3d. The contribution of resiliency at 46.75 percent was of borderline significance to provision of mentoring. Resiliency includes the ability to bounce back from adversity and cope with change (Luthans et al., 2007b). The Phase 3 findings are supported by Phase 2 of the research where mentoring was considered a contributing factor of resiliency. Though the lens of positive organisational behaviour aged care workers were reliant of the friendships they developed in the workplace and these were often peer relationships. The acceptance and confirmation, counselling and role modelling shared between aged care workers with these close peer relationships provided them with the strength and resiliency to continue working in the residential aged care environment.

Another important finding from this research is the significance of three of the constructs of psychological capital. Hope, optimism and self-efficacy were influenced by the five mentoring behaviours identified as important in this research. The level of significance of these constructs and evidence that psychological capital can be trained and that training and coaching are important behaviours of mentoring and particularly clinical mentoring is a key finding of this research. The researcher also notes that resiliency is the least significant of the psychological capital constructs and in the business, management and educational fields resiliency training is widely promoted for improving psychological capital. This finding suggests that further research is required.

7.6 Thesis conclusion

In conclusion, this research has uncovered an exciting story about the three types of mentoring used in the health care sector and the relationship of mentoring behaviours to psychological capital that had not been previously identified in the literature. This research provides a theoretical construct around the concept of clinical mentoring which has not been conceptualised in the literature previously. Thus, this research has filled a gap in the literature about the concept of clinical mentoring that has been widely adopted in practice but not previously supported by literature. By examining the concept of clinical mentoring and comparing it to career and psychosocial mentoring theory and early conceptualisations of mentoring as a process of human development, career advancement and a learning process this research has identified that clinical mentoring is predominantly a training and coaching support process as distinct from traditional mentoring theory. As such, clinical mentoring is an augmentation and not a replacement for other forms of mentoring.

This research identified that if the wider notion of coaching as a learning and development tool is adopted, instead of the narrower view of coaching for career advancement, then coaching is a key component of any mentoring strategy. Coaching that focuses on learning and maximising mentee potential has the ability to increase psychological capital, improve employee health and improve organisational culture and performance.

This research is the first to examine the influence of selected mentoring behaviours on the constructs of psychological capital and provide evidence that mentoring influences psychological capital. This analysis is important because the nature of work undertaken by health care professionals and residential aged care workers is emotionally difficult and if stressors associated with the work are not addressed employee health deteriorates and organisations suffer in terms of workplace health and safety and high turnover.

Finally, this research found that one-on-one, face-to-face mentoring was superior to group mentoring. A number of concerns were identified with the many-to-many group mentoring programme and the researcher made several recommendations in relation to group mentoring programmes. These recommendations were of a practical nature (detailed in section 7.6.2) and provided to the allied health professional association that participated in the research.

7.7 Theoretical and practical contributions

This research has made theoretical and practical contributions to the literature on mentoring and psychological capital as detailed below.

7.7.1 Theoretical contributions

This research made several significant contributions to the management and health care literature in terms of mentoring and psychological capital.

First, the research contributed to the literature on positive organisational behaviour by using the measure of psychological capital to identify whether mentoring could improve employee behaviours (Luthans, 2012). Some researchers have suggested that mentoring may be an antecedent of psychological capital (Knudson, 2015; Lunsford, 2016; Pineau Stam et al., 2015; Saks & Gruman, 2011; Toor, 2010). This research is the first to examine certain mentoring behaviours and provides theoretical insights into the relationship of mentoring and psychological capital. This research found that one of the behaviours of career mentoring and all of the psychosocial behaviours were positively related to mentoring. This finding is a significant theoretical contribution to the literature on psychological capital and mentoring.

Second, this research contributed to the theory of mentoring by examining mentoring behaviours from a learning perspective. Some researchers have suggested that traditional mentoring relationships are no longer able to meet the learning needs of employees who work in diverse and dynamic organisational contexts and regularly change careers (Lankau & Scandura, 2007). This research provided evidence that the mentoring needs of employees in the residential aged care and allied health sectors are predominantly focused on learning and provided through clinical mentoring. In addition, the research found that clinical mentoring was an augmentation and not a replacement for psychosocial and career mentoring. This is a significant contribution to the mentoring and learning literature and provides scope for further research into the relationship of mentoring functions and personal learning and personal growth.

Third, this research has enriched the literature by providing a comprehensive synopsis of clinical mentoring not previously conceptualised in the literature. This research was based on six components outlined in the I-TECH description (I-TECH, 2008). The components include; complicated cases, continuing education, case discussions, psychosocial support, on-site training and quality control. The researcher has drawn from the wider literature to explain the components

of clinical mentoring in greater depth and describe the differences to career and psychosocial mentoring. This is an important theoretical contribution to the management and health literature because the concept of clinical mentoring has not previously been articulated.

Fourth, a further contribution to the theories of mentoring and positive organisational behaviour is that only one behaviour (coaching) of the career mentoring function and all four behaviours (friendship, acceptance and confirmation, role modelling and counselling) of the psychosocial mentoring function were found to be related to psychological capital. The remaining career behaviours of sponsorship, advocacy, challenging assignments, exposure and visibility (Kram, 1985; Noe, 1988; Ragins & McFarlin, 1990) were not evident in the residential aged care context which could warrant further investigation.

Fifth, there is a body of literature that examines the delivery methods of mentoring programmes. The majority of that literature deals with dyadic relationships (Allen, 2007; Clawson, 1980; Dalton et al., 1977; Hunt & Michael, 1983; Kram, 1985; Ragins & Scandura, 1997). However Eby (1997) recognised that mentoring could be delivered to groups and teams in a variety of formats (Dansky, 1996; Huizing, 2012; Kostovich & Thurn, 2013; Scott & Smith, 2008). The findings of this research contribute to group mentoring the literature by identifying and analysing a professional association group mentoring programme delivered in two ways. Delivery of the face-to-face component adopted a concept of many mentors to many mentees, which is an unusual delivery method rarely reported on in the literature. Thus, this research has provided a detailed account on the delivery of many-to-many mentoring in an allied health professional association context. The second form of delivery investigated was an online discussion forum. E-mentoring is a relatively new area of research in the mentoring literature (Celik, 2013; Clouder et al., 2006; Meskill & Anthony, 2005). The findings of this research contribute to the existing body of knowledge and confirm outcomes consistent with existing literature.

Sixth, this research contributes to the literature on mentoring programmes to support early career practitioners (Causby, 2003; French & Dowds, 2008; Friedman & Phillips, 2002; Moran et al., 2014; SA Health, 2014; Struber, 2004). The findings of the research extend the existing literature by considering allied health professionals working in private practice and professional association mentoring programmes that are areas not often researched.

Finally, there is a considerable body of literature on mentoring in the acute care context (Stewart & Krueger, 1996; Vance, 1977; Yoder, 1990) and some research on residential aged care concentrating

on nurses (Block et al., 2005; Cameron & Brownie, 2010; Chenoweth et al., 2014; Jeon et al., 2015a; Jeon et al., 2010a; Karantzas et al., 2012; Omansky, 2010; Stack, 2003). Until recently very little research has examined the working experiences of paraprofessionals (care workers) in the residential aged care sector (Jeon et al., 2013; Jeon et al., 2015b; Ostaszkiewicz et al., 2016). The findings of this research contribute to the body of knowledge of mentoring for an under-researched group of paraprofessionals. In the residential aged care context, clinical mentoring is the predominant form of mentoring. However, for this group of participants, clinical mentoring did not provide the learning or psychosocial mentoring outcomes required by paraprofessionals. This is consistent with the teaching and learning process adopted by Stewart and Krueger (1996) and used in the acute care nursing context which focuses on the development of the profession rather than individual learning. This research provides a significant contribution to understanding the work experiences of under-researched group of paraprofessionals that make up a significant proportion of the aged care workforce.

7.7.2 Practical contributions

This research makes several practical contributions to the mentoring literature. Phase 1 of the research raised some practical implications for group mentoring programmes. The concept of using an MTMM model for a professional association mentoring programme has considerable merit. One of the keys to operating a successful MTMM group programme is to have a coordinator manage the face-to-face mentoring programme, as well as a mentor nominated to facilitate meetings.

The lack of a facilitator or coordinator for the professional association face-to-face group led the programme to become a social-networking function only. Participants wanted more than networking from the face-to-face group, and this resulted in a request by participants for a more structured one-on-one mentoring programme. A dedicated mentoring programme coordinator is required to address a variety of issues including confidentiality, transfer of knowledge and training of mentors and mentees. With the administration side of the programme taken care of, trained mentors may then commit time to undertake reflective practice and provide psychosocial support to mentees. The amount of work involved in providing additional services to members of a professional association cannot be under-estimated and usually these services are provided by a few members on a voluntary basis. It is commendable that individuals are prepared to give their knowledge and time to their profession. Unfortunately, such effort is not always acknowledged by members of professional associations.

All participants found the online group forum was a useful tool. It provided a platform for association members to post questions about diagnosis and treatment of patients, with responses open from any member. However, several problems were identified with the online forum including reluctance to contribute, lack of confidence, and the need to provide detailed clinical information to obtain an answer to a question. The online forum would also benefit from having a dedicated programme coordinator and moderator to encourage and promote a safe environment for participants that may lead to increased activity and engagement in the online group forum.

There was a small group of dedicated mentors who wanted to help mentees achieve their goals and remain in the profession for the long term. However, mentor participants were unsure of how to be a mentor and were keen to develop their skills through training. As such, training in basic mentoring skills would be of great benefit to mentors and mentees and may assist in developing trust and mutual understanding in the mentoring process.

A lack of organisation and meaningful topics for discussion was an issue for the face-to-face group and online forum. As noted above, findings support the need for a programme coordinator to be appointed to maintain a focus on the mentoring process. Ideally, the coordinator would not be a part of a face-to-face group. However, the facilitator of the online forum would ideally be a clinician with the ability to moderate discussion.

In a practical sense, there are four other features worthy of consideration in establishing an MTMM group within a professional association setting. These include: a) development of guidelines and protocols for conduct of the face-to-face group and online forum; b) a mentoring agreement covering confidentiality within the group environment; c) a formal mentoring process within the existing face-to-face group structure to provide early career professionals with one-on-one support during their first year in the workforce; and d) a system of matching mentors and mentees to provide support in the areas of specialisation of both parties.

Key recommendations derived from Phase 1 of this research are: firstly, engage a coordinator to manage and provide structure for the online programme and face-to-face sessions; secondly, an online programme may be an effective use of resources; however, it is important to recognise that sufficient resources need to be available to support online delivery and maintain engagement in the programme; thirdly, utilise one-on-one mentoring to provide psychosocial support, particularly to support less confident early career professionals and; lastly, recognition by professional associations

of the limits of group mentoring and likelihood that professionals, particularly in smaller professions, prefer a one-on-one mentoring relationship for confidentiality and perceived impact on career.

Phase 2 of this research highlighted several important factors about career mentoring in the residential aged care context. Firstly, two demographic factors are relevant to the residential care sector. That is, the aging population and difficulty recruiting suitably qualified workers to work in a sector where wages are low and much of the work available is part-time. Further, the work is physically and mentally demanding, often requiring suppression of emotions in the workplace. Against this background, analysis of career mentoring behaviours shows that the residential care sector is keen to promote career advancement by actively promoting formal training to existing workers to become ENs and RNs. This is considered a positive step to ensure qualified staff are available in the future.

The second career mentoring behaviour of coaching, other than training, was not widely or successfully implemented. In this study, leadership training, coaching and mentoring skills were delivered to the management team only, with the exception of one organisation which trained two CWs as mentors. As a result, managerial teams have a difficultly implementing change in residential care facilities. While there are individuals at all levels with exceptional communication skills, coaching was limited to task-based work provision and being a reference point, rather than empowering workers with self-efficacy. This is an area that could be improved in the residential care sector.

The third behaviour of advocacy was actively used by residential aged care facilities involved in this study. The need to shield and protect workers from others with negative behaviours was particularly important. Ways of managing behaviours and attitudes of workers was an area that needs improvement within the residential care sector. Further, the way that workers relate to residents with dementia and other difficult behaviours is an area where further improvement is needed. In all residential aged care facilities visited for this study, workers were reliant on life experience and communication skills when dealing with residents. Workers relied on mentors to provide feedback and advice on how to relate with residents. In some cases, feedback was not given in a constructive positive manner which can be detrimental to team work at residential aged care facilities.

Finally, exposure and visibility of workers was not a feature of career mentoring in residential aged care facilities. However, given the valuable contribution and emotional support that workers provide to residents, there may be scope for the residential care sector as a whole to promote the

aged care profession as a worthy and credible career option and increase its profile within the community.

This research identified limited application of psychosocial mentoring in the residential aged care context. Concerns about the level of emotional support provided were noted, including lack of social interactions outside the workplace, feeling of belongingness and willingness to speak out on work related matters. The overriding factor was negative attitudes of some workers that is acknowledged as an issue in the residential care sector as limited encouragement affects employee self-efficacy and perpetuates negative attitudes and behaviours in the workplace. Similarly, role modelling declines as workers chose not to emulate negative role models. Also, counselling support for work-related matters, such as managing difficult behaviours and support on death of residents, was affected by negative attitudes of some longer serving workers. As a result, many workers seek support from peers they trust to keep conversations confidential. This study shows that many workers in the residential aged care sector seek to provide compassion and empathy to residents, yet they are not supported by mentors or managers in an emotionally safe work environment.

There are several important factors about clinical mentoring in the residential aged care context. The first is that some elements of clinical mentoring overlap with areas of career and psychosocial mentoring. These overlapping elements are: psychosocial support in clinical mentoring and role modelling in psychosocial mentoring; complicated cases in clinical mentoring and challenging assignments in career mentoring; continuing education in clinical mentoring and sponsorship and finally, on-site training in clinical mentoring and coaching in career mentoring.

While there is some overlap in behaviours of career, psychosocial and clinical mentoring, the commonality is slight. This research found that clinical mentoring components fall into two distinct groups, training and policies and procedures. Firstly, continuing education, case discussions, on-site training and role modelling are all related to training and secondly, quality control and complicated cases are concerned with policies, quality of care and continued compliance and accreditation of facilities.

This research found that clinical mentoring involves focused training only and, while psychosocial support is considered a component of clinical mentoring, it differs from psychosocial mentoring as defined by Kram (1985). In clinical mentoring mentees are trained to provide psychosocial support for patients. Emotional support for workers undertaking challenging roles is not provided. Of particular significance is the specific exclusion of counselling support as a component of clinical

mentoring in the practitioner literature (World Health Organisation, 2006). Further, this research found no evidence of training in communication or resident behaviours and role modelling was minimal at residential aged care facilities visited.

In the residential care sector significant effort is placed on making residents physically comfortable but not enough time is spent providing psychosocial support to workers caring for residents who are experiencing difficult end of life situations. This research found that psychosocial support for aged care workers was minimal and more attention should be given to the emotional needs of aged care workers.

This research provides evidence that clinical mentoring is another term for training in clinical environments and psychosocial mentoring and emotional support for workers at all levels of the residential care system requires improvement, particularly for CWs, who are the workers least educated and arguably least equipped to understand the reasons for difficult behaviours of residents or death of residents which can to lead to the burnout of workers. More needs to be done to assist workers to cope with day-to-day stresses of dealing with the emotional issues of working with residents in the residential aged care sector.

7.8 Future research

As in all research, there are opportunities for further research arising from this thesis. The use of a qualitative approach enabled rich exploration of the functions and behaviours of mentoring in one professional association. This helps extend understanding of the mentoring needs of early career allied health professionals. Additional research is required to identify whether other allied health groups have similar experiences and responses. However, given that many allied health professionals work in multidisciplinary sites and that other allied health professional associations recognise a similar need, we expect at least part of this research to be transferable to other health professions.

This research found that group mentoring using a many-to-many mentoring model requires considerable organisation and facilitation to retain momentum and interest. As few studies have addressed group mentoring programmes, further research in different settings would add to the limited body of knowledge on many-to-many mentoring.

This research found that clinical mentoring is generally considered as training support in a variety of different ways. As such, this research found that clinical mentoring alone is not sufficient to

support the psychosocial needs of residential aged care workers. Further research needs to be undertaken to identify how the psychosocial needs of health workers can be improved without impacting on quality of care provided.

Another area identified for further research is the influence of mentoring on psychological capital, in particular the potential for coaching and training to increase psychological capital. In light of research findings that resiliency is the least influenced construct of psychological capital and training in resiliency is widely promoted, particularly in the educational sector, further research on the relevance of this training is recommended.

7.9 Concluding statements

In conclusion, this research makes important contributions to theoretical and practical understanding and academic literature on mentoring for professional associations in allied health and mentoring and psychological capital in the residential aged care sector in Australia. This thesis provides new insights into the most important behaviours of mentoring for residential aged care workers and knowledge on how mentoring influences psychological capital. While gaps in the literature remain, this research confirmed a relationship between mentoring and psychological capital and identified mentoring behaviours that influence psychological capital. Understanding these relationships provides guidance to professional associations and residential aged care organisations in establishment of mentoring programmes and in particular the need for clinical mentoring programmes to be augmented with career and psychosocial mentoring. This new knowledge gives organisations and researchers the ability to improve policies and practices around health and safety of health sector workers in general.

APPENDICES

Appendix A: Sample of interview questions

1. Background to your organisation: business sector, size, structure, organisational culture, nature of work setting.

2. What does mentoring mean? What kind of mentoring do you currently receive?
   a. is it formal/informal, weekly/monthly/quarterly/six monthly/annually?
   b. Peer/protégé, psychosocial/ career development?
   c. Face to face, online, group, webinars, e-mentoring?

3. Do you view individual mentoring as important, or is it the system (i.e. work processes, groups, organisational structure, and routines, etc.) within which you work that is more, or equally important?

4. Discussion of your experiences of mentoring in practice – objectives, programme design, implementation, coverage, and resources required.
   a. Is the current programme useful, not useful? In what way?
   b. How does it link and fit with performance review/management processes? And future career planning?
   c. To what extent are senior managers (& line managers) involved in the process of mentoring (i.e., psychosocial and career development)?
   d. If you are a manager, what role do you play in the mentoring &/or development of individuals or teams?

5. Is there a focus on mentoring, and/or internally developing your career?
   a. Do you use internal and/or external resources (mentors, coaches, career development professionals) to develop your career?

6. What would you like to achieve from the mentoring process?

7. Do you have any preferences in terms of how you would like this to be delivered?
   a. (Eg. face-to-face, Internet, social media, groups, individual)

8. What peer support do you receive?

9. Your assessment of the benefits of mentoring programmes. Problems encountered/anticipated, lessons learned, special constraints/imperatives

10. Connections to other HRM policies/practices
    a. Do you have a formal mentoring system, what the objectives of it are, who it involves, and the actual process. We are also interested in how formal mentoring fits in with the wider HRM process and practices such as training, development, reward, and promotion. Are there any special issues e.g. gender, ethnicity, age, which we should be thinking about?
    b. If a formal programme does not exist, how do you attract, develop and retain in demand people?

11. Any final comments.

Appendix B: Sample of interview questions

1. What does mentoring mean to you?
2. What kind of mentoring do you currently receive?
3. Is individual mentoring as important as the work processes and routines?
4. Do you find mentoring useful, not useful? In what way?
5. How does it link and fit with performance review/management processes? And future career planning?
6. To what extent are senior managers (& line managers) involved in the process of mentoring (i.e., psychosocial, career development, clinical training)?
7. If you are a manager, what role do you play in the mentoring &/or development of individuals or teams?
8. Do you use internal and/or external resources (mentors, coaches, career development professionals) to develop your career?
9. What peer support do you receive?
10. What supports are in place on the death of a resident or to deal with the difficult behaviours of residents?

INTRODUCTION

Dear participant,

You are invited to participate in the study titled "Career, psycho-social and clinical mentoring of health care professionals and paraprofessionals in the residential care sector".

This research project will gather data from health care professionals in the residential care sector about their experiences of mentoring. It will also gather information on the effectiveness of mentoring received and the level of organisational support provided. It is anticipated that the results of this research will form part of a thesis and an article to be published in an academic journal next year. It will also help to inform the development of the most appropriate mentoring program for aged care workers.

Participation in this study is completely anonymous and voluntary. You can choose to withdraw from this study at any time. You are not required to record your name, and the information you provide will be totally confidential. Please spend about 30 minutes to answer the following questionnaire.

Please do not hesitate to contact the researcher (details below) should you have any questions.

Rosie Coppin
Business School Flinders University, Australia, SA 5042
Email: rosalie.coppin@flinders.edu.au

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (6262). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

SURVEY CONSENT

I have read through the introduction of this survey and hereby consent to participate for the research project on career, psycho-social and clinical mentoring of health care professionals and paraprofessionals in the residential care sector.

I have read the information provided.

I understand that:
• Participation in this survey is completely anonymous and voluntary
• I may not directly benefit from taking part in this survey.
• I am free to withdraw from the project at any time and am free to decline to answer particular questions.
• While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
• Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.

* 1. Please tick here to give your consent to use your responses for statistical research purposes

○ Yes

PART 1: BACKGROUND INFORMATION

First we would like to ask you some questions about yourself
Please answer ALL questions.

2. Are you

- ◯ Male
- ◯ Female

3. How old are you?

- ◯ Under 25
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55+

4. Are you

- ◯ a registered nurse
- ◯ an allied health professional
- ◯ a personal care worker
- ◯ an administration worker
- ◯ a kitchen, laundry or other worker in residential care

5. How many years have you been working in aged care care?

- ◯ Less than 1
- ◯ 1 - 2
- ◯ 3 - 5
- ◯ 6 -10
- ◯ 10+
- ◯ 20+

6. Which of these best describes your work status?

- ◯ Full time
- ◯ Part time
- ◯ Casual
- ◯ Work placement

7. What is your highest qualification?

- ◯ Certificate III
- ◯ Certificate IV
- ◯ Diploma
- ◯ Undergraduate Degree
- ◯ Honours Degree
- ◯ Graduate Certificate/Graduate Diploma
- ◯ Masters Degree
- ◯ Doctoral Degree

Other (please specify)

[ ]

8. Are you currently working in your preferred job?

- ◯ Yes
- ◯ No

PART 2 INFORMATION ON MENTORING

9. Do you currently have a mentor?

- ○ Yes
- ○ No

10. If yes, is this person a

- ○ supervisor or senior professional
- ○ peer (colleague who is not your supervisor)
- ○ family member
- ○ friend
- ○ independent person outside of the profession or organisation
- ○ not applicable

11. If you do not have a mentor who supports you when difficult situations arise?

[ ]

12. How would you describe the mentoring you receive?

- ○ Formal (formal discussions held on a regular basis)
- ○ Informal (discussion held whenever required in any setting)
- ○ A combination of both
- ○ Not applicable

13. Choose as many answers as are applicable to you.
Does your mentor provide you with

- ☐ clinical training only (eg. practical training on the job)
- ☐ clinical supervision only (eg. supervision on the practical aspects of the job)
- ☐ career support only (eg. challenging work, coaching, advocacy, sponsorship, exposure and visibility)
- ☐ emotional support only (eg. friendship, role modelling, counselling, acceptance and confirmation)
- ☐ none of the above

14. How was your mentor chosen?

- ◯ Provided by the organisation
- ◯ Identified by yourself

15. Do you or have you had more than one mentor at anyone time?

- ◯ Yes
- ◯ No

PART 3: YOUR EXPERIENCE OF MENTORING

Listed below are a series of statements about mentoring. Please click the option that best represents your point of view.

16. With respect to your own experience of mentoring please indicate how much you agree or disagree with each statement.

	Strongly disagree	Moderately disagree	Disagree	Neutral	Agree	Moderately agree	Strongly agree
1. My mentor helps me attain desirable positions	○	○	○	○	○	○	○
2. My mentor suggests specific strategies for achieving career aspirations.	○	○	○	○	○	○	○
3. My mentor “runs interference” for me in the organization.	○	○	○	○	○	○	○
4. My mentor provides me with challenging assignments.	○	○	○	○	○	○	○
5. My mentor helps me be more visible in the organization.	○	○	○	○	○	○	○
6. My mentor is someone I can confide in.	○	○	○	○	○	○	○
7. My mentor and I frequently have one-on-one, informal social interactions outside the work setting.	○	○	○	○	○	○	○
8. My mentor reminds me of one of my parents.	○	○	○	○	○	○	○
9. My mentor serves as a role model for me.	○	○	○	○	○	○	○
10. My mentor guides my personal development.	○	○	○	○	○	○	○
11. My mentor accepts me as a competent professional.	○	○	○	○	○	○	○
12. My mentor uses his/her influence in the organisation for my benefit	○	○	○	○	○	○	○

	Strongly disagree	Moderately disagree	Disagree	Neutral	Agree	Moderately agree	Strongly agree
13. My mentor gives me advice on how to attain recognition in the organization.	○	○	○	○	○	○	○
14. My mentor shields me from damaging contact with important people in the organization.	○	○	○	○	○	○	○
15. My mentor assigns me tasks that push me into developing new skills.	○	○	○	○	○	○	○
16. My mentor creates opportunities for me to impress important people in the organization.	○	○	○	○	○	○	○
17. My mentor provides support and encouragement.	○	○	○	○	○	○	○
18. My mentor and I frequently socialize one-on-one outside the work setting.	○	○	○	○	○	○	○
19. My mentor is like a father/mother to me.	○	○	○	○	○	○	○
20. My mentor represents who I want to be.	○	○	○	○	○	○	○
21. My mentor serves as a sounding board for me to develop and understand myself.	○	○	○	○	○	○	○
22. My mentor thinks highly of me.	○	○	○	○	○	○	○
23. My mentor uses his/her influence to support my advancement in the organisation	○	○	○	○	○	○	○
24. My mentor helps me learn about other parts of the organization.	○	○	○	○	○	○	○
25. My mentor protects me from those who are out to get me.	○	○	○	○	○	○	○

	Strongly disagree	Moderately disagree	Disagree	Neutral	Agree	Moderately agree	Strongly agree
26. My mentor gives me tasks that require me to learn new skills.	◯	◯	◯	◯	◯	◯	◯
27. My mentor brings my accomplishments to the attention of important people in the organization.	◯	◯	◯	◯	◯	◯	◯
28. My mentor is someone I can trust.	◯	◯	◯	◯	◯	◯	◯
29. My mentor and I frequently get together informally after work by ourselves.	◯	◯	◯	◯	◯	◯	◯
30. My mentor treats me like a son/daughter.	◯	◯	◯	◯	◯	◯	◯
31. My mentor is someone I identify with.	◯	◯	◯	◯	◯	◯	◯
32. My mentor guides my professional development.	◯	◯	◯	◯	◯	◯	◯
33. My mentor sees me as being competent.	◯	◯	◯	◯	◯	◯	◯
34. My mentor trains me on the job.	◯	◯	◯	◯	◯	◯	◯

PART 4: PERSONAL CHARACTERISTICS

Listed below are some statements about yourself. Please indicate the degree of your agreement or disagreement with each statement by ticking the option that best represents your point of view.

17. Please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1. I feel confident analysing a long-term problem to find a solution.	○	○	○	○	○	○
2. I feel confident in representing my work area in meetings with management.	○	○	○	○	○	○
3. I feel confident contributing to discussions about the company's strategy.	○	○	○	○	○	○
4. I feel confident helping to set targets/goals in my work area.	○	○	○	○	○	○
5. I feel confident contacting people outside the company (eg. suppliers, customers) to discuss problems.	○	○	○	○	○	○
6. I feel confident presenting information to a group of colleagues.	○	○	○	○	○	○
7. If I should find myself in a jam at work, I could think of many ways to get out of it.	○	○	○	○	○	○
8. At the present time, I am energetically pursuing my work goals.	○	○	○	○	○	○
9. There are lots of ways around any problem.	○	○	○	○	○	○
10. Right now I see myself as being pretty successful at work.	○	○	○	○	○	○

	Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
11. I can think of many ways to reach my current work goals.	○	○	○	○	○	○
12. At this time, I am meeting the work goals I have set for myself.	○	○	○	○	○	○
13. When I have a setback at work, I have trouble recovering from it, moving on.	○	○	○	○	○	○
14. I usually manage difficulties one way or another at work.	○	○	○	○	○	○
15. I can be "on my own", so to speak , at work if I have to.	○	○	○	○	○	○
16. I usually take stressful things at work in my stride.	○	○	○	○	○	○
17. I can get through difficult times at work because I have experienced difficulty before.	○	○	○	○	○	○
18. I feel I can handle many things at a time at this job.	○	○	○	○	○	○
19. When things are uncertain for me at work, I usually expect the best.	○	○	○	○	○	○
20. If something can go wrong for me work-wise, it will.	○	○	○	○	○	○
21. I always look on the bright side of things regarding my job.	○	○	○	○	○	○
22. I'm optimistic about what will happen to me in the future as it pertains to work.	○	○	○	○	○	○
23. In this job, things never work out the way I want them to.	○	○	○	○	○	○
24. I approach this job as if 'every cloud has a silver lining".	○	○	○	○	○	○

PART 5: WORKPLACE BEHAVIOURS

Listed below are a series of statements about workplace behaviours. Please respond by ticking the option that best represents your point of view.

18. How often have you done each of the following things on your present job?.

	Never	Once or twice	Once of twice per month	Once or twice per week	Every day
1. Picked up meal for others at work	○	○	○	○	○
2. Took time to advise, coach, or mentor a co-worker.	○	○	○	○	○
3. Helped co-worker learn new skills or shared job knowledge.	○	○	○	○	○
4. Helped new employees get oriented to the job.	○	○	○	○	○
5. Lent a compassionate ear when someone had a work problem.	○	○	○	○	○
6. Lent a compassionate ear when someone had a personal problem.	○	○	○	○	○
7. Changed vacation schedule, work days, or shifts to accommodate co-worker's needs.	○	○	○	○	○
8. Offered suggestions to improve how work is done.	○	○	○	○	○
9. Offered suggestions for improving the work environment.	○	○	○	○	○
10. Finished something for co-worker who had to leave early.	○	○	○	○	○
11. Helped a less capable co-worker lift a heavy box or other object.	○	○	○	○	○
12. Helped a co-worker who had too much to do.	○	○	○	○	○

	Never	Once or twice	Once of twice per month	Once or twice per week	Every day
13. Volunteered for extra work assignments.	○	○	○	○	○
14. Took phone messages for absent or busy co-worker.	○	○	○	○	○
15. Said good things about your employer in front of others.	○	○	○	○	○
16. Gave up meal and other breaks to complete work.	○	○	○	○	○
17. Volunteered to help a co-worker deal with a difficult customer, vendor, or co-worker.	○	○	○	○	○
18. Went out of the way to give co-worker encouragement or express appreciation.	○	○	○	○	○
19. Decorated, straightened up, or otherwise beautified common work space.	○	○	○	○	○
20. Defended a co-worker who was being "put-down" or spoken ill of by other co-workers or supervisor.	○	○	○	○	○

19. How often have you done each of the following things on your present job?

	Never	Once or Twice	Once or Twice per month	Once or Twice per week	Every Day
1. Purposely wasted your employer's materials/supplies	○	○	○	○	○
2. Purposely did your work incorrectly	○	○	○	○	○
3. Came to work late without permission	○	○	○	○	○
4. Stayed home from work and said you were sick when you weren't	○	○	○	○	○
5. Purposely damaged a piece of equipment or property	○	○	○	○	○
6. Purposely dirtied or littered your place of work	○	○	○	○	○
7. Stolen something belonging to your employer	○	○	○	○	○
8. Started or continued a damaging or harmful rumour at work	○	○	○	○	○
9. Been nasty or rude to a client or customer	○	○	○	○	○
10. Purposely worked slowly when things needed to get done	○	○	○	○	○
11. Taken a longer break than you were allowed to take	○	○	○	○	○
12. Purposely failed to follow instructions	○	○	○	○	○
13. Left work earlier than you were allowed to	○	○	○	○	○
14. Insulted someone about their job performance	○	○	○	○	○
15. Made fun of someone's personal life	○	○	○	○	○

	Never	Once or Twice	Once or Twice per month	Once or Twice per week	Every Day
16. Took supplies or tools home without permission	○	○	○	○	○
17. Put in to be paid for more hours than you worked	○	○	○	○	○
18. Took money from your employer without permission	○	○	○	○	○
19. Ignored someone at work	○	○	○	○	○
20. Blamed someone at work for error you made	○	○	○	○	○
21. Started an argument with someone at work	○	○	○	○	○
22. Stole something belonging to someone at work	○	○	○	○	○
23. Verbally abused someone at work	○	○	○	○	○
24. Made an obscene gesture (the finger) to someone at work	○	○	○	○	○
25. Threatened someone at work with violence	○	○	○	○	○
26. Threatened someone at work, but not physically	○	○	○	○	○
27. Said something obscene to someone at work to make them feel bad	○	○	○	○	○
28. Did something to make someone at work look bad	○	○	○	○	○
29. Played a mean prank to embarrass someone at work	○	○	○	○	○
30. Looked at someone at work's private mail/property without permission	○	○	○	○	○
31. Hit or pushed someone at work	○	○	○	○	○

	Never	Once or Twice	Once or Twice per month	Once or Twice per week	Every Day
32. Insulted or made fun of someone at work	○	○	○	○	○

Following are some statements that represent possible opinions YOU may have about the organisation. Please indicate the degree of your agreement or disagreement with each statement by ticking the option that best represents your point of view.

20. Please indicate how much you agree or disagree with each statement.

	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	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.	○	○	○	○	○	○	○
2. I talk up this organization to my friends as a great organization to work for.	○	○	○	○	○	○	○
3. I feel very little loyalty to this organization.	○	○	○	○	○	○	○
4. I find that my values and the organization’s values are very similar.	○	○	○	○	○	○	○
5. I am proud to tell others that I am part of this organization.	○	○	○	○	○	○	○
6. This organization really inspires the very best in me in the way of job performance.	○	○	○	○	○	○	○
7. I am extremely glad that I chose this organization to work for over others I was considering at the time I joined.	○	○	○	○	○	○	○
8. Often I find it difficult to agree with this organization’s policies on important matters relating to its employees.	○	○	○	○	○	○	○
9. I really care about the fate of this organization.	○	○	○	○	○	○	○

Listed below are statements that represent possible opinions that YOU may have about working at your organisation. Please indicate the degree of your agreement or disagreement with each statement ticking the option that best represents your point of view about the organisation.

21. Please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Moderately disagree	Slightly disagree	Neither agree or disagree	Slightly agree	Moderately agree	Strongly agree
1. The organization values my contribution to its well-being.	◯	◯	◯	◯	◯	◯	◯
2. The organisation fails to appreciate any extra effort from me.	◯	◯	◯	◯	◯	◯	◯
3. The organisation would ignore any complaint from me.	◯	◯	◯	◯	◯	◯	◯
4. The organization really cares about my well-being.	◯	◯	◯	◯	◯	◯	◯
5. Even if I did the best job possible, the organisation would fail to notice.	◯	◯	◯	◯	◯	◯	◯
6. The organisation cares about my general satisfaction at work.	◯	◯	◯	◯	◯	◯	◯
7. The organisation shows very little concern for me.	◯	◯	◯	◯	◯	◯	◯
8. The organisation takes pride in my accomplishments at work.	◯	◯	◯	◯	◯	◯	◯

Listed below are statements that represent possible opinions that YOU may have about working at your organisation. Please indicate the degree of your agreement or disagreement with each statement by ticking the option that best represents your point of view.

22. Please indicate how much you agree or disagree with each statement.

	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1. If a good friend of mine told me that he/she was interested in a job like mine I would strongly recommend it.	○	○	○	○	○	○	○
2. All in all, I am very satisfied with my current job.	○	○	○	○	○	○	○
3. In general, my job measures up to the sort of job I wanted when I took it.	○	○	○	○	○	○	○
4. Knowing what I know now, if I had to decide all over again whether to take my job, I would.	○	○	○	○	○	○	○

23. Please indicate how much you agree or disagree with the following statements.

	Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1. I will probably quit my job in the next year.	○	○	○	○	○	○	○
2. I will probably search for alternative employment in the next year.	○	○	○	○	○	○	○
3. I frequently think about leaving my job.	○	○	○	○	○	○	○
4. I frequently think about leaving the profession.	○	○	○	○	○	○	○

Thank you for your time and effort in completing this survey. It is greatly appreciated.

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