Origins and Evolution of Mentoring

The term “mentor” originated in Greek mythology, inspired by the character of Mentor in Homer’s Odyssey. Mentor was a helper, teacher, and guide to Odysseus’ son Telemachus. Starting with Vance in the 1980s to the present, mentoring provides a clear tool for nursing leadership development (Galuska, 2012; Jakubik, Eliades, Gavriloff, & Weese, 2011; Vance, 1982; Weese, Jakubik, Eliades, & Huth, 2015). Formal mentoring programs began in the 1980s and grew in popularity in the 1990s. Mentoring emerged in the business world as an organizational phenomenon in the early 1980s. Today, mentoring is seen as part of corporate culture and success.

Nursing and service professions traditionally viewed mentoring as a relational phenomenon involving a dyad relationship (mentor and protégé). Following Zey’s (1991) Mutual Benefits Model, business views mentoring as an organizational phenomenon involving a triad relationship (mentor, protégé, and organization). Jakubik (2007) applied Zey’s (1991) model to nursing practice. According to this model, mentoring practices and benefits occur for each member of the triad mentoring relationship (Jakubik, 2007, 2008; Jakubik et al., 2011). Multiple studies demonstrate benefits of mentoring applying this combined perspective of mentoring as a triad relationship that is both a relational and organizational phenomenon (Jakubik, 2007, 2008; Jakubik et al., 2011; Weese et al., 2015). Further, 2013 studies of over 500 nurses demonstrated that six mentoring practices predict six mentoring benefits (Jakubik & Weese, 2014; Weese et al., 2015). Based on this conceptual model, mentoring in nursing is defined as an intentional, long-term career developmental relationship among an experienced nurse, a less-experienced nurse, and their workplace involving six mentoring practices (facilitated by the mentor and the workplace) that are associated with six mentoring benefits (experienced by the protégé, the mentor, and/or the workplace).

Related Definitions

The terms mentor, coach, and preceptor, and their associated processes of mentoring, coaching, orientation, on-boarding, and residency are often mistakenly used interchangeably. A mentor is a close, trusted, experienced counselor or guide who engages in a long-term, relationship-oriented, development-driven, mentoring relationship (Haggard, Dougherty, Turban, & Wilbanks, 2011). A coach is a content expert capable of teaching skill development, and coaching is a task-oriented, short-term, and performance-driven process (Taie, 2011). A preceptor is a staff nurse assigned based on his or her knowledge, skills, and experience in the given unit for a defined period of time to assist a newly hired nurse through an orientation process that is a time-limited, formal job training process to produce a competent employee with the skill and knowledge of philosophies, goals, policies and procedures, expectations, physical environment, and services of a particular work.
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unit (Greene & Puetzer, 2002; Kanaskie, 2006). Onboarding is an organizational socialization mechanism for new employees to become effective members and insiders of an organization (Bauer & Erdogan, 2011). Residency programs are time-limited, retention-focused, formal, either within a specific area of the hospital or nursing department-wide, with skill and knowledge outcomes (Kramer, Maguire, Halfer, Brewer, & Schmalenberg, 2013).

In the career continuum of a nurse, onboarding and precepted orientation lasts weeks to months, residency lasts 12 to 18 months, and mentoring continues throughout a career until retirement. The goal of onboarding is organizational socialization. The goal of precepted orientation is training to produce a competent employee. The goals of residency programs are retention, role transition, support, and unit/organizational acculturation. The goals of mentoring are lifelong learning, professional advancement, employee engagement, and succession planning.

Mentoring Benefits and Practices

Mentoring benefits are those positive outcomes of the mentoring relationship that are experienced by the protégé, the mentor, and/or the workplace (Jakubik, 2007, 2008). Mentoring benefits include 1) belonging, 2) career optimism, 3) competence, 4) professional growth, 5) security, and 6) leadership readiness. Benefits are measured using the 36-item valid and reliable Mentoring Benefits Inventory (MBI). Mentoring practices are specific career developmental phenomena that are facilitated by the individual mentor and the workplace (Jakubik & Weese, 2014; Weese et al., 2015). Mentoring practices include 1) welcoming, 2) mapping the future, 3) teaching the job, 4) supporting the transition, 5) providing protection, and 6) equipping for leadership. Practices are measured using the 36-item valid and reliable Mentoring Practices Inventory (MPI).

History and Evolution

Mentoring benefits were first identified, applied, and tested in nursing using a business mentoring model by Zey (1991). Multiple studies from 2007 to 2011 demonstrated that mentoring quality was the single best predictor of mentoring type, mentoring quantity, and length of employment (Jakubik, 2007, 2008; Jakubik et al., 2011). Although these first studies demonstrated a clear benefit of mentoring, there remained a gap in the literature about “how to” mentor to reap these established mentoring benefits. Mentoring practices were identified and tested in three national studies of over 500 nurses conducted in 2013 (Jakubik & Weese, 2014; Weese et al., 2015), demonstrating practices were a significant predictor of mentoring benefits. These studies were the first to quantify specific evidence-based mentoring practices, not only outlining a “how to” for mentoring, but also demonstrating that they, in fact, predicted mentoring benefits.

References


Additional Reading

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