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Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment

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FAMILY NURSE PRACTITIONER MENTORING RELATIONSHIPS' IMPACT ON ORGANIZATIONAL COMMITMENT

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ABSTRACT

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by

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Family nurse practitioners (FNPs) are vital primary care providers who are responding to increased primary health care needs in the United States. Organizational commitment is reflective of workplace relationships that foster professional development, innovation, and outcome achievement. An organizationally committed FNP workforce is essential to achieving primary health care goals.

Mentorship has been proposed as a strategy to foster FNP organizational commitment. Mentoring has been characterized as a teaching-learning relationship. The mentor can serve as a guide to foster graduate FNP practitioner transition into primary care practice. Types of mentoring relationships occur in formal workplace settings or develop as informal friendship-based relationships. Mentoring career functions promote protégé confidence and competency. Mentoring psychosocial functions have provided emotional support for nursing role development. Mentoring quality is associated with relationship satisfaction and goal achievement. There is a current research gap concerning mentoring relationships' impact on FNP organizational commitment during the first year of primary care practice. The purpose of this study was to examine factors of FNP mentoring relationships (presence, types, functions, and quality) and their impact on organizational commitment.

A national cross-sectional survey was conducted with postal mail and online survey methods in spring 2014. A sample of 1,500 FNPs, members of the American Association of Nurse Practitioners, was invited to respond to the survey concerning mentoring and organizational commitment during their first year of primary care practice. The study utilized four questionnaires: (a) the FNP Demographic Survey, (b) the Three-Component Model Employee Commitment Survey, (c) the Quality of Mentoring Relationship scale, and (d) the Mentoring Functions Questionnaire. Mentoring presence, functions, types, and quality of the relationships' impact on FNP organizational commitment were analyzed by bivariate and multiple regression and MANOVA.

There was a 26.9 % usable response rate from the 1,500 FNP sample. Four hundred and three survey responses met the study criteria and were used in the analysis. Non–mentored FNPs comprised 44% of the respondents. During the first year of primary care practice, 55% of the FNPs had mentoring relationships; 23% of the mentorships were comprised of informal relationships, 21% were a combination of formal and informal relationships, and 11% were solely formal relationships.

Mentored FNPs were significantly more affectively (emotionally) committed to the workplace than non-mentored FNPs. All mentoring career and psychosocial functions had a significant impact on affective and normative FNP organizational commitment. Additionally, mentoring career function was a significant individual predictor of affective FNP organizational commitment. Mentoring relationship quality had a significant impact on FNP affective and normative organizational commitment. This research study has provided a foundation for mentoring strategy development that will promote FNP organizational commitment in primary care settings.

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I have been fortunate to practice as a FNP within a foundation of nursing excellence at New York University Langone Medical Center. My thanks are extended to the Advanced Practice Nursing leadership. They sparked my curiosity concerning NP mentoring and organizational commitment.

Lastly, I dedicate this dissertation to my parents, the late Harry and Margaret Bartley. They were my lifelong mentors. Their immigrant journey in the United States inspired me to make a difference. My doctorate in nursing education will be the foundation for future scholarship and innovative practice.

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CHAPTER I

INTRODUCTION

This introductory chapter provides information about the study and includes the following sections: (a) background and significance of the study, (b) problem statement, (c) research purpose, (d) research questions, (e) definitions, (f) assumptions, and (g) chapter summary.

Background and Significance of the Study

Political, social, and demographic influences have dramatically increased the demand for primary care services in the United States (U.S.). The passage of the Patient Protection and Affordable Care Act, health care access demands, and an aging population are straining the capacity of the current primary care workforce (Aleshire & Wheeler, 2012; American Medical Group Association [AMGA], 2012). Primary care services include health maintenance, immunizations, disease prevention, and treatment of common health problems (Institute of Medicine [IOM], 1994). Primary care service goals have targeted quality of life indicators, healthy lifestyle initiatives, and health disparities elimination (U.S. Department of Health and Human Services, 2013). Although the demand for primary care services is increasing, there is a diminished supply of primary care physicians and health care providers (AMGA, 2012; McKinlay & Marceau, 2008). The annual primary care visits in the U.S. are expected to increase from 462 million in 2008 to 565 million in 2025 (Petterson et al., 2012). Family nurse practitioners (FNPs) are struggling to meet the evolving primary care needs of the people in the U.S.

The Institute of Medicine (IOM, 2010) and the American Academy of Nurse Practitioners (AANP; 2011) have supported increasing nurse practitioner responsibilities as a key strategy to meet national health goals. Nurse practitioners (NPs) have demonstrated the ability to deliver primary care services and achieve quality health outcomes (AANP, 2011; Gardner, Hase, Gardner, Dunn, & Carryer, 2008; Lenz, Mundinger, Kane, Hopkins, & Lin, 2004). Building the capacity of NPs prepared to deliver primary care services is critically important. Currently, 87% of the 189,000 NPs in the United States are prepared in primary care and 49% of those are FNPs (AANP, 2014). However, the NP job turnover rate has been reported to be 12.6%, twice as high as that of primary care physicians (AMGA, 2012).

Educational Challenges

Nurse practitioner (NP) academic programs are responding to the challenges of health care delivery and the demand for primary care providers. The annual U.S. graduation rates of primary care NPs have increased from 6,556 in 2006 to 11,936 in 2012. Seventy percent of the primary care NP graduates are FNPs (AANP, 2011; American Association of Colleges of Nursing [AACN] & National Organization of Nurse Practitioner Faculties [NONPF], 2013**).** In addition to the current master's or post master's degree, the Doctor of Nursing Practice (DNP) has been endorsed as the terminal academic preparation for all NPs by 2015 (AANP, 2010; IOM, 2010). The scope of FNP practice is being influenced by national health care policy initiatives and an evolving graduate preparation that supports primary care services delivery (ANCC, 2008; NONPF, 2002, 2012). The FNPs are expected to manage complex health care needs and assume

primary care provider responsibilities within their first year of clinical practice (Kelly & Matthews, 2001).

Mentoring and Family Nurse Practitioner Transition into Practice

The FNP graduates must become socialized in a new professional role, navigate complex regulatory and reimbursement requirements, and assume health care provider responsibilities (Kelly & Matthews, 2001). According to the American Nurses Credentialing Center Role Delineation study (ANCC, 2011), FNP critical work activities included health assessment, acute and chronic disease management, prescription, consultation, referral, and outcome evaluation during the first six months of practice. Successful FNP transition into primary care practice is essential to U.S. health care delivery (Aleshire & Wheeler, 2012; ANCC, 2011).

Mentoring has been explored as a strategy to foster NP transition into practice (Barker, 2006; Brown & Olshansky, 1998**).** Mentoring career, psychosocial, and role modeling functions support FNP transition into practice **(**Allen, Eby, Poteet, Lentz, & Lima, 2004; Gerhart, 2011; Harrington, 2011). Mentoring relationships can occur in formal workplace settings or develop as informal friendship-based relationships (Kram, 1985; Mariani, 2012). Current research is reflective of the need for NP mentoring. There has been a concentration on NP role transition strategies, formal mentoring program development, residency initiatives, orientation program planning, and short-term goal achievement in mostly acute care settings (Boyer, 2012; Doerksen, 2010; Gardner et al., 2008; Pop, 2011; Sargent & Olmedo, 2013). Although, there has been an identified need for FNP mentoring as a strategy to facilitate transition into practice, no research studies

were located that explored FNP mentoring relationships' impact on the workplace (Poronsky, 2012).

Nursing mentorship has been associated with retention, recruitment, professional support, and empowerment (Chung, 2011; Garbee & Killacky, 2008; Greene & Puetzer, 2002; Tourigny & Pulich, 2005). There is strong evidence that a lack of support is an important factor in the turnover of registered nurses (Brewer, Kovner, Greene, Tulov-Shuser, & Djukie, 2011). Though there is not as much evidence for its role in the NP turnover, there is some evidence that lack of support during transition to advanced nursing practice is a problem and contributes to the high primary care NP attrition rate (AMGA, 2012). Thus, there is a critical need to investigate the impact of FNP mentorship on successful role transition, retention, and assumption of health care provider responsibilities during the first year of primary care practice.

Family Nurse Practitioner Organizational Commitment

Organizational commitment is a multidimensional concept that integrates both individual and workplace goals. Organizational commitment is influenced by a workplace that encourages communication, professional relationships, support, and engagement (Fagenson-Eland, Marks, & Amendola, 1997; Gardner et al., 2008). Organizational commitment has been associated with workforce retention, quality care delivery, creativity, and innovation (Aryee & Chay, 1994; Coyle-Shapiro & Shore, 2007; Gregory, Way, Lefort, Barrett, & Parfrey, 2007).

In the U.S., FNPs are health care providers with diverse professional nursing and educational experiences. Prior to becoming a FNP, the average registered professional nursing experience has been 21 years. Respondents reported an average of 11 years of

FNP experience. Current FNP educational preparation has included 84% master's preparation, 11% with a post master's certificate, 2% with doctorates (Ph.D., DNS), and 3% with the a Doctorate of Nursing Practice (DNP; ANCC, 2011). Current role expectations are influencing FNP transition into primary care and assumption of health care provider responsibilities. Although, organizational commitment has been associated with workplace goal achievement, no studies were found that examined factors influencing NP organizational commitment (Coyle-Shapiro & Shore, 2007). Research studies have indicated that mentorship, orientation and residency programs, administrative support, and professional development activities foster RNs' organizational commitment (Bratt, 2012; Gregory et al., 2007; Liou, 2008; Meyer & Allen, 1997). Investigating the impact of mentoring relationships on FNP organizational commitment will **y**ield new knowledge concerning FNP role development and transition into practice (Poronsky, 2012).

Primary care service expansion has been limited by health care provider shortages, particularly in rural, urban, and economically depressed areas (Grover & Niecko-Najjum, 2013; McKinlay & Marceau, 2008; Weldon, 2008). The transformation of primary care health services is dependent upon FNPs who can provide high-quality, patient-centered care that is accessible to the American population (AANP, 2011). Mentorship can support FNP transition into primary care practice. Additionally, FNPs who are committed to the workplace may be more likely to engage in and advance health care initiatives. Mentorship is a potential strategy that can contribute to quality FNP health care outcomes (Aryee & Chay, 1994; Coyle-Shapiro & Shore, 2007).

Problem Statement

The need for FNPs to practice as primary care providers is critical to sustaining and expanding the health care delivery. Mentorship has the potential to foster FNP role development and organizational commitment in primary care settings. Although mentorship has been studied as a strategy to promote RN and nursing faculty organizational commitment, no studies have investigated the impact of FNP mentorship on organizational commitment in primary care settings (Gardner et al., 2008; Hayes & Kalmakis, 2007; Liou, 2008).

Research Purpose

The FNP workforce needs to be sustained and increased so primary care services can meet the health care needs of Americans. Mutual interaction among employees and the workplace provides an environment for individual and collective goal achievement (Liou, 2008). Although mentorship has been used with RNs and nursing faculty, no FNP research studies have explored mentoring relationships' impact on organizational commitment. The purpose of the study was to examine the factors of mentoring relationships (presence, types, functions, and quality) and their impact on FNP organizational commitment in primary care settings. Additionally, a national study could generate new knowledge concerning organizational commitment within the context of FNP mentoring relationships. Once the relationships are identified, mentoring strategies can be developed to support FNP organizational commitment.

Research Questions

The research questions were as follows:

1. Are there any differences in organizational commitment between mentored and non-mentored FNPs?
2. Are there any differences in FNP organizational commitment across formal, informal, and a combination of both formal and informal mentoring types?
3. Are there any differences in FNP organizational commitment across mentoring career, psychosocial, and role modeling functions?
4. What is the relationship between the mentoring relationship quality and FNP organizational commitment?

Definitions

Family Nurse Practitioner

Conceptually, a FNP is an advanced practice nurse with a graduate degree who is educationally prepared to provide health care to people throughout the life cycle. They specialize in advanced practice family nursing within the context of the community. Role competencies include health promotion, health status assessment, disease detection, and treatment. Family nurse practitioner responsibilities include therapeutic patient/family communication, professional role development, managing and negotiating health care systems, ensuring health care quality, and cultural competence (U.S. Department of Health & Human Services, 2002). The American Association of Nurse Practitioners (AANP) and the American Nurses Credentialing Center (ANCC) are the two national NP certification organizations. Operationally, a FNP is a certified FNP (AANP and/or ANCC) who has worked in primary care settings. They completed the survey based on

self-reports of the first year of FNP primary care practice. It was assessed by the first FNP Demographic Survey question (see Appendix B).

Family Nurse Practitioner Demographic Variables

Conceptually, FNP demographic variables included FNP personal and professional characteristics associated with working in a primary care setting, age, marital status, gender, ethnicity, prior RN experience, FNP academic preparation, years of FNP experience, type of workplace setting, and mentoring relationship presence and type. Operationally, FNP demographic variables were measured by the FNP Demographic Survey (see Appendix B). Respondents selected choices for gender, marital status, academic FNP graduate degree, working in primary care, and the types of workplace settings. Workplaces were primary care settings. The respondents were able to select single or multiple workplace settings during their first year of clinical practice. They entered whole number of years for age, number of years working as an FNP, and years of RN clinical experience prior to becoming a FNP, and the U.S. state location of primary care setting. If there was a mentoring relationship during the first year of FNP clinical practice, the mentor's job title and mentorship types were listed. All FNP participants were invited to complete the revised Meyer and Allen's (1997) Three Component Model Employee Commitment survey (MATCMEC). Mentored FNPs were able to continue and respond to the Quality of Mentoring Relationship Scale (QMRS) and the Mentoring Functions Questionnaire (MFQ-9; Allen & Eby, 2003; Castro, Scandura, & Williams, 2004).

Mentoring Relationships (Mentorship)

Conceptually, mentorship is defined as a relationship in which a more experienced professional (primary care NP) provides support and guidance for a mentee. Mentorship is characterized as a reciprocal teaching-learning process. The goal is to promote protégé career and personal achievement (Stewart & Krueger, 1996). Operationally, mentorship is characterized as a relationship with an experienced NP and a new graduate FNP. Mentoring relationship presence was determined by the FNP Demographic Survey question 13. It was reflective of one FNP mentoring relationship during the first year of primary care practice.

Types of Mentoring Relationships

Conceptually, mentoring relationship types are often divided into two major categories: formal and informal. Formal mentorships are structured agreements that foster mentor success and have specific timeframes (Ragins & Kram, 2007, p. 22). In most formal mentoring relationships, the mentee is assigned to a mentor in the workplace. In contrast, informal relationships develop as the result of mutual interests that are not confined to time, structure, or third party expectations (Ragins & Kram, 2007, p. 34). Operationally, formal and informal mentoring relationship definitions were provided and included a yes/no response for question 15 in the FNP Demographic Survey. If there was a mentoring relationship, the types of mentoring relationships occurring during the first year of FNP practice were selected. The choices included formal, informal, or a combination of formal and informal mentoring relationships.

Mentoring Relationship Functions

Conceptually, mentoring relationships encompass career and psychosocial functions. Mentoring functions are characteristics of formal and informal relationships. Career mentoring functions contribute to mentee career advancement, while psychosocial functions have been associated with friendship and support (Allen & Eby, 2003; Allen et al., 2004). Career functions include mentor coaching, providing opportunities for challenging assignments, and mentee sponsorship. Psychosocial mentor functions include role modeling, friendship, and counseling. Role modeling functions include protégé's observation and emulation of the mentor's behaviors, attitudes, and values. Counseling is reflective of advice and experience sharing between the mentor and mentee. Friendships may evolve as the result of mentor and protégé personal sharing and ar**e** not restricted to formal workplace responsibilities (Kram, 1985).

Operationally, mentoring functions was measured by the MFQ-9*,* a nine item scale that included career, psychosocial functions, and role modeling subscales (see Appendix B). The three subscales included career support, psychosocial support, and role modeling. The FNPs responded to the MFQ-9 concerning one type of mentoring relationship experienced during the first year of primary care practice. The career function subscale was comprised of the first three statements. The psychosocial function subscale was comprised of statements four through six. Role modeling was part of psychosocial functions. The role modeling subscale was comprised of statements seven through nine. Response options ranged from 1 (*strongly disagree)* to 5 (*strongly agree;* Castro et al., 2004). There were three subscale mean and composite score analyses.

Mentoring Relationship Quality

Conceptually, mentorship quality is the perceived level of satisfaction associated with the meaningfulness, benefits, and relationship depth. Mentorship quality is associated with relational effectiveness or success (Hinde, 1981; Kram, 1985). Operationally, mentoring relationship quality was measured by the QMRS (Allen & Eby, 2003; see Appendix B). The FNPs responded to the QMRS concerning one type of mentoring relationship experienced during the first year of primary care practice. This instrument consisted of five items. Response options ranged from 1 (*strongly disagree*) to 6 (*strongly agree*). A composite mean score was analyzed for the instrument.

Organizational Commitment

Conceptually, organizational commitment is defined as the psychological link between an individual FNP and his/her perceptions of the workplace setting. Meyer and Allen (1997) broadened the definition of organization to include multiple workplace settings and revised the original MATCMEC to an 18-item scale (see Appendix B). Operationally, FNPs responded to the MATCMEC*;* response options ranged from 1 (*strongly disagree)* to 7 (*strongly agree)*. Three subscale mean scores were analyzed. The MATCMEC subscale definitions are as follows:

Affective commitment. Conceptually, affective commitment is defined as the employee's emotional attachment to the workplace setting. There is an emotional connection, identification, and involvement with the workplace (Meyer & Allen, 1997). Operationally, affective commitment was measured by a six item affective commitment subscale of the MATCMEC utilizing a 7-point Likert scale.

Continuance commitment. Conceptually, continuance commitment is the "need" component or the gains versus losses of working in the workplace (Meyer & Allen, 1997). The FNP may commit to the organization because he/she perceives a high cost of losing organizational membership. Operationally, continuance commitment was measured by a six item continuance commitment subscale of the revised MATCMEC utilizing a 7-point Likert scale.

Normative commitment. Conceptually, normative commitment is associated with an FNP feeling of obligation to the workplace. It is supported by moral attitudes and personal values. Operationally, normative commitment was measured by a six item normative commitment subscale of the revised MATCMEC utilizing a 7-point Likert scale.

Primary Care Settings

Conceptually, primary care settings are defined as workplace locations where integrated, accessible health care services are provided. Primary care services include well-care, preventive health care, health screenings, education, immunizations, diagnosis, and management of commonly occurring health problems (IOM, 1994). Operationally, primary care settings included outpatient ambulatory care centers, private health care provider practices, outpatient clinics, health care stations, outpatient office settings, retail clinics, employee health clinics, long term care facilities, home care, hospice and palliative outpatient care, occupational health, and urgent care locations. The primary care settings may be private, governmental, profit, nonprofit, or group practice settings (ANCC, 2011; Keough, Stevenson, Martinovich, Young, & Tanabe, 2011). The FNPs

could select one or more workplace settings during the first year of primary care practice; this was determined by question 12 of the FNP Demographic Survey.

Assumptions

1. The FNP participants responded honestly and reflected upon their first year in primary care clinical practice.
2. The mentored FNPs answered the survey questions reflective of their mentoring relationship experiences during their first year of primary practice.
3. The mentor was not the FNP's supervisor.

Chapter Summary

This chapter offered background information concerning the national, political, and educational influences impacting the FNP workforce and primary care delivery. Family nurse practitioners are challenged to incorporate diverse health care provider responsibilities within the first year of practice. The relationships of mentoring and organizational commitment were explored as a foundation to foster FNP transition into primary care practice. The statement of the problem, research purpose, conceptual and operational definitions, assumptions, and research questions were developed to guide the study.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This chapter provides information about the review of literature and synthesis of findings concerning FNP mentoring relationships and organizational commitment. This chapter discusses the following: (a) mentoring relationships, (b) FNP mentoring relationships, (c) organizational commitment and nursing, (d) mentoring relationships and organizational commitment in nursing, and (e) the chapter summary.

A comprehensive literature search was conducted through the University of Nevada, Las Vegas (UNLV) and New York University Health Sciences Library. The electronic data bases of PubMed, CINAHL, PsycInfo, Scopus, ERIC, and ProQuest were searched. Additionally, manual searches were conducted from selected research article reference lists. Nursing literature and English language sources were considered. Search terms included *mentoring, nursing, nurse practitioner, nurse practitioner residency, family nurse practitioner, advanced practice nurse, primary care, and organizational commitment.* The timeframe of 2003 until 2014 was reflective of the most current available information. Older seminal mentoring works were included because of their significant contributions to the study's framework (Brown & Olshansky, 1998; Vance, 1977). Since the focus was FNP mentoring relationships during first year of primary care practice in the U.S., nursing student and faculty-student mentoring studies were excluded from the literature search. No studies were found on nurse practitioner organizational commitment or the impact of mentoring relationships on FNP organizational commitment in primary care settings.

Mentoring Relationships

Mentoring Relationships in Nursing

Historically, mentoring has been used in business, academia, and youth community programs to cultivate novice or less experienced individuals' development (Bozeman & Feeney, 2007; Ragins & Kram, 2007). Yoder (1990) explored the concept of mentoring within the nursing profession. Mentorship is characterized as a relational structure within an organization that focuses on the protégé's career development. Stewart and Kruger (1996) extended Yoder's work and conducted a nursing literature review between the years of 1977 and 1994. An evolutionary concept of mentorship was proposed. Mentorship is a reciprocal teaching-learning process that fosters current and future mentoring relationships. An initial experience differential existed between the participants. As the relationship continued, there were mutual mentor and mentee benefits. Mentoring relationships can continue over several years. Mentorship is considered essential for nurses' professional and personal satisfaction. Mentoring relationships foster professional connections, interpersonal growth, and contributions to the nursing profession. Mentorship has the potential to generate new nursing knowledge and practice innovation.

Informal Mentoring Relationship Functions in Nursing

The earliest located nursing mentorship research was a qualitative dissertation study of 71 nursing leaders by Vance (1977). The author reported that 83% of the participants had one or more mentors during their career. They described mentoring relationships as a foundation for career development and personal achievement. The mentor was viewed as a visionary who "sees the potential which the individual is

frequently unaware" and supports, motivates, and fosters the protégé's success (Vance, 1982, p. 13). Mentorship was described as a relational phenomenon that supports the nursing leaders' career and personal transitions. Mentors were characterized as living role models and examples of professional excellence. Informal mentoring relationships were described as developmental, empowering, and nurturing. Although the researcher did not explore the functions and quality of the mentoring relationships, nursing leaders identified mentorship as being essential for their personal and professional success. This seminal work confirmed the existence and importance of mentorship within the nursing profession.

Formal Mentoring Relationship Functions in Nursing

Allen et al. (2004) conducted a multidisciplinary meta-analysis to examine the career benefits of mentoring in organizational settings. Forty-two selected studies were chosen and included nurses and professional employees. In comparison to non-mentored individuals, protégés were more likely to be committed to their jobs and careers, believe there would be career advancement, and likely to stay in their organizations. Career and psychosocial mentorship functional outcomes were associated with greater protégé compensation, career growth, job satisfaction, retention, and mentoring relationship satisfaction. Career mentoring functions were more highly related to compensation and promotion. Psychosocial mentoring behaviors of role modeling, counseling, and friendship were more highly related to mentorship quality and mentee relational satisfaction. Objective career outcomes had a stronger relationship with career mentoring. Psychosocial mentoring was associated with greater career and job

satisfaction and the intention to stay in the workplace. Formal career and psychosocial mentoring functions contributed to protégé personal and career success.

Formal and Informal Mentoring Relationships in Nursing

Mariani (2012) investigated the effect of mentoring on RN career satisfaction and intent to stay in the nursing profession. A demographic survey and the Mariani Nursing Career Satisfaction scale (MNCSS) were used for data collection. The mailed survey was sent to 722 RNs currently working in the U.S. They were selected regionally from the state boards of nursing lists and were also part of a convenience sample. There was a 27% response rate. Of the total sample, 78.6% reported participation in a mentoring relationship as a mentor or mentee. Forty-one percent of the nurses participated in an informal mentoring relationship. Study findings indicated non-statistical differences in RNs' career satisfaction and intent to stay in the profession between mentored and non-mentored RNs. Study limitations included a low convenience sample response rate, an insufficient subsample of non-mentored nurses, and MNCSS measurement limitations.

Mentoring Relationship Quality in Nursing

In Jakubik's (2007) dissertation research, she explored the relationships among mentorship quality, quantity, and benefits and protégé knowledge, personal growth, protection, and career advancement of 214 hospital pediatric staff nurses. A descriptive correlational survey was conducted. Forty-seven percent of the sample had experienced a mentoring relationship. Formal workplace mentorships comprised 52% of the mentoring relationships. The demographic variables (age, years of nursing experience, years in the current organization, years in the current unit, and years in the current position) were not significantly related to mentoring benefits. Although mentorship quantity and types were

positively correlated to protégé benefits, they were excluded from the multiple regression analysis because of multicollinearity. Mentoring quality was identified as the single best predictor of mentoring benefits. The study was limited to a hospital pediatric nurse convenience sample and a focus on a formal mentoring program. Although informal mentoring relationships were identified, there was no exploration of their impact on pediatric nurses' career and psychosocial development.

Gwyn (2011) investigated the quality of mentoring relationships' impact on the occupational commitment of 133 Floridian nursing faculty. A cross-sectional, correlational internet survey included a demographic survey, the Quality of Mentoring Relationship Scale (QMRS), and Blau's Occupational Commitment instrument. Blau (2003) had extended Meyer and Allen's (1997) organizational commitment model. Occupational commitment encompassed affective and normative commitments, accumulated costs, and limited alternatives. Accumulated costs and limited alternatives were viewed in terms of an individual's performance and consideration of job alternatives. There was a significant relationship between the quality of mentoring and the number of years of faculty employment and affective commitment. High quality mentoring relationships were associated with faculty emotional ties to the workplace and longevity. The quality of the mentoring relationship was not correlated with normative commitment. The other occupational commitment components of accumulated costs and limited alternatives were not investigated. Study limitations included an 11% response rate and small convenience sample size.

Family Nurse Practitioner Mentoring Relationships

Brown and Olshansky (1998) conducted a qualitative study with 35 primary care NPs in Washington that differentiated the stages of transition during the first year of practice. Corbin and Strauss' (2007) grounded theory methodology guided the study. Eleven participants were individually interviewed and 24 NPs participated in focus groups at one, six months, and one year after NP graduation. A theoretical model of the transition to the primary care nurse practitioner role, From Limbo to Legitimacy, was developed from the qualitative data analysis. The first year of primary care was characterized as being tumultuous. The major theoretical stages were described as laying the foundation, launching, meeting the challenge, and broadening the perspective.

Following graduation, NPs described a limbo state of not feeling like a student, yet not being an NP. The NP job search, certification exam completion, and limited recuperation time after NP school graduation were described as challenges. As they transitioned to the second stage of launching, there were greater obstacles such as feeling like an imposter, dealing with anxiety, surviving daily role responsibilities, and not completing tasks during the allotted timeframes. The launching stage was considered the most painful part of the first year of NP practice.

As the NP transitioned into the third stage--meeting the challenge, repeated clinical experiences were described as confidence and competence building. There was a beginning NP acknowledgment of workplace system limitations. The last stage, broadening the perspective, was characterized by the NPs becoming system savvy, affirming their abilities, and challenging themselves with more complex clinical responsibilities. Although the stages of transition were not mutually exclusive or linear,

clinical experience development, disequilibrium, and anxiety were common themes. Role clarity, workplace resources, and support influenced a successful NP primary care practice transition. Upon completion of the first year of NP primary care practice, initial clinical experiences were viewed within the perspective of competency development and the ability to function as a primary care provider.

Barker (2006) described the process of mentoring in advanced practice nursing (APN), clarified definitions, and contrasted successful and problematic mentoring relationships. The author's personal mentoring experiences and a review of nursing mentoring literature were included. Mentoring relationships had different life spans and were characterized by mutual commitment, communication, expertise, and the mentor's ability to guide protégé. A successful mentoring relationship required a time commitment, communication, availability, and compatibility. Mentoring relationships incorporated career and psychosocial functions. Barker suggested strategies to resolve problematic mentoring relationships through communication, terminating the relationship without anger, and considering alternative mentorships. Although Barker differentiated mentoring functions and types, her findings were based on a limited literature search. The recommendations were general and did not necessarily reflect the best evidence on mentoring.

Formal Nurse Practitioner Mentoring Relationships

Sorensen (2010) developed a survey for his Doctor of Nursing Practice (DNP) project to assess the mentoring needs of 155 APNs and 38 physician assistants (PAs) in multiple Minnesota heath care system sites. There was a 71% response rate. One hundred and ten APNs and 25 PA surveys were completed. Mentoring was proposed as a

strategy to foster professional development and job retention. Burn's (2004) Transformational Model guided the study. Seventy-five percent of the respondents identified their willingness to participate in a formal mentoring program. The lack of role specific orientation and time constraints were identified as limiting APN and PA role implementation. Online orientation modules, specific competency assessments, and a formal mentorship program were planned. The U.S. economic downturn and a hiring freeze prevented program implementation. Additionally, the NP role was part of the APN classification and the total number of NPs and their specialties were not reported.

As part of a DNP project, Gerhart (2011) conducted an online mentoring needs assessment of 235 APNs and PAs of North Dakota's Sanford Health Care System. Egan's (2014) Skilled Helper and the Limbo to Legitimac*y* theoretical frameworks guided the study. Mentoring definitions, types, functions, and relationship quality were described. There was a 29% total response rate. Twenty-nine NPs completed the survey. There was a wide range of APN work experience from less than six months to greater than 10 years. Forty-two percent of the respondents indicated that they had experienced a mentoring relationship. Newly hired NPs described the lack of organizational and professional support for role development. They were challenged by clinical and time management skills, balancing work and personal responsibilities, and developing business acumen. A mentoring needs assessment was completed as a foundation for a formal mentoring program for NPs, PAs, Certified Registered Nurse Anesthetists, and Clinical Nurse Specialists. Technical email survey issues contributed to the low response rate. Even though respondents indicated a willingness to participate in the formal pilot

mentoring program, only one mentor-mentee match was completed at the time of the project publication.

Pop (2011) used Corbin and Strauss' (2007) grounded theoretical approach to create a model for mentoring NPs in a hospital setting. Pop's dissertation sample consisted of 16 pediatric nurse practitioners--eight mentors and eight mentees--who participated in an 18-month orientation program at a university-affiliated medical center in Texas. The author developed an interview guide and utilized a systematic method of qualitative analysis that resulted in the Mentoring NPs in a Hospital Setting Model. The model components were forming a relationship, developing a relationship, and outcomes. Mentoring relationship formation incorporated the themes of getting to know each other and identifying mutual participant needs. The mentoring relationship characteristics were described as defining the NP role, identifying a career path, finding a balance between work and life, and continuing on the relationship journey. Nurse practitioner mentorship outcome themes highlighted the importance of mentoring relationship satisfaction, successful role transition, professional and personal growth, and possible friendship formation. The study themes were described as a means to guide a formal NP mentoring program development in hospital settings.

Organizational Commitment

Organizational Commitment in Nursing

The concept of organizational commitment has recently attracted attention in the nursing literature. Organizational commitment is the psychological link between an individual and the workplace (Meyer & Allen, 1997). It is characterized by affective, normative, and continuance commitment components. Affective commitment is defined

as the employee's emotional attachment to the workplace setting. Continuance commitment is the perceived "need" component or the gains versus losses of working in the workplace (Meyer, Irving, & Allen, 1998). Normative commitment is associated with an individual's feeling of obligation to the workplace. It is supported by moral attitudes and personal values (Meyer & Allen, 1997). There were no NP organizational commitment studies in the literature. The review of the literature is inclusive of organizational commitment in nursing as a foundation for FNP organizational commitment knowledge generation.

Registered Professional Nurses' Organizational Commitment

Liou (2008) used Walker and Avant's (2010) technique to describe a concept analysis of RNs' organizational commitment. Mutual interaction among employees and organizations provided a foundation for individual and collective goal achievement. Liou defined organizational commitment characteristics: employee psychological attachment, dynamic interactive processes, willingness to contribute to workplace goals, and the individual's attitude toward the organization. Antecedents of organizational commitment included employee personal and job characteristics, work influences, and experiences. Nurses' empowerment was an important antecedent that provided a foundation for an organizationally committed workforce. Outcomes were described as improved employee attendance, job performance, and retention rates. Although job satisfaction was a related concept, organizational commitment was a broader concept of employee identification and attachment with the workplace.

Brewer et al. (2011) studied predictors of turnover in newly licensed registered nurses (NLRN) in an U.S. national survey. The study population was a subset of a larger

10-year longitudinal study. Surveys were mailed to 1,653 NLRNs twice, one year apart, during 2006-2007. Organizational commitment and job satisfaction were factors included in the analysis. Self-report scales examined job satisfaction, organizational commitment, job search, and intent to stay in the organization. Less than a quarter of the respondents reported participating in a formal internship, mentoring, or residency program. At the time of the second survey, 15% of the NLRNs had changed jobs. When intent to stay was omitted from the regression model, job satisfaction ($p = 0.001$) and organizational commitment ($p = 0.046$) were statistically significant predictors of turnover. Findings could be used with confidence as this national study incorporated strong design methodology. However, the study was limited to NLRNs working in hospitals and was not generalizable to other workplace settings.

Bratt (2012) investigated the influence of personal characteristics, job onboarding factors, and work environment on organizational commitment in new graduate RNs. She conducted a longitudinal correlational study with 16 cohorts of NLRNs over three years (2005-2008). The sample included 468 NLRNs who participated in a 12-month nurse residency program in 40 Midwestern hospitals. Data were collected when each cohort started the program, at six months, and at the one year program completion. Bratt used the Nursing Job Satisfaction scale, Job Stress scale, Clinical Decision Making in Nursing scale, the Modified-D Scale of Nursing Performance, and the Organizational Commitment Questionnaire.

Study findings indicated that personal characteristics of age, gender, race, nursing degree, and experience with a preceptor were not significant in predicting organizational commitment. The job characteristics of attaining a desired position, orientation

objectives achievement, and the hospital setting (urban, nonurban, or rural) explained 13% of the organizational commitment variance. Work experience variables explained 31% of the organizational commitment variance. The hospital setting, the nurse's desired position, personal enjoyment, physical environment, and staffing were found to be significant, explaining 40% of organizational commitment variance. At six months, work experience was significant and explained 30% of the nurses' organizational commitment variance.

Nursing Faculty Organizational Commitment

Gromley and Kennerly (2010) examined the influence of organizational climate and nursing faculty work role on organizational commitment in American university settings. The Multidimensional Model for Organizational Commitment guided the study. The sample was full-time tenure track, doctoral-prepared nursing faculty who were employed in U.S. private and public universities. Forty-five of the 81 contacted schools agreed to participate (a 55% response rate). Three hundred and sixteen nursing faculty participated in the online questionnaire. There were significant differences among teaching work role, role ambiguity, role conflict, and organizational commitment. Pearson correlational analyses yielded a moderately negative relationship between role ambiguity and role conflict and affective and continuance commitment. Role ambiguity, role conflict, and work expectations were associated with nursing faculty role strain.

Gutierrez, Candela, and Carver (2012) examined the relationships among organizational commitment, perceived organizational support, work values, person-organization fit, developmental experiences, and global job satisfaction in nursing faculty in the U.S. Participants completed a survey consisting of a 14-item author-developed

demographic tool, the MATCMEC, the Work Values Inventory, the Perceived Organization Support scale, the Perceived Person-Organization Fit scale, the Developmental Experiences Tool, and the Global Job Satisfaction instrument. The researchers used structural equation modeling (SEM) to analyze relationships among the constructs. The final model demonstrated that perceived organizational support, developmental experiences, person-organization fit, and global job satisfaction predicted nursing faculty organizational commitment. Cross-validation results indicated that the full SEM was valid and reliable.

This study showed that 40% of the nursing faculty indicated the presence of a current mentoring relationship. Normative commitment, developmental experiences, and global job satisfaction explained 82% of the variance in affective commitment. Perceived organizational fit and perceived person-organization fit explained 56% of the variance in normative commitment. Developmental experiences accounted for 27% of the variance in work values. There was a 64% variance in person-organization fit that accounted for perceived organizational fit and global job satisfaction. Perceived organizational fit and person-organization fit accounted for 49% variance in developmental experiences. The final SEM was considered an excellent fit to present the data. The continuance commitment scale did not perform well and was removed. The model was evaluated for fit with other nursing faculty using a cross-validation sample of 570 U.S. nursing faculty members. Both the full and cross-validated models were very reliable.

Mentoring Relationships and Organizational Commitment in Nursing

Most of the nursing literature on mentoring consisted of anecdotal reports, pilot studies, and limited literature reviews (Greene & Puetzer, 2002; Harrington, 2011; Tourigny & Pulich, 2005). Mentoring nursing research has focused on participant perceptions, career satisfaction, and job retention but and has been limited in workplace outcome evaluation (Gutierrez et al., 2012; Jakubik, 2007; Mariani, 2012). There were several research reports of formal nursing mentorship programs but they were limited to convenience RN and NP samples in acute care settings (Jakubik, 2007; Pop, 2011; Sorensen, 2010). Informal mentoring relationships have been occurring but no studies explored informal mentoring relationships' impact on nurses' organizational commitment (Jakubik, 2007; Mariani, 2012; Vance, 1977).

Informal and formal career and psychosocial, mentoring functions were associated with protégé personal, job and career satisfaction, and job retention (Allen et al., 2004). Nursing research identified that nurses engaged in both formal and informal mentoring relationships (Mariani, 2012; Vance, 1977). Although, mentoring relationship functional outcomes were discussed, no nursing studies addressed the impact of mentoring types, quality, and career and psychosocial functions' impact on FNP organizational commitment in primary care settings.

Mentoring has been proposed as a strategy to promote RN and nursing faculty job satisfaction, organizational commitment, and job retention (Bratt, 2012). The importance of mentoring quality and relational effectiveness has been supported in nursing research. Although mentorship quality was a significant influence, this finding was limited to a doctoral dissertation with pediatric nurses and nursing faculty (Jakubik, 2007; Mariani,

2012). The NP mentoring literature concentrated on mentoring needs assessment, formal mentoring program proposals, and concept clarification (Gerhart, 2011; Pop, 2011; Sorensen, 2010).

The majority of NP mentoring studies lacked scientific rigor, program implementation, and evaluation (Gerhart, 2011; Pop, 2011; Sorensen, 2010). The FNP population was difficult to identify in the NP mentoring studies and the focus was acute care settings (Gerhart, 2011; Pop, 2011; Sorensen, 2010). No studies concerned FNP mentoring functions, types, and quality relationships' impact on organizational commitment in primary care settings. Qualitative research confirmed the difficulties experienced by newly hired NPs in primary care settings. Mentoring was proposed as a strategy to support newly hired NPs during role transition, competence development, and assumption of health care provider responsibilities (Brown & Olshansky, 1998).

The nursing organizational commitment literature was comprised of concept analysis, RN retention, and turnover (Brewer et al., 2011; Liou, 2008). Nursing faculty studies highlighted the complexity of organizational commitment relationships (Gromley & Kennerly, 2010; Gutierrez et al., 2012). Both studies reinforced the importance of fostering positive work experiences through mentoring relationships. Mentoring strategies were proposed to promote nursing faculty and nurses' normative and affective commitment (Gutierrez et al., 2012). Although these findings have important implications for nurses' mentoring and organizational commitment development, generalizations to FNPs in primary care settings are limited. The investigation of mentoring relationships' impact on FNP organizational commitment provided a multidimensional analysis and guided the study design.

Chapter Summary

This chapter presented the current state of knowledge regarding mentoring relationships and organizational commitment among RNs, nursing faculty, and NPs in the U.S. A synthesis of the nursing literature identified a lack of scientific rigor, a focus on mentoring concept clarification, and NP mentoring needs assessment. Although mentoring and organizational commitment nursing studies were discussed, no research linked FNP mentoring relationships' impact on organizational commitment in primary care settings.

CHAPTER III

CONCEPTUAL FRAMEWORK

Introduction

The theoretical frameworks that guided this study were Kram's (1985) mentoring theory and Meyer and Allen's (1997) organizational commitment model. This chapter describes the theoretical frameworks and includes (a) mentoring theory, (b) mentoring theory and nursing, (c) organizational commitment theory, (d) organizational commitment theory and nursing, (e) the FNP Mentoring Relationships and Organizational Commitment Model, (f) research questions, and (g) the chapter summary.

Mentoring Theory

Social exchange theory is the foundation for mentorship. Mentoring relationships are reflective of the theoretical assumptions of participants' perceptions of goals, costs, and rewards (Huston & Burgess, 1979). Individuals grow, develop, and maintain mentoring relationships that are reciprocal, communicative, and mutually beneficial (Cropanzano & Mitchell, 2005; Huston & Burgess, 1979). Mentorship has been used in business, educational, and community settings to promote inexperienced individuals' growth and development (Bozeman & Feeney, 2007; Ragins & Kram, 2007; Sosik, Lee, & Bouquillon, 2005). Mentorships are unique in duration, intensity, and outcomes (Kram, 1985). Reciprocity, commitment, costs, benefits, and mutuality are integrated into mentoring relationships. Mentoring relationships evolve through the phases of initiation, cultivation, separation, and redefinition (Cropanzano & Mitchell, 2005; Huston & Burgess, 1979; Kram, 1985).

Mentoring Functions

Mentoring functions support protégé role identification and competency development (Allen & Eby, 2003; Allen et al., 2004; Wanberg, Welsh, & Hezlett, 2003). Career mentoring functions include coaching, assigning challenging projects, mentee sponsorship, and protection (Kram, 1985). Psychosocial mentoring functions include role modeling, friendship, and counseling. Psychosocial mentoring functions represent a deeper and more intense aspect of the mentoring relationship (Allen et al., 2004). Role modeling provides opportunities for the protégé to observe and assume effective mentor behaviors. Friendship and counseling support mentee personal growth, intimacy, trust, and self-efficacy.

Career functions are a stronger predictor of protégé compensation and advancement, while psychosocial functions have stronger associations with protégé mentoring relationship satisfaction and personal fulfillment (Allen & Eby, 2003; Allen et al., 2004; Wanberg et al., 2003). Kram (1985) has proposed that diverse and multiple mentoring relationship functions support protégé success. Mentoring relationship functions have contributed to job satisfaction, workforce retention**,** career advancement, and organizational commitment (Aryee & Chay, 1994; Chao, 1997; Kram, 1985; Noe, 2002).

Mentoring Relationship Types

Mentorship has been categorized into formal and informal relationship types. Kram (1985) integrated mentoring concepts and focused on formal workplace mentoring relationship development. A mentoring dyad is comprised of a more experienced person (the mentor) sharing advice and experience with a mentee (Aleshire & Wheeler, 2012).

Workplace mentoring relationships foster a sense of belonging and employee role identification with organizational goals. A formal mentorship is usually part of a workplace orientation program. Formal mentoring programs have been developed to foster new employee onboarding and role transition within the first year of employment (Sosik et al., 2005; Wanberg et al., 2003).

Formal mentorship programs involve mentor-mentee matching, role transition strategies, socialization, learning, and leadership development. Formal mentorship goals have been associated with organizational commitment development, job retention, and improved mentee performance (Aryee & Chay, 1994; Chao, 1997). Although formal mentoring relationships are time specific, they may continue and develop into friendship-based informal relationships (Kram, 1985).

Informal mentoring relationships evolve from participants' mutual interests and are not confined to time, structure, workplace, or third party expectations (Goudreau et al., 2011; Greene & Puetzer, 2002; Harrington, 2011; Hayes & Kalmakis, 2007; Kram, 1985; Lee & Fitzgerald, 2008; Ragins & Kram, 2007; Tourigny & Pulich, 2005). Informal mentorships **s**upport participants' personal, career, job, and role transitions (Chao, 1997; Kram, 1985). An individual may have a combination of formal and informal mentorships during a career. Formal and informal mentoring relationships may be initiated differently but have similar career and psychosocial outcomes (Fagenson-Eland et al., 1997; Kram, 1985; Sosik et al., 2005).

Mentoring Relationship Quality

Mentoring relational quality is reflective of the participants' effort and sustainability (Hinde, 1981; Huston & Burgess, 1979). Mentoring quality is a dimension

of both formal and informal relationships. High quality mentoring relationships are characterized by reciprocity, relatedness, interdependency, and mutuality (Hinde, 1981; Huston & Burgess, 1979). Mentorships may vary greatly in terms of quality and depth, suggesting that higher quality relationships are the basis for more effective relationships (Kram, 1985). Mentoring effectiveness can be evaluated by mutual mentor-protégé benefits, satisfaction, and relationship quality assessment (Allen & Eby, 2003). Mentoring relationship quality has been associated with career and psychosocial goal achievement. It also has been evaluated in terms of protégé personal and career success, job retention, and contributions to the workplace (Allen & Eby, 2003; Fagenson-Eland et al., 1997; Jakubik, 2007).

Mentoring Theory and Nursing

In nursing, mentoring has incorporated relationship functions, types, and quality with an emphasis on teaching-learning processes, professional development, and socialization (Bozeman & Feeney, 2007). Antecedents include the participants' altruism, integrity, knowledge, and time. Consequences include empowerment, institutional stability, and professional socialization. Nursing mentorship has been proposed as a strategy to foster professional generativity (Bozeman & Feeney, 2007; Stewart & Krueger, 1996; Yoder, 1990). High quality nursing mentorships provide the foundation for current and future mentoring relationship development (Gwyn, 2011). Mentoring relationships have the potential to support personal and nursing role development. Although NP role development was not been specifically addressed, mentoring functions, types, and quality have implications for FNP mentoring relationship development.

Mentorship has the potential to support newly hired FNPs during their transition into primary care settings**.**

Organizational Commitment Theory

Social Exchange Theory

Social exchange theory has contributed to organizational commitment theoretical development (Cropanzano & Mitchell, 2005; Gutierrez et al., 2012; Liou, 2008). Workplace-employee relationships develop through mutual exchanges and goal achievement. The employee-workplace relationship is a dynamic, interactive process. As long as the relationship remains mutually satisfying, the employee-workplace relationship will continue. Therefore, understanding the nature of organizational commitment through the lens of social exchange theory would shed light on the FNP organizational commitment in primary care settings.

Organizational commitment is defined as the individual's identification and involvement with workplace goals and values (Liou, 2008; Rhoades & Eisenberger, 2002; Riketta, 2002). Organizational commitment is broader and more complex than job satisfaction and separate from career commitment (Fletcher & Williams, 1996). Job satisfaction is associated with daily role fulfillment. Career commitment may transcend the workplace and include personal and professional life experiences (Liou, 2008; Robinson, Krantz, & Rousseau, 1994). Essential organizational commitment characteristics include a professional connection with the workplace, interaction, progression, and the readiness to contribute to organizational goals. Organizationally committed professionals are able to maintain performance in diverse conditions and

develop allegiances that achieve outcomes (Coyle-Shapiro & Shore, 2007; Klein, Becker, & Meyer, 2009; Liou, 2008).

Meyer and Allen's Three Component Model of Organizational Commitment

Meyer and Allen (1997) synthesized definitions and concepts of commitment within the workplace and constructed the Three Component Model of Organizational Commitment. Organizational commitment is a multidimensional construct that is reflective of a psychological state linking the employee to the workplace (Meyer & Allen, 1997). Employee socialization and relationships have the potential to influence work behaviors, roles, and dedication to the workplace (Gutierrez et al., 2012; Liou, 2008; Meyer et al., 1998; Rhoades & Eisenberger, 2002). The employee-workplace interaction fosters affective, normative, and continuance components of organizational commitment. Affective commitment is reflective of employees who are emotionally attached and motivated to perform their best. Normative commitment is reflective of employees who feel they ought to stay within the organization because they are obligated or morally bound. Employees may stay in their current position because the increased costs associated with leaving the job are characteristic of continuance commitment (Liou, 2008; Meyer, Stanley, Herscovitch, & Topolnysky, 2002).

Affective commitment antecedents include employee and workplace interactions. The workplace fosters employee self-esteem, affiliation, and positive work experiences through programs that facilitate role transition (Rhoades, Eisenberger, & Armeli, 2001). Consequences include decreased employee work stress, increased job satisfaction, job involvement, and work-family balance (Klein et al., 2009; Meyer & Allen, 1997). Affective commitment has been associated with decreased turnover, less absenteeism,

and increased productivity (Klein, et al., 2009; Meyer & Allen, 1997). In addition, affective commitment is reflective of employee role satisfaction, engagement, and workplace outcome achievement (Meyer & Allen, 1997). Affective commitment has also been positively associated with job satisfaction, employee productivity, occupational performance, and a positive organizational culture (Meyer et al., 2002; Rhoades et al., 2001; Riketta, 2002).

Normative commitment antecedents include pre-employment personal, social, and professional experiences. Normative commitment is influenced by early employee socialization experiences that internalize moral attitudes and behaviors (Meyer & Allen, 1997; Meyer et al., 2002). There is a psychological contract between the employee and organization that is supported by mutual obligations and responsibilities (Meyer & Allen, 1997, p. 62). Normative commitment is viewed positively but is less powerful than affective commitment (Manion, 2001). Robinson et al. (1994) observed that organizational affective and continuance commitment did not directly incorporate the role of obligations, reciprocity, and fulfillment that is associated with normative commitment. Thus, normative commitment may be the missing link in our understanding of psychological contracts and employee moral obligations.

Continuance commitment antecedents include employee perceptions of their investments and alternatives. Investments are characterized by potential benefits loss associated with job changes. Continuance commitment has been related to workplace longevity, salary, and job benefits. Employee perceptions of external job opportunities are considered alternatives (Aryee & Chay, 1994; Liou, 2008). Continuance commitment consequences are associated with job performance outcomes. Past research studies have

proposed that individuals with elevated affective commitment are able to transcend adversities and actively engage in the workplace. In contrast, individuals with elevated continuance commitment might exert minimum effort to complete tasks and job responsibilities (Laschinger, Finegan, & Shamian, 2001). Although individuals with strong continuance commitment are unlikely to leave the workplace, there is a potential loss of employee engagement, job satisfaction, and self-esteem (Meyer & Allen, 1997).

Organizational Commitment Theory and Nursing

Nursing has incorporated organizational commitment theoretical constructs into the workplace. Initial work experiences and relationships influence the development of nurses' organizational commitment (Liou, 2008; Manion, 2001). Formal nursing orientation and residency programs have targeted job retention, turnover, and role engagement (Bratt, 2012; Gromley & Kennerly, 2010; Kuokkanen, Leino-Kilpi, & Katafisto, 2003; McNeese-Smith, 2001). An organizationally committed nursing workforce will persist during times of adversity and develop strategies to achieve workplace goals (Meyer et al., 2002). Although there have been RN and nursing faculty mentoring studies, no research has explored mentoring presence, types, function, and relationship quality on FNP organizational commitment in primary care settings. An integrated model of these relationships is reflective of new knowledge generation that incorporates FNP mentoring relationships' impact on organizational commitment in primary settings.

The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model

Mentoring was a core concept of the newly developed conceptual model entitled The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model. A representation of the study concepts and their relationships is presented in Figure 1. Mentoring characteristics of function, type, and quality were explored in relationship to the three components of organizational commitment. The research study model linked FNP mentoring relationships' impact on affective, normative, and continuance organizational commitment concepts. While these relationships have been investigated separately, they have not been examined in an interactive model. The model is reflective of FNP organizational commitment relationships and mentoring presence, types, functions, and quality. The model's concepts and relationship predictions generated new knowledge development and identified the best mentoring relationship predictors that enhance FNP organizational commitment in primary care practice.

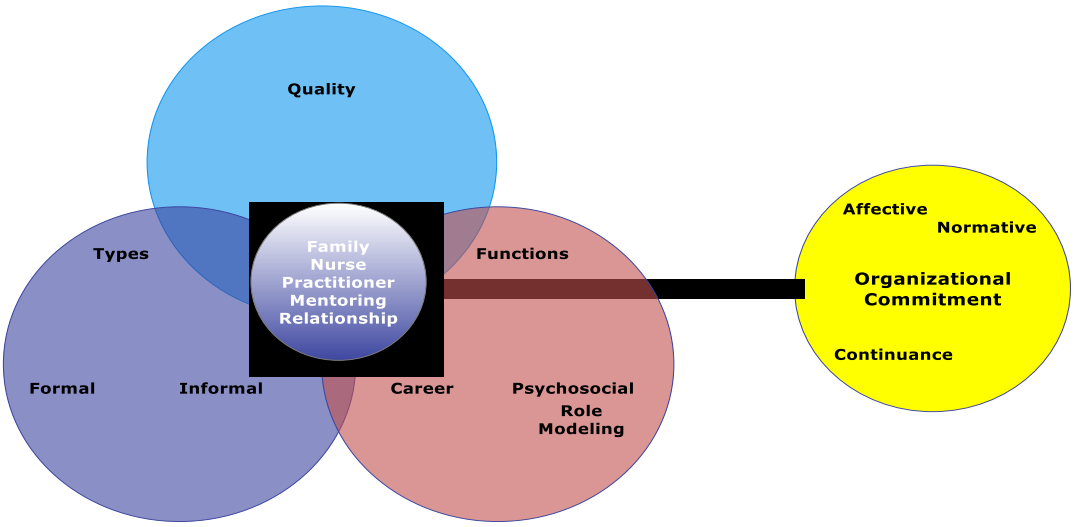

Figure 1. The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model.

Research Questions

The following research questions were derived from organizational commitment and mentoring theoretical constructs and the Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model.

1. Are there any differences in organizational commitment between mentored and non-mentored FNPs?
2. Are there any differences in FNP organizational commitment across formal, informal, and a combination of both formal and informal mentoring types?
3. Are there any differences in FNP organizational commitment across mentoring career, psychosocial, and role modeling functions?
4. What is the relationship between the mentoring relationship quality and FNP organizational commitment?

Chapter Summary

This chapter summarized social exchange theoretical assumptions that support mentoring relationships and organizational commitment development. Mentorship has been associated with mutual exchange, reciprocity, and communication between an experienced and a newly employed professional. Mentoring career, psychosocial, and role modeling functions can occur within formal and informal relationships. Additionally, mentorship quality has been associated with relationship effectiveness and workplace outcomes achievement. Organizational commitment is characterized by employee and workplace policies, relationships, and support. Organizationally committed professionals are able to advance workplace goals that are reflective of their moral and emotional bonds to the workplace.

The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model incorporated the concepts of Kram's (1985) mentoring and Meyer and Allen's (1997) organizational commitment theories. The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model was developed to explore the impact of FNP mentoring relationship presence, types, quality, and functions on organizational commitment in primary care settings. Research questions were derived from the theoretical constructs of organizational commitment and mentoring theories and the conceptual model.

CHAPTER IV

METHODOLOGY

Introduction

This chapter provides information about the methods utilized in this study and discusses the following sections: (a) research design, (b) population and sample, (c) measures and instrumentation, (d) ethical considerations, (e) data collection procedures, (f) statistical analysis methods, (g) study limitations, and (h) chapter summary.

Research Design

The study is a national cross-sectional FNP survey of AANP members regarding their perceptions of mentoring relationships and organizational commitment during their first year of primary care practice. A national sampling strategy was used as a means to represent FNP practice in the U.S. A sample of 1,500 FNPs was stratified by geographical region and randomly selected from the AANP member opt-in mailing database. The five U.S. geographical region selections (see Appendix C) were guided by the 2011 ANCC FNP Role Delineation Study. Stratified sampling provided appropriate representation of different segments of the population (Polit & Beck, 2004).

Design Strengths

Cross-sectional designs are advantageous because they are economical--both in terms of time and cost (Polit & Beck, 2004). Cross-sectional studies provide a practical method to build a research base in a timely manner (Houser, 2008). Since potential relationships among the study variables have not been compared in prior research, the descriptive, cross-sectional design was appropriate for this study. Since this was a one-step survey, there was no risk of attrition. A modified Total Dillman method (TDM) was

used. This multiple survey approach was selected to promote a large survey response rate, timeliness, and to minimize errors associated with a single survey method (Dillman, Smyth, & Christian, 2009). All potential participants received a postal invitation and had a choice of mailing the prepaid return paper survey or using a SurveyMonkey link to complete an online survey. One postal mail reminder was sent to the potential participants during the month of the study to promote the maximum response rate (Dillman et al., 2009).

Design Weaknesses

The study concepts changed over time. This cross-sectional design was designed to assess the variables at one point within a month timeframe. Since data were collected once, causality of the relationships could not be determined (Polit & Beck, 2004). Additionally, low survey responses and respondent self-selection bias might have influenced sample analysis and findings generalizability (Cook, Heath, & Thompson, 2000). Moreover, although respondents had a choice of an online or postal mail option, nonresponse survey rates might have limited the study generalizability to the FNP population. Cho, Johnson, and VanGeest (2013) reported an average 40% response rate with a mixed mode survey approach in their meta-analysis. The participant response rate increased to 57% with one follow-up reminder. This study incorporated a postal mail reminder to encourage FNP participation in the study with the choice of online or postal options. Although Dillman et al. (2009) utilized a monetary incentive to encourage a response rate, this was not included because of increased study costs and ethical concerns surrounding NP receiving financial incentives. The sampling response rate was calculated and non-parametric analysis was considered if the sample response did not

meet the criterion for parametric analysis. The instruments were self-report surveys and responses might have been influenced by FNP recall of their first year primary care clinical experiences.

Population and Sample

The target population for the study was FNPs who were working in primary care settings in the U.S. A total of 18,141 AANP members were eligible for the study and constituted the sampling frame (L. Riley, personal communication, February 2, 2014). The 2011 FNP Role Delineation study (ANCC, 2011) provided the most current demographics (see Appendix C). A 38% majority of FNPs worked in a private practice setting with an average of 21 years of RN experience. Sixty percent of the FNPs were 45-64 years old, 90% were female, and 87% were White. National FNP educational preparation included 84% with master's degrees, 11% with a post-master's FNP certificate, 3% with DNPs, and 2% with doctorates (Ph.D., DNS). Forty-four percent of the FNPs had been practicing from zero to nine years (ANCC, 2011).

The AANP and ANCC (2013) have national FNP certification programs. The AANP Certification Program (AANPCP; 2014) provides opportunities for FNP national certification. The ANCC, a subsidiary of the American Nurses Association (ANA), administers another FNP national certification program. The goal is to promote nursing excellence with national NP specialty practice certification (AANPCP, 2014; ANCC, 2013). An FNP must be either certified by AANPCP and/or ANCC to practice in 47 of the 50 states. The FNP certification requirements include (a) a current active RN license in the United States; (b) a master's, postgraduate, or doctoral degree from a FNP program accredited by the Commission on Collegiate Nursing Education or the National League

for Nursing Accrediting Commission; and (c) faculty supervised clinical hours in the FNP academic program. Family nurse practitioner educational preparation includes content in health promotion, maintenance, differential diagnosis ability, disease management, and prescription of pharmacological and non-pharmacological interventions (ANCC, 2013).

Ninety percent of the NPs credentialed to practice in the U.S. are actively practicing. Only California, Kansas, and Indiana do not require national NP certification for practice (National Council of the State Boards of Nursing [NCSBN], 2012). Therefore, certified FNPs working in primary care settings would be reflective of contemporary clinical practice. The study included FNPs who had completed their first year of primary care practice and may have experienced a mentoring relationship.

Sampling Procedures

The sample was selected from the AANP national NP member directory. The FNP database was for purchase with a minimum of 1,500 randomly selected names from the AANP opt-in mailing list. There was stratified random sampling from the five U.S. geographical regions (Polit & Beck, 2004): the Northeast, South, Midwest, West, and other U. S. regions (see Appendix C). The geographical selection was guided by the 2011 ANCC FNP Role Delineation Study. Random selection was completed by AANP staff and was purchased by the investigator.

The 1,500 FNP sampling plan exceeded the sampling size estimation. "Stratified sampling will guarantee the appropriate representation of different segments of the population" (Polit & Beck, 2004, p. 297). Additionally, a large sample size would accommodate a possible non-response rate and unusable returned surveys (Van Vorrhis

& Morgan, 2007). Large sample sizes were desirable to avoid Type II error because the data were more likely to be normally distributed (Houser, 2008).

The sample inclusion criteria included (a) an earned master's, post-masters, or doctorate in nursing with FNP preparation; (b) full-time employment as a FNP in a primary care setting; (c) licensed as a FNP in at least one state; (d) a postal address; (e) internet access for the online survey option; (f) FNP certification by AANPCP or ANCC (no multiple NP specialties); and (g) a prior agreement for opt-in AANP member list inclusion**.**

Sampling Calculation

Sampling size was determined by an online calculator--G Power (Softpedia, 2013). The current study included biserial, multiple linear regression, and MANOVA. Assuming a medium effect size ($f = .15$), a confidence interval of 95% ($\alpha = .050$), and a power of .80, multiple regression analysis required 127 participants to achieve empirical validity. Since the study sample was 1,500 FNPs, minimal sampling requirements were achieved. The anticipated 40% sampling response was projected to be 600 participants (Cook et al., 2000).

Measures and Instrumentation

The dependent variable (DV) was FNP organizational commitment; it was measured by the MATCMEC affective, continuance, and normative subscale mean scores (Meyer & Allen, 1997). The MATCMEC is a self-report instrument that measured FNP perceptions of the workplace. It is comprised of 18 items with a 7-point Likert scale. The minimum score is 18 and the maximum score is 126 (see Appendix B). The subscale mean scores were calculated in the analysis. Three affective

commitment scale statements and one normative commitment scale statement were reversed coded for the analysis according to the instrument's scoring directions (Meyer & Allen, 1997). The MATCMEC comparative fix index (CFI) = .91 indicated a good model fit. Cronbach's alpha for the affective, continuance, and normative scales were .85, .79, and .73, respectively, and demonstrated reliability and validity (Meyer et al., 1998).

The independent variables (IVs) for this study were FNP mentoring relationship function, types, and quality, respectively. Mentorship presence was selected by the respondent as either yes (dummy coded 1) or no (dummy coded 0). Mentorship function was measured by the MFQ-9. Mentoring type was categorized as formal as the reference variable and dummy coding for informal (yes=1 and no =0), or a combination of formal and informal mentorships (yes =1 and no =0). Mentorship quality was measured by the QMRS composite score. The FNP Demographic Survey was completed by all respondents and was summarized with descriptive statistics. The FNP demographic variables included the continuous variables of age, the number of years working as a FNP, and the number of years of RN clinical experience prior to becoming a FNP. The discrete variables of gender (dummy coded one as female and zero as other); ethnicity (dummy coded White = one and zero for the other choices); marital status (dummy coded one versus zero for the other); FNP academic preparation (dummy coded one for masters versus zero for other); and working in a primary setting during the first year of practice, primary care workplace setting**,** and the presence of a mentoring relationship type (dummy coded as one for presence and zero for none) were included in the analysis. The principal investigator designed the FNP Demographic Survey. The

primary care workplace was defined as the setting during the FNP's first year of clinical practice. Respondents could select one or multiple workplace settings. If the FNP did not work in a primary care setting, the results were eliminated from the analysis.

The FNPs were able to select the option of having a mentoring relationship during the first year of primary care practice. If there was a mentoring relationship, the job title of the mentor and the type of mentoring relationship were identified and summarized with descriptive statistics. The survey was derived from the review of the literature, the study's conceptual model, and expert review of the dissertation committee (see Appendix B).

The IV mentoring relationship functions were measured by the career, psychosocial, and role modeling subscale mean scores of the MFQ-9 (Castro et al., 2004). Although Kram (1985) originally proposed the two dimensions of career and psychosocial support, role modeling was considered a sub-dimension of psychosocial functions. The MFQ-9 is a self-report instrument measuring mentored FNP perceptions of career, psychosocial, and role modeling functions of a mentoring relationship. It is a 9-item refined instrument from the original 15-item instrument. The response format is a 5-point Likert scale, ranging in responses from 1 (*strongly disagree*) to 5 (*strongly agree*). The total score range is 9 to 45 (see Appendix B). The higher score is indicative of greater mentoring functions. Conversely, lower scores are indicative of less mentoring functions. The subscale mean scores were calculated in the analysis. The MFQ-9 was developed by factor analysis and content expert review. Three separate studies were conducted to validate the MFQ-9 (Castro et al., 2004). Experts reviewed theoretical construct definitions, factor loadings, and content adequacy. The MFQ-9

Cronbach's alpha was .91. The three-dimensional hypothesized model fit the best. The chi-square statistic was statistically significant, ($x^2 = 79.3$, $df = 24$, $p < .001$). Subscale reliability for career support was .82, psychosocial was .85, and role modeling was .82. Item to total correlations for all three scale items ranged from .62 to 78. Factor loadings were statistically significant ($p < .01$) with a range of .69-.89 and an average factor loading of .79. The MFQ-9 was considered to be valid, reliable, and recommended for use in research.

Mentorship types were selected by the mentored FNPs. Formal and informal mentoring relationship definitions were provided and included a yes/no response for question 15 in the FNP Demographic Survey. Formal mentorships were structured workplace agreements (Ragins & Kram, 2007, p. 22). Informal mentorships were defined as relationships of mutual interests and friendship. They were not confined to specific timeframes or the workplace (Ragins & Kram, 2007, p. 34). If there was a mentoring relationship, the types of mentoring relationships were selected. The choices included formal, informal, or a combination of formal and informal mentoring relationships. Mentored FNPs continued and responded to the MFQ-9 and the QMRS that were reflective of one selected formal or informal mentoring relationship.

Mentoring relationship quality was measured by the summary mean score of the QMRS (Allen & Eby, 2003). The QMRS is a five-item self-report instrument that measured mentored FNP perceptions of their relationship quality during their first year of primary care practice. Participants responded to statements regarding the effectiveness and their satisfaction with the mentoring relationship. The response format was a Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The

responses were summed to yield a composite score. The minimum score was 5 and the maximum score was 30 (see Appendix B). Higher composite scores were indicative of a perceived higher quality mentoring relationship. Lower composite scores were indicative of a lower quality mentoring relationship.

Allen and Eby (2003) examined the QMRS stability, consistency, dependability, and homogeneity. The Cronbach's alpha was .88, which was indicative of good reliability. Allen and Eby established construct validity. Confirmatory factor analysis included five goodness-of-fit indices. Statistical factor analysis results included "chi-square (df, 34) = 193.82, $p < .05$, root mean residual (RMSR) = .04; normed-fit index (NFI) =.91; and (CFI) =.92. All items loaded significantly onto their respective constructs" (Allen & Eby, 2003, p. 477). The QMRS demonstrated reliability and validity.

Ethical Considerations

The principal investigator completed all required University of Nevada, Las Vegas (UNLV; 2012) research and human subject protection training prior to any research activities. Once approval to conduct the research study was obtained from the Institutional Review Board (IRB) at UNLV (see Appendix D), the pilot study and data collection procedures began. The investigator emailed the New York State Nurse Practitioner Association (NYSNPA) concerning the pilot study (see Appendix F). The pilot study invitation letter, with a Flesch-Kincaid (Flesch & Kincaid, 2013) reading level of 10th grade, included an explanation of the intent, definition of terms, informed consent, and process for survey completion. A Flesch-Kincaid reading level of 10th grade was appropriate since all participants completed graduate nursing education (Flesch &

Kincaid, 2013). The survey participation consent form was provided. An online "Exit this survey" option was provided so the participant was able to exit SurveyMonkey at any time. Participant submission of the online or postal survey constituted consent for participation, data collection, and publication.

The research study survey was initiated by a postal letter invitation with the choice of a postal or online SurveyMonkey response option (see Appendix E). The choice of the physical setting for survey participation had the advantage of privacy, confidentiality, convenience, availability, and flexibility. The research study followed the same pilot study procedures concerning the invitation letter, consent, and anonymous participant online or postal survey submission. The survey completion date was included in the participant reminder letter with the closing survey date. No other data were collected after the deadline.

SurveyMonkey (version 20) was utilized to ensure confidentiality, efficient data entry, immediate coding, and removal of identifying information. Mail and online survey data were transferred from SurveyMonkey to Statistical Package for Social Sciences (SPSS) version 20 for analysis. Data are stored in a drawer with secure sole investigator locking bar and key lock access. Although there were plans for deletion of excess postal and SurveyMonkey pilot survey responses, it was not needed. Returned mail surveys had no identifying data and are stored by the investigator in a file cabinet with a locking bar and key lock access. All research study data, undeliverable mail, and responses received after the deadline are being handled according to UNLV organizational procedures and policies.

Data Collection Procedures

Pilot Study

There are approximately 2, 070 NYSNPA members (S. Hubbard, personal communication, February 3, 2014). The 14-day pilot study was conducted in February 17 to March 3, 2014. The participants were part of a convenience sample recruited through the NYSNPA (see Appendix F). The NYSNPA online member directory information is prohibited for direct contact and solicitation. Therefore, an online recruitment advertisement was included in *Insights*--the monthly member newsletter (see Appendix F). The *Insights* advertisement was reviewed and approved by the dissertation committee chairperson and UNLV IRB. While sampling bias is a limitation of utilizing a convenience sample, the objective of this pilot study was to obtain feedback concerning survey procedures and implementation (Houser, 2008). The FNP member was able to access the survey via an email link to the *Insights* online newsletter or by visiting the NYSNPA website. The NYNPA members had the option of completing the postal mail or online survey. The procedure followed the planned survey administration and informed consent procedures. The FNP Demographic Survey and MATCMEC could be submitted by all respondents. Mentored FNPs were able to continue and respond to the QMRS and the MFQ-9.

Pilot Study Response

Twelve FNPs responded to the *Insights* pilot study invitation. Ten respondents used SurveyMonkey, while two participants (17%) mailed in their responses. Participants reported FNP clinical practice ranging between 1 and 15 years with an average of 6.75 years (SD = 4.90). This sample's average age was 45.36 years old (SD =

7.26) and ranged from 35 to 57 years old. There was an average of 9.82 (*SD* = 5.95) years of RN clinical experience before becoming a FNP, a minimum of one year of experience, and a maximum of 19 professional nursing years. Descriptive pilot study demographic variables are presented in Table 1 (see Appendix A).

Pilot Study Instrument Reliability

The MATCMEC has three subscale scores (affective, continuance, and normative commitment). The MFQ-*9* is comprised of the career, psychosocial, and role modeling function subscales. The QMRS is a five item scale. Each score was calculated as a mean of the constituent survey items; as such, missing data did not need to be addressed for scoring computations accurately. There were no missing scale data. Cronbach's alpha reliability tests were conducted. The alpha values were interpreted using the guidelines suggested by George and Mallory (2010) where $a > .9$ Excellent, $> .8$ Good, $> .7$ Acceptable, $> .6$ Questionable, $> .5$ Poor, and $< .5$ Unacceptable. Results indicated that the scales had between unacceptable reliability (MATCMEC continuance subscale) to excellent reliability (the MATCMEC affective and normative subscales, the MFQ-9 career, psychosocial, role modeling functions subscales, and the QMRS). The MATCMEC continuance subscale reliability was interpreted with caution because of its association with employment longevity (Meyer & Allen, 1997, pp. 56-59). Cronbach's alpha means and standard deviations are presented in Table 2 (see Appendix A).

In addition to completing the pilot survey, all pilot participants were requested to answer questions related to the amount of time (in minutes) for survey completion (see Appendix B). This information was included in the invitation letter for potential study participants. Additional questions addressed the survey directions and instrument

statement clarity, understandability, areas of confusion, or difficulty with survey completion. The revised postal survey, SurveyMonkey link directions, and choice option modifications for multiple FNP workplace locations were recommended by the dissertation chairperson.

The pilot study participants were questioned concerning their choice of the postal or online SurveyMonkey survey. Participant recommendations contributed to verb tense modification of the MATCMEC and the MFQ-9 to reflect FNP past perceptions of the first year of primary care practice. Author permissions for the use of the instruments and modifications were obtained (see Appendix B) but did not require UNLV IRB modification review (see Appendix D). All pilot study recommendations were incorporated into the research survey.

Research Study

This national survey of AANP members collected data once from FNPs within a four-week timeframe inclusive of dates March 24 until April 24, 2014. Data entry and analysis continued until May 25, 2014. Since AANP did not provide email contact information, a postal mail invitation described the study and invited FNP participation. The postal invitation included a choice of a paper survey with a return stamped envelope or the SurveyMonkey link for survey participation (see Appendix E).

The parts of the informed consent for the paper and SurveyMonkey versions (see Appendix D) included the following: (a) the title and description of the research study, (b) the investigator contact information and a copy of IRB approval, (c) participant survey eligibility, (d) research study procedures, (e) the benefits and risks of survey participation, (f) a voluntary participation and consent statement, (g) study confidentiality

procedures, (h) the participant's choice of setting to complete the study and (i) the SurveyMonkey link for the online survey choice (see Appendix D). An explanation of the participant for SurveyMonkey link option was included in the postal invitation. The survey responses were never connected to the participant identifying information and were completed anonymously (Dillman et al., 2009; UNLV, 2012). There was no cost to the participant and anticipated completion time was 20 minutes. Upon completion of the survey, the AANP FNP mailing list was shredded and permanently deleted from the investigator's computer files.

A statement of the consent to participate in the study preceded the paper and online survey versions. The informed consent page included an explanation of the anticipated benefits and risks of survey participation and UNLV IRB approval. A postal mail reminder to all mailing list FNP members was sent two weeks after the initial mailing (see Appendix E). The reminder timeframe was optimal to encourage a maximal response rate for survey completion within one month (Dillman et al., 2009). A multiple survey approach was selected to encourage study participation. The postal mail and SurveyMonkey survey options provided opportunities for FNPs with and without accessible internet access. Additionally, it provided personal postal or online response choice options, timely survey administration, increased sample coverage, and a low non-response rate associated with the one survey method. A potential disadvantage of the initial postal survey mailing included FNP postal address changes that were not included on the AANP list but this resulted in only 14 undeliverable surveys.

Multiple survey approaches have provided efficient, timely, and diverse ways to promote study participation. Survey submission choices were tailored to individual

preferences for paper or online participation in an environment selected by the participant. Additionally, postal mail and online options for survey completion improved past participant survey response rates (Cho et al., 2013; Dillman et al., 2009; Greenlaw & Brown-Welty, 2009). The postal mail invitation provided information about the study, directions for paper and online survey access, and investigator contact information. Both the postal and online surveys included the investigator contact information and a way to follow-up and encourage participation (Cook et al., 2000; Dillman et al., 2009; Thompson, Surface, Martin, & Sanders, 2003).

The investigator entered all paper survey data into an electronic survey, SurveyMonkey (version 20), which ensured confidentiality, efficient data entry, immediate coding, and removal of identifying information. Data from the mail and online surveys were transferred to Statistical Package for Social Sciences (SPSS) version 20 for analysis. Data were stored in a drawer with secure sole investigator locked bar and key locked access. All data and mailed survey responses will be destroyed according to UNLV organizational procedures and policies. The participant choice of the physical setting for the survey had the advantage of convenience, availability, and flexibility. Disadvantages included the lack of environmental control and procrastination concerning survey participation (Thompson et al., 2003). Oversampling was used to overcome potential inadequate response rates. Additionally, the initial postal invitation included the time requirements and directions for paper and internet survey access (Dillman et al., 2009).

Main Sample Response

A total of 1,500 FNPs were contacted via postal mail and 466 individuals responded, resulting in a 31.06% response rate. Before the data were used in analyses, responses were evaluated for inclusion criteria:

1. Forty-six participants (10%) were eliminated for not working in primary care.
2. Five surveys were eliminated because there was no response to the primary care item.
3. Four participants were eliminated because of no FNP graduate degree.
4. Three surveys were eliminated for having earned more than one NP certification.
5. Two surveys were eliminated for respondents who were not working as a FNP.
6. Three participants were eliminated for working part time, being employed outside of the U.S., or being retired.

Final analyses and descriptive statistics were calculated with the remaining sample of 403 participants.

Data were screened for accuracy and outliers. The resulting sample was 26.87% of the originally contacted participants. Eighty-six percent of participants (n= 345) mailed in their surveys and 14% of the respondents (n = 58) submitted the online SurveyMonkey version. Geographical region return survey rates for these useable surveys are presented in Table 3 (see Appendix A).

Main Sample Instruments' Reliability

Cronbach's alpha reliability tests were conducted on the MATCMEC, the MFQ-9, and the QMRS for the main sample. The alpha values were interpreted using the guidelines suggested by George and Mallory (2010) where $a > .9$ Excellent, $> .8$ Good, $> .7$ Acceptable, $> .6$ Questionable, $> .5$ Poor, and $< .5$ Unacceptable. Results indicated good reliability (MATCMEC subscales and MFQ-9) to excellent reliability (QMRS). Cronbach's alpha means and standard deviations are presented in Table 4 (see Appendix A).

Statistical Analysis Methods

Descriptive analysis was performed for the FNP demographic data. The collected demographic covariates included the years working as an FNP, years working as an RN, age, gender, ethnicity, marital status, and graduate degree. The independent variable in the analysis was mentorship (mentored vs. non-mentored). Mentorship was dummy coded as 1 and no mentoring relationship was labeled as 0. The continuous demographic covariates including age, the years working as an FNP, and years working as an RN were described with percentages, means, and standard deviations. Gender was dummy coded female (1) versus other (0). Ethnicity was dummy coded White (1) versus other (0), married was dummy coded as 1 versus other (0). Graduate FNP degree was transformed into a dichotomous variable of master's degree (one) versus other (zero).

Tests of normality were assessed through analysis of skewness, kurtosis, and visual plot inspection. Tabachnick and Fidell (2007) emphasized the importance of assessing the shape of the distribution when sample sizes are greater than 200. Assumptions of normality supported parametric analysis such as Pearson product

moment correlation and multiple regression. Non-normal distributed variables analysis by non-parametric tests such as Spearman rho was proposed but not required.

Data were examined to ensure that underlying assumptions were met. Underlying assumptions such as testing for normality of distribution and homogeneity of variance were analyzed with the Levene's test. The distribution was evaluated by histogram means and the Kolmogorov-Smirnov statistic. Data were screened and cleaned for missing data. The IV and DV outliers, singularity, multicollinearity, normality, linearity, and homoscedasticity of residuals were examined with scatterplots (Tabachnick & Fidell, 2007). The data were evaluated to determine if parametric testing assumptions were met (Tabachnick & Fidell, 2007).

Descriptive statistics of univariate analysis included means and standard deviations (SD); medians were computed for all continuous variables. Discrete responses had numbers and percentages for each item. Since all DVs were continuous variables, analysis of variance (ANOVA) was applied for all discrete IVs to examine bivariate relationships between DVs and IVs, respectively. A MANOVA was applied to examine relationships between each of the DVs (MATCMEC normative, affective, continuance scale mean scores) and the FNP mentoring relationship type (informal, informal, or a combination of relationships).

Correlation analysis and simple regression were applied to examine bivariate relationships between DVs and IVs for the continuous IVs. Pearson product-moment correlations were performed to explore the relationships between variables. The strength of correlational relationship was interpreted as follows: very low (.01-.1), low (.2-.3), moderate (.4-.5), substantial (.6-.7), and very high (.8-.9; Field, 2009). The data were

assumed to be normally distributed, had at least 20 cases per independent variable, and possessed the necessary degree of linearity (Tabachnick & Fidell, 2007).

Multiple linear regression, a parametric analysis, was used to determine which IVs best predicted the dependent variables. To control for making a Type 1 error, alpha was set at .05 and to control for Type II error, *B* was set at .95. The effect size was moderate ($r^2 = .13$) for multiple regression analyses (Polit & Beck, 2004). Concepts were compared to determine significant relationships but not to the point of multicollinearity (Field, 2009). Multivariate outliers were determined by Mahalanobis distance and multiple correlations among the IVs were not greater than 0.8. The dependent variable scores were normally distributed, homoscedastic, and equally dispersed about the line of best fit. Data transformation was considered if DVs were not normally distributed. The *y* scores had equal variance with each *x* value (Grove, 2007).

The IV and DV outliers, singularity, multicollinearity, normality, linearity, and homoscedasticity of residuals were examined with scatterplots (Tabachnick & Fidell, 2007). Standard multiple regression results included the sample size, the IVs and DVs, regression coefficients, the value of R^2, the significance of the overall regression, and the individual predictors' significance (Tabachnick & Fidell, 2007). The *F* and *p* values for the omnibus and standardized regression coefficients were reported. The effects size, the R^2, and adjusted R^2 were included. A summary reporting included *F, p,* R^2, and statistically significant *B*s (Tabachnick & Fidell, 2007). Multiple R^2 and the confidence intervals, *F* ratio, significant of the regression coefficients, squared semi partial correlations, post hoc analyses of significant results, post hoc unstandardized *B* weights with confidence levels, and standardized *B* weights were included. An overall prediction

equation was included in the summary. All instruments' reliabilities were analyzed by Cronbach's alpha (Polit, 2009).

Research Questions

1. Are there any differences in organizational commitment between mentored and non-mentored FNPs?

The DV of organizational commitment was measured by the MATCMEC normative, affective, and continuance subscale mean scores. The IV was the presence or absence of FNP mentorship. An analysis of variance (ANOVA) was conducted for bivariate analysis between the organizational commitment DVs and the mentoring IVs. Multiple linear regression calculations were completed on significant bivariate results Multiple linear regression was conducted with each of the three subscales of organizational commitment as the dependent variable. The independent variable in the analysis was mentorship (mentored = 1, non-mentored = 0). The collected demographic covariates included the years working as an FNP, years working as an RN, age, gender, ethnicity, marital status, and graduate degree. Ethnicity was dummy coded as White = 1 (the largest group). Marital status was coded as married = 1 versus other = 0. Graduate FNP degree was coded as master's degree = 1 and other graduate degrees = 0**.** Gender was dummy coded female (1) and other (0).

Primary bivariate analyses were conducted using ANOVAs to assess the bivariate relationships between the three organizational commitment scores and mentorship. Prior to analysis, the assumptions of multiple linear regression were assessed. Multiple linear regression assumed that residual values followed a normal distribution (normality) and the data were equally distributed from one end of the regression line to the other

(homoscedasticity). Normality was assessed through visual examination of a normal P-P plot for each model. Homoscedasticity was visually assessed through a residuals scatterplot for each model; if the plot roughly followed a rectangular distribution, this assumption was met (Grove, 2007). Statistical significance was determined within a 95% confidence interval ($\alpha = .050$).

Multiple linear regression calculations were completed on significant bivariate results. Multiple regression analyzed the relationship between a dichotomous grouping variable and a continuous dependent variable while controlling for the covariates. Significance testing was used to indicate differences in the relationship between each group and the DV. The *F* test assessed whether the set of independent variables collectively predicted the dependent variable. The R^2 was reported and used to determine how much variance in the dependent variable could be accounted for by the set of independent variables. The *t*-test determined the significance of each predictor and beta coefficients were used to determine the extent of prediction for each independent variable.

Standard multiple regression results included the sample size, the IVs and DVs, regression coefficients, the value of R^2, the significance of the overall regression, and the individual predictor's significance (Tabachnick & Fidell, 2007). The *F* and *p* values for the omnibus and standardized regression coefficients were reported. The effect size, the R^2, and adjusted R^2 were included. A summary reporting included *F, p,* R^2 and statistically significant *Bs* (Tabachnick & Fidell, 2007). Multiple R^2 and the confidence intervals, *F* ratio, and significant regression coefficients were included. There were post hoc analyses of significant results. Post hoc unstandardized *B* weights with confidence

levels and standardized *B* weights were included. An overall prediction equation was included in the summary.

2. Are there any differences in FNP organizational commitment across formal, informal, and a combination of both formal and informal mentoring types?

The MATCMEC normative, affective, and continuance subscale mean scores measured the DV of organizational commitment. The IV was FNP mentorship types. An analysis of variance (ANOVA) was conducted for bivariate analysis between the organizational commitment DVs and the mentoring IVs. Multiple linear regression calculations were completed on significant bivariate results. Multiple linear regression was conducted with each of the three subscales of organizational commitment as the dependent variable. The independent variable was mentorship types with formal as the reference variable, dummy coding of informal (1 = yes, 0 = no), and a dummy coding of the combination of formal and informal mentorships (1 = yes, 0 = no). The collected demographic covariates included the years working as an FNP, years working as an RN, age, gender, ethnicity, marital status, and graduate degree. Ethnicity was dummy coded as White = 1 (the largest group). Marital status was coded as married = 1 versus other = 0. Graduate FNP degree was coded as master's degree = 1 and other graduate degrees = 0**.** Gender was dummy coded female (1) and other was (0).

Primary bivariate analyses were conducted using ANOVAs to assess the bivariate relationships between the three organizational commitment scores and mentorship types. Prior to analysis, the assumptions of multiple linear regression were assessed. Multiple linear regression assumed that residual values followed a normal distribution (normality) and the data were equally distributed from one end of the regression line to the other

(homoscedasticity). Normality was assessed through visual examination of a normal P-P plot for each model. Homoscedasticity was visually assessed through a residuals scatterplot for each model; if the plot roughly followed a rectangular distribution, this assumption was met (Grove, 2007). Statistical significance was determined within a 95% confidence interval ($\alpha = .050$).

Multiple regression analyzed the relationship between a discrete grouping variable and a continuous dependent variable while controlling for the covariates. Significance testing was used to indicate differences in the relationship between each group and the DV. The *F* test assessed whether the set of independent variables collectively predicted the dependent variable. The R^2 was reported and used to determine how much variance in the dependent variable could be accounted for by the set of independent variables. The *t*-test determined the significance of each predictor and beta coefficients were used to determine the extent of prediction for each independent variable.

Standard multiple regression results included the sample size, the IVs and DVs, regression coefficients, the value of R^2, the significance of the overall regression, and the individual predictor's significance (Tabachnick & Fidell, 2007). The *F* and *p* values for the omnibus and standardized regression coefficients were reported. The effect size, the R^2, and adjusted R^2 were included. A summary reporting included *F, p,* R^2 and statistically significant *Bs* (Tabachnick & Fidell, 2007). Multiple R^2 and the confidence intervals, *F* ratio, and significant regression coefficients were included. There were post hoc analyses of significant results. Post hoc unstandardized *B* weights with confidence

levels and standardized *B* weights were included. An overall prediction equation was included in the summary.

3. Are there any differences in FNP organizational commitment across mentoring career, psychosocial, and role modeling functions?

The DV was FNP organizational commitment. Organizational commitment was measured by the three MATCMEC subscale mean scores. The IVs were FNP mentoring functions of career, psychosocial, and role modeling. The IVs were coded as career functions = 1, psychosocial functions = 2 and role modeling = 3. Preliminary tests were conducted as a matrix of Pearson correlations to assess the bivariate relationships between organizational commitment and mentoring functions. Multiple linear regression calculations were completed on significant bivariate results.

A series of multiple regressions were used to assess the relationship between mentoring functions and the continuous MATCMEC dependent variable while controlling for one or more covariates. The *F* test was used to assess whether the set of independent variables collectively predicted the dependent variable. The R^2 determined how much variance in the dependent variable could be accounted for by the set of independent variables. The *t*-test determined the significance of each predictor and beta coefficients were used to determine the extent of prediction for each independent variable. If a significant relationship was found, beta values were reported about the effect mentoring functions on organizational commitment. For each one unit increase in relationship function scores, the organizational commitment increased or decreased by the number of unstandardized beta coefficients.

Prior to analysis, the assumptions of multiple linear regression were assessed. Normality was assessed through visual examination of a normal P-P plot for each model and homoscedasticity was visually assessed through a residuals scatterplot for each model (Stevens, 2009). Statistical significance was determined within a 95% confidence interval ($\alpha = .050$).

Standard multiple regression results included the sample size, the IVs and DVs, regression coefficients, the value of *R2*, the significance of the overall regression, and the individual predictor's significance (Tabachnick & Fidell, 2007). The *F* and *p* values for the omnibus and standardized regression coefficients were reported. The effects size, *R2*, and adjusted *R2* were included. A summary report included the *F, p, R2*, and statistically significant *Bs* (Tabachnick & Fidell, 2007). Multiple R^2 and the confidence intervals, *F* ratio, and significant regression coefficients were included. There were post hoc analyses of significant results. Post hoc unstandardized *B* weights with confidence levels and standardized *B* weights were included. An overall prediction equation was part of the summary.

4. What is the relationship between the quality of mentoring relationship and FNP organizational commitment?

The DV was FNP organizational commitment. Organizational commitment was measured by the three MATCMEC subscale mean scores. The continuous IV was mentoring relationship quality. It was analyzed by the QMRS composite mean score. Preliminary tests were conducted as a matrix of Pearson correlations to assess the bivariate relationships between organizational commitment and mentoring quality. Multiple linear regression calculations were completed on significant bivariate results.

The seven collected demographics were used as covariates and included years working as an FNP, years working as an RN, age, gender, ethnicity, marital status, and graduate degree. Dichotomous demographic covariates were dummy coded and remained the same throughout all the research question analyses.

Prior to multiple regression, bivariate regression was performed to assess the relationships between the DVs of organizational commitment and the IV of mentoring quality. Multiple regression was used to assess the relationship between a dichotomous grouping variable and a continuous dependent variable while controlling for one or more covariates. The *F* test was used to assess whether the set of independent variables collectively predicted the dependent variable. The R^2 determined how much variance in the dependent variable could be accounted for by the set of independent variables. The *t*-test determined the significance of each predictor and beta coefficients were used to determine the extent of prediction for each independent variable. If a significant relationship was found, beta values were reported about the effect relationship quality on organizational commitment. For each one unit increase in relationship quality scores, the organizational commitment increased or decreased by the number of unstandardized beta coefficients.

Prior to analysis, the assumptions of multiple linear regression were assessed. Normality was assessed through visual examination of a normal P-P plot for each model and homoscedasticity was visually assessed through a residuals scatterplot for each model (Stevens, 2009). Statistical significance was determined within a 95% confidence interval ($\alpha = .050$).

Standard multiple regression results included the sample size, the IVs and DVs, regression coefficients, the value of R^2, the significance of the overall regression, and the individual predictor's significance (Tabachnick & Fidell, 2007). The *F* and *p* values for the omnibus and standardized regression coefficients were reported. The effects size, R^2, and adjusted R^2 were included. A summary report included the *F, p,* R^2 and statistically significant *Bs* (Tabachnick & Fidell, 2007). Multiple R^2 and the confidence intervals, *F* ratio, and significant regression coefficients were included. There were post hoc analyses of significant results. Post hoc unstandardized *B* weights with confidence levels and standardized *B* weights were listed. An overall prediction equation was part of the summary.

Study Limitations

The FNP participants were recalling the first year of clinical practice in primary care settings. Their present and historical personal experiences may have influenced survey responses. It was also limited to FNPs working in primary care settings. Other NP specialties and primary care NPs working in different settings might benefit from the study findings but generalizations are not assumed. The survey was also limited by self-report responses, recall, internet access and usage, and a potentially low postal and online survey response rate. Additionally, more mentored FNPs may have responded to a mentoring survey request. Although a postal invitation with paper and SurveyMonkey survey choices were efficient ways to obtain data, environmental distractions may have interfered with participant concentration and effort. Since data were collected once within a one-month timeframe, longitudinal effects of mentoring relationships could not be derived from this study. This study was a beginning investigation of the best

predictors of FNP mentoring relationships' impact on organizational commitment in primary care settings.

Chapter Summary

This chapter addressed the research design, sample selection, instrumentation, ethical considerations, data collection procedures, data analysis plan, and study limitations. The chapter sought to describe the methodological considerations related to implementation of a national FNP survey that utilized a multiple survey approach to measure mentoring relationships' impact on FNP organizational commitment in primary care settings. Organizational commitment of mentored versus non-mentored FNP organizational commitment was compared. An analysis of mentorship type, quality and functions' impact on FNP organizational commitment was conducted. The chapter provided a blueprint for the study's implementation.

CHAPTER V

FINDINGS OF THE STUDY

Introduction

This chapter presents the findings of this study, the results section, and chapter summary**.** The results section provides a description of the sample, variables, and the study instruments' reliability. Statistical findings for each research question are included.

The following research questions were used to guide and implement this study.

1. Are there any differences in organizational commitment between mentored and non-mentored FNPs?
2. Are there any differences in FNP organizational commitment across mentoring types, formal mentoring, informal mentoring, and a combination of both formal and informal mentoring?
3. Are there any differences in FNP organizational commitment across mentoring career, psychosocial, and role modeling functions?
4. What is the relationship between the quality of a mentoring relationship and FNP organizational commitment?

Results of the Study

The results section begins with the main sample's descriptive information and statistical findings for each research question. The chapter summary provides an overview of the analyses.

The final 403 participant sample consisted of 87% White (*n* = 352), 6% Black (*n* = 24), 4% Asian (*n* = 16), and 2% Hispanic (*n* = 8) FNPs. Seventy-three percent of the sample were married (*n* = 292), and 92% were female (*n* = 369). Eighty-two percent of

the FNPs' initial academic preparation was a master's degree (n = 329) followed by 16% with a post-master's certificate (n = 63). During the first year of practice, 41% of the FNPs worked in private practice (n = 166), 26% worked in an outpatient clinic (n = 103), and 23% worked in an outpatient office setting (n = 93). The study participants reported working as a FNP for between 1 and 44 years with an average of 9.34 years (SD = 7.20). This sample's average age was 49.47 years old (SD = 11.10) and ranged from 26 to 76-years-old. Participants reported an average of 13.55 (SD = 8.91) years of RN clinical experience before becoming a FNP, a minimum of zero years of experience, and a maximum of 40 years. Demographic variable descriptive statistics are presented in Table 5 (see Appendix A).

Fifty-five percent of the FNPs (n = 223) engaged in a mentoring relationship during their first year of primary care practice. The mentored FNPs selected the relationship types during the first year of primary care practice: 23% informal (n = 92), 11% formal (n = 46), and a 21% (n = 86) combination of formal and informal relationships. Mentoring type descriptive statistics are presented in Table 6 (see Appendix A). Demographic variable descriptive statistics are presented in Table 7 (see Appendix A).

Research Question One

Are there any differences in organizational commitment between mentored and non-mentored FNPs?

A series of multiple linear regressions were conducted to determine differences in MATCMEC subscale scores between mentored and non-mentored FNPs. Statistical control included the covariates of years working as an FNP, years of RN clinical

experience before becoming a FNP, age, gender, ethnicity, marital status, and FNP academic degree. After review of the respondent data, marital status, ethnicity, and FNP academic degree were transformed into dichotomous variables: (a) gender was dummy coded as female =1 (92% of the respondents) or other coded as 0, (b) ethnicity was dummy coded as White= 1 (87% of the respondents) or other =0, (c) marital status indicated either married =1 (73% of the respondents) or other =0, and (d) FNP academic degree was dummy coded as master's degree = 1 (82% of the respondents) or other graduate degrees = 0. Mentoring relationship presence was coded as 0--no mentoring relationship and 1--mentoring relationship. Each score was calculated as a mean of the constituent survey items; as such, missing data did not need to be addressed to score computations accurately. No more than two instrument scale responses were missing from the respondents.

Primary bivariate analyses were conducted using ANOVAs to assess the direct relationships between mentorship and the three commitment scores. Results indicated a relationship between mentorship and normative commitment ($F(1, 391) = 6.11$, $p = .014$) as well as affective commitment ($F(1, 389) = 8.81$, $p = .003$). Results of the ANOVA with mentorship and continuance commitment did not suggest any direct relationship ($F(1, 395) = 0.05$, $p = .816$). Results of these preliminary ANOVAs are presented in Table 8 (see Appendix A).

The first multiple regression analysis was conducted on the MATCMEC affective scale. Prior to analysis, assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a

residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of variance inflation factors (VIFs), where any VIF greater than 10 was considered to possess high levels of multicollinearity and violate the assumption. The VIFs ranged from 1.02 to 3.32 so the assumption was met.

Significant differences were found in affective commitment between FNPs with and without a mentoring relationships, $F(8, 362) = 2.15$, $p = .031$, $R^2 = .05$. The FNP mentoring relationship, as well as the covariates, contributed to approximately 5% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), the presence of mentorship had a significant relationship with affective commitment scores ($t = 2.72$, $p = .007$). The beta value of ($B = 0.45$) indicated that participants who were mentored had average affective commitment scores 0.45 points higher than those who were not. Results of the first multiple linear regression are presented in Table 9 (see Appendix A).

The second multiple regression analysis was conducted on the normative scale. Prior to analysis, assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of VIFs, where any VIF greater than 10 was considered to possess high

levels of multicollinearity and violate the assumption. The VIFs ranged from 1.02 to 3.32 so this assumption was met.

Results of the multiple linear regression to determine differences in normative commitment between those FNPs with and without a mentoring relationships did not indicate a significant model, $F(8, 362) = 1.62$, $p = .117$, $R^2 = .04$. Thus, no further inferences could be made.

Research Question Two

Are there any differences in FNP organizational commitment across mentoring types, formal mentoring, informal mentoring, and a combination of both formal and informal mentoring?

A series of multiple linear regressions was conducted to determine relationships in MATCMEC subscale scores between mentoring types. Data analysis was conducted on mentored FNPs. Statistical control included the covariates of years working as an FNP, years of RN clinical experience before becoming a FNP, age, gender, ethnicity, marital status, and FNP academic degree. After review of the respondent data, marital status, ethnicity, and FNP academic degree were transformed into dichotomous variables: (a) gender was dummy coded as female =1 (92% of the respondents) or other coded as 0, (b) ethnicity was dummy coded as White = 1 (87% of the respondents) or other = 0, (c) marital status indicated either married = 1 (73% of the respondents) or other = 0, and (d) FNP academic degree was dummy coded as master's degree = 1 (82% of the respondents) or other graduate degrees = 0. Mentorship types were coded as formal as the reference variable and dummy coding of informal mentorship (yes = 1 and no = 0), and dummy coding of the combination of informal and formal mentorships (yes = 1 and

no = 0). Each score was calculated as a mean of the constituent survey items; as such, missing data did not need to be addressed to score computations accurately. No more than two instrument scale responses were missing from the respondents.

Preliminary analyses were conducted to determine whether there were direct bivariate relationships between the three MATCMEC commitment scales and mentoring types using a series of ANOVAs and the MANOVA. Three ANOVAs were assessed to examine bivariate relationships for each MATCMEC score individually. Results of the ANOVAs suggested a direct relationship between mentoring type and normative $F(3, 376) = 3.02$, $p = .030$) and affective $F(3, 376) = 3.03$, $p = .029$) commitment scores. However, continuance was not found to have a significant relationship with mentoring type $F(3, 376) = 1.52$, $p = .210$), and was not examined further. The MANOVA was found to be significant $F(9, 910) = 2.45$, $p = .009$).

A series of multiple linear regressions was conducted to determine differences in normative and affective scores between participants with different mentoring types while controlling for demographics. Prior to analysis, the assumptions of the multiple linear regression were assessed. First, the assumption of normality was assessed using normal P-P plots. Each of the two regressions followed a normal distribution based on a visual inspection of these plots. Next, the assumption of homoscedasticity was assessed. Visual inspection of the residual scatterplot indicated no strong deviation from a rectangular distribution for any of the regressions and the assumption was met for both. The assumption of an absence of multicollinearity was assessed using variance inflation factors (VIFs). The highest VIF for either regression's independent variables was 3.28, suggesting that the assumption was met for both regressions.

Although the normative and affective commitment bivariate results were significant, the multiple linear regression analysis did not indicate significant models for either of the two MATCMEC scores. After controlling for demographics the multiple regression model for the regression predicting affective commitment score did not indicate a significant relationship $F(9, 204) = 1.14$, $p = .337$). Similarly, for the regression predicting normative scores, after controlling for demographics the model did not indicate a significant relationship $F(9, 204) = 1.08$, $p = .376$). Since neither regression indicated a non-significant model, *t* tests were not conducted to examine individual predictors and unstandardized betas (*B*) were not interpreted. Results of the preliminary bivariate analysis are in Table 10 (see Appendix A).

Research Question Three

Are there any differences in FNP organizational commitment across mentoring career, psychosocial, and role modeling functions?

To examine research question three, a MANCOVA and ANCOVA were originally proposed. However, the three mentoring functions were not nominal categories. Rather, the functions were three MFQ-9 individual subscale mean scores. Thus, the analysis was changed to a series of multiple linear regressions and examined in relation to the MATCMEC subscale mean scores. The DV was organizational commitment subscale scores and the IV was mentoring functions. Mentoring functions were dummy coded as career = 1, psychosocial = 2 and role modeling = 3. Data analysis was performed on the mentored FNPs.

Statistical control included the covariates of years working as an FNP, years of RN clinical experience before becoming a FNP, age, gender, ethnicity, marital status, and

FNP academic degree. After review of the respondent data, marital status, ethnicity, and FNP academic degree were transformed into dichotomous variables: (a) gender was dummy coded as female =1 (92% of the respondents) or other coded as 0, (b) ethnicity was dummy coded as White= 1 (87% of the respondents) or other =0, (c) marital status indicated either married = 1 (73% of the respondents) or other = 0, and (d) FNP academic degree was dummy coded as master's degree = 1 (82% of the respondents) or other graduate degrees = 0. Each score was calculated as a mean of the constituent survey items; as such, missing data did not need to be addressed to score computations accurately. No more than two instrument scale responses were missing from the respondents.

Preliminary tests were conducted as a matrix of Pearson correlations to assess the bivariate relationships between the three mentoring functions and three measures of organizational commitment. Results indicated that all bivariate correlations were significant ($p < .05$) with the exception of career functions with continuance commitment scores ($p = .101$) and role modeling with continuance commitment scores ($p = .087$). However, both career and role modeling functions were included in the model predicting continuance commitment as additional control variables (see Table 11 in Appendix A).

The first multiple regression analysis was conducted on the MATCMEC affective scale. Prior to analysis, the assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through

examination of VIFs, where any VIF greater than 10 was considered to possess high levels of multicollinearity and violate the assumption. The VIFs ranged from 1.05 to 3.21 so this assumption was met.

Results of the multiple linear regression to assess the effect of career, psychosocial, and role modeling functions on MATCMEC affective commitment indicated a significant model, $F(10, 200) = 3.88$, $p < .001$, $R^2 = .16$. The three mentoring functions, as well as all covariates, predicted approximately 16% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), career function had a significant effect on affective commitment scores ($t = 2.70$, $p = .008$). None of the other functions were significantly related to affective commitment scores. The beta value of ($B = 0.42$) indicated that as career function scores increased by one, affective commitment scores increased by 0.42. Results of the first multiple linear regression are presented in Table 12 (see Appendix A).

The second regression analysis was conducted on the MATCMEC continuance scale. Prior to analysis, assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of VIFs, where any VIF greater than 10 was considered to possess high

levels of multicollinearity and violate the assumption. The VIFs ranged from 1.04 to 3.18 so this assumption was met.

Results of the multiple linear regression to assess the effect of career, psychosocial, and role modeling functions on continuance commitment did not indicate a significant model, $F(10, 201) = 1.63$, $p = .101$, $R^2 = .08$. Thus, individual predictors were not examined and no further inferences could be made. .

The third multiple regression analysis was conducted on the MATCMEC normative scale. Prior to analysis, the assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of VIFs, where any VIF greater than 10 was considered to possess high levels of multicollinearity and violate the assumption. The VIFs ranged from 1.04 to 3.24 so this assumption was met.

Results of the multiple linear regression to assess the effect of career, psychosocial, and role modeling functions on normative commitment indicated a significant model, $F(10, 200) = 1.88$, $p = .050$, $R^2 = .09$. The three mentoring functions and all covariates predicted approximately 9% of variance in MATCMEC normative commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), none of the individual mentoring functions had any effect on normative commitment. Thus, beta

values were not interpreted and no further inferences could be made. Results of the third multiple linear regression are presented in Table 13 (see Appendix A).

Research Question Four

What is the relationship between the quality of a mentoring relationship and FNP organizational commitment?

The DVs were the MATCMEC organizational commitment subscale scores. The IV was the QMRS scores. All the variables were continuous. Data analysis was performed with mentored FNPs. Statistical control included the covariates of years working as an FNP, years of RN clinical experience before becoming a FNP, age, gender, ethnicity, marital status, and FNP academic degree. After review of the respondent data, marital status, ethnicity, and FNP academic degree were transformed into dichotomous variables: (a) gender was dummy coded as female =1 (92% of the respondents) or other coded as 0, (b) ethnicity was dummy coded as White = 1 (87% of the respondents) or other = 0, (c) marital status indicated either married = 1 (73% of the respondents) or other = 0, and (d) FNP academic degree was dummy coded as master's degree = 1 (82% of the respondents) or other graduate degrees = 0. Each score was calculated as a mean of the constituent survey items; as such, missing data did not need to be addressed to score computations accurately. No more than two instrument scale responses were missing from the respondents.

Preliminary bivariate assessments of the three measures of organizational commitment scales and mentoring quality were conducted using a matrix of Pearson correlations. Results of these bivariate analyses indicated a significant relationship between affective commitment and mentoring quality ($p < .001$) as well as normative

commitment with mentoring relationship quality (p = .011). However, mentoring relationship quality was not found to have a significant relationship with continuance commitment scores. Thus, the regression modeling mentor relationship quality as a predictor of continuance commitment was not conducted (see Table 14 in Appendix A).

Multiple linear regression was conducted to determine the effect of mentoring quality on MATCMEC subscale scores. A series of multiple linear regressions were conducted for the QMRS mean scores. The first regression analysis was conducted on the affective scale. Prior to analysis, the assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of VIFs, where any VIF greater than 10 was considered to possess high levels of multicollinearity and violate the assumption. The VIFs ranged from 1.03 to 3.44 so this assumption was met.

Results of the multiple linear regression to determine the effect of mentoring quality on affective commitment indicated a significant model, $F(8, 202) = 5.80$, $p < .001$, $R^2 = .19$. Mentoring quality as well as all covariates predicted approximately 19% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), mentoring quality had a significant effect on affective commitment scores (t = 5.99, $p < .001$). The beta value of (B = 0.64) for mentoring quality indicated that as

participants' mentoring quality scores increased by 1, affective commitment scores increased by 0.64. Results of the first multiple linear regression are presented in Table 15 (see Appendix A).

The second multiple regression analysis was conducted on the MATCMEC normative scale. Prior to analysis, the assumptions of the multiple linear regression were assessed. Normality was assessed using a normal P-P plot; the data did not deviate greatly from the normal line so this assumption was met. Homoscedasticity was assessed using a residuals scatterplot; the data did not deviate greatly from a rectangular distribution so this assumption was met as well. The absence of multicollinearity was assessed through examination of VIFs, where any VIF greater than 10 was considered to possess high levels of multicollinearity and violate the assumption. The VIFs ranged from 1.04 to 3.44 so this assumption was met.

Results of the multiple linear regression to assess the effect of mentoring quality on normative commitment indicated a significant model, $F(8, 203) = 2.09$, $p = .038$, $R^2 = .08$. Mentoring quality as well as all covariates predicted approximately 8% of the variance in normative commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), mentoring quality had a significant effect on normative commitment scores ($t = 2.78$, $p = .006$). The beta value of ($B = 0.28$) for mentoring quality indicated that as participants mentoring quality scores increased by 1, normative commitment scores increased by 0.28. Results of the third multiple linear regression are presented in Table 16 (see Appendix A).

Chapter Summary

The FNP study sample results were analyzed with the appropriate multivariate statistical methods using SPSS 20. The statistical analyses were guided by the four research questions. The chapter presented the pilot and main study results. The study instruments' reliability was analyzed with Cronbach alpha. The FNP MATCMEC scores were analyzed and related to mentoring presence, types, functions, and relational quality with the selected study demographic covariates.

CHAPTER VI

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This chapter provides information about the methods utilized in this study and includes the following sections: (a) summary of the research study, (b) discussion of the findings, (c) limitations of the study, (d) implications for advanced practice nursing, (e) recommendations for future research, and (f) chapter summary.

Summary of the Research Study

The purpose of this study was to examine the factors of mentoring relationships (presence, types, functions, and quality) and their impact on FNP organizational commitment in primary care settings. The dependent variable was FNP organizational commitment. Meyer and Allen's (1997) Three Component Employee Commitment Survey (MATCMEC) measured the organizational commitment. The independent variable was FNP mentoring relationship (presence, types, functions, and quality). Mentoring relationship presence was categorized as FNPs being mentored or not mentored. Mentorship types were categorized as formal, informal, or a combination of formal and informal relationships. Mentoring functions were measured by the MFQ-9 (Allen & Eby, 2003). Mentoring relationship quality was measured by the QMRS (Castro et al., 2004). The following demographic variables were used as covariates: years working as a FNP, years working as an RN, age, gender, ethnicity, marital status, and FNP graduate degree.

The theoretical frameworks that guided this study were Meyer and Allen's (1997) organizational commitment model and Kram's (1985) mentoring theory. Social exchange theory provided the foundation for organizational commitment and mentoring

theory development (Huston & Burgess, 1979; Liou, 2008; Riketta, 2002). Positive workplace relationships foster dynamic, interactive, and mutually beneficial interactions. Perceptions of goals, costs, and rewards support individual and organizational growth and development (Huston & Burgess, 1979). Organizational commitment is reflective of a connection with the workplace and individuals' wiliness to contribute to outcomes. Mentorship fosters participants' career and psychosocial development through mutual exchange (Allen & Eby, 2003). Thus, mentoring has the potential to support organizational commitment through participant mutual interaction, communication, and engagement in the workplace. These relationships were reflective in the Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model proposed in the research study (see Figure 1, page 38).

Fifteen hundred FNPs were contacted to participate in the study. The sample was stratified according to the five U.S. geographical regions and randomly selected from the AANP (2011) opt-in mailing list. Data collection was completed once during a one month timeframe. Respondents were able to choose either the postal mail or the online SurveyMonkey option. There were 466 respondents. Surveys were screened and 403 FNP surveys met criteria: 345 via postal mail responses and 58 responses via SurveyMonkey. There was a 26.9% usable survey response rate. Both postal and online responses were entered into SurveyMonkey for statistical analysis.

Discussion of the Findings

This section provides a discussion of findings of the study and includes the following sections: (a) interpretation of demographic information (b) organizational

commitment findings, and (c) FNP Mentoring Relationships and Organizational Commitment Model summary.

Interpretation of Demographic Information

This section examines the demographic results of the current FNP study and compares them with the most recent 2011 AACN FNP Role Delineation Study. Overall, the research study sample reflected the demographics of the current FNP population in the U.S. (see Appendix C). The FNP respondents were a majority of White females, middle-aged, master's prepared, and working in private practice, outpatient office, and clinic settings. Respondents responded an average age of 49.5 years (*SD*= 11.1) with 9.3 years (*SD* = 7.2) of FNP experience, and prior 13.6 years (*SD* = 8.9) of RN clinical experience. Fifty-five percent of the respondents had a mentoring relationship during the first year of FNP clinical practice. Mentors included FNPs, primary care NPs, or other professionals (physician, PA, respiratory therapist, and midwife). The majority of mentoring relationships were informal (23%) followed by a combination of formal and informal mentoring (21%). Surprisingly, only 11% of the FNPs had a formal mentoring relationship in their workplace during their first year of primary care practice.

The FNPs entered the APN workforce with a background of RN clinical experience. Mentoring relationship types were predominantly informal and a combination of formal and informal relationships. This research study confirmed mentoring relationship presence during the first year of FNP primary care practice (Poronsky, 2012). Formal, informal, and a combination of mentoring relationships supported FNP career and psychosocial development. Additionally, FNPs sought

multiple types of mentorship within and outside the workplace setting (Brown & Olshansky, 1998; Dorerksen, 2010; Sargent & Olmedo, 2013).

Although FNP mentoring relationships are occurring, research has concentrated on needs assessment and orientation program planning (Pop, 2011; Sorenson, 2010). Nationally, AANP (2013) has a formalized mentorship program to support novice NP career and psychosocial development but it does not target the NP workplace transition and competency development during the first year of primary care practice. Nurse practitioner residency and orientation programs with mentorship components have been proposed (Pop, 2011). Workplaces are developing NP residency, orientation, and mentorship programs. The review of literature is supportive of NP residency development with mentorship components but mentoring definitions and outcomes have not been clearly defined or evaluated (Boyer, 2012; Flinter, 2012; Poronsky, 2012; Sargent & Omedo, 2013).

The majority of FNPs identified primary care NPs as their mentors but there were other professionals (physicians, midwives, and PAs) who served as mentors during the first year of primary practice. The demographic information is included in Table 5, Appendix A. The majority of FNPs worked in private practice, outpatient office, and clinic settings. Past research has focused on NP mentoring relationship dyads with professionals who had similar roles and responsibilities (Brown & Olshansky, 1998; Gardner et al., 2008; Gerhart, 2011; Harrington, 2011). The study research finding identified the presence of multiple interdisciplinary mentors during the first year of FNP clinical practice. Since the majority of FNPs work in private practice or ambulatory care

settings, there may have been a limited number of NPs who were potential mentors (Grover & Niecko-Najjum, 2013).

Organizational Commitment and Mentorship

In response to the first research question, the three MATCMEC subscale mean scores measured differences in organizational commitment between mentored and non-mentored FNPs. The affective, continuance, and normative commitment scales were analyzed by multiple regression. There were significant differences in affective commitment between FNPs with and without mentoring relationships. The FNP mentoring relationship, as well as the covariates, contributed to approximately 5% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), the presence of mentorship had a significant relationship with affective commitment scores. Mentored FNPs had higher affective commitment scores than those who were not mentored.

In previous research, affective organizational commitment has been associated with perceived workplace support in previous professional research (Allen & Eby, 2003; Coyle-Shapiro & Shore, 2007; Fletcher & Williams, 1996). Emotional support can foster FNP mentee transition into practice within a nurturing environment. Effective mentoring relationships fulfill the mentee's need to belong and develop positive relationships within the workplace (Rhoades & Eisenberger, 2002). There is increased affiliation with others and acceptance among colleagues that fosters FNP emotional connections to the workplace. Affective commitment has been positively associated with employee

productivity, performance, and a positive organizational culture (Meyer et al., 2002; Rhoades et al., 2001; Riketta, 2002).

Mutuality, trust, and empathy have been recurrent themes in organizational commitment and mentoring research (Barker, 2006; Bozeman & Feeney, 2007; Brown & Olshansky, 1998; Colye-Shapiro & Shore, 2007; Gregory et al., 2007; Gromley & Kennerly, 2010; Kuokkanen et al., 2003; Liou, 2008; Manion, 2001; Mariani, 2012; McNeese-Smith, 2001; Meyer et al., 1998; Sargent & Olmendo, 2013). The study findings supported the FNP mentoring relationships' significant impact on organizational affective commitment. Additionally, it provided a lens to view FNP mentoring relationships' ability to foster emotional attachments and connections within the workplace during the first year of primary care practice (Brown & Olshansky, 1998; Doerksen, 2010; Gardner et al., 2008; Harrington, 2011; Kelly & Matthews, 2001).

Both FNP MATCMEC continuance and normative commitment results were not significant in relationship to mentoring presence. Organizational continuance commitment is reflective of the individual's consideration of personal investments and other employment alternatives (Meyer & Allen, 1997). During the first year of primary care practice, FNPs have multiple demands concerning NP certification, competency development, and role transition (Brown & Olshansky, 1998; Meyer et al., 2002). Continuance commitment is associated with employee longevity and may not be a factor during FNP transition during the first year of practice (Meyer et al., 2002).

Role clarity development has a positive association with affective commitment but has a slightly negative or no association at all with continuance commitment (Allen & Meyer, 2000; Meyer et al., 2002). As FNPs transition in primary care, role clarity can be

promoted through mentorship (Brown & Olshansky, 1998). Additionally, there have been continuance commitment measurement challenges. In the past, the continuance commitment scale analysis has performed poorly in comparison to affective and normative commitment scales. Future research and organizational commitment construct refinements are recommended (Allen & Meyer, 2000; Gutierrez et al., 2012; Meyer et al., 2002).

Organizational normative commitment is associated with employee sense of obligation to the workplace setting. Work experiences contribute to normative commitment. Organizational support, role clarity, and employee relationships are positively associated with work engagement and job satisfaction (Meyer et al., 2002). Although there was no significant normative commitment relationship with FNP mentorship, early socialization workplace interactions have been associated with organizational normative commitment (Allen & Meyer, 2000; Meyer et al., 2002). It has been proposed that normative commitment might contribute to affective nursing faculty commitment (Gutierrez et al., 2012). Other researchers have questioned the differentiation between organizational normative and affective commitment relationships. Additionally, this preliminary research study was supportive of a mentorship's impact on FNP organizational affective commitment. Future research to differentiate normative and affective commitment constructs is recommended (Allen & Meyer, 1996; Bergman, 2006; Gutierrez et al., 2012).

Organizational Commitment and Mentoring Relationship Types

In response to the second research question, the multiple regression measured normative and affective MATCMEC subscale mean scores and differences in

organizational commitment among the FNP participants who engaged in different mentoring types (formal vs. informal vs. a formal and informal combination).

Descriptive study findings supported the presence of multiple mentoring perspectives. The research study findings supported the multiple mentoring perspectives approach (Allen & Eby, 2010, p. 60). Mentorship constellations are relationship clusters that foster mentee psychosocial and career success and are not limited to one mentor-mentee dyad and may include multiple professionals (de Janasz &Sullivan, 2004; Higgins & Kram, 2001; Kram, 1985). Multiple mentoring relationship types were utilized by FNPs to meet their psychosocial and career goals.

Bivariate analysis yielded significant MATCMEC normative and affective commitment scores and mentoring types. Multiple regression of MATCMEC normative and affective commitment scales between participants did not reach significance. It did highlight the possible relationships between normative and affective organizational commitment. It has been proposed that a sense of obligation (normative commitment) might precede emotional workplace attachment (affective commitment; Gutierrez et al., 2012; Meyer & Allen, 1997; Meyer et al., 2002). The study results were reflective of the first year of FNP primary care practice. Affective and normative organizational commitment might be fostered by longer formal and informal FNP mentoring relationships. In both business and academia, mentoring relationships have continued over the years and supported personal and professional transitions throughout a career (Allen et al., 2004; Aryee & Chay, 1994; Sosik et al., 2005).

There was no significant continuance commitment relationship with FNP mentoring types. Continuance commitment is associated with employee longevity (Allen

& Meyer, 2000; Meyer et al., 2002). Thus, the first year of FNP primary care practice might not be long enough to evaluate the risks associated with leaving the job. Additionally, the first year of FNP transition into clinical practice is a challenging time of finding employment, transition, and competency development (Brown & Olshansky, 1998; Doerksen, 2010; Gardner et al., 2008; Harrington, 2011; Sargent & Olmedo, 2013). Consideration of risks and benefits associated with leaving an initial FNP position may occur after one year of practice

Organizational Commitment and Mentoring Functions

In response to the third research question, multiple regression measured the three MATCMEC subscale mean scores and differences in organizational commitment among the FNP participants who engaged in career, psychosocial, and role modeling mentoring functions. The MFQ-9 measured the mentoring function mean scores. Career, psychosocial, and role modeling functions' impact on the MATCMEC affective commitment indicated a significant model. The three mentoring functions, as well as all covariates, predicted approximately 16% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), career function had a significant effect on affective commitment scores ($t = 2.70$, $p = .008$). None of the other functions were significantly related to affective commitment scores.

During the first year of FNP primary care practice, there are personal and professional challenges. Stronger employee attachment and identification with workplace goals are fostered by a supportive environment, competency development, and

reducing role stress (Ahmad & Oranye, 2010; Concha, 2009; Hulpia, Devos, & Rosseel, 2009; Stazyk, Pandey, & Wright, 2011; Yun, Takeuchi, & Liu, 2007). Prior career functions mentoring research has demonstrated successful protégé role transition through coaching, increasing mentee visibility, providing professional opportunities, and protecting the mentee from adversity (Allen & Eby, 2003; Allen et al., 2004). Career mentoring functions support FNP protégé confidence building, emotional connections, role identification, and assumption of primary care responsibilities. Moreover, career mentoring functions foster FNP mentee organizational commitment through communication, engagement, and professional relationship building (Aryee & Chay, 1994; Bozeman & Feeney, 2007; Gardner et al., 2008). All mentoring relationship types occurred within and/or outside the workplace. The study findings supported the significant impact on FNP affective commitment by career mentoring functions during the first year of primary care practice.

Results of the multiple linear regression to assess the effect of career, psychosocial, and role modeling functions on normative commitment indicated a significant model. The three mentoring functions and all covariates predicted approximately 9% of variance in MATCMEC normative commitment scores. Further inspection of the individual predictors indicated that in the presence of all covariates (marital status, ethnicity, years working as a FNP, gender, graduate degree, years of RN clinical experience before becoming a FNP, and age), none of the mentoring functions had any effect on normative commitment. Organizational normative commitment is associated with FNP mentee sense of obligation to the workplace. Although career, psychosocial, and role modeling functions collectively predicted normative commitment,

there was no specific mentoring function that fostered FNP organizational normative commitment.

Results of the multiple linear regression to assess the effect of career, psychosocial, and role modeling functions on continuance commitment did not indicate a significant model. During the research study, FNPs reflected on their first year of primary practice. The timeframe may have been too short to measure mentoring functions' impact on FNP continuance organizational commitment (Allen & Meyer, 2000; Meyer et al., 2002).

In response to the fourth research question, multiple linear regression was conducted to determine the effect of mentoring quality on MATCMEC scores. A series of multiple linear regressions were conducted for each MATCMEC subscale. Mentoring quality, as well as all covariates, predicted approximately 19% of the variance in affective commitment scores. Inspection of the individual predictors indicated that in the presence of all covariates, mentoring quality had a significant effect on affective commitment. Mentorship quality is associated with protégé satisfaction (Gwyn, 2011; Jakubik, 2007). Mentorship meaningfulness, benefits, and depth contribute to high quality relationships (Hinde, 1981; Kram, 1985). High quality mentoring relationships have promoted protégé empowerment (Bozeman & Feeney, 2007; Gwyn, 2011; Jakubik, 2007). Thus, high quality FNP mentoring relationships have the potential to foster protégé emotional attachments within the workplace. High quality mentoring outcomes support protégé growth, confidence, vitality, and motivation to contribute to the workplace (Dutton & Ragins, 2007).

The effect of mentoring quality on FNP continuance commitment did not indicate a significant model. Again, continuance commitment remained problematic when evaluating organizational commitment during the first year of FNP primary care practice. The effect of mentoring quality on FNP normative commitment indicated a significant model, $F(8, 203) = 2.09$, $p = .038$, $R^2 = .08$. Mentoring quality, as well as all covariates, predicted approximately 8% of the variance in normative commitment scores.

Normative commitment is associated with a protégé's obligation to the workplace. High quality mentoring relationships have promoted protégé normative commitment through mentor role modeling and engagement with workplace goals and initiatives (Hinde, 1981; Kram, 1985). High quality mentoring relationship is supportive of FNP affective and normative organizational commitment. High quality mentoring relationships have the potential to support FNP emotional and moral commitments to the workplace.

The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model Summary

The Family Nurse Practitioner Mentoring Relationships and Organizational Commitment Model was proposed in the research study (see Figure 1, page 38). The concepts of FNP mentoring were linked to organizational commitment. The conceptual model depicted mentoring relationships' (presence, functions, types, and quality) effects on FNP organizational commitment. The research study findings were partially supportive of the proposed model.

Mentored FNPs were significantly more affectively committed to the workplace than non-mentored FNPs. Career, psychosocial, and role modeling mentoring functions

had a significant impact on affective and normative FNP organizational commitment. Further analysis supported the significant impact of career functions' impact on FNP affective commitment. High quality FNP relationships had a significant impact on both normative and affective organizational commitment.

The study findings were supportive of mentoring relationships' impact on FNPs' emotional attachments and ethical obligations that support organizational commitment. Although there were associations with mentoring and FNP normative and affective organizational commitment, more research is needed to determine the development of these two organizational commitment concepts and mentorship. Additionally, there was no significant impact of FNP mentoring relationships (presences, types, functions, and quality) on continuance commitment. Continuance commitment is associated with job longevity and may not be a factor during FNPs' transition into practice. Further research is recommended to differentiate organizational commitment concepts.

Limitations of the Study

The research study investigated the impact of FNP mentoring relationships on organizational commitment. Although it was a national study, it was limited to AANP FNP members working in primary care settings during the first year of primary care practice. The current study's FNP demographics were consistent with the previous national ANCC FNP Role Delineation Survey (ANCC, 2011). The predominantly White, middle aged female FNP sample results could not be generalized to current and future FNPS who are racially diverse, male, with limited to no prior RN experience, and not working in primary care settings. Additionally, there is a projected increase in DNP and

doctoral prepared FNP graduates in 2016 (ANCC, 2011). The current sample comprised only 3% of doctoral prepared FNPs.

Current health care reforms and evolving NP educational requirements might limit generalizability of the study findings. Future FNP role expectations and transition into complex primary care settings will continue to be a challenge. The current FNP population is middle-aged and a potential FNP shortage can be projected because of retirement and attrition. It supports the need for an increased FNP workforce in primary care. Mentoring has the potential to support and sustain FNPs in the workplace. Currently, 10% of the FNP respondents were not working in primary care settings. Study findings cannot be generalized to FNPs or other NPs working in non-primary care workplace settings.

Mentoring relationship types (informal, formal, and a combination of formal and informal) were present during the first year of FNP primary care practice. More research is needed to clarify the organizational commitment normative and affective constructs. Family nurse practitioner mentoring types are potential areas for future qualitative and quantitative research for concept clarification and measurement. Additionally, formal mentoring comprised only 11% of the FNP mentoring relationships. Formal mentoring program development and evaluation is needed. Formalized mentoring programs have the potential to promote FNP role transition, job retention, and personal and professional development.

The study was limited by a useable 26.9% response rate, FNP recall of the first year of primary care practice, and a possible increased mentored FNP response to a mentoring survey. Eligibility criteria were limited to FNP respondents working full time

during the first year of primary care practice. Research study participation was limited to a four-week timeframe. A postal reminder was mailed to encourage participation. A second postal study reminder was not possible because of the increased mailing and production costs; however, a second postal reminder may have increased the response rate.

Although, mentoring and organizational commitment definitions were included in the survey, FNP respondents may not have correctly identified and differentiated the concepts. More research is needed to explore and define organizational commitment and mentoring concepts through the lens of advanced practice nursing. Additionally, historical effects had the potential to influence FNP recall of the first year of primary care practice. The FNP sample reported an average of 9.3 years as a FNP and 13.6 years of nursing experience. Recall of the first year of FNP primary care practice might have been difficult for experienced FNPs. Moreover, experienced FNPs may not have participated in the study because recall of their first primary care was remote. Additionally, newly hired FNPs have competing demands that may have limited their study participation.

Implications for Advanced Practice Nursing

The study findings confirmed the presence of mentoring during the first year of FNP primary care practice. Mentoring strategies can promote FNP transition into primary care practice. Mentorship functions (career, psychosocial, and role modeling) support FNP personal and professional development. High quality mentoring relationships foster FNP emotional and moral obligations to the workplace. Recommendations for advanced practice nursing include:

1. Mentoring qualitative studies that explore NP perceptions of organizational commitment and mentoring.
2. Longitudinal NP mentoring and organizational commitment studies that are greater than one year.
3. Development and evaluation of formal mentoring programs during the first year of FNP primary care practice.
4. Development and evaluation of NP orientation and residency programs with opportunities for formal and informal mentoring relationship development.
5. National and local NP professional organizational initiatives to promote a mentoring culture for NP graduates.
6. Development of workplace and professional organizational initiatives for multiple mentoring opportunities and perspectives.
7. Development of online education and virtual communities to foster NP mentoring, career and psychosocial development, and workplace commitment.

Recommendations for Future Research

The study findings supported the need for future research and concept clarification concerning the organizational normative, continuance, and affective commitment concepts (Meyer & Allen, 1997; Meyer et al., 2002). This study was the first study of FNP organizational commitment. Future study recommendations include NP organizational commitment and mentoring research that target outcomes.

Mentoring research has focused on the relationship dyad of experienced and novice participants. An evolutionary concept of mentorship has been proposed in nursing

(Stewart & Krueger, 1996). Future research studies should include mentorship concept clarification and qualitative studies with other APN groups. Additional recommendations include exploration of mentoring relationships' impact on organization commitment with other NP specialties and workplace settings.

Informal, formal, and a combination of formal informal relationships are reflective of multiple FNP mentoring types. Multiple FNP mentorship types and constellations were utilized in the study. Family nurse practitioner transition into practice may require multiple mentors to meet primary care role responsibilities (de Janasz & Sullivan, 2004; Higgins & Kram, 2001; Kram, 1985). Future research recommendations include exploration of multiple mentoring relationship types' impact on NP organizational commitment, job retention, career, and personal satisfaction. Additionally, there is a need to develop formal NP mentoring programs that foster FNP transition into practice and organizational commitment (Allen, Finkelstein, & Poteet, 2009).

Mentorship quality is associated with FNP protégé relationship satisfaction (Jakubik, 2007). Future research recommendations include mentoring quality concept clarification. Both qualitative and quantitative studies are needed to identify significant indicators of mentoring relationship quality that impact FNP organizational commitment. Mentorship has been characterized as a reciprocal relationship. Future NP mentoring studies should include mentors' perceptions.

Chapter Summary

This chapter presented a discussion of study findings related to FNP mentoring relationships' (presence, type, functions, and quality) impact on organizational commitment. The FNP demographic characteristics were described and related to current

and future research recommendations. The proposed FNP Mentoring Relationships and Organizational Commitment Model was compared to the study findings. Limitations of the study were included. Implications for advanced practice nursing were proposed. Recommendations for future research included quantitative and qualitative studies that will explore organizational commitment and mentoring with other NP specialties and advanced practice nurses. The current study focused on FNP practice during the first year of primary care. Longitudinal studies are needed to explore the impact of NP mentoring on organizational commitment and health care outcomes. Additionally, NP mentoring studies from mentors' perspectives were recommended.

APPENDIX A

TABLES

Table 1

Pilot Sample Demographic Descriptive Summary

Demographic	*n*	%
Response type		
Electronic	10	83
Mail-in	2	17
Ethnicity		
Asian	1	8
Black	1	8
White	10	83
Marital Status		
Single or never married	2	17
Married	6	50
Living with a partner or significant other	3	25
Separated, divorced, or widowed	1	8
Gender		
Female	10	91
Male	1	8
Graduate degree earned for initial FNP academic preparation		
Masters in Nursing as an FNP	7	58
Post-masters in Nursing as an FNP	*3*	25
Doctor of Nursing Practice (DNP)	2	17
Primary care workplace during first year as an FNP		
Ambulatory care center	1	8
Private practice	1	8
Outpatient clinic	2	17
Outpatient office setting	3	25
Retail clinics	1	8
Employee health clinic	1	8
Long-term care facility	1	8
Urgent care location	2	17
State worked during first year of clinical practice		
Connecticut	1	8
New Jersey	1	8
New York	9	82
Texas	1	8

Note. Due to rounding error, some percentages may not sum to 100%.

Table 2

Pilot Study Instrument Cronbach's Alpha Reliability, Means, and Standard Deviations

Scale	No. of items	α	*M*	*SD*
MATCMEC				
Affective commitment	6	.90	4.54	1.19
Continuance commitment	6	-.10	3.59	0.60
Normative commitment	6	.88	4.00	1.23
MFQ-9				
Career function	3	.95	3.63	1.14
Psychosocial function	3	.90	3.59	0.81
Role modeling function	3	.98	3.81	1.13
QMRS	5	.99	4.44	1.38

Table 3

Family Nurse Practitioner Surveys Returned by Geographic Region

	Family Nurse Practitioner	
Geographic Region	Number Selected (percent of total pop.)	Number Return (percent of total pop.)
Northeast--NY, CT, MA, NJ, ME, PA, NH, VT, RI	261 (17%)	78 (19%)
South--TN, MS, TX, FL, LA, AL, GA, AR, OK, VA, MD, SC, DC, NC, WV, DE, KY	644 (43%)	157 (39%)
Midwest--IA, NE, KS, OH, MO, MN, SD, ND, MI, IL, IN, WI	327 (22%)	104 (26%)
West--WA, AZ, CA, OR, CO, AK, ID, NM, UT, HI, NV, WY, MT	267 (18%)	63 (16%)
Other--AE, AP, APO	1 (<1%)	1 (<1%)
Total	1500 (100%)	403 (100%)

Table 4

Main Study Instrument Cronbach's Alpha Reliability, Means, and Standard Deviations

Scale	No. of items	α	*M*	*SD*
MATCMEC				
Affective commitment	6	.88	4.46	1.57
Continuance commitment	6	.82	3.47	1.43
Normative commitment	6	.83	3.86	1.37
MFQ-9				
Career function	3	.89	3.57	0.91
Psychosocial function	3	.88	3.27	1.01
Role modeling function	3	.85	3.77	0.86
QMRS	5	.93	4.90	0.91

Table 5

Main Sample Demographic Descriptive Statistics

Demographics	*n*	%
Response type		
Electronic	58	14
Mail-in	345	86
Ethnicity		
Asian	16	4
Black	24	6
Hispanic	8	2
White	352	87
Marital Status		
Single or never married	38	10
Married	292	73
Living with a partner or significant other	16	4
Gender		
Female	369	92
Male	34	8
Graduate degree earned for initial FNP academic preparation		
Master's in Nursing as an FNP	329	82
Post-master's in Nursing as an FNP	63	16
Doctor of Nursing Practice (DNP)	7	2
PhD, DNSc, ND, Ed.D, DrPH or other terminal degree	2	1
Primary care workplace during first year as an FNP		
Ambulatory care center	29	7
Health care station	8	2
Outpatient office setting	93	23
Retail clinics	13	3
Employee health clinic	11	3
Long-term care facility	20	5
Urgent care location	4	1
Mentoring relationship		
No mentoring relationship in first year	178	44
Mentoring relationship in first year	223	55
Mentor's position*		
FNP	97	24
(Primary care NP)	26	7
Other (MD, PA, Respiratory Therapist, Midwife, etc.)	107	27
Mentor relationship type		
Formal	46	11
Informal	92	23
Combination of both formal and informal	86	21
Not applicable	176	44

Note. Due to rounding error and participant ability to select two or more categories, some percentages may not sum to 100%. *Participants could respond to FNP or non-FNP as well as other; thus, the categories do not sum to 100%.

Table 6

Means and Standard Deviations for Commitment Scores for Each Mentoring Type

	Affective		Continuance		Normative	
Mentoring Type	*M*	*SD*	*M*	*SD*	*M*	*SD*
Formal	4.53	1.67	3.78	1.50	3.86	1.42
Informal	4.73	1.55	3.25	1.34	4.11	1.34
Both formal and informal	4.73	1.38	3.51	1.49	4.11	1.29

Table 7

Means and Standard Deviations for Continuous Main Sample Descriptive Statistics

Variable	Min.	Max.	*M*	*SD*
Years working as an FNP	1	44	9.34	7.20
Age	26	76	49.47	11.10
Years of R.N. experience before becoming a FNP	0	40	13.55	8.91

Table 8

Preliminary Bivariate Analyses for Research Question One

Dependent variable	*df*	*SS*	*MS*	*F*	*p*
Normative commitment	1	11.40	11.40	6.11	.014
Affective commitment	1	21.28	21.28	8.81	.003
Continuance commitment	1	0.11	0.11	0.05	.816

Note. MANOVA $F(3, 377) = 4.19$, $p = .006$

Table 9

Multiple Linear Regression: Mentorship and Covariates in Relation to MATCMEC Affective Commitment Scores for Research Question One

Variable	*B*	*SE*	β	*t*	*p*
Mentoring (Reference: no mentoring)	0.45	0.17	.14	2.72	.007
Marital status (Married vs. other)	-0.22	0.19	-.06	-1.18	.240
Ethnicity (White vs. other)	0.26	0.25	.06	1.04	.299
Years working as FNP	0.03	0.02	.13	1.78	.076
Gender (Female vs. other)	-0.09	0.31	-.02	-0.30	.764
Master's degree as an FNP (versus other)	0.04	0.18	.01	0.23	.821
Years as an R.N.	0.01	0.01	.03	0.43	.665
Age	0.00	0.01	.00	0.02	.987

Note. $F(8, 362) = 2.15$, $p = .031$, $R^2 = .05$, adjusted $R^2 = .24$.

Table 10

Preliminary Bivariate Analysis for Research Question Two

Dependent variable	*df*	*SS*	*MS*	*F*	*p*
Normative commitment	3	17.00	5.67	3.02	.030
Affective commitment	3	21.87	7.29	3.03	.029
Continuance commitment	3	9.38	3.13	1.52	.210

Note. MANOVA $F(9, 910) = 2.45$, $p = .009$

Table 11

Preliminary Bivariate Analyses for Research Question Three

Mentoring function	Affective		Continuance		Normative	
	p	*r*	*p*	*r*	*p*	*r*
Career	< .001	.34*	.101	.110	.001	.23*
Psychosocial	< .001	.25*	.008	.18*	.006	.18*
Role modeling	< .001	.24*	.197	.09	.004	.20*

Table 12

Multiple Linear Regression: Mentoring Functions with Covariates in Relation to MATCMEC Affective Commitment Scores for Research Question Three

Variable	*B*	*SE*	β	*t*	*p*
Career function	0.42	0.16	.26	2.70	.008
Psychosocial function	0.18	0.12	.12	1.54	.126
Role modeling function	0.03	0.16	.02	0.20	.844
Marital status (Married vs. other)	-0.44	0.23	-.13	-1.93	.055
Ethnicity (White vs. other)	0.17	0.28	.04	0.60	.547
Years working as FNP	0.03	0.02	.15	1.60	.112
Gender (Female vs. other)	0.25	0.43	.04	0.59	.554
Master's degree as an FNP (versus other)	0.12	0.23	.03	0.50	.615
Years as an R.N.	0.02	0.02	.09	1.00	.319
Age	0.00	0.02	-.02	-0.17	.867

Note. $F(10, 200) = 3.88$, $p < .001$, $R^2 = .16$, adjusted $R^2 = .12$.

Table 13

Multiple Linear Regression: Mentoring Functions with Covariates in Relation to MATCMEC Normative Commitment Scores for Question Three

Variable	*B*	*SE*	β	*t*	*p*
Career function	0.23	0.14	.16	1.60	.112
Psychosocial function	0.08	0.11	.06	0.72	.470
Role modeling function	0.05	0.15	.03	0.31	.756
Marital status (Married vs. other)	-0.01	0.21	.00	-0.06	.954
Ethnicity (White vs. other)	-0.24	0.26	-.06	-0.90	.367
Years working as FNP	-0.02	0.02	-.09	-0.86	.391
Gender (Female vs. other)	-0.08	0.38	-.01	-0.21	.838
Master's degree as an FNP (versus other0	-0.04	0.21	-.01	-0.19	.850
Years as an R.N.	0.01	0.02	.06	0.61	.541
Age	-0.02	0.01	-.13	-1.03	.303

Note. $F(10, 200) = 1.88$, $p = .050$, $R^2 = .09$, adjusted $R^2 = .04$.

Table 14

Preliminary Bivariate Analyses for Organizational Commitment and Mentoring Quality for Research Question Four

	Mentoring Relationship Quality	
Commitment	*p*	*r*
Affective	< .001	.37*
Continuance	.108	.11
Normative	.011	.17*

Table 15

Multiple Linear Regression: Mentoring Quality with Covariates in Relation to MATCMEC Affective Commitment Scores for Question Four

Variable	*B*	*SE*	β	*t*	*p*
Mentoring quality	0.64	0.11	.39	5.99	.000
Marital status	-0.52	0.23	-.15	-2.28	.024
Ethnicity (White vs. other)	-0.05	0.28	-.01	-0.17	.867
Years working as FNP	0.04	0.02	.17	1.77	.078
Gender (Female vs. other)	0.22	0.41	.03	0.53	.596
Master's degree as an FNP (versus other)	0.22	0.23	.06	0.98	.329
Years as an R.N.	0.02	0.02	.09	0.92	.357
Age	-0.01	0.02	-.07	-0.55	.584

Note. $F(8, 202) = 5.80$, $p < .001$, $R^2 = .19$, adjusted $R^2 = .16$.

Table 16

Multiple Regression: Mentoring Relationship Quality (QMRS) with Covariates in Relation to MATCMEC Normative Commitment Scores for Question Four

Variable	*B*	*SE*	β	*t*	*p*
Mentoring quality	0.28	0.10	.19	2.78	.006
Marital status (Married vs. other)	-0.07	0.21	-.02	-0.33	.744
Ethnicity (White vs. other)	-0.36	0.26	-.10	-1.39	.166
Years working as FNP	-0.01	0.02	-.04	-0.42	.673
Gender (Female vs. other)	-0.20	0.37	-.04	-0.54	.589
Master's degree as an FNP (versus other)	0.04	0.21	.01	0.20	.841
Years as an R.N.	0.01	0.02	.09	0.90	.371
Age	-0.02	0.02	-.19	-1.52	.129

Note. $F(8, 203) = 2.09$, $p = .038$, $R^2 = .08$, adjusted $R^2 = .04$.

APPENDIX B

FAMILY NURSE PRACTITIONER SURVEY

Family Nurse Practitioner Demographic Survey

IF YOU USE POSTAL MAIL, PLEASE RETURN THE SURVEY ONLY. THE LETTER, IRB APPROVAL, AND CONSENT FORMS ARE FOR YOUR INFORMATION AND SHOULD NOT BE MAILED BACK. PLEASE REMOVE THE INFORMED CONSENT FORM AND MAIL BACK THE SURVEY THAT BEGINS ON PAGE 2.

IF YOU USE the SURVEYMONKEY LINK, YOU HAVE ONE OPPORTUNITY TO COMPLETE THE SURVEY. YOU CAN NOT RETURN, AT A LATER TIME, TO PARTICIPATE IN THE SURVEY.

2. Please check whether this survey is being filed online or through the postal service.

- ◯ Online Survey
- ◯ Mail-in Survey

3. During your first year as a FNP, were you working in a primary care setting?

- ◯ Yes
- ◯ No

4. How many years have you worked as a FNP? (Enter a whole number of years)

5. What is your gender?

- ◯ Female
- ◯ Male

Other (please specify)

6. What is your ethnicity? (Choose one or more that best describes your ethnicity)

- ☐ Asian
- ☐ Black
- ☐ Hispanic or Latino
- ☐ White

7. What is your age? (Enter a whole number of years)

8. What is your marital status?

- ◯ Single or never married
- ◯ Married
- ◯ Living with a partner or significant other
- ◯ Separated, divorced, or widowed

9. What graduate degree did you earn for your initial FNP academic preparation?

- ◯ Masters in Nursing as a FNP
- ◯ Post masters in nursing as a FNP
- ◯ Doctor of Nursing Practice (DNP)
- ◯ PhD, DNSc, ND, Ed.D, DrPH or other terminal degree

Other (please specify)

10. How many years of registered professional nursing (R.N.) clinical experience did you have before becoming a FNP? (Enter a whole number of years)

11. In which state did you practice as a FNP during the first year of clinical practice?

12. During your first year as a FNP, what was your primary care workplace?

Select all locations that describe to your workplace location during the first year of primary care practice.

- ☐ Ambulatory care center
- ☐ Private practice
- ☐ Outpatient clinic
- ☐ Health care station
- ☐ Outpatient office setting
- ☐ Retail clinics
- ☐ Employee health clinic
- ☐ Long term care facilities
- ☐ Home care
- ☐ Hospice and palliative outpatient care
- ☐ Occupational health
- ☐ Urgent care location

13. During your first year working as a FNP in primary care, did you have a mentoring relationship?

◯ Yes ◯ No

14. With whom did you have a mentoring relationship during your first year as a FNP?

- ◯ A FNP
- ◯ A Primary care NP (not FNP)

Other (enter the mentor's job title)

15. A formal mentorship is associated with a workplace assigned mentor-protégé relationship. An informal mentorship is associated with a relationship that is based on mutual interests, friendship, and not confined to workplace or time. A combination of formal and informal relationships includes both workplace and friendship based mentorships.

If you had a mentoring relationship, what types of mentoring relationship did you have during the first year of FNP practice in primary care?

- ◯ Formal
- ◯ Informal
- ◯ A combination of formal and informal mentoring relationships
- ◯ non applicable. There was no mentoring relationship.

The Three-Component Model Employee Commitment Survey

An organization is a workplace, practice, or setting in which you worked as a FNP during YOUR FIRST YEAR OF PRIMARY CARE PRACTICE.

16. With respect to your own feelings about your workplace during YOUR FIRST YEAR OF PRIMARY CARE PRACTICE, check the circle below that indicates the degree of your agreement or disagreement with each statement.

Affective Commitment Scale

	Strongly disagree	Disagree	Slightly disagree	Undecided	Slightly agree	Agree	Strongly agree
I would have been very happy to spend the rest of my career with the organization.	○	○	○	○	○	○	○
I really felt as if the organization's problems were my own.	○	○	○	○	○	○	○
I did not feel like "part of the family" at my organization.	○	○	○	○	○	○	○
I did not feel "emotionally attached" to the organization.	○	○	○	○	○	○	○
The organization had a great deal of personal meaning for me.	○	○	○	○	○	○	○
I did not feel a strong sense of belonging to the organization.	○	○	○	○	○	○	○

17. With respect to your own feelings about your workplace during YOUR FIRST YEAR OF PRIMARY CARE PRACTICE, check the circle below that indicates the degree of your agreement or disagreement with each statement.

Continuance Commitment Scale

	Strongly disagree	Disagree	Slightly disagree	Undecided	Slightly agree	Agree	Strongly agree
It would have been very hard for me to have left my organization, even if I wanted to.	○	○	○	○	○	○	○
Too much in my life would have been disrupted if I had decided to leave the organization.	○	○	○	○	○	○	○
Staying with my organization was a matter of necessity as much as desire.	○	○	○	○	○	○	○
I believed that I had too few options to consider leaving the organization.	○	○	○	○	○	○	○
One of the few negatives of leaving the organization would have been the scarcity of available alternatives.	○	○	○	○	○	○	○
One of the major reasons I continued to work for the organization was that leaving the organization would have required considerable sacrifice; another organization may not have matched the overall benefits that I had.	○	○	○	○	○	○	○

18. With respect to your own feelings about your workplace during YOUR FIRST YEAR OF PRIMARY CARE PRACTICE, check the circle below that indicates the degree of your agreement or disagreement with each statement.

Normative Commitment Scale

	Strongly disagree	Disagree	Slightly disagree	Undecided	Slightly agree	Agree	Strongly agree
I did not feel any obligation to remain with my employer.	◯	◯	◯	◯	◯	◯	◯
Even if it were to my advantage, I did not feel it would have been right to leave the organization.	◯	◯	◯	◯	◯	◯	◯
I would have felt guilty if I left the organization.	◯	◯	◯	◯	◯	◯	◯
The organization deserved my loyalty.	◯	◯	◯	◯	◯	◯	◯
I did not leave my organization because I had a sense of obligation to the people in it.	◯	◯	◯	◯	◯	◯	◯
I owed a great deal to my organization.	◯	◯	◯	◯	◯	◯	◯

19. If you had a mentoring relationship during your first year as a FNP in primary care, please continue and answer the following questions based on ONE mentoring relationship. They include the Quality of Mentoring Relationship and the Mentoring Functions Questionnaires.
If you had not a mentoring relationship during the first year of primary care practice, you have completed the survey. Thank you.

Please check below.

◯ I was not mentored (Select and click next)

◯ Continue to next page (Select and click next)

Mentoring Relationship Quality Questionnaire

20. These statements pertain to one mentoring relationship DURING YOUR FIRST YEAR of FNP clinical practice. Check the type of mentoring relationship that best describes the mentoring relationship:

- ◯ Formal
- ◯ Informal

21. Please rate these statements as they pertain to the ONE previously selected mentoring relationship DURING YOUR FIRST YEAR OF FNP clinical practice. Using the scale provided, please indicate to what extent you disagree or agree with each of the statements by checking the circle for each statement.

	Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
My mentor and I enjoyed a high quality relationship.	◯	◯	◯	◯	◯	◯
Both my mentor and I benefited from the mentoring relationship.	◯	◯	◯	◯	◯	◯
I effectively utilized my mentor.	◯	◯	◯	◯	◯	◯
The mentoring relationship with my mentor was very effective.	◯	◯	◯	◯	◯	◯
I was very satisfied with the mentoring relationship with my mentor.	◯	◯	◯	◯	◯	◯

Mentoring Functions Questionnaire

Please rate these statements as they pertain to the **ONE** previously selected mentoring relationship DURING YOUR FIRST YEAR OF FNP clinical practice.

22. Using the scale provided, please indicate to what extent you disagree or agree with each of the statements by checking the circle for each statement.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
My mentor took a personal interest in my career.	○	○	○	○	○
My mentor helped me coordinate professional goals.	○	○	○	○	○
My mentor devoted special time and consideration to my career.	○	○	○	○	○
I shared personal problems with my mentor.	○	○	○	○	○
I exchanged confidences with my mentor.	○	○	○	○	○
I considered my mentor to be a friend.	○	○	○	○	○
I tried to model my behavior after my mentor.	○	○	○	○	○
I admired my mentor's ability to motivate others.	○	○	○	○	○
I respected my mentor's ability to teach others.	○	○	○	○	○

Thank you for your participation in this survey

Pilot Participant Evaluation Survey

23. Enter the number of minutes needed to complete your survey. It includes the time reading the study description and consent.
(Please estimate a whole number)

24. What part of the survey took you the longest to complete?

- ◯ The FNP Demographic survey
- ◯ The Three Component Employee Commitment Survey.
- ◯ The Quality of Mentoring Relationship Questionnaire
- ◯ The Mentoring Functions Questionnaire.

25. Was everything clear and understandable?

- ◯ Yes
- ◯ No

26. Was the survey easy to read?

- ◯ Yes
- ◯ No

27. Was there anything confusing about the survey directions or questions?

- ◯ Yes
- ◯ No

28. If there was anything confusing about the survey directions or questions, please explain in the comment box.

29. Was there anything that frustrated you when taking the survey?

- ◯ Yes
- ◯ No

30. If any part of this survey frustrated you, please explain in the comment box.

31. Describe your reason for selecting the postal or online survey option.

32. Do you have any suggestions or comments about the survey or recommendations for improvement?
Your input is welcomed and appreciated.

AUTHORS' PERMISSIONS FOR USE OF INSTRUMENTS AND THEIR MODIFICATIONS

The Three-Component Model Employee Commitment Survey Author Permission

The Three-Component Model Employee Commitment Survey academic license was obtained from the TMC Commitment Survey website on December 2, 2013:

http://employeecommitment.com/index.html

The Three-Component Model Employee Commitment Survey Permission
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In this agreement, the following words, when capitalized, have the indicated meanings:

"Academic Researcher" indicates someone whose position presumes that they will conduct research and be responsible for the publication or other dissemination of the results of that research or be responsible for the teaching of students.

"Inventors" indicate the authors, Dr. John Meyer and Dr. Natalie Allen, in the faculty of Social Science at UWO.

"Questionnaire" indicates the TCM Employee Commitment Survey, Academic Version 2004 developed by the Inventors. The Questionnaire includes the User's Guide and the Organizational Commitment Survey which is available in two versions; the "Original" which contains 24 questions and the "Revised" which contains 18 questions. The license granted under this Agreement includes both versions of the survey and the User's Guide and can be downloaded from this website as a single PDF file.

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(h) YOU should print out or download a copy of this Agreement and retain it for your records.

(i) YOU consent to the use of the English language in this Agreement.

Complete Your Information to Download...

Please complete the following information to obtain your copy of the Academic version of the TCM Employee Commitment Survey

Full Name: P. Bartley Da

Email: pd11234@g

How did you hear about us: Google

☑ I agree to the terms of this **Academic License** outlined above.

The Quality of Mentoring Questionnaire Author Permission

The Quality of Mentoring Questionnaire permission was obtained from the author via email: Dr. Tammy Allen, University of South Florida- Department of Psychology. The email address is tallen@shell.cas.usf.edu

Email permission:

from: **Tammy Allen** <tallen@mail.usf.edu>to: Patricia Bartley-Daniele <bartleyd@unlv.nevada.edu>

cc: "Allen, Tammy" <tallen@shell.cas.usf.edu>

date: Fri, Dec 6, 2013 at 7:42 AMsubject: Re: Doctoral Student Request to use the Quality of Mentoring Instrumentmailed-by: unlv.nevada.edusigned-by: mail.usf.edu

Dear Patricia,

Feel free to use the measure. Good luck with your dissertation.

Best regards,

Tammy

On Fri, Dec 6, 2013 at 7:34 AM, Patricia Bartley-Daniele <bartleyd@unlv.nevada.edu> wrote:
Dear Dr. Allen,

My name is Patricia Bartley Daniele. I am a nursing PhD candidate at University of Nevada, Las Vegas. My dissertation chairperson is Dr. Alona Angosta. The title of my dissertation is *Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment.*

As part of my dissertation, I plan to conduct a national study of United States Family Nurse Practitioners about mentoring and organizational commitment. I have read many of your publications and am requesting permission to use your instrument, *The Quality of Mentoring Questionnaire.* The use of your questionnaire will provide an opportunity to explore an important area in the nursing profession.

Thank you.
Patricia Bartley Daniele MSN, FNP-BC, CCRN, CNRN, CPAN, CAPA

The *Mentoring Functions Questionnaire* Author Permission

The *Mentoring Functions Questionnaire* permission was obtained from the author via email: Dr. Terri A. Scandura, University of Miami, School of Business. The email address is scandura@miami.edu
Email permission:

Scandura, Terri <tscandur@bus.miami.edu>

to: Patricia Bartley Daniele <pd11234@gmail.com>

date: Tue, Dec 10, 2013 at 8:23 AM

subject: Re: Doctoral Student Request to use the Mentoring Functions Questionnaire (MFQ-9)

mailed-by: bus.miami.edu

You have permission to use the MFQ-9 for your dissertation research.

Sent from my iPad
Terri A. Scandura
Professor of Management, University of Miami

The Three-Component Model Employee Commitment Survey Author Modification Permission

From: John Meyer meyer@uwo.ca

to: Patricia Bartley Daniele <pd11234@gmail.com>

date: Mon, Feb 24, 2014 at 9:43 AM

subject: RE: Patricia Bartley Daniele Nursing Doctoral Candidate and the Employee Organizational Commitment

mailed-by: uwo.ca

Dear Patricia,
Given what you are doing, it probably makes sense to change the tense. However, the wording of some items might be awkward with the tense changed - you will need to be careful with the rewording. Another option might be to keep the tense as is but instruct nurses to respond to the items as they would have near the end of their first year of clinical practice. Do whatever you think will make it easiest for nurses to respond in a meaningful way.
I hope all goes well with the study.
Best regards,
John Meyer
Dr. John Meyer
Department of Psychology
Rm 8411, Social Science Centre
Western University
London, Ontario, Canada

Mentoring Functions Questionnaire Author Modification Permission:

from: Patricia Bartley Daniele pd11234@gmail.com

to: "Scandura, Terri" <tscandur@bus.miami.edu>

date: Thu, Feb 27, 2014 at 5:36 PM

subject: Re: Doctoral Student Request to use the Mentoring Functions Questionnaire (MFQ-9)

mailed-by: gmail.com

I am a nursing doctoral student a UNLV. I had emailed you on 12/10/13 and obtained your permission to use the Mentoring Functions Questionnaire in my doctoral dissertation.

I am in the midst of my pilot study. Survey feedback included confusion concerning the tense of the verb in the MFQ. Since I am surveying Nurse Practitioners about their first year of clinical practice, it is in the past. I am requesting your permission to adjust the verb tenses in the past to reflect the purpose of the study. Thanks again.
Pat Bartley Daniele
UNLV Nursing Doctoral Student
917 349 1819

from: **Scandura, Terri** tscandur@bus.miami.edu

Feb 27 (3 days ago)

to: Patricia Bartley Daniele <pd11234@gmail.com>

date: Thu, Feb 27, 2014 at 5:46 PM

subject: Re: Doctoral Student Request to use the Mentoring Functions Questionnaire (MFQ-9)

mailed-by: bus.miami.edu

This should be fine.

Sent from my iPad

APPENDIX C

SAMPLE SELECTION

The ANCC FNP Role Delineation Study (2011) utilized a random sample of certified FNPs that was stratified according to U.S. geographic regions. The AANP list provided an updated demographic data and reflected the current geographical regional FNP distribution. The past sampling demographic data of the ANCC FNP Role Delineation Study were:

Geographical Region	**Percent of total population**
Northeast-NY, CT, MA, NJ, ME, PA, NH, VT, RI	17.4%
South-TN, MS, TX, LA, AL, GA, AR, OK, PROPSED VA, SC, DC, NC	42.9%
Midwest-IA, NE, KS, OH, MN, SD, ND, MI, IL, IN, WI	21.8%
West-WA**,** AZ, CA, OR, CO, AK, ID, NM, UT, HI, NV, WY, MT	17.8%
Other-AE, AP, APO	0.2%
Total	**100%**

APPENDIX D

INSTITUTIONAL REVIEW BOARD APPROVAL AND INFORMED CONSENT FORM

Biomedical IRB – Exempt Review Deemed Exempt

DATE: January 16, 2014
TO: **Dr. Alona Dalusung-Angosta**, School of Nursing
FROM: Office of Research Integrity – Human Subjects
RE: Notification of IRB Action
Protocol Title: Family Nurse Practitioner Mentoring Relationship's Impact on Organizational Commitment
Protocol # 1312-4667

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:
Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 895-2794.

UNLV
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INFORMED CONSENT

Department of School of Nursing

TITLE OF STUDY: Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment

INVESTIGATOR(S): Alona Angosta PHD, APN, FNP, NP-C, Principal Investigator, Patricia Bartley Daniele MSN, FNP-BC, Student Investigator

For questions or concerns about the study, you may contact

Dr. Angosta at 702-895-1218, or Patricia Bartley Daniele at 917-349-1819.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of the study is to examine the factors of mentoring relationships (presence, types, functions, and quality) and their impact on Family Nurse Practitioner (FNP) organizational commitment in primary care settings.

Participants

You are being asked to participate in the study because you fit this criteria: (a) an earned master's, post-masters, or doctorate in nursing with FNP preparation; (b) full-time employment as a FNP in a primary care setting during your first year of FNP practice; (c) licensed as a FNP in at least one state; (d) a postal address; (e) internet access for the online survey option; (f) FNP certification (no multiple NP specialties); and (g) your prior agreement for release of information for American Association of Nurse Practitioners opt-in mailing list.

Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1312-4667
Exempt Date: 01-16-14

TITLE OF STUDY: Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment

Procedures

If you volunteer to participate in this study, you will be asked to respond to survey questions. The survey includes the Family Nurse Practitioner demographic survey and the Three-Component Model Employee Commitment Survey. If you had a mentoring relationship during your first year of primary care practice, you will be asked to continue and respond to the Quality of Mentoring Relationship Scale and the Mentoring Function Questionnaire. You have two choices for survey participation. You may use the enclosed paper survey and return it with the prepaid postal envelop. The second choice is to enter your responses online into the *Survey Monkey* version. If you choose to participate, use either the paper or online version of the survey. By returning the postal paper or online survey, you are giving your implied informed consent to participate in the study. Submitting the survey will constitute informed consent for the use of the encrypted data for analysis and possible future study and data analysis publication.

Benefits of Participation

While there are no direct benefits to you for your participation in the study, the aim of the study is to identify factors of mentoring relationships which influence organizational commitment. Through identification of these factors, we hope to develop mentoring strategies that foster organizational commitment in primary care settings.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. You may find that you are uncomfortable answering some of the questions. You may choose not to respond to any survey item, without consequence, and still complete the survey. You may also choose not to complete the paper survey or exit the online survey at any time.

Cost /Compensation

There will be no financial cost to you to participate in this study. The study will take 20 minutes of your time. You will not be financially compensated for your time.

Confidentiality

All information gathered in this study will be kept as confidential. No reference will be made in the online, written, or oral materials that could link you to this study. All survey responses will be entered into *Survey Monkey* and encrypted to protect identifying information. All records will be stored in a

Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1312-4667
Exempt Date: 01-16-14

locked facility in the principal investigator's office at UNLV for three years after completion of the study. After the storage time, the information will be destroyed according to UNLV guidelines.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent for the paper and online versions:

By checking (✓) "Yes" below, I am indicating that I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been provided to me.

☐Yes

☐No

Deemed exempt by the ORI-HS and/or the UNLV IRB. Protocol #1312-4667
Exempt Date: 01-16-14

APPENDIX E

RESEARCH STUDY LETTERS

Pilot Survey Recruitment Letter

PILOT SURVEY RECRUITMENT LETTER

Dear Pilot Study Participant,

I am a doctoral student enrolled in the University of Nevada, Las Vegas (UNLV) PhD nursing program. My dissertation chair is Dr. Alona Angosta. I am conducting this pilot survey as part of my doctoral dissertation. The dissertation title is *Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment*. You are invited to participate in a pilot survey for a future research study. Your participation involves answering 45 survey questions, followed by eight questions related to your experiences with taking the survey. It is estimated that it will take 25 minutes to complete the pilot study. The survey is focused on your perceptions of being a FNP during your first year of primary care practice. Mentoring is defined as a relationship in which a more experienced NP provides support, knowledge, and guidance for a newly hired FNP. Mentorship differs from preceptorship which is short term and concentrates on specific orientation tasks and skills. Organizational commitment is the FNP's identification and involvement in workplace goals and values.

You are being asked to participate in the pilot study because you are a certified FNP (no multiple NP specializations), with an earned master, post-masters, or doctorate preparation in nursing. Study inclusion criteria includes full time FNP employment in primary care settings during your first year of FNP practice, licensed as a FNP in at least one state, and having a postal address. The survey can be completed via prepaid return postal mail or online via *SurveyMonkey*. This pilot study is being conducted to evaluate the survey questions and the effectiveness of the survey as a data collection method.

At the end of the survey, questions have been included concerning your experience with taking the survey. These questions ask about the time it took to complete the survey, the part that took the longest, if it was clear, understandable, easy to read, and if there was anything confusing, frustrating, or annoying. If you volunteer to participate in this pilot survey, you will be asked to do the following:

1. Read the participant invitation letter and the UNLV Protection of Human Subjects Informed Consent Form.
2. Chose to participate in the survey by returning the enclosed prepaid postal paper survey or completing the same online version, using the *Survey Monkey*.
3. By returning the postal paper or online survey, you are giving your implied informed consent to participate in the study. Submitting the survey will constitute informed consent for the use of the encrypted data for analysis, and possible future study and data analysis publication. If you do not wish to participate, do not return the survey.
4. Your informed consent for the participation will precede the survey. You will be asked to:
   a. Respond to the *FNP Demographic Survey* and the *Three Component Employee Commitment Survey* statements and questions.
   b. Respond to the *Quality of Mentoring Relationship Questionnaire* and the *Mentoring Functions Questionnaire*, if you had a mentoring relationship during the first year of FNP primary care practice.
   c. Answer questions about taking pilot study survey.

5. If you choose the *Survey Monkey* option, your consent for the Survey Monkey survey version will precede the survey with clicking on the agreement button. Click on the Next button at the end of each page in the survey to proceed to the next page. Click the Submit button at the end of the online survey to send results.
6. Note the time it took to complete the survey (in minutes).

Pilot Survey Recruitment Letter (Continued)

7. Answer the questions about your experience with taking the pilot study survey.

If you agree to participate in the pilot study survey, we would appreciate it if you could complete the survey within 5 days of receipt of this letter. There may be no direct benefits to you as a participant of this study. However, your participation in this pilot test will assist to improve the survey. There are risks involved in all research studies. This pilot survey study may include only minimal risks. You may feel uncomfortable when answering some questions. If a question makes you uncomfortable you will be able to skip the question, leaving it unanswered, and proceed to the next survey question.

If you have any questions or concerns about this research study, you may contact me, Patricia Bartley Daniele. Additional questions regarding this research study procedures and rights of human subjects can be obtained from the UNLV Office for the Protection of Research Subjects at 702-895-2794. If you are interested in receiving information concerning the study findings, please contact me directly at bartleyd@unlv.nevada.edu.

Your participation in this research study is voluntary. You may refuse to participate in this pilot study. You may withdraw at any time (by not returning the paper survey, or leaving responses blank), or by clicking the Exit This Survey in *Survey Monkey*. All information gathered in this study will be kept confidential. The principal investor and student investigator of this study will be only persons looking at the survey responses. No reference will be made in written or oral materials that could link you to this study. All survey responses will be entered into *Survey Monkey* for data collection will be encrypted to protect you.

The completed online and paper survey results will be saved on a four (4) gigabytes USB flash drive. This flash drive will be stored in a locked facility at UNLV for three years after completion of the study. The surveys completed online will be permanently deleted from the *Survey Monkey* system once all of the data has been collected and saved on the flash drive. Data will be imported into the software systems for analysis. After the storage time, the flash drive will be destroyed. The following is the *Survey Monkey* link: https://www.surveymonkey.com/s/******* You can also complete the enclosed survey and return it with the prepaid postal envelop. Please complete only one survey.

Thank you for your participation,

Patricia Bartley Daniele, MSN, FNP-BC
UNLV School of Nursing PhD Doctoral Student Investigator
Contact: Phone *** *** ****
Email contact: **********
Dr. Alona Angosta, Dissertation Chair

Participant Recruitment Letter

PARTICIPANT RECRUITMENT LETTER

Dear Family Nurse Practitioner,

I am a doctoral student enrolled in the University of Nevada, Las Vegas (UNLV) PhD nursing program. My dissertation chair is Dr. Alona Angosta. I am conducting a survey as part of my doctoral dissertation. You are invited to participate in a doctoral nursing research study entitled Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment. Your participation involves answering 45 survey questions. The survey is focused on your perceptions of being a FNP during your first year of primary care practice. Mentoring is defined as a relationship in which a more experienced NP provides support, knowledge, and guidance for a newly hired FNP. Mentorship differs from preceptorship which is short term and concentrates on specific orientation tasks and skills Organizational commitment is the FNP's identification and involvement in workplace goals and values.

You are being asked to participate in the study because you are a certified FNP (no multiple NP specializations), with an earned master's, post-master's, or doctorate preparation in nursing. Study inclusion criteria includes full time FNP employment in primary care settings during your first year of FNP practice, being licensed as a FNP in at least one state, and having a postal address.

There is a choice of completing your survey by returning the enclosed prepaid postal mail survey or using the enclosed Survey Monkey link to complete the survey. The survey includes a total of 45 questions. You should allow approximately 20 minutes for completing the survey. However, pilot test participants reported that it required 10 to 15 minutes to complete it. You may withdraw at any time (by not returning the paper survey, or leaving responses blank), or by clicking the Exit This Survey in Survey Monkey. There is no financial cost to you. Your participation is voluntary.

If you volunteer to participate in this pilot survey, you will be asked to do the following:

1. Read the participant letter and the UNLV Protection of Human Subjects Informed Consent form.
2. Chose to complete the survey by returning the enclosed prepaid postal paper survey or completing the same online survey, using the Survey Monkey.
3. By returning the postal paper or online survey, you are giving your implied informed consent to participate in the study. Submitting the survey will constitute informed consent for the use of the encrypted data for analysis and possible future study and data analysis publication. If you do not wish to participate, do not return the survey.
4. Your informed consent will precede the survey. You will be asked to:
   a. Respond to the FNP Demographic Survey and the Three Component Employee Commitment Survey statements and questions.
   b. Respond to the Quality of Mentoring Relationship Questionnaire and the Mentoring functions Questionnaire, if you had a mentoring relationship during the first year of primary care practice.

Participant Recruitment Letter (continued)

5. Your informed consent for the Survey Monkey version will precede the survey with clicking on the agreement button. Click on the Next button at the end of each page in the survey to proceed to the next page. Click on the Submit button at the end of the online survey to send the results.

If you agree to participate in the survey, we would appreciate it if you could complete the survey within 5 days of receipt of this letter. There may be no direct benefits to you as a participant of this study. There are risks involved in all research studies. You may feel uncomfortable when answering some questions. If a question makes you uncomfortable you will be able to skip the question, leaving it unanswered, and proceed to the next survey question.

If you have any questions or concerns about this research study, you may contact me, Patricia Bartley Daniele. Additional questions regarding this research study procedures and rights of human subjects can be obtained from the UNLV Office for the Protection of Research Subjects at 702-895-2794. If you are interested in receiving information concerning the study findings, please contact me directly at bartleyd@unlv.edu.

Your participation in this research study is voluntary. You may refuse to participate in this study. You may withdraw at any time (by not returning the paper survey, or leaving responses blank), or by clicking the Exit This Survey in Survey Monkey. All information gathered in this study will be kept confidential. The principal investor and student investigator of this study will be only persons looking at the survey responses. No reference will be made in written or oral materials that could link you to this study. All survey responses will be entered into Survey Monkey for data collection will be encrypted to protect you.

The completed online and paper survey results will be saved on a four (4) gigabytes USB flash drive. This flash drive will be stored in a locked facility at UNLV for three years after completion of the study. After the storage time, the flash drive will be destroyed. The surveys completed online will be permanently deleted from the Survey Monkey system once all of the data has been collected. Data will be saved on the flash drive, and imported into the software systems for analysis. The following is the Survey Monkey link: https://www.surveymonkey.com. You can also complete the enclosed survey and return it with the prepaid postal envelop. Please complete only one survey.

You will receive a postal letter in two weeks to thank you for returning the survey or encouraging your participation in the survey. If you have any questions about this research survey completion, please contact the investigators of the study.

I thank you for your time and look forward to hearing from you.

Patricia Bartley Daniele, MSN, FNP-BC
UNLV School of Nursing PhD Doctoral Student Investigator

[redacted]

Dr. Alona Angosta, Dissertation Chair

Family Nurse Practitioner Survey

Dear Family Nurse Practitioner:

Approximately two weeks ago, a survey was mailed to you concerning *Family Nurse Practitioner Mentoring Relationships' Impact on Organizational Commitment* in primary care settings. If you have completed the prepaid postal or online *Survey Monkey* survey, we want to thank you for your participation and contribution to knowledge development concerning this important topic.

If you have not responded, we are writing again to encourage your participation so that the study results will be accurate and reflect current FNP practice. As previously mentioned, there are two options for survey completion. There is a return prepaid postal mail option that was included with the initial family nurse practitioner survey letter and online *Survey Monkey* option. The time for completion is estimated at 20 minutes. Your responses are voluntary and will be kept confidential. If you chose the online *Survey Monkey* link the access is:

https://www.surveymonkey.com/s/*******

Your participation in this research study is voluntary. You may refuse to participate or choose not to answer any survey question. You may withdraw at any time (by not returning the prepaid postal paper survey, or leaving responses blank), or by clicking the *Exit This Survey* in *Survey Monkey*. Data collection, storage, and destruction will follow UNLV Protection of Human Subjects guidelines and policies. If you need assistance with the survey completion, please contact me, Patricia Bartley Daniele. Additional questions regarding this research study procedures and rights of human subjects can be obtained from the UNLV Office for the Protection of Research Subjects at 702-895-2794. I thank you for your time and look forward to hearing from you. The survey closing date for participation is April 25, 2014.

Sincerely,

Patricia Bartley Daniele

Patricia Bartley Daniele, MSN, FNP-BC
UNLV School of Nursing PhD Doctoral Student
Investigator Contact:
Phone*** *** ****
Email**********

Dr. Alona Angosta, Dissertation Chair

APPENDIX F

RECRUITMENT EMAIL AND ADVERTISEMENT

On Wed, Jan 22, 2014 at 12:57 PM, Sue Hubbard <SHubbard@thenpa.org> wrote:

Hi Pat,

Our procedure is that approved surveys are disseminated via NPA Insights. Concerning your inquiry about the online member directory I can only refer you to the disclaimer that we have posted.

Please let me know if you would like me to include this in the February Insights.

Best,

Sue

Insights February 2014 Monthly Online Newsletter
Member Research – FNPs in primary care settings

Nurse Practitioner Association Members,

I am a PhD nursing student at the University of Nevada, Las Vegas. I am conducting a research study with FNPs who were working in primary care during their first year of clinical practice. It is exploring organizational commitment and mentoring. The survey is estimated to take 15 to 20 minutes. I would like to invite you to participate in this survey on this important research area. The data is being collected anonymously and the survey will close after the required sample is achieved. You have 2 options. You may email me and I can mail you a prepaid postal paper version of the survey. The second option is to click on the link to complete the survey.

https://www.surveymonkey.com/s/*******

Sincerely,

Pat Bartley Daniele MSN, FNP-BC

Email: bartleyd@unlv.nevada.edu
Phone: *** *** ****
Dr. Alona Angosta, Dissertation Chairperson

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