BMC Nursing

RESEARCH

Open Access

The stakeholders' role in informal mentoring: a qualitative descriptive study of nurses and midwives working in acute care settings

Tracy Alexis Kakyo[1*], Lily Dongxia Xiao[2] and Diane Chamberlain[2]

Abstract

Aim To understand the role of stakeholders (mentee, mentor, and the organisation) in informal mentoring of nurses and midwives working in acute care settings.

Design A qualitative descriptive study guided by reflexive thematic analysis. This manuscript was written in adherence to the Standards for Reporting Qualitative Research.

Methods Semi-structured interviews with a convenience sample of 35 nurses and/or midwives working in three regional hospitals in Uganda were conducted between June and September 2022.

Results Five overarching themes were identified reflecting nurses' and midwives' perceptions on building blocks of successful mentoring; approaches to mentor/mentee selection; varied strategies for mentoring in hospital environments; responsibilities of the stakeholders; and mentoring being a win-win for all stakeholders. Collectively, these themes highlight the input, processes, and short-term outcomes of engaging nurses and midwives in mentoring within acute care settings.

Conclusion Our findings reveal that informal mentoring offers advantages comparable to those of formal mentoring programs. These findings also challenge the prevailing notion of unidirectional mentoring. Mentees, just like mentors, play a proactive role in the informal mentoring process. Furthermore, the organisation is not simply a contextual variable; it actively contributes to the dynamics of informal mentoring relationships. The study also highlights the potential for inter-unit and inter-facility mentoring.

Clinical trial number Not applicable.

Keywords Mentoring, Nurses, Midwives, Qualitative research, Acute care settings

*Correspondence:
Tracy Alexis Kakyo
t.kakyo@muni.ac.ug; kakyotracy@yahoo.com
[1]Faculty of Health Sciences, Muni University, Arua, Uganda
[2]College of Nursing and Health Sciences, Flinders University, Adelaide, Australia

Background

Unlike the popular belief that "nurses eat their young" [1, 2], mentoring serves as a key strategy among nurses and midwives for nurturing their own within the profession. Mentoring continues to be an explicit requirement by nursing and midwifery bodies requiring all nurses and midwives to provide education and support to their colleagues [3, 4]. While existing literature predominantly focuses on the roles and contributions of the mentor, offering insights into career and psychosocial support for the mentee in formal mentoring programs [5], studies rarely explore the responsibilities of the mentees within this relationship [6, 7]. This perpetuates mentoring as a unidirectional relationship where mentoring activities are performed by the mentor and mentoring benefits realised by the mentee [8]. The imbalance in roles and responsibilities of the mentor and mentee can lead to reduced motivation to engage in the mentoring process, unmet expectations for the mentee, and ultimately, a negative impact on the overall effectiveness of the relationship [9, 10]. This gap (unexplored responsibilities of the mentee) is especially pronounced in contexts of informal mentoring where organisation sponsored structure mentoring programs are inaccessible to clinicians, particularly in resource constrained practice [11, 12]. In this study, informal mentoring is defined as a relationship that arises naturally between the mentor and mentee, where both parties enter a mutual agreement to sustain the relationship for their personal and professional growth [13]. Although the hospital does not participate in the formal pairing of the mentor and mentee, it uniquely contributes to the effectiveness of these relationships [14]. Research has explored various aspects of mentoring, including challenges and advantages, but there is an opportunity for a more holistic evaluation of the entire stakeholder triad involved in the mentoring process [15, 16].

Formal mentoring programs are professional development approaches initiated by the organisation, aiming to support early-career nurses/midwives in adapting to the workplace [17]. A defining characteristic of formal mentoring is the active involvement of the hospital. This involvement entails providing support for mentoring relationships by coordinating structured programs, matching mentors and mentees, offering training that empowers them to fulfil their responsibilities, and granting rewards for active participation in a mentoring relationship [17–19]. In resource-limited settings, formal mentoring is not always accessible to new graduates and nurses returning to practice. Instead, they often depend on informal mentoring principles to integrate and socialise into practice [11, 14]. Despite appearing to be the predominant form of mentoring, informal mentoring is frequently underestimated and underreported in mentoring literature, underscoring the need for further exploration.

Mentoring is not a unidirectional process but rather a complex interplay involving the mentee, mentor, and the overarching organisation — the hospital [20]. When delving deeper into the realm of this professional development approach, it becomes evident that an effective mentoring relationship does not solely pivot on the mentor-mentee dynamic. The organisation too plays a crucial part, shaping the context and providing the necessary resources and infrastructure [18]. A holistic perspective on mentoring demands recognition of these three entities as key stakeholders. This approach acknowledges the collective contributions of the mentee, mentor, and organisation significantly influence the initial contributions (inputs), the ongoing interactions (processes), and the short-term outcomes (outputs) of mentoring.

In the context of mentoring, *inputs* encompass the various elements and attributes contributed by all stakeholders involved, including the nurse/midwife and the hospital. Notably, mentees have identified certain qualities in an effective mentor, such as confidence, competence, and a strong commitment to the mentoring process [21]. Mentees have traditionally been perceived as receptive learners, seeking to gain insights from expert clinicians. This view stems from the traditional conceptualisation of mentoring as a hierarchical relationship between a senior clinician and a junior nurse or midwife [5, 22]. This paradigm often portrays the nurse/midwife mentor as an active giver of knowledge and the mentee as a passive recipient. However, it is important to note that this perspective primarily applies to settings where the mentee is a student, a characterisation that does not entirely align with the description of a new graduate or a returning professional in a service-oriented role. The combined attributes of the mentor, mentee, and the organisation play a pivotal role in shaping the effectiveness of the mentoring process [18, 19].

The *processes* within mentoring encompass a range of activities conducted within the mentoring relationship. These activities are traditionally categorised as career development, psychosocial support, and role modelling functions [23]. These processes are often discussed in terms of what the mentor does for the mentee, with comparatively less attention given to the activities undertaken by the mentee [22]. The organisation's contribution to mentoring has typically been viewed through the lens of the level of support it provides, including the establishment of structured mentoring programs and the pairing of potential mentees with suitable mentors in formal mentoring programs [18]. However, the mentoring literature often overlooks the organisation's role in informal mentoring, especially in acute care settings [11]. Despite

this gap, informal mentoring persists as a notable practice in nursing and midwifery.

When evaluating the *outcomes* of mentoring, it is important to view mentoring as mutually beneficial to all stakeholders [18]. Novice nurses, for instance, have reported gaining a sense of belonging, experiencing professional growth, and enhancing their clinical competence [24]. Additionally, hospitals have benefited from a more satisfied workforce, increased retention rates, and have often employed mentoring for recruiting new nurses and midwives [25]. Moreover, mentors themselves have reported personal career growth through mentoring and have used mentoring to demostrate their leadership abilities [26]. Collectively, the literature suggests that mentoring yields benefits for both the nurse or midwife and the hospital or healthcare institution where mentoring occurs [20, 27]. This breakdown underscores the mutual benefits of mentoring for all parties involved in healthcare. There are no formal mentoring programs being implemented in hospitals in Uganda for newly qualified nurse/midwives prompting clinicians to rely on informal support [8]. Literature on the benefits of informal mentoring practices particularly in acute care settings in Uganda has not been accessible to the authors. This study aimed to provide a comprehensive evaluation of stakeholders, examining their contributions, processes, and immediate outcomes in informal mentoring using the Input-Process-Output framework [28, 29].

The aim of this study was to understand the role of stakeholders (mentee, mentor, and the organisation) in mentoring within acute care settings in Uganda. The specific objectives of the study were to:

1. Explore the contributions of individual stakeholders to the mentoring process.
2. Examine the specific mentoring processes utilised by stakeholders.
3. Identify the benefits for stakeholders engaged in mentoring.

Methods

Design

A qualitative descriptive research design was employed to elucidate stakeholders' perspectives on inputs, processes, and outcomes within mentoring [30]. This design enables researchers to deconstruct the complex phenomena of mentoring, where a nuanced understanding is essential [31]. Qualitative descriptive research design allowed the researchers to explore the complexity of mentoring by examining the involvement of multiple stakeholders, their respective roles, the activities undertaken, and the resulting outcomes. The goal was to provide a rich understanding of stakeholder experiences, thereby capturing the complexity inherent in the mentoring process. This study is part of the second phase of a large sequential explanatory mixed methods study [8, 10, 32, 33]. This manuscript was written in adherence to the Standards for Reporting Qualitative Research (SRQR).

Study setting and participants

The research was conducted among nurses and midwives working in acute care settings in Uganda. The Ugandan health system faces challenges such as low nurse-to-patient ratios, understaffing, heavy workloads, and resource constraints [34]. These challenges have potential to overwhelm new graduates, hence needing support. Additionally, the nursing workforce in Uganda is predominantly composed of individuals with lower qualifications, with bachelor trained nurses/midwives making up only 9% of the nursing population [35]. Government, as the largest employer of nurses/midwives in Uganda, particularly in public hospitals, provides an ideal setting for studying the state of mentoring in the country. These hospitals reflect the diverse characteristics of the nursing and midwifery workforce, with clinicians at various stages of their careers. Since most job positions in public hospitals are permanent, these institutions provide a representative view of the challenges and opportunities in mentoring within Uganda's healthcare system [36]. Therefore, the study was conducted in three public hospitals in Uganda. The first hospital is one of 14 regional referral hospitals in Uganda situated in the western part of the country, approximately 320 km from the capital, Kampala. It comprises 14 units with an average bed capacity of 350 and is staffed by 130 nursing and midwifery professionals. The second hospital, also a regional referral hospital, is located in the north-western region of Uganda, approximately 496 km from Kampala. This facility has a staffing of 167 nursing and midwifery professionals. The third hospital, a teaching institution, offers specialised services to the greater Northern region of Uganda. It is located approximately 342 km away from Kampala and encompasses six departments with a bed capacity of 110 and nursing/midwifery staffing of 54 clinicians [36]. These regional hospitals play a vital role in serving neighbouring districts and countries that share borders with Uganda. We utilised convenience sampling whereby nurses and midwives were invited to participate via an advertisement flyer on hospital noticeboards with the contact information for the first researcher. Once potential participants made contact, they were assessed for eligibility and scheduled for an interview. Participants in the study were eligible if they worked as nurses or midwives in the hospitals, regardless of their cadre. Furthermore, participants were included if they had prior experience with mentoring relationships or were actively engaged in mentoring activities. Ultimately the study recruited 13 participants from the first hospital, 11

participants from the second hospital and 10 from the third hospital. In addition, one participant who had an executive role, overseeing the three hospitals also participated in the study.

Data collection

Data were collected by the first researcher between June and September 2022. The researcher was experienced in conducting interviews and received additional training in qualitative research during the period of the study. A semi-structured interview guide was used. The interview guide was developed by the research team based on literature [20]. It consisted of two distinct parts. The initial section aimed to gather data regarding the demographic attributes of the participants. The subsequent section consisted of questions relating to mentoring (see Table 1). Probing questions were used to moderate the interview and obtain deeper description of their mentoring roles, responsibilities, and benefits. The interview guide was not piloted since its sole purpose was to facilitate discussions with participants; for example, if a question was unclear to a participant during the interview, it was paraphrased for clarity. Interview sessions took place on the hospital premises, either in ward offices or in the hospital's boardroom. The interviews lasted between 20 and 90 min highlighting the individual differences in their experiences with mentoring. Whilst some participants provided brief responses, focusing on only a few aspects of mentoring, others, who had more experience with mentoring, engaged in more detailed discussions, sharing a broader range of mentoring perspectives and reflections. The first researcher audio-recorded the interviews and subsequently transcribed them.

Ethical considerations

The Flinders University Research Ethics Committee granted ethical approval for the study, under the approval number 5313. Additionally, the in-country approval was obtained from TASO Research Ethics Committee (TASOREC/056/21-UG-REC-009 (AMEND)). Approval to engage with study participants was acquired from the management of the acute care facilities involved. An information sheet outlining the study details along with the consent form were provided to participants. After reviewing the information, participants provided their signed informed consent before data collection began. Copies of the signed consent form were retained by the participant, and the researcher.

Data management and analysis

Upon transcription of the interviews, the interview transcripts underwent anonymisation and were subsequently imported into NVivo software. The process of data analysis employed an inductive method to thematic analysis [37]. Inductive coding started with familiarising with data. Data was listened to during transcription and read multiple times after transcription. The subsequent steps in the analysis involved both descriptive and evaluation codes [38]. Codes were then systematically grouped into broader categories, from which subthemes were derived [37]. Initial coding of the 35 transcripts was completed by the first author. The second author checked the coding for 18 transcripts, and the third author checked the codes for the remaining 17 transcripts. Any disagreements were discussed and resolved in team meetings. Regular meetings were held to further discuss and develop emerging codes, subthemes, and overarching themes. During the collaborative meetings, similar codes were merged, while distinct ones were extracted.

Table 1 Showing interview questions

Personal characteristics
What is your:
Gender
Qualification
Type of facility work for
Registration identity
Number of years worked as nurse/midwife.
Previous experience in formal mentoring
Participants were asked:
• How did the mentoring relationship with your mentee/ mentor start?
o what activities have you initiated when you mentored other nurses/midwives,
• What roles do mentors/mentees play in your hospitals?
• What capabilities do you believe that a mentor/mentee should have to successfully mentor other nurses in the workplace?
o What attributes do you look for in a mentee/ mentor.
• What responsibility do you believe that a mentor/mentee needs to take on to successfully mentor other nurses/midwives or be mentored in the workplace?
• What are some of the benefits you have realised mentoring others or being mentored?
o How has mentoring others affected your career in nursing?

Trustworthiness

To strengthen the study's credibility, the first author both collected and transcribed the data. The entire research team collaboratively engaged in the data analysis, generating, and verifying codes. To ensure alignment between the raw data and its interpretation, relevant data excerpts have been included in the presentation of findings [39]. Furthermore, we returned the initial data analysis summary to participants who had indicated a willingness to be contacted. Of these, only one participant provided feedback, agreeing with the analysis. To establish the rigor of the research process, a detailed audit trail was maintained by reporting the processes of data collection, analysis and presentation of findings in accordance with the Standards for Reporting Qualitative Research (SRQR) [40].

Findings

A total of 35 nurses and midwives participated in the study. Thirty-one participants were staff nurses/midwives, while four were executive management staff at the hospitals. This sample size was within the recommended range for qualitative studies and accounts for variations in gender, professional experience, qualifications, and type of registration [41]. The sample consisted of 10 males and 25 females. Participants had professional experience in clinical settings that varied from 3 months to 32 years. Six of the participants held a Master of Science degree in nursing, specialising in either Women's Health and Midwifery or Critical Care Nursing. The remaining participants held either a bachelor's degrees in nursing or midwifery ($n = 15$), had a diploma as highest qualification ($n = 13$), and one person had a certificate in nursing. Majority were nurses ($n = 20$), whilst others were midwives ($n = 6$), and others identified as having dual registration as both nurses and midwives ($n = 9$). Participants experiences of mentoring were largely informal with only one of the participants reporting past experience with formal mentoring. Five overarching themes were identified reflecting nurses' and midwives' perceptions on building blocks of successful mentoring; approaches to mentor/mentee selection; varied strategies for mentoring in hospital environments; responsibilities of the stakeholders; and mentoring being a win-win for all stakeholders.

Theme 1: Building blocks of successful mentoring

Participants identified attributes that were considered ideal for successful mentoring. The data showed that as a collective, the dyad brought to mentoring certain attributes in the form of desirable qualities for the mentor and mentee. Participants described their ideal mentee as one who was willing to learn and willing to engage in mentoring:

> *And you also need to have the zeal of wanting to expand your knowledge not to only base on what your mentor tells you, from whatever he tells you, you expand on it and also if you seat with these mentors, they are able to tell you what they want to achieve, as a mentee you also have the responsibility to help them achieve that (P-13).*

Other attributes in the order of how frequently they were referenced were: having clear personal career goals, being adaptable and flexible, have ability to communicate appropriately and change behaviour. Other attributes included managing their time, being knowledgeable, hardworking, humble, patient, being active and having a good attitude toward the profession.

Participants also described their ideal mentor. The most desirable attribute was having discipline-specific knowledge and skill as one participant stated: "*both practical and clinical skills for our setting... should have updated knowledge all the time, should continuously be reading. So as when faced with a challenge they can easily navigate it*" (P-11). The second most desirable attribute was having relational skills such as good communication and interpersonal skills. Other attributes were being approachable, being respectful and kind and having enough years of experience working in the clinical area.

Theme 2: Aapproaches to mentor/mentee selection

There was no formal pairing of the mentor with the mentee in the included hospitals "*you just find yourself working with someone... but being attached to someone, that hasn't happened*" (P-02). The dyad relationship started as a result of day-to-day activities of the nurses and midwives on the ward. Once staff were allocated to the ward or assigned a particular task within the organisation, then there were opportunities to start a mentoring relationship: "*the ones you find on the ward are your responsibility*" (P-25). This allowed the relationship to develop organically based on a good personality mix, comparable passions and admirable or impressive work ethic as participants reflect on the start of their mentoring relationships: *"Maybe they saw something in me, if they speak to the whole group, maybe in the corridors they will say something to me after* [meeting the rest of the group]*"* (P-07). Another participant reflected on their mentor attraction: *"I don't know what attracted me (laughs). Am so joyful I think that was what attracted them to me"* (P-15).

On some occasions mentoring relationships arose from the direct initiative of the mentor or mentee "*most cases the mentees identify their own mentors. So, it would be a sort of privilege when someone identifies you to mentor them depending on how well they feel they can relate with you or at least connect with you*" (P-04).

Theme 3: Varied strategies for mentoring in hospital environments

Four approaches to mentoring existed in the hospitals, namely individual one-on-one mentoring, group mentoring, inter-unit mentoring and inter-facility mentoring. Individual mentoring most commonly occurring, although it was non-mandated at the hospitals, as described by one participant:

> *Even in the employment process it's not enforced. Ok, you can support but then it's not that it's mandatory. It's not mandatory that I must mentor,... it is not part of whatever is enforced that you must do it: like as you come on duty like you must manage, you must treat patients; so, it's not mandatory that you must teach, you must mentor, no (P-33).*

This approach to mentoring was largely left to chance and circumstance. It was characterised by brief informal episodes in which participants felt they were unaware of the mentoring concept but the supportive activities they engaged in seemed to align with mentoring:

> *But sometimes we do it when we don't think we are mentoring someone. Like I have done it several times, but I would not attach mentorship to it. But you don't even think that you are actually mentoring someone, you just think its good work. There those who look at you and really want to be like you (P-01).*

These mentoring episodes were brief, lasting only as long as the nursing/midwifery task at hand or until the goal was achieved, or until the placement ended particularly for the students and interns.

The hospitals received students and interns from the nursing and midwifery schools in the region. Due to the overwhelming numbers, the second approach to mentoring, group mentoring was used. It was expected that the mentor attends to the students in a group leveraging group dynamics in mentoring:

> *you do as a group the ENT [Ear, Nose, and Throat] group have come here for practical part, first of all you orient them, you ask them their objectives and also you give them time like a week, you see where the weak area is and then you plan for a CME [Continuous Medical Education] and teach these further (P-27).*

The last two approaches to mentoring were unique to the hospitals. Inter-unit mentoring occurred in the hospitals, although rarely. These were mentoring activities organised between departments within the same facility. The departments had specific similarities particularly in the demographics of patients they managed, for example, between paediatric outpatients and paediatric inpatient wards, paediatric ward and neonatal intensive care unit (NICU) as participants 19 and 33 explained:

> *We do inter-unit visits, these exchange-visits like I am in under-five [unit], we can go to paediatric ward or medical ward we learn from them, and they learn from us we share experiences regarding different activities. And they are also able to tell us several things which we don't know (P-19).*
> *Some [mentees] are staff in other wards and want to learn something they come to you... Because I am the quality improvement focal person... I handle 5S [a quality improvement strategy], all that I do is mentorship for example in NICU [Neonatal Intensive Care Unit] they had their own issues. If you go to NICU, they have appreciated me taking it up to support the nurses there (P-33).*

Inter-facility mentoring was the formal approach to mentoring used in these hospitals. The hospitals were regional referrals, therefore were higher in the country's health systems structure with better infrastructure and human resource compared to lower facilities. Inter-facility mentoring was semi-structured in nature. Mentors were appointed by the hospital administration and activities funded by Ministry of Health (MoH) and Non-Governmental Organisations (NGOs) in the region. Mentoring activities included needs assessments which were followed by training by senior staff from the regional hospitals to the lower facilities: *that one is about going to the facility, and seeing what people are doing, guide them on the right things to do. The organisation appoints you and outsource you* (P-09).

Theme 4: Responsibilities of the stakeholders

The data revealed distinct responsibilities for the mentor, mentee, and hospital that each contributed towards an effective mentoring relationship.

Responsibility of the mentee

Participants highlighted that the mentee was not just a passive entity in the mentoring relationships, they too had a responsibility. Firstly, it was the responsibility of the mentees to learn and demonstrate that learning had occurred. It was the initiative of the mentee to listen and apply their mentor's guidance. This in turn motivated the mentor to continue the relationship. Secondly, participants acknowledged that although a lot of advice was given and knowledge was shared, the onus was on the mentee to determine the relevance of this information to

their own personal and career goals as participant 20 said (see Supplementary Table 1).

Thirdly, the participants emphasised demonstrating respect to the mentor as one of the responsibilities of the mentee. The nurses/midwives believed that respect was not just an abstract concept but should be demonstrated in culturally prescribed ways as participant 31 explained (see Supplementary Table 1). A mentee was also expected to be proactive and take the initiative to consult when the need arose. This initiative could extend its focus from personal concerns to focusing on desirable improvements in clinical practice, as explained by Participant 3 (see Supplementary Table 1). Lastly the mentee was expected to extend the cycle of mentoring by being exemplary and mentoring other junior colleagues.

Responsibilities of the mentor

The responsibilities of the mentor were described in seven separate categories as shown in Supplementary Table 1. Developing the mentee's clinical competencies was the main category. Mentors did this through various mentoring activities such as coaching and demonstrating daily clinical skills and procedures on the ward. Guiding, teaching, and delegating were some of the other mentoring activities done to enhance the mentees competencies in the clinical area. It was important that the novice nurse/midwives or the newly recruited nurses and midwives fit well into the profession and the organisation. Therefore mentors oriented the mentees into workplace systems as participant 13 described (see Supplementary Table 1). The mentors also had the responsibility of supervising the mentees to ensure they practicing as per professional standards and organisational guidelines. The next important category relates to the mentor's role in creating a conducive practice environment for the mentee to practice. The nurses/midwives advocated for team work, open communication, and the sharing of resources. Rather than isolating or reprimanding the mentee, the mentors opted to offer constructive guidance and ensure that the necessary tools for professional success were readily available as participant 19 said (see Supplementary Table 1). Furthermore, the clinical area triggered many emotions for many nurses/midwives and the mentor helped them cope well considering they had been through similar experiences.

It was the mentor's responsibility to identify mentoring needs of the mentee and identify the potential in the mentee as participant one clearly described (see Supplementary Table 1). Mentors also identified learning opportunities such as nursing and midwifery courses, CPD (Continuous Professional Development) opportunities, and conferences that were relevant to address the mentoring needs of the novice nurse/midwife. These two functions formed an important responsibility of the mentor to pay close attention to the mentoring needs and opportunities.

Role modelling was another clear responsibility of the mentor present in the data. Mentors modelled good practice and made the profession admirable and their competencies exemplary as participant two elaborated (see Supplementary Table 1). Mentors were the gateway that was necessary for the integration of the mentees into the nursing/midwifery profession. This applied to particular mentees such as students and interns who could only join the profession after being signed off by the mentors. Nurse/midwifery mentor served as a connector, bridging the gap between the mentee and other resources or experts that can help in areas where the mentor may lack specific skills. The participants acknowledged that mentorship was not confined to a single skill set; if the mentor couldn't provide expertise in a particular area (like Technology), they could still add value by linking the mentee to someone who could assist as participant three gave an example (see Supplementary Table 1).

For other mentees who were not new to practice, mentors were responsible for their career progression. Mentors proactively identified career opportunities for their mentees, as they looked out for, and shared job advertisements and promotion opportunities with them. The hospital implemented a human resource appraisal system which provided mentoring opportunities. These appraisal processes played a crucial role in future promotions within the organisation. When new career opportunities arose, mentors supported their mentees by recommending them during the application process, as explained by participant 12 (see Supplementary Table 1).

Another important responsibility of the mentors was providing psychosocial support for the mentees in the clinical area. Support was especially needed when dealing with difficult situations such as breaking bad news to a patient or dealing with a particularly difficult patient. In such situations, mentor offered words of encouragement to the newly qualified nurse/midwife. These mentors' guidance was especially useful coming from an individual a mentee particularly admired as participant 14 described (see Supplementary Table 1).

Responsibilities of the organisations

It is important to note that no formal mentoring occurred in these hospitals. Nurses and midwives perceived the role of the hospital management in supporting mentoring as two-fold. Firstly, hospitals needed to cultivate an optimal practice setting to make it conducive for mentoring. Secondly, hospitals needed to focus their efforts on formalising mentoring in the workplace as explained below.

Cultivate an optimal practice setting for mentoring Participants believed that the clinical environment in which mentoring occurred needed to align with the mentoring vision in three main ways. Firstly, by creating a mentoring culture in which mentoring was supported by the organisation. Mentoring culture could be cultivated through providing protected mentoring time, providing mentoring guidelines and tools and a policy specifically designed for mentoring as participant four explained (see Supplementary Table 1). Participants also believed that a mentoring atmosphere could be created by improving the practice environment itself. The organisation ought to provide the infrastructure that depicts quality and safe care. Maintaining a supply of sundries and equipment was important for mentors to demonstrate good and ideal clinical practice.

Mentoring was demanding on the human resource, therefore effecting the mentoring environment by recruiting more nursing and midwifery staff was essential in demonstrating support for mentoring. Although recruitment was important, more crucial was representation of all nursing and midwifery cadres within the human resource structure as well as representation of nursing and midwifery in executive positions within the organisation as participants nine and 30 described (See supplementary Table 1). This would ensure that every clinician has access to a mentor and role models learn from and aspire to emulate.

Direct efforts toward the mentoring program The participants emphasised the role of the organisations in building a mentoring program. Five perceived responsibilities were highlighted. The main responsibility of the organisation was to build awareness around mentoring. Participants believed this could be done through training on roles and benefits of mentoring and demonstrating good mentoring to the rest of the stakeholders. Awareness could also be created through benchmarking for good mentoring practices as participants 24 explained (see Supplementary Table 1). Providing oversight over mentoring activities within the hospital was another perceived responsibility of the organisation. Facilitating mentoring activities such as compensations and rewards as well as providing coordination.

Participants expressed desire for the organisations to initiate mentoring programs through establishing formal structured programs. Active involvement of the stakeholders in all aspects of the mentoring program was essential. Participants suggested that nurses and midwives be offered the opportunity to identify their own mentors and mentees or at the very least matched using appropriate mechanisms as explained by participant six (see Supplementary Table 1).

Mandating mentoring activities was another feature salient in the data. Participants suggested creating an atmosphere in which good mentoring was rewarded and bad mentoring was sanctioned. Participant's prescribed rewards ranged from tangible financial rewards such as mentoring allowances and welfare incentives to non-tangible rewards of appreciation and acknowledgement. The issue of fairness in the reward system was also emphasised and participants warned of the outcomes of an imbalance in the issuance of rewards as a participant 12 explicitly stated (see Supplementary Table 1).

The final responsibility of the organisation was about have clearly defined mentoring. Participants advocated for clearly defined boundaries in mentoring marked by contracts with clear goals and objectives, stakeholder roles and clearly planned methods of mentoring. Furthermore, participants emphasised the role of organisations in evaluating and auditing mentoring programs through mechanisms such as support supervision (see Supplementary Table 1).

Theme 5: It's a win-win for all stakeholders

Outputs from mentoring relationships were expressed distinctly in three forms as benefits for the mentor, mentee, and the hospital. Contrary to the common goal of mentoring that primarily aims at benefiting the mentee, nurses and midwives believed that both the mentor and the hospital also gained valuable outcomes from the relationship.

Benefits of mentoring to the mentor

Participants experienced the benefits of mentoring in the clinical settings. One of the most popular benefits was self-improvement. Participants believed that mentoring helped them stay accountable, encouraging them to be their best selves and set a positive example for others in the profession and within the hospital, as explained by participant 13 (see Supplementary Table 2).

The mentors also gained knowledge by directly learning from the mentees but also indirectly when they had to read the latest evidence and consult widely on behalf of the mentees. Participants spoke of the thrill that came with mentoring junior nurses/midwives in the hospital. Mentoring brought joy, happiness, and satisfaction. In fact, participants considered mentoring others a privilege. The third benefit of mentoring was about building a professional network of nurses and midwives present in the all the geographical regions of the country and even abroad. Mentoring increased their visibility within the organisation and the profession, it advertised their work and skills. Mentoring snowballed opportunities for the mentor showcasing their work and efforts. Mentors inferred that the good deeds they did in mentoring often spoke for themselves. This meant that the reverse

was also true in which a mentor could easily be known for bad mentoring. In other words, mentoring presented an opportunity to write on a canvass how you wanted to be known within the organisation and the profession as participant 33 explained (see Supplementary Table 2).

Participants also felt that mentoring reduced their workload in the clinical settings. The nurses and midwives that were mentored were able to do the mentor's work in event s/he was absent due to other engagements but also could enable early or timely retirement. As the participants mentored varying cohorts of mentees, they felt that their own confidence to mentor others increased with time as participant four described (see Supplementary Table 2). Participants in their sharing of the mentoring experiences, brought to awareness the role of good karma and emphasised that doing good to others always returned to you in a different form. To these participants mentoring had a spiritual benefit. For few of the nurses and midwives mentoring was a steppingstone in their career journey. Mentoring was a tool they could use to get promotions in the organisation. While to other participants, mentoring affirmed their relevance to the organisation as participant 18 stated (see Supplementary Table 2). Some participants although few had access to the mentoring rewards. Rewards in the form of acknowledgements like a thank-you note. While others in some departments in the hospital received rewards that were welfare in nature such as snacks, tea, and coffee (see Supplementary Table 2).

Benefits of mentoring to the mentee

Participants agreed that mentoring was very beneficial to the mentee. Overall, mentoring contributed to the development of a well-rounded nurse/midwife, capable of effectively navigating the clinical environment and harnessing their own abilities. This, in turn, enabled them to achieve a balance in managing the complexities of the healthcare system. Through mentoring, they developed their clinical competences, leadership abilities and shaped their perceptions of self within the profession. In summary, the participants identified eleven outcomes of mentoring for the mentee: (1) developing confidence, (2) developing clinical expertise, (3) socialise and cope in the workplace, (4) career choices and growth, (5) personal growth, (6) professional support, (7) function as full member of the profession, (8) be a well-balanced social person, (9) develop leadership and management abilities, (10) offer a sense of belonging, and 11) shaping the perceptions of the profession. Details of the mentee benefits are shown in Supplementary Table 2.

Benefits of mentoring for the organisation

Participants also indicated the advantages that mentoring brought to the healthcare facility where they were employed. Mentoring practices resulted into a clinical environment that was comfortable and dependable for the nurses and midwives. Mentoring dyads were groups of colleagues that provided mutual support and guidance at the workplace. They had a shared vision of patient care which shaped the workplace environment. This made strong cohesive and personal bonds with implications for improved service delivery, improved individual commitment to the organisation, continuity of work and increased job satisfaction as participants nine and 24 explained the impact of mentoring on their work environment (see Supplementary Table 2).

Discussion

The study aimed to holistically investigate the role of the main stakeholders in mentoring in acute care settings. We aimed to identify contributions, processes and short-term outcomes realised from engaging in mentoring for nurses and midwives in hospital settings. Differing from most of the nursing and midwifery literature which depict mentoring as a formal approach [20, 42], mentoring among these clinicians was informal. Mentor-mentee relationships evolved naturally, without formal pairings by the hospital management. This characteristic highlights the prevalent yet understudied nature of informal mentoring in resource limited practice settings. Our findings support an earlier review, suggesting that just like formal mentoring programs, informal mentoring ought to acknowledge mentee, mentor, and organisation as active entities [20]. Figure 1 provides a visual synthesis of stakeholder input, processes, and short-term outcomes in informal mentoring. Our study findings align with previous studies regarding the desirable characteristics of a mentor, emphasising the need for a competent mentor with good relational skills and approachable demeanour. These findings support the findings of other studies that explore formal mentoring programs [6]. Within the realm of informal mentoring, the lack of formalised matching practices highlights the paramount importance of relational attributes including approachability and respectfulness in fostering mentoring relationships [11]. Furthermore, this study unveils new insights into expectations of the mentees. We found that mentees are expected to demonstrate willingness to learn, well-defined clinical and personal goals, adaptability, and a demonstrable commitment to learning through behavioural changes. This challenges the traditional one-way mentoring and underscores the role of the mentee as an active entity, thus holding them accountable for both the effectiveness and ineffectiveness of the mentoring process.

Our study reveals that the majority of mentoring instances were one-on-one, aligning with the conventional mentoring approaches in formal programs [19].

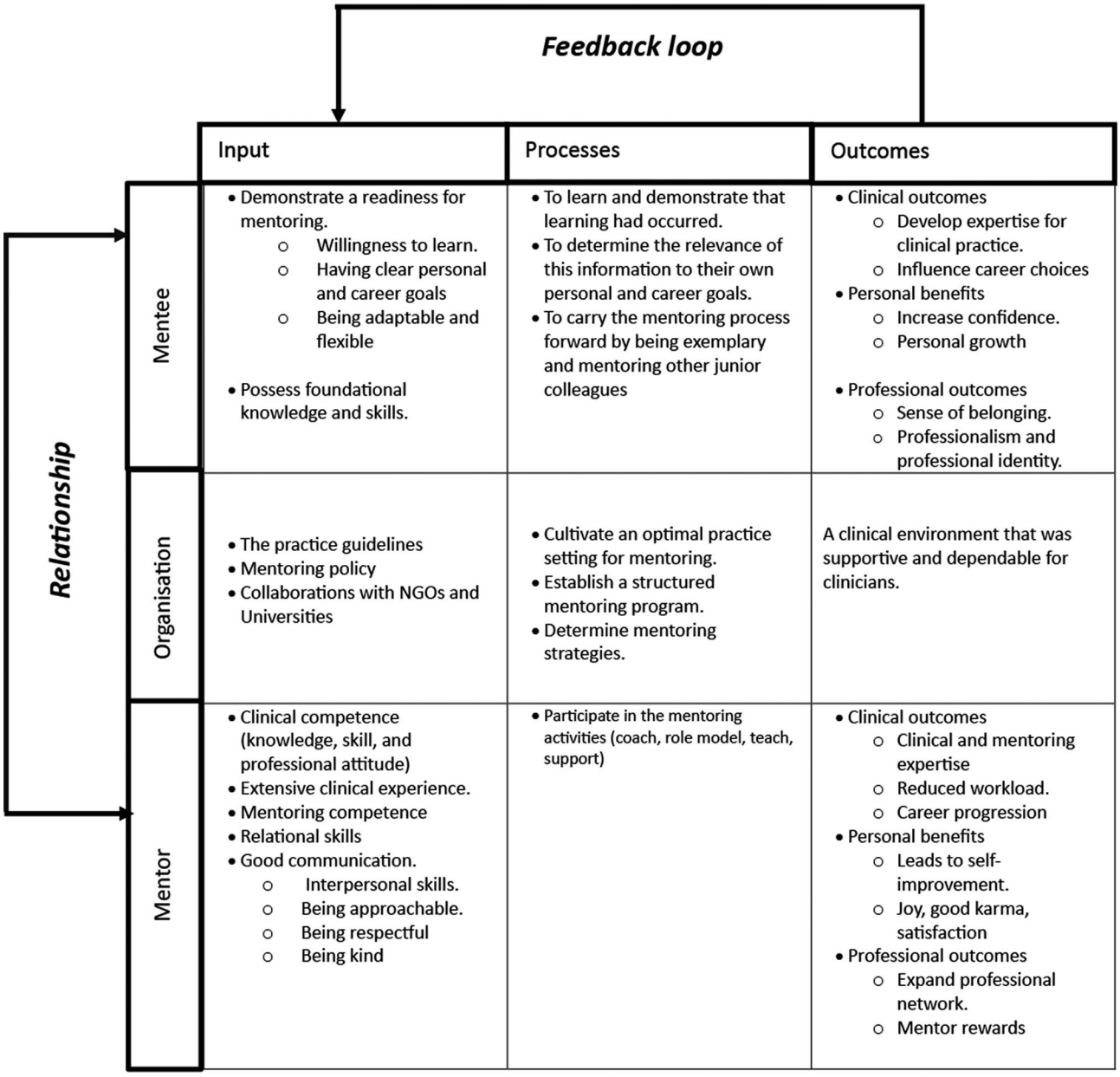

Fig. 1 Visual synthesis of stakeholder input, processes, and short-term outcomes in informal mentoring

However, also highlights inter-unit and inter-facility activities as potential areas for mentoring in low-resource facilities, suggesting the need for further investigation. Regarding mentoring responsibilities, our findings align with studies on formal mentoring that study the mentee [43] and mentor [44] and organisations [17]. Figure 1 illustrates how each entity actively contributes to the effectiveness of mentoring. In this context the participants acknowledge that the organisation plays a particularly significant role, extending beyond a mere supporter of mentoring to actively engage in this professional development approach. One notable responsibility of the nursing and midwifery executives in our study was the implementation of mandatory mentoring programs for nurses and midwives in acute care settings. While this approach differs from previous studies that advocate for voluntary mentoring [45], there are several explanations for this discrepancy. Firstly, mentoring in these settings were majorly informal. Informal mentoring in previous studies presents the risk of excluding potential mentees, particularly those who may not readily initiate mentoring relationships due to their personality traits [46]. This mandatory approach aims to ensure that all eligible new-graduates benefit from mentoring opportunities. Secondly, informal mentoring often goes unrecognised by hospitals, resulting in a lack of acknowledgment

and rewards for the contributions of both mentees and mentors. The lack of active engagement from hospital management in mentoring efforts could impede the realisation of the long-term benefits of mentoring, which include successful recruitment of new graduates and the retention of experienced nurses and midwives [47].

This study underscores the substantial advantages of mentoring, benefiting the mentor, the mentee, and the hospital as shown in Fig. 1. Recognising mentoring as being mutually beneficial has been highlighted in previous nursing and midwifery research [6, 27]. Furthermore, our study highlights that these benefits are predominantly short-term, serving as a pathway to long-term goals of retention for both new and experienced professionals within the clinical workforce. The creation of a supportive workplace environment was conducive to the growth and development of novice practitioners. Mentoring has the potential to create a ripple effect. A collection of the immediate outcomes of mentoring may lead towards an organisation culture of mentoring characterised by low turnover rates, motivated professionals and on overall positive practice environment [48].

We found the inputs, processes, and outcomes framework is essential to inform the evaluation of mentoring relationships if our profession aims to achieve its long-term mentoring goals. For instance, the activities and benefits derived from current mentoring relationships profoundly influence individual perceptions and expectations for future mentoring experiences [9]. This continuous feedback loop evolves over time and adapts to changing mentoring needs and goals, serving as a source of adaptability.

Our study establishes a foundation for adopting a holistic perspective on informal mentoring. Our findings urge nursing and midwifery executive managers to scrutinise the contributions stakeholders when evaluating the effectiveness of mentoring relationships and programs. As descriptive research, this study prompts several critical reflections on the nature of mentoring. First and foremost, our study shows that informal mentoring offers advantages in acute care settings comparable to those of formal mentoring programs. Secondly, future research ought to acknowledge that mentoring is a professional development approach in which every stakeholder plays an active role. Thirdly, it underscores the mutual benefits reaped by all three stakeholders, underscoring the reciprocal nature of mentoring. Lastly, to comprehend the impact of mentoring on outcomes such as retention, it is imperative to recognise and differentiate between short-term and long-term benefits. Mentoring program and approaches should be evaluated holistically, considering the roles and contributions of all stakeholders involved. When mentoring is not working as expected, it's important to assess which factors might be presenting limitations—whether it be the mentor, the organisation, or the mentee. It's crucial to recognise that the success of mentoring is a shared responsibility, and all parties, including the mentee, play a significant role in its outcomes.

Limitations

While our study provides valuable insights into mentoring inputs, processes, and short-term outcomes, it is important to recognise the limitations inherent in qualitative methodologies. Firstly, the findings are contextually based posing limitations regarding generalisability. However, we have provided a detailed description of the study settings to support potential transferability of our findings. Secondly, given our study adopts a qualitative descriptive approach, any inferences drawn should be approached with caution. Thirdly, we acknowledge that the findings represent experiences of participants in a specific local context within one country. These contextual factors can influence the interpretation of mentoring concepts, and their applicability may vary across different countries.

Recommendations for practice and future research

For the nursing and midwifery practice, a holistic view of mentoring is necessary. Mentoring of new career nurses/midwives is beneficial to not only the mentee, but to the mentor and the hospital context in which it is occurring. When setting up mentoring programs, it is crucial to specify the roles and responsibilities of the stakeholders in mentoring in order to realise the benefits of mentoring. Hospitals can contribute to the mentoring process by cultivating an optimal practice environment and allocate resources: both human resourced and associated policy for formal mentoring programs.

Future research endeavours can build upon our study by delving into the intricate relationships that exist between these various facets of mentoring. The field of mentoring research would benefit from the integration of inferential studies. These studies could explore the causal and predictive links between mentoring inputs, the processes that unfold during mentoring relationships, and their direct impact on short-term outcomes in both formal and informal mentoring. Such investigations would contribute to a more nuanced understanding of the dynamics at play within mentoring relationships. Moreover, there is a pressing need for longitudinal research in the realm of mentoring. While our study touches upon short-term benefits, it is imperative to engage in long-term research to comprehensively assess the enduring effects of mentoring.

Conclusion

Our study achieved new understandings of the role of the mentee, the mentor, and the organisation in informal mentoring for nurses and midwives in hospital settings. The use of the Input-Process-Output framework enabled the researchers to illuminate several key findings essential for enhancing mentoring practices in hospital settings in developing countries. These findings emphasise the desirable attributes from each stakeholder revealing that mentoring was mostly one-on-one, with pairings forming naturally. The success of these pairings heavily relied on the relational skills of the stakeholders. Our findings show equal responsibilities from each stakeholder to ensure effective, mutually beneficial mentoring processes. We argue for a holistic approach that considers the mentor, mentee, and organisation as active contributors to the mentoring process. This article calls for a nuanced analysis of mentoring that incorporates the inputs, processes, and outputs of mentoring within the nursing and midwifery professions. Such an approach is likely to yield more meaningful insights into the complex dynamics of professional development and retention or nurses/midwives in healthcare settings.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12912-025-03020-0.

Supplementary Material 1

Acknowledgements
The authors acknowledge nurses and midwives from the hospitals in Uganda that participated in the study.

Author contributions
TAK: conceptualisation, methodology, data collection, data analysis, writing – original draft, writing – editing and review. LDX: methodology, data analysis, supervision, writing – editing and review. DC: methodology, data analysis, supervision, writing – editing and review.

Funding
The first author was under the Flinders International Postgraduate Research Scholarship at the time of the study.

Data availability
All data generated or analysed during this study are included in this published article [and its supplementary information files].

Declarations

Ethics approval and consent to participate
The Flinders University Research Ethics Committee granted ethical approval for the study, under the approval number 5313. Additionally, the in-country approval was obtained from TASO Research Ethics Committee (TASOREC/056/21-UG-REC-009 (AMEND)). Participants provided signed consent prior to data collection. The study was conducted in accordance with the Helsinki Declaration.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Received: 1 November 2024 / Accepted: 21 March 2025
Published online: 01 April 2025

References

1. Gillespie GL, Grubb PL, Brown K, Boesch MC, Ulrich D. Nurses eat their young: A novel bullying educational program for student nurses. J Nurs Educ Pract. 2017;7(7):11–21. https://doi.org/10.5430/jnep.v7n7P11.
2. Edmonson C, Zelonka C. Our own worst enemies: the nurse bullying epidemic. Nurs Adm Q. 2019;43(3):274–9. https://doi.org/10.1097/naq.0000000000000353.
3. The ICN code. of ethics for nurses [https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf]
4. International code of ethics for midwives [. https://www.internationalmidwives.org/our-work/policy-and-practice/international-code-of-ethics-for-midwives.html]
5. Jacobs S. An analysis of the evolution of mentorship in nursing. Int J Mentor Coaching Educ. 2018;7(2):155–76. https://doi.org/10.1108/IJMCE-06-2017-0042.
6. Wissemann K, Bloxsome D, De Leo A, Bayes S. What are the benefits and challenges of mentoring in midwifery? An integrative review. Women's Health. 2022;18:1–12. https://doi.org/10.1177/174550572211101.
7. Vidal J-AM, Olley R. Systematic literature review of the effects of clinical mentoring on new graduate registered nurses' clinical performance, job satisfaction and job retention. Asia Pac J Health Manage. 2021;16(4):70–82.
8. Kakyo TA, Xiao LD, Chamberlain D. The role of motivation in the initiation and maintening mentoring relationships among nurses and midwives. Int Nurs Rev. 2024;72(1):e12977. https://doi.org/10.1111/inr.12977
9. McBride AB, Campbell J, Deming K. Does having been mentored affect subsequent mentoring?? J Prof Nurs. 2019;35(3):156–61. https://doi.org/10.1016/j.profnurs.2018.11.003.
10. Kakyo TA, Xiao LD, Chamberlain D. Exploring the dark side of informal mentoring: experiences of nurses and midwives working in hospital settings in Uganda. Nurs Inq. 2024:e12641. https://doi.org/10.1111/nin.12641
11. Mohtady HA, Könings KD, van Merriënboer JJ. What makes informal mentorship in the medical realm effective? Mentor Tutoring: Partnersh Learn. 2016;24(4):306–17. https://doi.org/10.1080/13611267.2016.1252111.
12. Ssemata AS, Gladding S, John CC, Kiguli S. Developing mentorship in a resource-limited context: A qualitative research study of the experiences and perceptions of the Makerere university student and faculty mentorship programme. BMC Med Educ 2017; 17(1):1–9. https://doi.org/10.1186/s12909-017-0962-8
13. James JM, Rayner A, Bruno J. Are you my mentor? New perspectives and research on informal mentorship. J Acad Librariansh. 2015;41(5):532–9.
14. Janssen S, Van Vuuren M, De Jong MD. Informal mentoring at work: A review and suggestions for future research. Int J Manage Reviews. 2016;18(4):498–517. https://doi.org/10.1111/ijmr.12069.
15. Oluchina S, Gitonga LK. Factors hindering formal and informal nursing mentorship programs in Kenyan public universities. Am J Health Res. 2016;4(2):23–9. https://doi.org/10.11648/j.ajhr.20160402.12.
16. Tourigny L, Pulich M. A critical examination of formal and informal mentoring among nurses. Health Care Manag 2005; 24(1).
17. Djiovanis SG. Effectiveness of formal mentoring on novice nurse retention: A comprehensive literature review. J Nurses Prof Dev. 2022. https://doi.org/10.1097/NND.0000000000000838.
18. Giacumo LA, Chen J, Seguinot-Cruz A. Evidence on the use of mentoring programs and practices to support workplace learning: A systematic multiple-studies review. Perform Improv Q. 2020;33(3):259–303. https://doi.org/10.1002/piq.21324.
19. Mullen CA, Klimaitis CC. Defining mentoring: A literature review of issues, types, and applications. Ann N Y Acad Sci. 2021;1483(1):19–35. https://doi.org/10.1111/nyas.14176.
20. Kakyo TA, Xiao LD, Chamberlain D. Benefits and challenges for hospital nurses engaged in formal mentoring programs: A systematic integrated review. Int Nurs Rev. 2022;69(2):229–38. https://doi.org/10.1111/inr.12730.
21. Horner DK. Mentoring: positively influencing job satisfaction and retention of new hire nurse practitioners. Plast Surg Nurs. 2020;40(3):150–65. https://doi.org/10.1097/PSN.0000000000000333.

22. Hale R. Conceptualizing the mentoring relationship: an appraisal of evidence. Nurs Forum. 2018;53(3):333–8. https://doi.org/10.1111/nuf.12259.
23. Weng RH, Huang CY, Tsai WC, Chang LY, Lin SE, Lee MY. Exploring the impact of mentoring functions on job satisfaction and organizational commitment of new staff nurses. BMC Health Serv Res. 2010;10:240–240. https://doi.org/10.1186/1472-6963-10-240.
24. Weese MM, Jakubik LD, Eliades AB, Huth JJ. Mentoring practices benefiting pediatric nurses. J Pediatr Nurs. 2015;30(2):385–94. https://doi.org/10.1016/j.pedn.2014.07.011.
25. Stanford MD. Mentoring and TeamSTEPPSRTM Implemented to Improve Patient Safety, to Improve Nurse Retention, and to Improve Patient Satisfaction. Mentoring & Teamsteppsrtm Implemented to Improve Patient Safety, to Improve Nurse Retention & to Improve Patient Satisfaction 2018;1–1.
26. Woolnough HM, Davidson MJ, Fielden SL. The experiences of mentors on a career development and mentoring programme for female mental health nurses in the UK National health service. Health Serv Manage Res. 2006;19(3):186–96. https://doi.org/10.1258/095148406777888071.
27. Bradford H, Hines HF, Labko Y, Peasley A, Valentin-Welch M, Breedlove G. Midwives mentoring midwives: A review of the evidence and best practice recommendations. J Midwifery Women's Health. 2022;67(1):21–30. https://doi.org/10.1111/jmwh.13285.
28. McGrath J. Social psychology: A brief introduction. New York.: Holt, Rinehart & Winston; 1964.
29. Wang Y. An overview on the team interaction process. Open J Social Sci. 2018;6(12):1–11. https://doi.org/10.4236/jss.2018.612001.
30. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description–the poor cousin of health research? BMC Med Res Methodol. 2009;9(1):1–5.
31. Sandelowski M. Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed-method studies. Res Nurs Health. 2000;23(3):246–55.
32. Kakyo TA, Xiao LD, Chamberlain D. Exploring the mediating role of social exchange orientation in the relationship between mentoring experiences and mentoring intentions: A Cross-Sectional study. Nurs Health Sci. 2025;27(1):e70034. https://doi.org/10.1111/nhs.70034.
33. Kakyo TA, Xiao LD, Chamberlain D. Evaluating psychometric properties of three mentoring scales among nurses and midwives in hospital settings: A methodological study. International Nursing Review. 2022;1–11. https://doi.org/10.1111/inr.12889
34. Namaganda G, Oketcho V, Maniple E, Viadro C. Making the transition to workload-based staffing: using the workload indicators of staffing need method in Uganda. Hum Resour Health. 2015;13(1):1–11. https://doi.org/10.1186/s12960-015-0066-7.
35. State of the world's nursing report. 2020: Uganda [https://www.who.int/publications/i/item/9789240003279]
36. Human resources for health audit report. [https://www.health.go.ug/cause/human-resources-for-health-audit-report-2019-2020/]
37. Braun V, Clarke V. Reflecting on reflexive thematic analysis. Qualitative Res Sport Exerc Health. 2019;11(4):589–97. https://doi.org/10.1080/2159676X.2019.1628806.
38. Miles MB, Huberman AM, Saldaña J. Qualitative data analysis: A methods sourcebook. In., Third edn: Thousand Oaks, CA: Sage; 2014.
39. Guba EG. Criteria for assessing the trustworthiness of naturalistic inquiries. Ectj. 1981;29(2):75–91.
40. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245–51. https://doi.org/10.1097/acm.0000000000000388.
41. Doyle L, McCabe C, Keogh B, Brady A, McCann M. An overview of the qualitative descriptive design within nursing research. J Res Nurs. 2020;25(5):443–55. https://doi.org/10.1177/1744987119880234.
42. Zhang Y, Qian Y, Wu J, Wen F, Zhang Y. The effectiveness and implementation of mentoring program for newly graduated nurses: A systematic review. Nurse Educ Today. 2016;37:136–44. https://doi.org/10.1016/j.nedt.2015.11.027.
43. Austin C, Halpin Y. Evaluation of a personal professional mentor scheme for newly qualified nurses. Br J Nurs. 2021;30(11):625. https://doi.org/10.12968/bjon.2021.30.11.672.
44. Coventry T, Hays A-M. Nurse managers' perceptions of mentoring in the multigenerational workplace: A qualitative descriptive study. Australian J Adv Nurs. 2021;38(2):34–43. https://doi.org/10.37464/2020.382.230.
45. Washington R, Cox E. How an evolution view of workplace mentoring relationships helps avoid negative experiences: the developmental relationship mentoring model in action. Mentor Tutoring: Partnersh Learn. 2016;24(4):318–40. https://doi.org/10.1080/13611267.2016.1252109.
46. Liu Y, Abi Aad A, Maalouf J, Abou Hamdan O. Self-vs. other-focused mentoring motives in informal mentoring: conceptualizing the impact of motives on mentoring behaviours and beneficial mentoring outcomes. Hum Resource Dev Int. 2021;24(3):279–303. https://doi.org/10.1080/13678868.2020.1789401.
47. Voss JG, Alfes CM, Clark A, Lilly KD, Moore S. Why mentoring matters for new graduates transitioning to practice: implications for nurse leaders. Nurse Lead. 2022;20(4):399–403. https://doi.org/10.1016/j.mnl.2022.01.003.
48. Eby LT, Durley JR, Evans SC, Ragins BR. The relationship between short-term mentoring benefits and long-term mentor outcomes. J Vocat Behav. 2006;69(3):424–44. https://doi.org/10.1016/j.jvb.2006.05.003.

Publisher's note