A mentoring programme to meet newly graduated nurses’ needs and give senior nurses a new career opportunity: A multiple-case study

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ABSTRACT

Aim: To evaluate the implementation of a multifaceted mentoring programme in a large university hospital and describe its value from the perspectives of newly graduated nurses, experienced nurses and the hospital organisation.

Background: Healthcare organisations need long-term competence-planning strategies to retain nurses, prevent their premature departure from the profession and use their competencies. This paper reports a mentoring programme focused on supporting newly graduated nurse’s transition to practice and senior nurses’ professional development as supervisors.

Design: A multiple-case study.

Methods: We performed 35 interviews with nurses, supervisors and nurse managers in the five units that implemented the programme, mapped the programme at the hospital level and extracted the nurses’ working hours. The interviews were analysed thematically using the theoretical lens of the head–heart–hand model to interpret the results.

Results: Of 46 units in the hospital, 14 had implemented one or several of the components in the mentoring programme. The programme corresponded to the newly graduated nurses’ needs, gave senior nurses a new career opportunity and contributed to an attractive workplace. The main theme, Giving new nurses confidence, experienced nurses a positive challenge and the organisation an opportunity to learn, reflects the value of the programme’s supervisory model to new and experienced nurses and to the organisation as a whole.

Conclusion: The mentoring programme appeared to be a promising way to smooth the transition for newly graduated nurses. The experienced supervising nurses were key to the success of this complex programme, supporting the new nurses at the bedside and being available to respond to their questions and reflections. Embedding the supervisors in the units’ daily practice was necessary to the success of the different parts of the programme. Despite the strategic and well-designed implementation of this mentoring programme aimed to solve the everyday challenge of nurse shortages in the hospital, it was a challenge to implement it fully in all the units studied.

1. Introduction

Hospitals everywhere find it difficult to recruit and retain nurses. This is a complex problem, but nurses’ high workloads in organisations providing insufficient support is a central component (Hayes et al., 2012; Lu et al., 2019; Morsiani et al., 2017). Low staffing and lack of competence leads to fewer available hospital beds and postponed care, treatment and surgeries. The results of the European research programme RN4Cast showed a link between deficiencies in nurses’ education and competence and patients’ risk of injury and postoperative mortality (Aiken et al., 2014). High turnover also leads to fewer experienced professionals available to advise newly graduated nurses (Willman et al., 2020).

New nurses face many challenges and the first year after graduation is a critical time in nurse turnover (Ahlstedt et al., 2019; Currie and Carr Hill, 2012; Rudman et al., 2014, 2020). Nurses are especially difficult to
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provide supportive leadership to and have strategies in place for their
work to achieve that goal (Lindqvist et al., 2014, 2015). Being able to influence their work, to develop and learn by
solving complex tasks and to get feedback from supportive colleagues are all important factors to nurses considering whether to stay in the
profession (Ahlstedt et al., 2019). It is crucial that the organisation provides supportive leadership to and have strategies in place for their
professional development (Blomberg et al., 2016; Wei et al., 2019).

Early supervision is valuable in keeping nurses in the profession
(Cummins, 2009) and group supervision is effective (Francke and de Graaff, 2012). Strengthening nurses' professional identity supported by
mentoring programmes is central to helping them use and develop their
skills and vision of nursing (Brook et al., 2019; Brunero and Stein-Parbury, 2008; Cummins, 2009) and clinical supervision can provide both skill and knowledge development and stress relief (Brunero and Stein-Parbury, 2008). A systematic review identified a variety of interventions (e.g. mentorship programmes, transition to practice pro-
grames) where the teaching, preceptor, mentor and supervision
components seem promising in the retention of newly graduated nurses
(Brook et al., 2019). Supervision of individuals or groups is an ethical
action by which supervisors use and share their competence to help
newer clinical staff talk about everyday work life and discover their own
needs, opportunities and limitations in clinical work (Tveiten and Severinsson, 2004).

1.1. Theoretical framework

This study’s theoretical starting point is the ‘head–heart–hand’
model for evidence (Dock and Stewart, 1920), which was developed and
interpreted by Eriksson et al. (1999). The model encompasses the
timeless truths of nursing and is ‘based on the assertion that nursing is
simultaneously an art and a science and summarizes the linguistic
meaning of evidence’ (Eriksson, 2010). In this model, the head repre-
sents theoretical knowledge and scientific methods, the heart stands for
ethical reflections and high morals and the hand symbolises the nurse’s
practical work and technical knowledge. All three parts must be
included for nursing care to be complete and evidence-based and this
holistic approach leads to professionalism in nursing (Eriksson et al.,
1999; Eriksson, 2010). The model is described as a practical tool for
nurses to self-evaluate their professional development and support them
in basing their practice on evidence (McLean, 2012). However, to the
best of our knowledge the model’s effect on NGNs, senior nurses and the
organizations has not been studied.

Healthcare organisations need long-term competence-planning
strategies to retain nurses and prevent nurses from prematurely leaving
the profession (National Board of Health and Welfare, 2018). Several
national initiatives have been implemented in Sweden to strengthen the
supply of nursing skills, increase the number of nurses and support
long-term regional strategies and initiatives to retain nurses and use
their competencies. In the present study a multifaceted mentoring pro-
grame was implemented in a large university hospital- challenged by
both a high turnover of nurses and difficulties in recruitment. The
project involved many facilitators and stakeholders, as well as newly
graduated and experienced nurses. It is important to study the outcomes
of this investment in a large university hospital.

1.2. Aim

The purpose of this study was to evaluate the implementation of the
mentoring programme and describe its value from the perspectives of
newly graduated nurses, experienced nurses and the hospitalorganisation.

2. Methods

2.1. Design

We used a multiple-case study design (Baxter and Jack, 2008; Yin,
1991), allowing multiple facets of the phenomenon to be revealed and
understood in context using a variety of data sources. The focus of a case
study is on ‘how’ and ‘why’ questions: the researcher cannot manipulate
the behaviour of those involved and the contextual conditions are
relevant to the phenomenon under study. We interpreted the results
through the theoretical lens of the head–heart–hand model (Eriksson
et al., 1999).

2.2. Context

We conducted the study in a large Swedish university hospital with
46 somatic units, approximately 800 patient beds and 8600 employees
including 2300 registered nurses. We refer to registered nurses in this
paper as nurses rather than RNs.

2.3. The mentoring programme

The programme, supported by a national grant from the government,
was initiated in the hospital in 2017. The main objectives were to sup-
port newly graduated nurses' transition to practice and senior nurses' professional development. An intern facilitator.

led the development and implementation in cooperation with a
hospital steering group including representatives from nursing and
human resource management. A reference group (managers, nursing
faculty, human resources and nurses) met regularly to discuss strategies
during the project’s development. The head–heart–hand model by
Eriksson et al. (1999) was chosen as it clearly proves the importance of
all parts of nursing care. The model also made it feasible to divide the
supervisor assignment into three parts, as one of the aims was to engage
as many experienced nurses as possible. The hospital board supported
implementing the programme in all units.

The experiences and needs of nurses and leaders at the hospital were
gathered through workshops and questionnaires. The facilitator visited
units and provided guidance on the programme’s implementation. In-
formation about the project was also distributed on the intranet and at
management meetings. The programme’s roles (clinical supervisor,
group supervisor and theoretical supervisor) and components are pre-
sented in Fig. 1.

Supervisors were recruited among clinically experienced nurses at
the hospital and their training was developed in collaboration with other
experienced nurses and psychologists. A total of 104 nurses completed
the internal supervisory courses (2017–2019) and were offered regular
guidance during their first years in the role.

2.4. Sample and setting

The study began by mapping the programme’s implementation in all
somatic units. Five units were strategically chosen for interviews based
on their implementation of one or several of the programme’s compo-
nents and their representation of five different specialties in the somatic
care of adults and children in general care (n = 2), step-down (n = 1)
and intensive care (n = 2) units (Table 1). A convenient sample of par-
ticipants included nurses taking or having completed the programme
(n = 10), nurse managers (interviewed twice) (n = 5), clinical supervi-
sors (n = 8), group supervisors in reflection groups (n = 4) and theo-
retical supervisors (n = 3). Participants were approached by email until
data saturation was achieved. All invited nurse managers and supervi-
sors agreed to participate, but six nurses out of 16 did not respond to the
invitation.
2.5. Data collection and procedure

A member of the research team and a research assistant conducted a structured interview survey with all nurse managers at the 46 somatic units at the hospital to map the implementation of the programme. The interviews, including questions about whether, which and why components of the programme were or were not implemented, were conducted by telephone in November and December 2019.

We performed 35 individual interviews with nurses, supervisors and nurse managers in five units from September 2019 to January 2020. Interviews with the nurse managers included a ward visit from the leader of the research team. The focus in this stage of interviewing was to collect information about the units, their available competencies, their recruitment of nurses and any ongoing nursing projects at the unit.

We held individual interviews with nurses and supervisors after this step using an interview guide with open-ended questions. Thereafter follow-up interviews (focusing around implementation) were performed with the nurse managers. The interview questions (Appendix A) were generated based on the head–heart–hand model (Eriksson et al., 1999), the literature and discussed among the research team. Minor adjustments were made after the first two interviews, which are included in the study. During the interviews the participants were asked to reflect on their own competence in relation to perceived challenges and skills. The first author (female senior researcher with a longstanding experience in qualitative research) conducted all interviews but two, which were conducted by a research assistant (male PhD student guided by the first author and trained on interviewing skills). The audio-recorded interviews were conducted in a conference room (nurses and supervisors)
or office (nurse managers) at a time convenient for participants and lasted from 36 to 60 min. Reflective notes were made after the interviews. Interview data were transcribed by professional secretaries and transcripts were verified by the research assistant. Transcripts were not returned to participants. The quantitative data on registered working hours for nurses in the five units and the hospital as a whole were extracted from the hospital’s payroll data.

### 2.6. Data analysis

The interviews were thematically analysed following Braun and Clarke (2006). The analysis progressed from description to interpretation of patterns within and across the included units guided by the head–heart–hand model (Eriksson et al., 1999). The research team held regular meetings to reconcile findings in the analytical process (Table 1).

### 2.7. Ethical considerations

The project followed the guidelines of the Helsinki Declaration (World Medical Association, 2018). The Swedish Ethical Review Authority did not mandate any approval process for the study (No. 2019-03102). Participants were informed about the study (verbal and written information) and the voluntary nature of their participation and were assured of the confidentiality of their identities and data. All participants provided written informed consent. The responsible researcher was familiar with the hospital, but had no previous relationship with the participants or any professional role with, or commitment to, the included units.

### 3. Results

The main theme and the four subordinate themes reflecting the value of the mentoring programme for both new and senior nurses are elaborated below, following an initial description of the programme’s implementation in the hospital and the included units.

#### 3.1. Implementation at the hospital level

Fourteen of the hospital’s 46 units had implemented one or more of the supervisory roles and most nurse managers (n = 39) reported they were aware of the programme. Reasons, stated by the nurse managers, for not implementing the programme included the nurse manager’s recent recruitment or work overload, a shortage of senior nurses to act as supervisors, insufficient resources to allow anyone time to work within the project and in one case organisational issues due to the unit’s move to new premises. At the time of this study 21 supervisors were actively working within the programme (Table 2).

<table>
<thead>
<tr>
<th>How supervision was conducted</th>
<th>One-to-one supervision. New nurses were supervised for 2 or 3 whole days in their first year or the supervisor were available for questions most of the day in combination with other assignments in the department.</th>
<th>A supervisor led a group of 5-10 new nurses. The group met every two or three weeks for 1.5 hours.</th>
<th>A supervisor led a group of 2-5 new nurses or one-to-one supervision. The group met every two or three weeks for 1.5 hours.</th>
<th>One-to-one supervision The couple met 2-4 times in six months. Each meeting lasted 1.5 hours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous qualifications</td>
<td>Solid clinical knowledge and nursing experience</td>
<td>Good ability to listen and confidence in professional role.</td>
<td>Master’s degree or higher</td>
<td>Solid experience in academia, clinical work and/or management</td>
</tr>
<tr>
<td>Length and content of education</td>
<td>12 hours over 3 occasions Methodology: supervision –Independent nursing interventions in contrast to interdependent and dependent nursing interventions –Nursing competencies</td>
<td>20 hours over 4 occasions Methodology: conversation</td>
<td>8 hours over 4 occasions Methodology: practical supervision –Getting started with nursing rounds</td>
<td>One 3-hour occasion Methodology: conversation –Goal awareness</td>
</tr>
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Fig. 1. (continued).
prioritising their tasks and structuring their day and were available to discuss various upcoming issues throughout their shifts. The clinical supervisors at implementation had remained in their role. Clinical supervisors focused on supporting new nurses in their first year by supervisors who followed them and were initially involved and those still in use at the time of the interviews. Most supervisors were aware that their supervisor be sensitive to their gradual transition from student to professional, as well as increase their technical skills. But also, how much of this new knowledge they centre themselves and acquire a sense of security and begin to trust their professional role. The supervisors said they needed to be confident in their own nursing role and skills to be able to adapt to and handle new situations. They also discussed the many new nursing interventions they were exposed to and how to perform different routines (e.g., assessing and dressing central intravenous lines, calculating and preparing drug doses for children or postoperative fluid balances) and availability to answer their many questions. The nurses said that the clinical supervisor role corresponded to their needs and the arrangements in the programme supported them in their transition into the nursing role. They described how learning by performing complex tasks while receiving continuous and straightforward feedback from a supportive supervisor facilitated this transition. The supervisors’ feedback, confirmation and availability boosted their confidence and improved their nursing skills and abilities. However, it was also important to new nurses that their supervisor be sensitive to their gradual transition from needing supervision to functioning well unsupervised and treat them individually as colleagues rather than students. Having a sympathetic supervisor to talk with was invaluable when new nurses doubted their abilities or even their own choice of becoming a nurse:

This is something she’s been good at discussing with me. She [the clinical supervisor] has always answered my questions and made sure that I take responsibility – that I have the courage to take responsibility, to test things and to question. ( Newly graduated nurse)

The supervisors addressed the importance of being humble and openminded to the differences among trainees. Being a supervisor was a positive role overall, but also had many challenges, especially when a new nurse showed a less than positive attitude towards their patients or did not follow the expected learning curve and take on more responsibility for their patients. The supervisors said they needed to be confident in their own nursing role and skills to be able to adapt to and approach nurses as individuals and encourage or challenge them to take on more responsibility. Overall, supervisors found the role inspiring:

I enjoy supervising. Maybe that’s what it takes to be good at it. I think it’s fun to see how others develop, as they grow as individuals and as professionals, as well as increase their technical skills. But also, how they centre themselves and acquire a sense of security and begin to feel comfortable as nurses. It makes me proud and happy when I see a nurse interacting with others in a kind and professional manner. (Clinical Supervisor)

Clinical supervision at bedside focused mainly on the tasks (hand aspect) of nursing. The nurses talked vividly about how to structure their day and prioritise the various tasks and routines they needed to learn. They also discussed the many new nursing interventions they were expected to perform. Several new nurses had started their career working in the specialist field of intensive care immediately after completing their undergraduate nursing degree and were expected to care for

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Process of analysis and pre-understanding.</th>
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</thead>
<tbody>
<tr>
<td><strong>Step in analysis</strong></td>
<td><strong>Description of actions</strong></td>
</tr>
<tr>
<td>Familiarizing with data</td>
<td>Transcripts (in Swedish) listened through by research assistant and first author. Transcripts read by all authors</td>
</tr>
<tr>
<td>Generating initial codes</td>
<td>Data coded by all authors in two units followed by research meeting and discussion of codes. Entire dataset was thereafter coded by two authors, followed by research meeting discussion of coding. The coding was performed with the participants’ different perspectives in mind (nurses, supervisors and nurse managers). Step performed in NVivo (first author) and Excel (last author)</td>
</tr>
<tr>
<td>Searching for themes</td>
<td>Collated codes allocated to potential themes</td>
</tr>
<tr>
<td>Creating initial thematic maps (nurses and supervisors separately) discussed and revised</td>
<td></td>
</tr>
<tr>
<td>Reviewing themes</td>
<td>Themes checked in relation to codes</td>
</tr>
<tr>
<td>New thematic maps generated. Discussions among all authors on the interpretation of the results and identification of similarities and differences in the five units</td>
<td></td>
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<tr>
<td>Following the discussions, themes were revised, translated into English, and a convergent finding of the data agreed upon. Transcripts were read again by first and last authors to confirm the findings.</td>
<td></td>
</tr>
<tr>
<td>Defining and naming themes</td>
<td>Refining of each theme, including identifying the essence of what each theme is about, and the overall theme. Checking that the themes fit into the overall theme, but without too much overlap between themes (all authors). No cross-checking was performed with participants.</td>
</tr>
<tr>
<td>Producing report</td>
<td>Writing up the report, including examples which captured the essence. The theoretical model was used as the theoretical lens in writing up the narrative</td>
</tr>
<tr>
<td>Pre-understanding and experience</td>
<td>Before the analysis the first and last authors’ pre-understanding was individually written down. The pre-understandings and how background, experiences and perspectives affected the findings were recurrently discussed at research meeting among all authors. All authors are female registered nurses with multiple years’ clinical experience.</td>
</tr>
<tr>
<td>Author 1 (EJ): Associate professor of nursing at the university with a joint position at the university hospital. Earlier experience as supervisor of group supervision – no involvement in the clinical implementation of the mentoring program. No previous relationship with the participants or any professional role with, or commitment to, the included units.</td>
<td></td>
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<tr>
<td>Author 2 (LG): Professor of nursing at the university. Member of steering group of the mentoring program at the university hospital.</td>
<td></td>
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<tr>
<td>Author 3 (LN): PhD in nursing at the university hospital. Extent facilitator for the mentoring program and member of steering group at the university hospital.</td>
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</table>

3.2. Components implemented at the studied units

The five units in the study varied in the component(s) introduced initially and those still in use at the time of the interviews. Most supervisors at implementation had remained in their role. Clinical supervision was the most commonly implemented component in the units, labelled A–E in the results (Table 2).

Clinical supervisors in the units focused on supporting new nurses in prioritising their tasks and structuring their day and were available to discuss various upcoming issues throughout their shifts. The clinical supervisors also allocated time at the end of the day for reflection and feedback on the day’s work. In three of the units (B: cardiac intensive care, C: step-down unit neurosurgical unit and E: thoracic surgical ward) the clinical supervisor could focus on that role without any other commitments that day. The new nurses in these units were supervised for 2 or 3 days in their first year by supervisors who followed them and were available throughout the shift. Clinical supervisors in unit A (neonatal intensive care unit) and unit D (general ward for paediatric care) combined their role as supervisor with other assignments in the department, but were available if questions arose and supervision was needed during the day.

3.3. Main theme

The main theme, **Giving new nurses confidence, experienced nurses a positive challenge and the organisation an opportunity to learn and the four contributing themes reflect the value to new nurses of having supervision and the value to senior nurses of providing it. The head–heart–hand model is integrated in the narratives of the themes, presented in Fig. 2.**

3.3.1. Theme I. Senior competence available in daily practice: nurturing and inspiring

The new nurses described the many demands of nursing and their great appreciation of the support provided by clinical supervisors. The results show that new nurses initially needed support with the daily routines, finding a structure for the day including when and how to perform different routines (ward rounds, handovers) and becoming familiar with the many electronic systems in use. The nurses appreciated the supervisors’ support during new bedside interventions (e.g., assessing and dressing central intravenous lines, calculating and preparing drug doses for children or postoperative fluid balances) and availability to answer their many questions. The nurses said that the clinical supervisor role corresponded to their needs and the arrangements in the programme supported them in their transition into the nursing role. They described how learning by performing complex tasks while receiving continuous and straightforward feedback from a supportive supervisor facilitated this transition. The supervisors’ feedback, confirmation and availability boosted their confidence and improved their nursing skills and abilities. However, it was also important to new nurses that their supervisor be sensitive to their gradual transition from needing supervision to functioning well unsupervised and treat them individually as colleagues rather than students. Having a sympathetic supervisor to talk with was invaluable when new nurses doubted their abilities or even their own choice of becoming a nurse:

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patients with complex care needs they had not been trained for. Their clinical supervision often included a shorter period of reflection at the end of the shift focused mainly on the different clinical situations during the day (hand and heart).

3.3.2. Theme II. Awareness of the ethical dimension of nursing: reflection with colleagues

This theme shows the importance of group supervision as a complement to clinical supervision. The group supervisions, which sometimes included both new nurses and the assistant nurses they worked with, provided opportunities for in-depth reflections about clinical situations, ethical dilemmas and the high demands nurses make on themselves. This supportive group environment, with time to share and reflect on similar thoughts and challenges with their peers and an experienced supervisor supported new nurses’ transition into their professional role and their confidence in their abilities:

I think it’s been very valuable, those times I’ve attended group supervision, because it helped me think about things that have occurred to others. Sitting in a group and just talking has been very good and rewarding. (Newly graduated nurse)

Being a supervisor in these groups supported not only the participants but also the supervisors’ own development through new insights into role and responsibilities of the senior nurse in daily work. The reflections during group supervisions allowed supervisors to identify many ethical dilemmas that they had not recognised earlier:

‘I never considered the notion of me being some kind of group supervisor. I’ve always looked up to people who know how to ask the right questions and when to be quiet and listen and so on. But now I’m beginning to think that I’m reaching that stage, or at least becoming better at it. I think I’ve learned a lot – quite a lot – and challenged myself. I think that even when I’m working clinically, I see things through my ‘reflection glasses’. (Group Supervisor)

The supervisor quoted above had a mixed group of newly graduated nurses and assistant nurses and shared a difficult situation that arose in a group session. The group was presented with a case where an assistant

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Table 2

<table>
<thead>
<tr>
<th>Case</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Intensive care unit</td>
<td>Intensive care unit</td>
<td>Step-down unit</td>
<td>General ward</td>
<td>General ward</td>
</tr>
<tr>
<td>Type of care</td>
<td>Neonatal intensive care</td>
<td>Adult Cardiac intensive care</td>
<td>Adult neurosurgery</td>
<td>Paediatric orthopaedic, urologic, and neurologic surgery</td>
<td>Adult thoracic surgery</td>
</tr>
<tr>
<td>Education level</td>
<td>Registered nurses and clinical nurse specialists</td>
<td>Registered nurses</td>
<td>Registered nurses</td>
<td>Registered nurses and clinical nurse specialist</td>
<td>Registered nurses</td>
</tr>
<tr>
<td>Supervisors in 2018 when the programme was started</td>
<td>CS*</td>
<td>CS*</td>
<td>CS*</td>
<td>CS*</td>
<td>CS*</td>
</tr>
<tr>
<td></td>
<td>GS*</td>
<td>GS*</td>
<td>GS* (from another unit)</td>
<td>CS*</td>
<td>GS* (from another unit; the group mixed RNs and assistant nurses)</td>
</tr>
<tr>
<td>Supervisors in 2019 when the interviews were performed</td>
<td>Fresh start with a newly educated CS*</td>
<td>CS*</td>
<td>GS*</td>
<td>CS*</td>
<td>CS*</td>
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<td></td>
<td>TS*</td>
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Fig. 2. Overview of main theme and themes (I-IV).
nurse was helping a male patient with pre-operative bathing. The patient, who was unable to do his own perineal care, made sexual allusions while the assistant nurse bathed him. This situation provoked shame in the assistant nurse, who instead of talking about it with the attending nurse or other colleagues, finished the work and carried the experience by herself. The group supervision was an opportunity to share the experience in a trustful environment. Reflecting on this, the group discussed how to act professionally and continue to offer evidence-based care and follow guidelines for pre-operative bathing in future similar situations. The reflection also led them into a dialogue around how important it is to support each other in challenging caring situations. This situation exemplifies how when all parts of the evidence model (head–heart–hand) are integrated, the ethical dimensions and value of nursing care are made visible. Reflecting on ethical issues supported the members of the groups not only in their clinical practice but also in their professional development. This process also initiated a discussion resulting in agreement that nursing interventions should be performed according to evidence (head).

3.3.3. Theme III. Bridging the theory/practice gap: a challenge despite available competence

This theme describes the supervisors to bring evidence into practice and to find a natural forum for this integration. The theoretical supervisors were trained to use different tools to bring current research into everyday decisions. Some positive opportunities for this were nursing rounds focused on patients with more complex care needs and seminars on specific nursing issues (head). For example, patient cases could be used to discuss nutrition and the importance of individual nutritional care plans for different patient groups. One supervisor implemented a patient safety tool for visualising adverse events such as pain in neonatal care. Visualising pain assessment revealed the need for quality improvement (head). The theoretical supervisor was identified as an important facilitator of improvements in nursing care, but it was evident that this role was not prioritised or used in the studied units despite the competent nurses available.

3.3.4. Theme IV. Contributing to an attractive workplace and a learning organisation

The new nurses said they felt allowed to ‘be new’. They appreciated the nurturing and inspiring atmosphere in the programme and knowing they had the support of their clinical supervisor reduced their stress outside of work:

I’ve had enormous use of clinical supervision. It gives you the chance to be new and get the support you need. It does a lot for one’s wellbeing. You don’t have to leave work and feel like crap, that you’re in the way, that you’re insecure, that you’re someone who asks questions and bothers experienced nurses. (Newly graduated nurse)

New nurses, supervisors and nurse managers described ways the programme contributed to an attractive organisation. The new nurses said that knowing the unit offered structured supervision through the mentoring programme influenced their decision to work there and said that knowing the unit offered structured supervision through the programme, they were an important component in recruiting nurses, offered senior nurses new career opportunities and also relieved some of their own workloads as leaders:

I get to hear about problems a lot sooner than I otherwise would have. This is because the clinical supervisors are quick to snap up so much of what’s going on. They can also help out when we’re talking to one another […] It means that I have a work partner in a way that I otherwise wouldn’t have. So now I can sort of focus resources on what I want to accomplish. (Nurse Manager)

3.4. Reported working hours for nurses

Fig. 3 shows the percentual development of registered working hours for nurses in the studied units and the hospital as a whole from December 2017 to December 2019. Four units of the five in the study had increased working hours for nurses, while the hospital had a slight decrease. Units A, C, D and E educated their first supervisor in April 2018 and Unit B in September 2018. During the study period, the number of beds in the units and the hospital as a whole underwent no major changes.

4. Discussion

The findings show that the mentoring programme corresponded to new nurses’ needs in transitioning to the nursing role and provided experienced nurses with a new career opportunity where they could develop their skills in an unexpected direction. The programme also seems to have increased the numbers of newly recruited and re-employed nurses as measured by the increased nursing hours in the studied units. The programme, however, was either uninitiated or discontinued in most of the units.

The clinical supervisor role was the component considered most necessary by most units. In the interviews, both experienced and newly graduated nurses talked about the supervision’s high focus on ‘how to do things’. In Eriksson’s model (1999), this is the work of the hand, the nurse’s practical skills and technical knowledge. Despite the programme’s equal emphasis on central dimensions of nursing related to the heart, such as establishing a relationship with the patient and providing holistic, person-centred care, these were not mentioned in the interviews. Could it be that the culture of the unit rewarded the hand aspect of work, but not the holistic approach to patient care? The findings indicate that we need to go beyond ‘doing’ in supervision and encourage in nurses the core values of compassion, respect and relationship (McLean, 2012). McLean suggests that educators stimulate students’ professional identity through questions such as ‘What knowledge, skills and attitudes do I need to develop?’ This kind of reflective question could be useful for newly graduated nurses in both the group reflection sessions and at the end of a day of clinical supervision. Kitson et al. (2014) emphasised the need to embed reflection in nurses’ thoughts and actions to ensure holistic patient care. Such reflection can deepen understanding of the importance of the nurse–patient relationship and strengthen person-centred care (Karlsson et al., 2019b). When this project was developed, Eriksson’s head–heart–hand model seemed a good way to structure the components of the programme. The supervision was divided into several separate (head, heart, hand) roles so that as many experienced nurses as possible should have the opportunity to take on the role, which we assumed and hoped would increase their job satisfaction and professional development. In retrospect and after discussion, we now agree with Eriksson (1999) that the three components cannot stand separately. The hand cannot work well without the evidence of the head and the compassion of the heart, nor are any one or two of the elements sufficient to provide optimal patient care without
the others. The implementation and logistics of this project would have been easier if we had educated only one type of supervisor to be responsible for all three components of the model. It would have been difficult, however, to recruit clinical nurses who could master all these parts and if only one supervisor were responsible for all three components, the organisation would be more vulnerable if that person should quit. In line with Cummins (2009), the key to successful clinical supervision is that it aims not only to retain nurses in an effective workforce, but also to empower nurses to realise their vision of nursing.

It emerged in the interviews that the newly graduated nurses wanted support from the clinical supervisor, but also wanted to feel independent. This is a difficult balancing act for a supervisor and similar findings have been reported (Cummins, 2009). Supervisors should be recruited based on their competence and ability to take on the challenges of supervising. Those senior nurses who participated as supervisors mostly enjoyed this new career opportunity, which suggests that hospitals would benefit from investing in senior nurses’ competence development.

We know the critical time of turnover in nurses is during their first years after graduation (Currie and Carr Hill, 2012; Rudman et al., 2014) and that supervision early in the transition, within a mentoring programme, can be important in retaining nurses (Cummins, 2009; Brook et al., 2019). Recent evidence shows that job-related stress symptoms in early-career nurses has long-term consequences on numerous aspects of their psychological functioning (Rudman et al., 2020) and needs to be prevented by mentoring programmes and supervision (Brook et al., 2019; Francke and de Graaff, 2012). However, even with a strategic hospital decision in place and a mentoring programme based on theory and evidence (Bisholt, 2012; Blomberg et al., 2016; Eriksson et al., 1999), the findings show that it was still a challenge to implement the programme. The programme may, however, have improved the numbers of newly recruited and re-employed nurses. The increments shown in the graph of working hours are clearly related to the starting points of the programme. The studied units had no increase in their number of beds; their increased nursing hours was the result of vacancies being filled. Several factors, such as good leadership or a unit’s good reputation for leadership and organisation, can cause the increase of registered working hours for nurses. The positive result is probably due to a combination of these interconnected factors.

The part of the programme focused on evidence-based nursing was found to be the most challenging, for several possible reasons. First, although evidence-based nursing is part of the national nursing curriculum, a phenomenographic study revealed that the concept was often understood as fragmentary and difficult (Karlsson et al., 2019a). Second, nursing education in Sweden focuses more on teaching scientific methods and less on preparing nursing students to work according to the principles of evidence-based nursing (Ehrenberg et al., 2016). The programme employed supervisors with master’s or doctoral degrees, but their training might have to include more on the principles of evidence-based nursing and quality improvement (Ehrenberg et al., 2016; Harvey and Kitson, 2016). However, to achieve these expectations nurses need to be supported by supervisors who can integrate this knowledge into daily practice.

Finally, we found that several new nurses had started their career by working in an intensive care unit where they were expected care for patients with complex needs they were not trained for. It is worrying that the hospital employs newly graduated nurses in a specialist field due to the shortage of specialist nurses. No matter how well the mentoring programme works with newly graduated nurses, its purpose is not and should not be to replace the advanced university training of specialist nurses.

4.1. Methodological considerations

A strength of the study was the use of a multiple-case study design, which enabled us to gather and analyse both quantitative and qualitative data. In the study the boundaries were not clear between the phenomenon and the context and it would have been impossible for us to obtain a true picture of the nurses’ and supervisors’ experiences without considering the contexts of both the individual units and the university hospital. Our study design, however, does not allow us to make any causal conclusions, as other projects running parallel to the mentoring
programme might explain the findings. To achieve trustworthiness in the findings all authors were involved in the study design, development of the interview guide and considered reflexivity during the process of analysis. During the analysis we returned to the data over and over again to see if our interpretations and findings made sense (Patton, 2015). A strength is that the head–heart–hand model (Eriksson, 1999) used in the development of the programme was integrated also in the research process (Braun and Clarke, 2006). As presented earlier, the role of the theoretical supervisor was a challenge to implement, also illustrated in the brief description in one theme. Nevertheless, we found it important to present this diverse finding. In future research the implementation of this role needs to be explored further. Another strength is that all supervisors and managers invited agreed to participate in the interview. However, a limitation is that several nurses taking or having completed the programme did not respond on the email invitation. The reasons behind not responding are unknown. Limited time and interest to share the experience were probably reasons for non-responding. A limitation is that the interviews were transcribed by several secretaries instead of one member of the research team. However, the secretaries were professionally educated and to achieve credibility all transcripts were verified by the research team.

5. Conclusion

The mentoring programme, particularly the clinical supervision, was shown to be a promising way to smooth the transition for newly graduated nurses. The experienced supervisors were key in this complex programme to support new nurses by being available at bedside and later to respond to nurses’ questions and reflections. Embedding the supervisors in the daily practice in the units was prerequisite for the different parts of the programme to be successful. The structure of the mentoring programme involving nurses at all career stages could be used globally. The findings support that hospitals would benefit from investing in senior nurses’ competence development to encourage them to remain in their work as supervisors and nurses. However, despite a strategic well-designed programme aimed to solve the everyday challenge of nursing shortages in the hospital, it was a challenge to fully or even largely implement the programme. Further research focusing on the implementation process and sustainability of the implementation is warranted.

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CRedit authorship contribution statement

Eva Jangland: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Software, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. Lena Gunningberg: Conceptualization, Formal analysis, Methodology, Validation, Writing – original draft, Writing – review & editing. Lena Nyholm: Conceptualization, Formal analysis, Investigation, Methodology, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships, that could have appeared to influence the work reported in this paper.

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Conflicts of interest

None.

Appendix. A: Interview questions

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<th>Nurses</th>
<th>Supervisors</th>
<th>Nurse Managers</th>
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<tbody>
<tr>
<td>Could you please tell me about your last supervision session? How did it work out?</td>
<td>Could you please tell me about your last supervision session? How did it work out?</td>
<td>Interview I, including ward visit</td>
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<tr>
<td>Could you please tell me another patient case/situation when you (a) received clinical supervision or (b) discussed during group supervision? How did it work out?</td>
<td>Could you please tell me another supervision session? How did it work out? What has been the main focus of the supervision sessions?</td>
<td>Could you please tell me a bit about this unit focusing on the following topics?</td>
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<td>Could you please tell me about a situation/assignment: (a) when you were satisfied? (b) that you found difficult or were dissatisfied with your work as a nurse? In what way were you supported during this situation?</td>
<td>Could you please tell me about a supervision session: a) when you were satisfied? b) that you found difficult? How did you handle the situation?</td>
<td>Patient groups</td>
</tr>
<tr>
<td>Can you act and interact with patients the way you were trained to? What enables or hinders you? How has the supervision in the mentoring programme supported you in (a) your transition into the nursing role after graduation? (b) your competence development? Could you please tell me about something that has been particularly important for you? Do you have any other support or mentor than the supervision in the mentoring programme?</td>
<td>Could you act as a supervisor the way you were trained for? What enables or hinders you? How has the supervision in the mentoring programme supported you in your competence development as a nurse? Could you please tell me about something that has been particularly important for you? Do you have any support or mentoring as a supervisor? What do you need?</td>
<td>Level of care</td>
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<td>Working hours/rotations</td>
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<td>Roles available to support newly graduated nurses</td>
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<td>Vision for nursing care/goals</td>
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<td>Model of nursing</td>
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<td>Ongoing projects</td>
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<td>Interview II*</td>
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<td>Could you please tell me about your role in the mentoring programme in your unit? In the planning phase and today? Could you please tell me about the main focus of the implementation in your unit? Do you have any support as a leader in this implementation? What do you need? How has the mentoring programme affected your role in supervising newly graduated nurses on your unit?</td>
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(continued on next page)
Could you please reflect on the degree of difficulty in your work as a nurse/senior nurse in relation to your competence at the moment? What are your thoughts about the mentoring programme at the hospital? What are the important parts of the programme from your perspective? What do you think needs to be improved? How does the programme meet your needs as a newly graduated nurse, supervisor, or leader?

References


