Impact of Social Support and Mentoring on the Career Advancement of Internationally Educated Nurses

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Abstract

Background: The upward growth in work level, position, and title, as well as the rise in compensation and income, is known as career advancement (CA). CA is the outcome of career preparation and supportive organizations. Both individual and organizational supports often influence CA among nurses in Canada. Mentorship and social support facilitate CA among nurses, and these supports are available differently to both Canadian Educated Nurses (CENs) and Internationally Educated Nurses (IENs)

Purpose: This study identified the perceived impact of mentorship and social support on CA among CENs and IENs.

Methods: Data were collected utilizing Organizational Career Growth Scale (OCG), Multidimensional Perceived Social Support (MPSS), and Mentoring Functioning Questionnaire (MFQ 9), from 127 nurses across three provinces, namely Ontario, Manitoba, and British Columbia who met the inclusion and exclusion criteria through an online survey.

Results: There were 44 CENs and 83 IENs. The mean score of CENs on OCG was 65.24%, and for IENs, it was 67.68%. The mean score of MPSS for CENs was 76.61%, and for IENs, 73.65%. The mean score on MFQ 9 was 77.84% and 69.11% for CENs and IENs, respectively. There was a positive correlation between MPSS and MFQ 9 with OCG scores. The positive correlation was statistically significant for IENs. With the subscales of OCG, IENs had a statistically significant higher score in remuneration growth (RG) than CENs. In the career growth progress (CGP) subscale, CENs scored higher than IENs. Having a mentor with the title of RN and meeting the mentor regularly positively impacts OCG scores.

Conclusion: CENs and IENs have a moderate level of perceived OCG, and IENs have higher scores than CENs. There are differences in the level of mentorship and social support available to CENs and IENs.

Recommendations: Organizations/Employers must establish formal mechanisms to facilitate CA among nurses (both IENs and CENs). Coordinated efforts are necessary to help IENs overcome barriers to accessing support. Establishing formal mentorship programs at the workplace will facilitate better career growth among nurses that will help improve job satisfaction, retention, and, ultimately, quality patient care.

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The terms *career growth*, *career mobility*, and *career advancement* are used interchangeably in the literature. However, these concepts are distinct. A *career* is the progression of a person's work experiences over time (Modem et al., 2021). Career growth encompasses a person's life, not just their occupation. As such, it involves the whole person and affects them in the context of an ever-changing life. Contextual variables that must be taken into account while evaluating career progress include environmental influences and limits, ties to important others, responsibility for upbringing of children and old parents, and the overall structure of one's surroundings. Personal development and career development converge in these terms. Self and circumstances–both evolving in tandem–constitute career development (Wolfe & Kolb, 1980, pp. 1–2, as cited in Arthur & McMahon, 2019). Other terms closely related to *career advancement* are *career growth*, *career growth potential*, *career growth prospects*, *career growth opportunities*, and organizational career growth (Modem et al., 2021).

The world has been facing a global shortage of healthcare workers, primarily nurses (Ni et al., 2022). The impact of the COVID-19 pandemic has exacerbated the pre-existing nursing shortage. Numerous nations have investigated the causes of the nursing shortage during the COVID-19 pandemic, reporting acute staff shortages, inadequate supply of medical equipment, and fear of contracting the virus as common themes among the healthcare workers (Mhawish & Rasheed, 2022).

Several factors have contributed to the shortage of nurses even before the pandemic. Poor working conditions, lack of promotional opportunities, and failure to integrate successfully into a workplace often hinder nurses from thriving in their jobs. Nurses who do not have career goals

or supportive, uplifting environments often leave the profession earlier than expected (Liu et al., 2015).

Career advancement (CA) is also a critical factor in retaining nurses, as it promotes job satisfaction and enhances mental health. CA is the upward progression in work level, position, and title and the increase in earnings or income. CA results from career planning with an organization's support and possibilities for employees (Verma, 2020), such as mentorship and training to overcome structural barriers in the organization (Nasurdin et al., 2018). All employees should have an equal opportunity to be promoted and advance in their careers (Jauhar & Lau, 2018).

Both individual and organizational factors influence nurses' CA. Individual factors include motivation, self-worth, psychological wellbeing, peer networks, and support from family and friends, and organizational factors include opportunities for continuing professional development, professional recognition, and career development (Sheikhi et al., 2016b). Many health institutions aim to increase awareness of career issues, enable knowledge progress, and enhance nurses' competencies. Hence, these organizations often provide formal and structured activities such as participation in professional developmental programs to this end (Sheikhi et al., 2016a. Participation in professional development activities is essential for enabling nurses to update their skills and competencies (Adeniran et al., 2013), as nurses have to be qualified with specific skills to achieve CA in healthcare institutions (Sheikhi et al., 2016b).

CA is a path to empowering nurses (Kuokkanen & Leino-Kilpi, 2001). Opportunities for individualized mentorship, transparent rules, and incentives demonstrate an organization's commitment to empowering nurses (Wheeler & Foster, 2013). Nurses at all levels of their careers need a supportive environment that helps with professional development through

ongoing training (Price & Reichert, 2017). Effective CA requires constant forethought and deliberate action toward one's professional and life aims. *Progression*, or *advancement*, is becoming more capable of obtaining and using one's abilities (Verma, 2020).

Career growth denotes the extent to which employees experience career advancement within their current organization; it is the growth of an individual within an organization. Nurses often consider training opportunities, learning resources, leadership, motivation to pursue higher degrees, promotion opportunities, and adequate human resources as support from organizations (Ni et al., 2022). Increasing healthcare costs, budget cuts, complex patient needs, and a lack of commitment to facilitating career advancement are challenges for nurses in advancing their careers. However, more research is needed to understand better how these affect CA.

In addition to the individual and organizational factors that facilitate career growth, social-level factors, such as social support (SS) and the development of structured behavior at an individual level, also contribute (Ni et al., 2022).

Few studies have been conducted on social support and career advancement. However, nurses point out that social support is the most helpful resource in coping with pressures at work (Chen et al., 2012). Researchers have found that when people feel like they have a strong social support system, they can better regulate their negative emotions—like fear, worry, and mistrust—and engage in healthy coping practices when facing adversity. Actively building supportive, collegial connections is critical in establishing the resilience that helps the transition of clinical nurses from their student roles (Wang et al., 2018); indeed, SS has a significant mediating effect on work-related stress experienced by nurses (Chen et al., 2020).

Another factor influencing CA is quality mentorship. *Mentorship* is a process through which an experienced individual helps a less experienced individual achieve their goals (Pelin &

Ayise, 2019); it is a one-on-one connection meant to foster personal and professional growth. Mentorship in nursing is essential for enhancing the future development of nursing practice and clinical education (Evans et al., 2020), as mentored employees show improved retention, productivity, and job satisfaction in a variety of work situations (Martin & Haar, 2021). When formal mentoring programs are in place, employees are more invested in their work and more independent in their career, and advance more quickly (Gruber-Page, 2016).

As suggested by some authors, mentoring may boost the likelihood of nurses staying with an organization. However, this claim lacks empirical support (Morioka & Kitaoka, 2017). For example, although SS and mentorship are linked to CA generally (Hoover et al., 2020; Jolly et al., 2021), this correlation has not been studied among nurses.

In Canada, Canadian Educated Nurses (CEN) and Internationally Educated Nurses (IEN) must continually update their skills and competencies to comply with licensing bodies and provide quality patient care. Although both CENs and IENs face challenges in advancing their careers, IENs often face unique challenges, such as racism and discrimination (Allen, 2018). Research is needed to identify how to support nurses in general, IENs in particular, to achieve the highest levels of CA. Facilitating and assisting IENs in integrating into the workforce will help bridge the gap between the supply and demand in the nursing workforce in Canada.

IENs are like uprooted trees, looking for solid ground in their host countries; they require additional support and nourishment. There are many hurdles, or blocks, that IENs face before becoming registered nurses (RN) in Canada, such as long credentialing and licensing wait times, lack of access to support services, lack of recognition of their educational status, and communication barriers (Baumann et al., 2021). Successfully integrating migrants into a host country's workforce depends on several factors, such as overcoming discrimination in the

recruitment process, dealing with prejudice, and overcoming the biases of executives (Baumann et al., 2021).

Although the success of an IEN becoming an RN depends on many factors, one important factor is the amount and the nature of support available to the IENs (Covell et al., 2014). Differences in the quality of support available to IENs determine whether the IENs will become RNs. It is a loss to Canada if IENs cannot integrate into the profession as the country will continue to grapple with shortage of nurses (Covell et al., 2014). The stressors faced by many IENs during the transition process lead to unhappiness, lack of hope, confusion, and even psychological disturbances, such as depression, which affects their quality of life (Goh & Lopez, 2016). Many IENs are employed in survival jobs to meet their financial needs, and most of them are unable to pursue their journey of becoming an RN in Canada because of their inability to withstand the financial burden (Covell et al., 2022).

A major challenge for IENs is obtaining registration. IENs are often viewed as professionals with lesser competence and are not equal to the nurses educated locally (Crick et al., 2019). This is due to a belief that the credentials of IENs are inferior to those of CENs, as the education received by IENs is perceived by regulatory bodies and healthcare professionals as deficient (Cruz, 2021).

Another major challenge for IENs is transitioning into the workforce. Recruiting IENs is often considered an easy route for managing staffing shortage issues. For IENs, discrimination, racism, and being given non-nursing jobs (such cleaning and dishwashing) are some frequent difficulties (Cruz, 2021).

Healthcare organizations across Canada are trying to provide equal opportunities and support for the initial onboarding or orientation of CENs and IENs. However, the “standard

onboarding opportunities" are insufficient for helping IENs overcome the challenges associated with transitioning. The professional development opportunities are limited.

The unique challenges for IENs and inadequate professional development opportunities often lead to undesirable outcomes, compromising patient safety (Allen, 2018). Literature from the United States suggests that, compared to nurses educated in the host countries, IENs progress slowly through the career ladder (Adeniran et al., 2013). IENs are often minorities in leadership and faculty positions across Canada (Salma et al., 2012).

IENs often struggle to be recognized as capable professionals in host countries, even after obtaining credentials. Through bridging programs and other support systems, many IENs overcome the challenges of getting a full-time job as an RN, transitioning into the workplace, and advancing their careers (Covell et al., 2018). Considering the unique challenges of IENs, healthcare organizations need to take a more active role in supporting their CA.

IENs are often the victims of discrimination and mistreatment at the workplace due to their gender, class, race, or immigration status (Walani, 2015). Studies conducted in many developed countries suggest that, compared to their peers educated in the same country, IENs often struggle to adjust to their employment (Salma et al., 2012). In a participatory action research, the authors reported that IENs progress through the stages of (1) acknowledging barriers, (2) learning the culture, (3) addressing the gaps, and (4) transitioning into power (Belita & Ford, 2021).

In a study of 1,000 nurses, IENs earned significantly less money (10%) than CENs despite all other factors—such as education, experience, and place of employment—remaining constant (Buhr, 2010). IENs perceive racism as an essential factor that hinders their ability to

thrive, and being a visible minority is also perceived as a predictor of workplace integration (Covell & Sands, 2021).

The nursing profession is at a crucial stage, experiencing an acute shortage, heavy workload, burnout among those at work, and an aging workforce (Marceau et al., 2022). Often, nurses leave if the working conditions are not favorable or have low job satisfaction, emotional exhaustion, uncertainty about the future, and fear of acquiring and transmitting COVID infection (Lopez et al., 2022). Organizations need to consider that IENs stay longer than their counterparts, which provides an excellent opportunity to facilitate their career growth through appropriate support and mentorship (Liou et al., 2013).

When CENs and IENs experience burnout, attrition, and a lack of motivation to continue in the profession, organizations must resort to measures that boost nurses' morale and help with retention. Interventions tailored to reduce anxiety and stress, improve job satisfaction, and provide opportunities for career growth facilitate the retention of nurses (Tolksdorf et al., 2022). It is important to investigate the effect of SS and mentorship in mitigating job stressors and whether these supports are equally available to CENs and IENs.

Many structural barriers make it challenging for IENs to advance in their careers. There are fewer IENs in leadership positions in Canada and the United States (Covell & Sands, 2021; Iheduru-Anderson, 2020). Opportunities available for career growth for CENs and IENs are neither equal nor comparable. CENs may have strong social networks, whereas IENs are new to the country and are trying to establish social and professional networks, which may disadvantage them concerning CA.

The present study aimed to identify the perceived organizational career advancement and the factors impacting organizational career growth. It investigated the differences in the

perception of and desire for career growth among IENs and CENs, as well as whether IENs have access to social support and mentorship like CENs. Therefore, the objectives of this research are as follows:

1. To identify the perceived level of career advancement among IENs and CENs.
2. To determine the current level of perceived social support among IENs and CENs.
3. To measure the mentorship available to IENs and CENs.
4. To identify the relationship between social support, mentorship, and career advancement among IENs and CENs.
5. To make recommendations to facilitate career advancement.

The results of this study will contribute to establishing support services for facilitating career advancement among IENs and CENs.

Chapter 2

Literature Review

A literature review was conducted using the MEDLINE, Cumulative Index for Nursing and Allied Health Literature (CINAHL), PsycINFO, and EMBASE databases. The literature search was limited to nurses and was not limited to a time frame. All the published literature in nursing and non-nursing professions, such as education, business, and social sciences, were included.

Career Advancement

Career comes from the Latin word *carrus*, which means "chariot" and is currently used to denote the course of one's public or professional life (Harper, 2022). During the past two decades, *career advancement*, or *career mobility*, has received much attention from scholars. The landscape of job markets and career avenues have changed dramatically because of wage increases. International migration, globalization, and changes in the family structure have all led to significant changes in career mobility.

Career mobility is often used interchangeably with *job change* and *career change*, and it refers to transitions that result in a change of responsibilities that require a specific skill set (Feldman & Ng, 2007) and leads to increased financial compensation (Jauhar & Lau, 2018). "The career is the individually recognized sequence of attitudes and behaviours linked with job-related events and activities over the duration of the person's life" (Hall, 2002, p. 12, as cited in Verma, 2020). For employed individuals, both financial gain and overall success are perceived as career advancement (Verma, 2020).

Facilitators of and Barriers to Career Advancement

Several factors facilitate career advancement (CA) and can be divided into personal and systemic factors. Personal factors include being self-motivated, independent, and hard-working (Weng & Zhu, 2020). Systemic factors include opportunities, mentorships, family support, and full-time appointments (Weng & Zhu, 2020). Some factors are unique to females. For example, a study conducted among worldwide female leaders identified that independent of the organization, family support is an important factor that helped them progress in their careers (Lan & Nguyen, 2013). Sometimes, barriers attributed to a lack of progress are related to stereotypical mindsets in society, especially regarding women. Popular media considers the lack of progress among women as attributed to their lack of motivation or hard work (Ahmed, 2011).

Several systemic barriers hamper the growth of professionals, including a lack of mentorship or support in the workplace, racism, and discrimination. Language barriers, the female gender, and stereotypes regarding gender are some systemic barriers (Fowler, 2020). In a study among minority public health nurses, the authors identified several themes facilitating CA among participants, such as a commitment to health and motivation to grow their careers (Fowler, 2020). In contrast, preferential treatment, racism, inability to speak Spanish, and lack of administrative support were barriers to CA (Fowler, 2020).

Differences in gender regarding career progress are well-documented in the literature. For example, Kanter (1977, as cited in Lyness & Thompson, 2000) identified that women received less mentorship than men, were not included in informal interactions where vital information was shared, and were perceived as having challenges in moving geographically from one area to another (Lyness & Thompson, 2000).

Career optimism is an emerging branch in career advancement research that attributes major responsibility to an individual's outlook on career growth. The concept stems from social cognitive career theory, in which higher career optimism yields higher engagement, satisfaction, and progress toward goal achievement (McLennan et al., 2017). For example, if an individual is optimistic and has high levels of career optimism, the individual views new career opportunities as realistic, interprets career and work events positively, has positive expectations about achieving their career goals, and consider setbacks as temporary. However, the responsibility is not solely on the individual; Contextual factors, such as the standard of the work environment, the availability of possibilities for professional advancement, and the presence of encouraging leadership in the workplace, can either encourage or impede career growth (Hung & Lam, 2020), and social support (Eva et al., 2020). A narrative review that aimed to identify facilitators and barriers to success for female academics in UK higher education revealed that mentorships through appropriate networks, having an appropriate work-life balance, institutional policies that promoted inclusion, and supportive male partners facilitated career success, and double discrimination (such as being of foreign ethnicity and a woman), everyday sexism in the workplace, and unsafe workplace atmospheres inhibited career success (Westoby, 2021).

Gender inequality plays an important role in career mobility. Women often experience injustice that inhibits their career mobility. Terms like *glass ceiling*, *glass cliff*, and *sticky floor* denote that many women cannot advance in their careers (Verma, 2020). Women are required to demonstrate twice as much worthiness and perform in the absence of professional development opportunities or policies that create inclusive environments (Gandhi & Sen, 2021).

Individuals who advance their careers, or "move up" in the social hierarchy, are generally considered successful. However, institutions or organizations have different perspectives on how

employees ascend career ladders. The first is *contest mobility*, in which individuals move up based on their potential and skills, and the second is *sponsored mobility*, in which organizations invest in individuals with high potential. These two perspectives play a significant role in determining whether a person moves up in their career (Ng et al., 2005).

In nursing, IENs often fail to receive an organization's support due to the inability to exhibit their talents or otherwise demonstrate their potential. For example, nurse managers often prefer CENs over IENs in providing institutional support. Visible minorities (often IENs) tend to struggle with workplace integration (Covell & Sands, 2021).

In the West, language is often a barrier to career growth. In an unpublished thesis, Andriesz (2019) collected data from Asian-born, educated leaders in global organizations and identified that poor English proficiency inhibits career progress. They also found that mentorship, adaptiveness, and self-mastery facilitated career growth, whereas colonial ethnocentrism inhibited it. Participants liked promoting others who looked and sounded similar to themselves (Andriesz, 2019).

Although most of the facilitators and barriers are similar among several professionals, specific unique barriers are experienced by certain professionals. In a study conducted to understand how nurses pursue a career in research, the authors of the study identified having a clear career path and being awarded a fellowship as enablers, and lack of organizational and personal support as barriers (Avery et al., 2022). In a similar study that aimed to identify potential variations between men and women in their career progressions, junior research faculty responded to a focus group interview that two significant barriers unique to women were childbearing and childcare. In addition, women reported receiving poor mentorship and not having adequate skills of negotiation (Zakaras et al., 2021).

CA is even more challenging for people with disabilities. People with disabilities receive lower pay, are more likely to quit their jobs, and receive less on-the-job training than persons without impairments. For individuals with disabilities, interventions to manage their careers, establishing social networks, organizational and societal factors are vital in facilitating their career growth (Samosh, 2021).

Organizational Career Growth

Both individual and organizational factors play a key role in employees' career advancement. However, growing literature emphasizes the role of organizations in providing opportunities for employees to grow their careers (Liu et al., 2015). Only such organizations could retain and help their employees achieve their career goals.

Based on this philosophy, a new concept termed *organizational career growth* (OCG) has emerged. OCG denotes the extent to which employees experience career advancement within their current organization. Career goal progress, professional ability development, speed of promotion, and financial compensation are the factors that contribute to OCG. These factors can be broadly divided into extrinsic (promotion speed and compensation growth) and intrinsic (career goal progress and professional aptitude) career growth factors. OCG also facilitates work engagement and work commitment among employees (Sujin & Kim, 2021).

OCG studies the growth of an individual's career within an organization (Weng & Zhu, 2020); it is upward mobility within an organization determined by individual and organizational factors (Vande Griek et al., 2020). OCG differs from related measures of career success in that it focuses on perceived opportunities within an organization as opposed to the accumulation of favorable outcomes throughout a career (Weer & Greenhaus, 2020).

Four subdimensions characterize OCG: (1) career goal progress, which describes the degree to which a job supports a worker's career goals; (2) professional ability development, which describes the extent to which a job facilitates professional development; (3) promotion speed, which describes the probability and speed of promotion within an organization; and (4) remuneration growth, which describes the relative rate at which a worker's salary increases (van Osch & Schaveling, 2020).

Career growth is an area of interest to both employees and employers, as individual career growth eventually contributes to the organization's growth (Ng et al., 2005). OCG is an important factor in the retention of employees in an organization (Jiang et al., 2021).

Career Advancement in Nursing

Career advancement (CA), or *career mobility*, in nursing refers to any form of personal growth within the profession. It is an essential aspect of a professional's life. Any recognition of talent in nursing practice is considered career advancement in the nursing profession. CA is essential to quality nursing care (Adeniran et al., 2012). CA in nursing can take different forms, such as attending professional development courses, obtaining specialized certifications, pursuing formal degrees, and experiencing vertical mobility in the current organization (Adeniran et al., 2013).

In the current study, CA is measured through OCG. Key aspects of OCG include professional development, achieving one's career goals, opportunities to get into higher positions, and remuneration (Yang et al., 2015). OCG requires commitment from both the employer and the employee. A study of Chinese nurses showed that organizational career growth scores mediated the nurses' intentions to leave the organization (Yang et al., 2015). The authors of the study also measured the impact of work support extended by the leaders and the

organization and reported a positive effect on retaining nurses within the organization (Yang et al., 2015).

CA in nursing has not been studied extensively in Canada. In a study of visible minority healthcare professionals, the authors identified that the career advancement of visible minority nurses is hampered by many factors, including language, lack of colleague support, and mentoring. The authors also recognized that there were not many managers who belonged to the visible minority group (Bouabdillah et al., 2016). In a longitudinal study with secondary data analysis from the College of Nurses of Ontario (CNO), the authors identified that nurses do not return to the nursing profession after one year of leaving their initial nursing jobs (Alameddine et al., 2009).

The world is currently facing an acute nursing shortage due to the pandemic. In a study involving 2,000 nurses in the US, the authors reported that the employment rates of older nurses and nurses less than 30 years old dropped significantly and that RNs ages 55–64 intended to retire early (Spetz, 2021). This highlights the importance of creating avenues for career growth in the profession to prevent attrition and facilitate retention.

Mentorship is a significant factor of career growth (Osman & Gottlieb, 2018). In a study of registered nurses and licensed practical nurses, the authors identified that Canadian nurses generally prefer to continue with their education. However, the nurses felt that both financial and scheduling difficulties hamper them from continuing their education (Lalonde et al., 2013). In a qualitative study of IENs in Alberta, the authors identified a need for mentorship in facilitating the career advancement of IENs. The participants also expressed a need for ongoing support with language, cultural training, funding, and childcare services to enable career growth/career

advancement. These efforts will help increase the representation of IENs in leadership positions (Salma et al., 2012).

IENs often struggle to be recognized as competent professionals in their host countries. IENs experience transition difficulties not because of a lack of knowledge or clinical skills but rather because of socioeconomic inequalities and a lack of familiarity with their new environment. (Adeniran et al., 2009). IENs experience cultural shock when migrating to Western countries; it takes time to learn the nuances of the language and understand the socio-political system. Socioeconomic adaptation is influenced by one's ability to be re-educated and successfully integrate into society (Mesidor & Sly, 2016). Canada, being an "immigration-friendly country," has invested in preparing IENs and supporting them in successfully transitioning (Covell et al., 2017). If supported adequately, IENs will not only be successful but also will be able to thrive in a competitive environment.

Since 2000 a lot of progress has been made regarding literature on IENs and their struggles. However, a review of 157 papers published in Canada between 2000 and 2013 showed that the literature is focused on initial registration and regulatory requirements. The review also highlighted that the government and other regulatory boards had initiated many strategies to assist IENs. However, these strategies were aimed at initial registration and credentialing. The authors also added that there is little evidence on the effectiveness of the assistance programs offered by various agencies. The authors also shed light on the fact that research needs to be done on factors that facilitate hiring IENs into the workforce, IENs' ability to thrive in a work environment, and the success and retention of IENs in the profession (Covell et al., 2014). A few articles that deal with successful integration after initial registration have been published and they reported that the support systems have been strengthened, but much needs to be done.

Projects that aim to facilitate workforce integration have raised the awareness of employers and promoted workforce diversity (Baumann et al., 2021).

The career advancement of nurses depends on several personal, social, and environmental factors. Staying motivated, fulfilling familial role expectations, lack of mentorship, and language barriers are some challenges that IENs face (Salma et al., 2012). In contrast, CENs do not face discrimination, language barriers, or lack of mentorship as compared to the IENs although CENs belonging to black and indigenous populations may face similar hardships as IENs (Iheduru-Anderson, 2020). Further, education in Canada has certain advantages, such as language and familiarity with the work culture. Thus, identifying through research whether there are differences in career advancement between IENs and CENs would help in extending appropriate support systems.

The career advancement of nurses was hampered by their lack of verbal and nonverbal communication skills, interpersonal skills, English proficiency, and technology-related skills, according to a meta-synthesis of qualitative studies that examined the migration motives of and barriers to and facilitators of integration experienced by international dental graduates in the United Kingdom, compared with nurses and doctors. Nurses in particular cited communication difficulties, differences in technical skill levels, fear of speaking up, and system invisibility as obstacles (Davda et al., 2018).

Social Support

Social support is an old concept but is nevertheless difficult to define and has no universal definition. *Social networks*, *social support*, and *social integration* are used interchangeably (House et al., 1988). One author suggested that social support is a person's assistance through interactions with others. Support may be emotional, tangible (e.g., practical

assistance), or informative (Dambi et al., 2018). Humans live and interact with each other; these interactions are fundamental to the overall development of individuals (Rueger et al., 2016). Research also indicates that providing social support may be more beneficial than just receiving social support (Colbert et al., 2016).

The buffering effects of social support have been established with several life-changing events. For example, during times of stress, social support reduces psychological distress, such as depression and anxiety (Fleming et al., 1982 ; Lin et al., 1999 ; Sarason et al., 1997 as cited in Taylor, 2011). Social support makes it easier for people to cope psychologically with long-term stress, which is known to cause a number of illnesses, including coronary artery disease, diabetes, HIV, cancer, rheumatoid arthritis, renal disease, childhood leukemia, and stroke. Social support also guards against heart disease in recently widowed people, psychological suffering after stressful experiences, and cognitive decline in older adults. Social support also helps people survive and maintain their physical health (Taylor, 2011).

The interaction between individuals and their social environments is a fundamental aspect of a person's wellbeing and plays a vital role in psychosocial development (Rueger et al., 2016). Social support is a dynamic transaction process between people and their support networks. Social support can be beneficial in two ways: it protects people irrespective of whether they are experiencing adverse events, and the buffering effect protects people from the impacts of stressful events (Hlebec et al., 2012). In a meta-analysis of 341 articles, the authors evaluated the relationship between social support and depression and proposed two models of social support: general benefits and stress-buffering. The authors also identified robust evidence to suggest the benefits of social support in mitigating stress and improving the mental wellbeing of

the youth (Rueger et al., 2016). Social support interventions are likely to positively impact work outcomes, regardless of the specific intervention initiated (Wagner et al., 2015).

The benefits of social support have been established well in the literature. In a landmark study documenting this point, epidemiologists tracked nearly 7,000 California residents for nine years to identify factors contributing to their longevity or premature death. During the follow-up period, those who lacked social and community ties were more likely to die from all causes than those who fostered or maintained social relationships. Social contacts predicted a 2.8-year increase in longevity on average for women and a 2.3-year increase on average for men, and these increases were statistically significant for women (Berkman & Syme, 1979).

Social Support in Nursing

A major stressor for IENs is discrimination, and social support mitigates the impact of discrimination. In a study using an epidemiological survey of Asian Americans, the authors identified that perceived emotional support from family had a mitigating effect on high stress levels caused by discrimination (Mossakowski & Zhang, 2014). In a systematic review of 115 articles published between 2000 and 2012, researchers found that social support positively affects work outcomes (Wagner et al., 2015).

In a mixed review, social support was identified as a facilitator of successfully transitioning RNs into a new country (Chok et al., 2018). Social support has also been linked to work engagement and job performance in nursing. In a study that aimed to assess the effects of three forms of social support (organizational support, supervisory support, and peer support), the authors collected data from 639 nurses in Malaysia. Based on the data, the authors concluded that three forms of social support from supervisors such as appropriate feedback, paying attention to the requirements and support, impact individuals' workplace performance (Nasurdin

et al., 2018). Nurses, particularly those migrating from one country to another, face acculturation. Strong social networks, such as supportive family members, friends, or significant others help moderate acculturation (Tonsing et al., 2012). Social support is also directly linked to quality of life (Alsubaie et al., 2019). During the COVID-19 pandemic, researchers collected data from 325 nurses to identify the links between personal resilience, organizational support, and social support and concluded that social support is a predictor of anxiety and that nurses who received adequate social support reported less anxiety (Labrague & De los Santos, 2020).

All the reviewed literature established that social support from colleagues, supervisors, family, and significant others strongly impact career advancement. However, there is little data on the degree of support received. In a systematic review analyzing the relationship between social support and burnout among nurses, the authors reviewed CINAHL, PsycINFO, ProQuest, PubMed, and Scopus and found 19 articles. The authors reported that social support provided by supervisors and coworkers is fundamental to preventing burnout among nurses (Velando-Soriano et al., 2020).

IENs often are faced with anxiety, depression, and burnout. In a qualitative study that assessed the experience of recertification while undergoing multiple examinations to obtain a Swedish license, IENs reported that the combination of high job demands and low social support resulted in psychological strain, such as fatigue, anxiety, depression, and physical illnesses (Högstedt et al., 2021). Job stress has a direct effect on anxiety and depression; social support, especially in work environments, helps reduce emotional drain and job stress, thus preventing depression among nurses (Chen et al., 2020).

Measurement of Social Support

Since there is ambiguity in defining social support, measuring social support is a challenge. In an integrated review of social support in the workplace, the authors reported that only 57% of the published articles had a clear definition of social support (Jolly et al., 2021). Researchers have used several open-ended questions and self-report surveys, which are time-consuming and laborious. The Multidimensional Perceived Social Support (MPSS) tool is reliable and valid for assessing social support from friends, family, and significant others (Alsubaie et al., 2019; Tonsing et al., 2012).

In a cross-sectional correlational study, authors in Jordan collected data from 365 healthcare workers in Amman, intending to assess the levels of fear, anxiety, and social support during the COVID-19 pandemic. MPSS was used to measure the level of social support available to the healthcare workers, most of whom were nurses (69.3%). The authors reported that the assessment indicated moderate to high levels of perceived social support. The mean score of social support from significant others was 5.17 out of 7 (73.85%); from family, it was 5.03 (71.86%); and from friends, it was 5.05 (72.14%). The authors also grouped the scores into low, moderate, and high scores. However, the basis for grouping the scores were not described (Alnazly et al., 2021).

In another study that aimed to assess the psychometric properties of the MPSS scale among Greek nurses working in oncology and mental health settings, the authors collected data from 150 nurses. The MPSS tool was translated into Greek, and the findings suggested that the perceived level of social support available to nurses from family was 5.87 (83.86%), from friends was 5.15 (73.57%), and from significant others was 5.70 (81.42%). The authors also

concluded that a total score of 65 or greater out of 84 (77.38%) was considered a high level of perceived social support (Tsilika et al., 2019)

In a study among nurse practitioners (NPs) in Taiwan, authors measuring social support using the same tool reported that the mean score was 64.07 (76.23%). The authors also concluded that the support received from family, friends, and significant others was an essential contributor to the self-efficacy of NPs. In addition, the authors shed light on the significance of support received from family, friends, and significant others in Taiwanese culture (Hu et al., 2018).

Three hundred and seventy nurses in Turkey also reported having a total social support score of 67.33 (80.15%), with support from family being 24.08 (86%), support from friends being 21.27 (75.96%), and support from significant others being 21.96 (78.42). The authors concluded that the social support received was very good and that it had a positive impact on psychological resilience during the COVID-19 pandemic (Kılınç & Sis Çelik, 2021).

Mentorship

In Greek, *mentor* means "to endure." Mosby's medical online dictionary (2018) includes two definitions of *mentor* : "a more experienced, trusted adviser or counselor who offers helpful guidance to less experienced colleagues," and "a person who enters into a relationship with a new nurse to provide them with a source of support and information as they learn a new role" (as cited in Olaolorunpo, 2019, p. 144). Mentorship is a process through which an experienced individual helps a less experienced individual to achieve their goals (Pelin & Ayise, 2019). Mentorship is more than an orientation program; it is an intentional long-term career development relationship that starts during the first year of employment and continues for an extended period (Jakubik et al., 2017).

Mentorship in nursing is an essential factor in facilitating retention and professional growth and increases the self-confidence of new nurses (Simon, 2015). Mentorship has increased job satisfaction and facilitated career advancement in both nursing and medicine (Nowell et al., 2015). Mentorship is a two-way process whereby mentors and mentees identify the outcomes of the relationship (Billings, 2008). Mentorship is a relationship wherein the mentor shares professional knowledge, skills, and experience with less experienced nurses to facilitate professional development (Weese et al., 2015). Sometimes, *preceptorship* and *mentorship* are used synonymously. However, preceptorship is different from mentorship, as precepting may be limited to the orientation of the novice nurse to the unit as well as to a particular period, whereas mentorship is a long-time relationship (Weese et al., 2015). Advancing careers, improving self-confidence and esteem, preparing for better leadership roles, and contributing to the upliftment of the profession are benefits mentees receive through mentorship programs (Zey, 1991).

Mentorship relationships can be formal or informal. In formal mentorships, institutions or organizations develop mentorship programs that are structured and extend beyond orientation programs. Organizations require resources to establish formal mentorship programs. However evidence indicates that informal mentoring is more advantageous than formal mentoring (Wang et al., 2010). Informal mentorship depends mainly on mentees to initiate professional relationships with mentors (Young & Perrewé, 2000). One-on-one mentorship helps with the transition of recent nursing graduates, as these often experience reality shock when entering professions and as such intend to leave the profession quickly. In a study among new nursing graduates in China, the researchers reported that new nurses who had one-on-one mentorships had a lower attrition rate than those who did not have mentors (Zhang et al., 2019).

Measuring mentorship is an issue in nursing, as there is no comprehensive definition of *mentorship*. Hence, researchers have focused on the experience of mentees and measured the support from the perspective of mentees (Chen et al., 2016).

Many mentorship models have been described in the literature. In dyad mentorship, mentees are paired with experienced mentors. In peer mentorship, similar-ranking professionals are paired with each other. Peer mentorship is typical among faculty in nursing (Nowell et al., 2017a). Different models, such as group mentorship, constellation mentoring, and learning partnership, are uncommon in clinical practice (Nowell et al., 2017a). Face-to-face mentorship is ideal. Electronic peer mentoring is also influential in helping students with their care plan preparation. In a study that compared face-to-face mentorship with electronic peer mentorship among nursing students, the researchers identified that online peer mentoring had higher scores in patient care planning. However, those who had face-to-face mentorship had increased levels of confidence (Ozkan et al., 2022).

In a systematic review of mentorship programs available for new nurses, the authors identified that mentorship generally lasted from three months to one year, and mentorship programs significantly improved clinical decision-making skills, caring abilities, clinical skills, and reduced staff turnover (Chen & Lou, 2014). Mentoring is a challenging concept, and mentoring internationally educated nurses is even more challenging, as it is difficult to adequately prepare mentors to cater to a group of nurses who have migrated from different cultural backgrounds (Allan, 2010).

Measurement perspective is also an important factor to consider while measuring mentorship. For example, a mentee's perspective may differ from that of a mentor. In a study among nursing faculty, researchers collected data from mentors and mentees on their perceived

effectiveness of mentorship. The results indicated significant differences in the perception of effectiveness; mentors rated their effectiveness higher than mentees (Ephraim, 2021).

Mentoring functions are three-fold: career functions, psychological functions, and role-modeling (Hu et al., 2011).

Mentorship Programs for Nurses in Canada

Mentorship is integral to professional success. In Canada, several projects have included mentorship, primarily to address the nursing shortage. Legacy Mentors, a project for educational pathways in British Columbia where senior nurses over age 55 who were retiring provide mentorship to novice nurses, has demonstrated positive mentorship outcomes (Clauson et al., 2011). In a mixed-method outcome study of a mentorship intervention for Canadian nurses providing HIV care, mentorship was found to be an essential component in raising patient care standards by influencing mentees' knowledge, attitudes, and abilities (Worthington et al., 2016). In a qualitative exploration of the quality of work life among novice nurses in Canada, the authors identified a lack of standardized mentorship programs across the country that even pushed novice nurses to leave the profession. The authors also determined that mentorship is critical to the successful transition of novice nurses into the workplace (Worthington et al., 2016).

To advance leadership in long-term care, the Ministry of Health and Long-term Care, in collaboration with St. Joseph’s health center in Guelph, initiated a project called the Mentor Team Program. The project included the presence of trained mentors, leadership training, and having one full-time employee for two part-time employees. Through the constant, facility-wide presence of trained mentors to answer nurses’ questions regarding care, the team demonstrated improved quality of care, change in the culture, and enhanced interprofessional care in a long-

term care setting (O'Brien et al., 2010). In a Canadian demonstration project that aimed to build the capacity of nurse managers in hiring and managing IENs, the authors identified a need for an ongoing commitment to integrating IENs into the workforce through adequate support and training. Through a needs assessment survey of clinical managers, they also identified that the support provided by mentors and educators would help enhance the sustainability of IENs in the workforce (Hoxby et al., 2010).

In a literature review of peer mentorship programs available for faculty in nursing, the authors identified inconsistencies in the duration of the mentorship programs in Canada. They noted that the opportunities for frequent communication between mentors and mentees, providing constant feedback and evaluation, are critical for a successful mentorship program (Nowell et al., 2017a).

There are a few studies on the effectiveness of mentorship. In an integrated review of the available literature, McGill University researchers identified positive outcomes associated with peer mentorship (Wong et al., 2016). However, the authors also identified many challenges in implementing the programs, such as varying durations of the mentorship programs, inconsistent mentor preparation, and a lack of a theoretical framework guiding the mentorship programs. The authors recommended that mentorship program developers conduct needs assessments before developing peer mentorship programs (Wong et al., 2016). In a large-scale review examining nursing students' peer mentorship, peer mentorship was influential in fostering communication between peers and clients, which improved the quality of care provided to clients. Peer mentoring also helps recruit new nurses, retain those already employed, and promote successful evolution from a student role to a professional role (Jacobs, 2017). It is also important that the mentors feel competent to mentor their mentees, especially when there is a group of culturally

diverse mentees. In Finland, in a self-report regarding competence in mentoring culturally and linguistically diverse nursing students, mentors reported that they faced several challenges such as language ability, the experience of living in another country in providing mentorship to culturally and linguistically diverse nursing students (Oikarainen et al., 2018).

Mentors with greater experience than their mentees, the provision of individualized support based on the mentees' requirements, and the development of a relationship characterized by a sense of mutual gain, involvement, and commitment are three major success criteria in mentoring (Abdullah et al., 2014). Through this coaching, champions can be created to advance the adoption of evidence-based practice (EBP) in their departments and other areas of influence, such as the clinical departments (Abdullah et al., 2014). This shows how EBP can be used in bedside practice, a key factor in lowering clinical nurses' resistance to EBP.

Mentorship is an essential facilitator of professional growth among IENs (Adeniran et al., 2013). In a qualitative study using interpretive description, the authors identified a need for mentorship among IENs to advance their careers (Salma et al., 2012). Mentorship is often the key to positive behavioral, career, and attitudinal changes among nurses (Nowell et al., 2017b).

Several factors can optimize the mentoring experience so mentees get the best out of the mentoring relationship. Availability of mentors for face-to-face contact whenever needed, mentors belonging to the same institution as the mentees, and regular feedback from the mentors are some factors that promote satisfaction in a mentoring relationship (Folz et al., 2018).

Mentorship to facilitate career advancement among women employees has also been established. In a study among women employees in South Africa, 200 employees reported that women perceived mentorship as an essential factor in their career advancement (Mcilongo & Strydom, 2021).

Mentoring is still an evolving field. In a large-scale review of the available mentorship programs around the world, the authors, after reviewing 69 articles published between 2006 and 2010, reported that most of the literature on mentorship programs for nurses is from high-income countries like the US, Australia, and Canada. However, mid-and low-income countries like Rwanda, South Africa, and India also contribute to the literature. The authors also noted that the mentorship programs varied in length, mode of delivery, frequency of interactions, and the number of mentees per mentor, which sheds light on the heterogeneous nature of mentorship programs around the world (Hoover et al., 2020).

In a time of a severe nursing shortage, experienced nurses must share their skills with beginner nurses to ensure the future success of the nursing profession. Mentorship is a professional commitment and key to improving nursing practice and clinical education. Mentorship improves nursing skills, knowledge, and values. The novice-to-expert model has a theoretical foundation (Benner, 1982). This model describes how a person begins at the novice level and advances through numerous stages to reach the specialist level by acquiring new skills and information. According to this concept, there are five skill levels: novice, advanced beginning, competent, proficient, and expert (Benner, 1982). As a nurse progresses through these stages, mentorship helps them build field-specific abilities. Professional socialization helps mentees build a structured foundation of knowledge, abilities, and values as they proceed through the stages. Multiple professional connections can exist and inspire the student and new nurses to become more competent care providers. Continuous contacts between mentors and mentees help novices deal with unpleasant feelings, which boosts their self-esteem, confidence, comfort, and professional skills (Evans et al., 2020).

Impact of Social Support and Mentorship on Career Advancement

Social support has been positively linked to career advancement and mitigating burnout among professionals. In a study of 17,524 nurses working in Europe that assessed the impact of social support on preventing nurses from leaving prematurely, the authors concluded that having social support from supervisors plays a significant role in improving the growth potential of nurses (Van der Heijden et al., 2010)

In a study among 1,187 Dutch nurses, a similar finding was reported. The authors conducted a longitudinal study comprised of two measurements. All the nurses completed an initial survey, and 753 nurses completed a follow-up survey one year later. Social support received from the supervisors and immediate colleagues, as well as the impact of these on the meaning of work, were measured, and the results indicated that social support from supervisors and colleagues increased purpose of work levels and decreased perceived burnout levels (Van Der Heijden et al., 2019).

In another study among Malaysian nurses, the authors reported a similar finding. To address whether social support contributed to work engagement among nurses, the authors recruited 402 staff nurses working in three general hospitals and collected data through the Utrecht work engagement and social support scale. The results indicated that social support from supervisors positively impacted nurses' work engagement and was identified as a significant predictor of work engagement. However, the social support received from colleagues did not impact work engagement (Othman & Nasurdin, 2013).

An integrative review assessed the transition experiences of IENs in the United States. The researchers reviewed 18 studies published between 2008 and 2018. The results of this review indicate that the support received from family and colleagues facilitated the successful

transition. The authors also reported that the differences in the culture, communication, and language, as well as the stigma of being an IEN, variations in nursing practice, and fear of litigation, were barriers to successful transitioning (Ghazal et al., 2020).

In an unpublished dissertation, the migration experiences of 14 Filipino IENs who migrated to Ontario were explored using a transnational feminist concept of global care chains. The nurses expressed that connecting with social networks helped their social and economic integration and that they experienced gender inequality by waiting for their husbands to find jobs first while nurses were looking after their children at home (Marcelino, 2022).

When dealing with a pandemic and an acute shortage of nurses, addressing issues impacting job performance, such as burnout and anxiety is crucial. Social support has a moderating effect in reducing anxiety and job stress. Decreasing emotional exhaustion through adequate support and strengthening social support available at workplaces through mentorship programs reduce anxiety, enhance coping, and decrease burnout among nurses (Chen et al., 2020).

Empowerment and Career Advancement

Psychological empowerment enhances employee performance and job satisfaction. Empowerment is the ability to make decisions of one's own free will and the capability to act independently (Saleh et al., 2022). In a study among the employees of an automotive company, researchers collected data from 241 employees on their perceptions of empowerment and performance. The results of this study indicated that psychological empowerment is a strong predictor of job performance (Rani et al., 2021). Similarly, in a nonexperimental cross-sectional (Wang & Liu, 2015) study of nurses in China, researchers collected data from 300 registered nurses on nursing practice environments and psychological empowerment. The results revealed

that psychological empowerment directly affected work engagement (Wang & Liu, 2015). Nurses who felt empowered also felt respected and demonstrated an outstanding commitment to the organization. In another study among nurses in Jordan, researchers collected data from 383 registered nurses and reported that psychological empowerment influences job satisfaction and turnover intentions (Amarneh et al., 2021).

Empowered employees feel competent and self-determined. Internationally educated professionals often feel disempowered rather than feeling empowered, not because they lack internal motivation but because they must overcome structural challenges. Lack of access to information, the novelty of a system, and lack of support are some challenges that Internationally Educated Professionals (IEPs) must overcome (Neiterman & Bourgeault, 2015). In a study among foreign-educated academics, researchers reported that the academics felt empowered as individuals but disempowered as a collective and that they struggled to establish academic collaborations (Han, 2022). Thus, meaningful mentorships help in empowering people (Dunlap, 2021).

Unemployment among immigrants is often attributed to their lack of equivalent educational preparation for host countries. However, research highlights that the structural barriers and lack of appreciation of cultural differences often inhibit obtaining meaningful employment. Immigrants should be provided with opportunities to enhance career advancement opportunities to feel autonomous and empowered (Dorter & Damani, 2022). This is true of nurses in general and of IENs in particular. If IENs are empowered through appropriate mentorship and social support, they will be able to overcome all challenges (structural and psychological) and will advance their careers. Empowering IENs through mentorship and social

support positively affects their career advancement, which is the basis for the conceptual framework of this dissertation (Eriksson & Engström, 2018).

Conceptual Framework

The conceptual framework of this dissertation is based on Kanter's theory of empowerment. According to Kanter, workplace structures affect staff wellbeing and organizational efficiency. Kanter identified two crucial aspects, which are organizational structures and power structures (Eriksson & Engström, 2018). According to Kanter, employees feel empowered when they believe they have access to the resources they need to perform their jobs and that their work settings offer opportunities for advancement. Employees feel powerless in the absence of these conditions, which jeopardizes organisational productivity because vulnerable people are more prone to burnout and decreased job satisfaction (Kanter, 1979, as cited in Sarmiento et al., 2004).

Access to support, information, and resources are the three sources of the power structure. Feedback and direction from superiors, peers, and subordinates constitute support. Information refers to the data, technical knowledge, and expertise required to perform one's job properly. Resources are the materials, funds, supplies, equipment, and time required to achieve organizational objectives (Sarmiento et al., 2004).

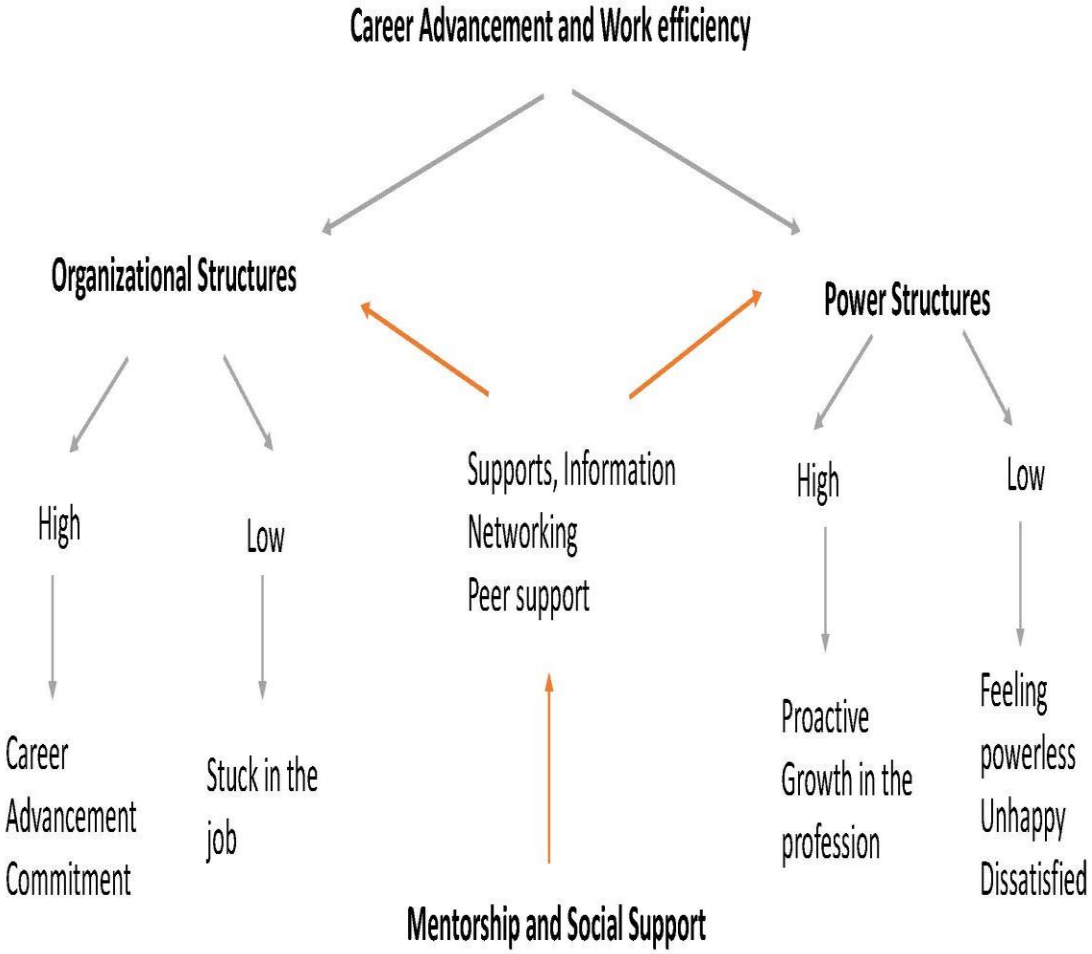
Examining IENs through the lens of empowerment would yield that IENs often struggle to integrate into new workplaces. Communication barriers and cultural adjustments make it difficult for IENs to be successful in their careers (Eriksson & Engström, 2018). In an integrated review of the facilitators of and barriers to adjustment among IENs, researchers identified that IENs could adjust well to new countries if they have access to support, practice assertive communication, and are given opportunities to learn (Kawi & Xu, 2009). This is an important

finding, as most other studies have identified issues with communication (Lum et al., 2016) and cultural shock (Eriksson & Engström, 2018) that hinder successful integration. Kanter's theory of empowerment addresses most of the issues regarding access to information, discrimination in the workplace, support, and informal power (Eriksson & Engström, 2018).

Structural empowerment among nurses enhances positive organizational behavior. In a study of 152 nurses at a university hospital, the researchers used standardized questionnaires to collect data on structural empowerment, psychological empowerment, and positive organizational behaviors. The authors reported that structural empowerment measures such as allowing access to the organization's facilities, delegating power, and providing information, support, and all other necessary resources were predictors of positive organizational behaviors (Jafari et al., 2021).

Through conscious efforts, organizations and employers can make a difference by enhancing social support and mentorship available to IENs and CENs. These efforts will help both groups have equitable access to promote empowerment.

Conceptual Framework Based on Kanter's Theory of Empowerment



(Eriksson & Engström, 2018; Laschinger, 1996)

Summary

The literature review identified challenges faced by both IEN and CENs. The challenges faced by CENs are different from those of IENs, and the opportunities for career growth available to CENs are much better than those available to IENs. The two groups are different regarding their access to opportunities and progress. Literature on IENs has exploded over the past two decades. The published literature reveals that IENs face challenges from obtaining licenses to integrating into the workplace. Several studies have highlighted the struggles that IENs face in getting their credentials assessed and obtaining equivalent education as that in their home countries.

The challenges faced by IENs after obtaining a license are unique. Often, these challenges can be overcome by supportive organizational practices, such as establishing mentorship programs and social support networks. There is an issue of equity, especially with the facilitators of career growth. Most studies have identified mentorship and social support in facilitating workplace integration. However, no study has compared CENs with IENs on the perceived impact of mentorship and social support on career advancement. Researchers have used quantitative and qualitative methodologies and collected data across Canada.

Based on this literature review, it is evident that organizational career growth is an emerging field of career growth. The higher the perceived career growth, the higher the intention to stay in the profession. IENs often struggle to move up in their careers as compared to CENs.

There are specific gaps in the literature. The effects of social support and mentorship have been studied separately. The impact of social support and mentorship on career advancement and the interrelationships between these concepts have not been studied previously. Much research has been published on the challenges IENs face in getting their licenses in host

countries. After receiving the right to practice in Canada, IENs continue to face challenges that impede their career growth, which has not been researched.

Chapter 3

Method

Goal

This research aimed to identify the perceived impact of social support and mentorship on the career advancement of IENs compared to CENs in Canada. Such a comparison will help determine if the perceived issues are unique to IENs or common among IENs and CENs.

Objectives

The objectives of this research are as follows:

1. To identify the perceived level of career advancement among IENs and CENs.
2. To determine the current level of perceived social support of IENs and CENs.
3. To measure the mentorship available to IENs and CENs.
4. To identify the relationship/impact of social support, mentorship, and career advancement among IENs and CENs.
5. To make recommendations to facilitate career advancement.

Hypotheses (Null)

1. There is no difference in the levels of career advancement between IENs and CENs.
2. There is no difference in the levels of perceived social support and mentorship between IENs and CENs.
3. Mentorship or social support has no relationship with levels of perceived career advancement among IENs and CENs.

Design

This study used a cross-sectional design to determine the impact of social support and mentorship among IENs and CENs on career advancement.

Sampling

Data were collected from IENs and CENs from Ontario, British Columbia, and Manitoba. A survey was deployed using Qualtrics software. The supervisor, doctoral committee, and an expert at the Institute of Social Research, York University, reviewed the tool. The following inclusion and exclusion criteria were used to recruit participants for the study:

Inclusion Criteria

- Registered nurses with three years of work experience in Canada, as nurses typically move up the ladder after their second year of practice.
- Employed either part-time or full-time.
- Canadian- or internationally educated (first degree in nursing)

Exclusion Criteria

- Nurses who are unemployed
- Nurses who are not working in nursing

Sampling Strategy

Ontario

In Ontario**,** a list of nurses' names and mailing addresses was collected from the College of Nurses of Ontario (CNO). Two thousand letters with an invitation (see Appendix B) to participate in the study were sent out between February 2021 and April 2022. The link to the survey was added to the invitation along with a QR code for easy access. CNO has a policy of sharing only the mailing addresses, not the emails. Thus, in the invitation, if the participants were interested in receiving the link to the survey via email, the link would be sent to them. Eight participants requested to have the link sent via email. A reminder letter was also sent one month after the participants responded.

A short presentation about the study's purpose was given to all members of the CARE Center for Internationally Educated Nurses. A copy of the invitation, along with the link to the survey, was sent out to potential participants by the CARE staff. The chief nursing officers of the major hospitals in the Greater Toronto Area (GTA) were also contacted, requesting permission to circulate the invitation. The hospitals were dealing with the COVID-19 pandemic, and the response to the request to disseminate the survey was not encouraging. The invitation was sent out to this author's friends and contacts. The Registered Nurses Association of Ontario (RNAO) was also contacted to disseminate the invitation. The invitation and the link/QR code to the survey were also posted on Facebook and Twitter.

Manitoba

The College of Registered Nurses of Manitoba kindly sent out emails to their members in Manitoba. There were 1,000 emails sent to registered nurses in Manitoba with the invitation and the link to participate in the survey. A reminder email was also sent out at one- and three-month intervals.

The Manitoba nurses' union leadership team also sent all their members the invitation and the link. The Manitoba nurse's leadership members invited their friends and contacts through social media.

British Columbia

The nurse's union of British Columbia (BC) agreed to invite all its members. British Columbia College of Nurses and Midwives (BCCNM) was also contacted, and they responded that BCCNM neither sent out the invitation nor shared the nurses' contact details. The invitations were also sent out to several healthcare agencies in BC. Invitations were also sent to all friends and their contacts through social media.

Tools for Data Collection

Data were collected from potential samples using the following survey questionnaires (Appendix C):

Survey Questionnaire

Part 1: Screening Questions and Informed Consent

The first part of the survey contained questions related to informed consent. The purpose of the survey and the option to participate in the survey with a "yes" or "no" were provided to the participants.

Part 2: Measurement of Career Advancement

Career advancement was measured using the Organizational Career Growth (OCG) scale. This tool is widely used to measure professionals' perceptions of career growth or advancement. This scale has 15 items under four subscales—namely, career goal progress (4 items), professional ability development (4 items), promotion speed (4 items), and remuneration growth (3 items). The participants must respond to a five-point Likert scale ranging from *strongly disagree* to *strongly agree* (Spagnoli & Weng, 2019).

Psychometrics

The OCG scale has appropriate internal consistency (Cronbach's alpha = .890). The subscales also have high internal consistency and the scores for career goal progress, professional ability development, promotion speed, and remuneration growth were .85, .86, .86, .80, and .78, respectively (Parsa et al., 2016). Although this tool has been widely used in business and corporate industries, the instrument has also been used to collect data from nurses (Yang et al., 2015).

Part 3: Measurement of Mentorship

The mentorship was measured using the Mentoring Functions Questionnaire (MFQ 9), which includes two subsections. The first subsection identifies participants who had a mentor during their nursing careers. It gathers demographic information about the mentors' gender, ethnicity, and position at work. The second subsection consists of a nine-item, multidimensional, five-point Likert-type scale instrument modified form proposed initially by Scandura and Ragins (with 15 items; 1993) to measure the level of mentorship received by the participants in three mentoring relationship functions: (a) vocational support / career development involves one-on-one career coaching activities between a mentor and a mentee and deals with the practical aspect of a job; (b) psychosocial support function entails friendship activities in which mentees consider their mentors friends; and (c) role modeling, which sought to learn participants' feelings of respect and identification with their mentor and whether they tried to model their behaviors after their mentor (Hu et al., 2011).

Psychometrics

MFQ-9 is a valid tool established through exploratory and confirmatory factor analysis. This tool has been used extensively by nurses, educators, and large multinational corporate agencies across the USA (Chen et al., 2016). The instrument has stable and partial metric stability across satisfied and dissatisfied protégés, which is evidence of the tool's construct validity. The tool also contains few items and is therefore easy to translate and use across populations (Hu et al., 2011).

Part 4: Measurement of Social Support

The Multidimensional Scale of Perceived Social Support (MPSS) was used to measure social support. The MSPSS consists of 12 items relating to perceived social support, such as "My

family tries to help me," "I have friends with whom I can share my joys and sorrows," and "There is a special person who is around when I am in need" (Gallagher & Vella-Brodrick, 2008). Each item is rated on a seven-point Likert-type scale ranging from *very strongly disagree* to *very strongly agree*. This scale measures social support from family, friends, and significant others (Zimet et al., 1988).

Psychometrics

This tool has been tested across various groups and is a fit tool for measuring social support. The reliability of the total scale was .88. These values indicate the right internal consistency for the scale as a whole and the three subscales (Zimet et al., 1988). The Cronbach's coefficient alpha values for the Significant Other, Family, and Friends subscales were .91, .87, and .85, respectively.

Part 5: Demographic Data

The participants' demographic data were collected in this part of the survey. Most of the questions were optional.

Validity

Several experts, including the supervisor, reviewed the tool. The tool was also reviewed by an Institute of Social Research (IRS) expert at York University.

Pilot Study

The link to the survey was shared with twenty potential participants. After the participants completed the survey, the tool was edited. The following changes were made to the demographic data questionnaire.

Changes made:

1. Questions were added related to the supports available, like mentorship and informational support.
2. The flow of the questions was also edited for a smooth transition online.

Ethics

The proposal was submitted to the research and ethics board of York University. The initial plan was to collect data from the participants through an in-person interview. However, due to the pandemic, it was converted into an online survey. No personally identifying information was collected, and the data collected were kept confidential. The survey took approximately 20 minutes to complete.

Sample Size

To test the hypothesis with the significance at an alpha of 0.05 and to perform a regression analysis, a minimum sample of 110 nurses, with 55 in each group, was needed. This estimate was based on a similar study in the United States (Adeniran et al., 2013). The data were collected from 127 participants. The plan was to collect data from 400 participants. However, due to the pandemic, the response rate was low. Many nurses who were contacted had expressed job stress, burnout, and lack of time to engage in research studies. Of the 127 nurses who participated in the study, only 90 completed the survey related to mentorship, as only 90 had mentors.

Chapter 4

Results

In this chapter, the findings of the primary analyses are presented in three parts. Part 1 includes the demographic variables of the participating IENs and CENs. Part 2 consists of the scores in each of the tools previously mentioned, using descriptive statistical measures, comparisons between through *t*-tests, and inter-relationships between the three scales using correlational analysis. Part 3 includes the significant results from inferential statistical analysis (i.e., testing for equality of means of OCG and its sub-scale scores), with different groups of independent variables, using *t*-tests, an analysis of variance (ANOVA), and the total influence of independent variables on OCG and its sub-scale scores, using multiple regression analysis. The descriptions of each table precede the tables.

Demographics

Table 1 shows the responses of participants by province. 71% of respondents were from Ontario, 25% were from Manitoba, and 3% were from British Columbia. Since the number of respondents from British Columbia was low, for statistical purposes, the responses of British Columbia and Manitoba participants were combined and considered as other provinces.

Table 1

Number of respondents by province

Province	**Ontario**		**Manitoba**		**BC**		**Total**	
	#	%	#	%	#	%	#	%
# Total Responses Received	123	69.1	50	28.1	5	2.8	178	100

# Incomplete Responses	32	18	18	10.1	1	0.6	51	28.7
# Valid Responses	91	71.7	32	25.2	4	3.1	127	100

Note. Valid responses = 127

Table 2 shows the demographic data (divided based on the country of education). Most respondents were from Ontario (71.65%), and 86.61% were females. Most of the respondents were IENs (65.35%). Most of the respondents among the CENs were 35 years or younger whereas most of the respondents among the IENs were ages 36–50. 72.5% of the respondents had a bachelor's degree in nursing, and 14.17% had a graduate degree in nursing. 71% of the respondents had a mentor either currently or in the past, and 29% had not had a mentor in the past. Out of the 127 participants, only 90 had had a mentor in the past; among the 37 who did not, 24 (65%) were IENs.

The demographic data shows that the IENs and CENs have similar demographic characteristics except in age group, country of birth, and country of education.

Table 2

Demographic Data

	CEN		IEN		Total	
	#	%	#	%	#	%
Province						
ON	35	79.55	56	67.47	91	71.65
Others	9	20.45	27	32.53	36	28.35
Total	44	100.00	83	100.00	127	100.00
Gender						

Male	4	9.09	13	15.66	17	13.39
Female	40	90.91	70	84.34	110	86.61
Total	44	100.00	83	100.00	127	100.00
Age						
35 years or under	20	45.45	21	25.30	41	32.28
36–50 years	9	20.45	35	42.17	44	34.65
Over 50 years	15	34.09	27	32.53	42	33.07
Total	44	100.00	83	100.00	127	100.00
Country of Education						
International Education	0	0.00	83	100.00	83	65.35
Canadian Education	44	100.00	0	0.00	44	34.65
Total	44	100.00	78	100.00	122	100.00
Country of Birth						
Canada	36	81.82	1	1.20	37	29.13
Europe and other developed	2	4.55	11	13.25	13	10.24
Philippines	3	6.82	24	28.92	27	21.26
India	1	2.27	30	36.14	31	24.41
All Others	2	4.55	17	20.48	19	14.96
Total	44	100.00	83	100.00	127	100.00
Mentoring Support (independent question)						
Yes	27	62.79	43	59.72	70	60.87
No	16	37.21	29	40.28	45	39.13
Total	43	100.00	72	100.00	115	100.00
Emotional Support						
Yes	41	95.35	66	91.67	107	93.04
No	2	4.65	6	8.33	8	6.96
Total	43	100.00	72	100.00	115	100.00
Informational Support						
Yes	41	95.35	61	84.72	102	88.70
No	2	4.65	11	15.28	13	11.30
Total	43	100.00	72	100.00	115	100.00
RN International						
Yes	9	20.93	60	82.19	69	59.48

No	34	79.07	13	17.81	47	40.52
Total	43	100.00	73	100.00	116	100.00
Currently Employed						
Yes	43	100.00	70	97.22	113	98.26
No	0	0.00	2	2.78	2	1.74
Total	43	100.00	72	100.00	115	100.00
Mentors (Current or Past)						
Current Mentor	11	25.00	23	27.71	34	26.77
Past mentor	20	45.45	36	43.37	56	44.09
No mentor	13	29.55	24	28.92	37	29.13
Total	44	100.00	83	100.00	127	100.00
Education in Nursing						
Diploma in Nursing	6	13.64	10	13.16	16	13.33
Bachelors	31	70.45	56	73.68	87	72.50
Masters or plus	7	15.91	10	13.16	17	14.17
Total	44	100.00	76	100.00	120	100.00
Family Status						
Living Alone	6	13.95	4	5.56	10	8.70
Living with family/relatives/friends	37	86.05	68	94.44	105	91.30
Total	43	100.00	72	100.00	115	100.00
Country						
Canadian or Other Europe Countries	38	86.36	12	14.46	50	39.37
Other Asia or developing countries	6	13.64	71	85.54	77	60.63
Total	44	100.00	83	100.00	127	100.00
Current Title						
RN	35	85.37	55	88.71	90	87.38
Others = Manager/educator/Professor	6	14.63	7	11.29	13	12.62
Total	41	100.00	62	100.00	103	100.00
Have a Mentor (Past or Present)						
No mentor	13	29.55	24	28.92	37	29.13
Yes mentor	31	70.45	59	71.08	90	70.87
Total	44	100.00	83	100.00	127	100.00

Note. The total number of participants varied because of the optional answers to some demographic variables.

Analysis of the participants' demographic data based on province, as shown in Table 3, indicates that in Ontario, 62.2% of the respondents were females. In the other provinces, 24.41% were females. 34.65% were ages 36–50, and 29.1% were born in Canada. 44% of respondents from Ontario are internationally educated, and 27.56% were educated in Canada.

Table 3

*Demographic data based on the province (*n *= 127)*

Demographic Variables		**Ontario**		**Other Provinces**		**Total**	
		#	%	#	%	#	%
Gender	Male	12	9.44	5	3.93	17	13.39
	Female	79	62.20	31	24.41	110	86.61
Age in years	35 years or below	31	24.41	10	7.87	41	32.28
	36 -50 years	31	24.41	13	10.24	44	34.65
	>50 Years	29	22.83	13	10.24	42	33.07
Country of Birth	Canada	28	22.05	9	7.09	37	29.13
	Europe	12	9.45	1	0.79	13	10.24
	Philippines	11	8.66	16	12.60	27	21.26
	India	22	17.32	9	7.09	31	24.41
	Others	18	14.17	1	0.79	19	14.96
Place of Education	Canada	35	27.56	9	7.09	44	34.65
	International	56	44.09	27	21.26	83	65.35
	Diploma	11	9.17	5	4.17	16	13.34

Educational Qualification (Nursing) N=120	Bachelor's degree	58	48.33	29	24.17	87	72.5
	Graduate degree	15	12.5	2	1.67	17	14.17
Living Status n=115	Living Alone	6	5.21	4	3.48	10	8.19
	Living with family/friends	76	66.09	29	25.22	105	91.31

Note. The total number of participants varied because of the optional answers to some demographic variables.

Results of the Measurement Scales and Interrelationships

Reliability

Before conducting all inferential statistics, reliability analysis was done for each scale. As indicated in Table 4, Cronbach's alpha for all the subscales in all three scales is greater than 0.80.

Table 4

Reliability Scores for Scales

Scale	Subscales	Cronbach's Alpha
Organization Career Growth Scale (OCG)	Career Goal Progress	0.939
	Professional Ability Development	0.924
	Promotion Speed	0.839
	Remuneration Growth	0.874
	Overall	0.923
Social Support Scale (MPSS 12)	Family	0.946

	Friends	0.929
	Significant Others	0.898
	Overall	0.939
Mentoring Functions Questionnaire (MFQ 9)	Career Support	0.875
	Psychological Support	0.83
	Role Modeling	0.868
	Overall	0.922

Inferential Statistics

Objective 1

The study's first objective was to identify the perceived level of career advancement among IENs, and CENs measured through the organizational career growth scale (OCG). The mean scores for the OCG scale indicate that both CENs and IENs have a moderate level of perceived career advancement (as indicated in Table 5). The differences in scores between IENs and CENs were not statistically significant. There was no statistical difference between CENs and IENs in career goal progress, professional ability development, and promotion speed. IENs scored higher than CENs in the remuneration growth subscale, which was statistically significant ($t = -2.81$, $p < .01$).

To engage in parametric testing, data were checked for normality. Skewness and kurtosis are within the permissible range of 2 to +2, demonstrating that the data is normally distributed and that the fundamental presumption of parametric testing is met (Kim, 2013). Thus *t*-test results are robust. As shown in Table 5, the mean score for IENs was 50.76 (SD 10.6), and the mean score for CENs was 48.93 (SD 9.46).

Table 5

Organizational Career Growth Scale Scores (n = 127)

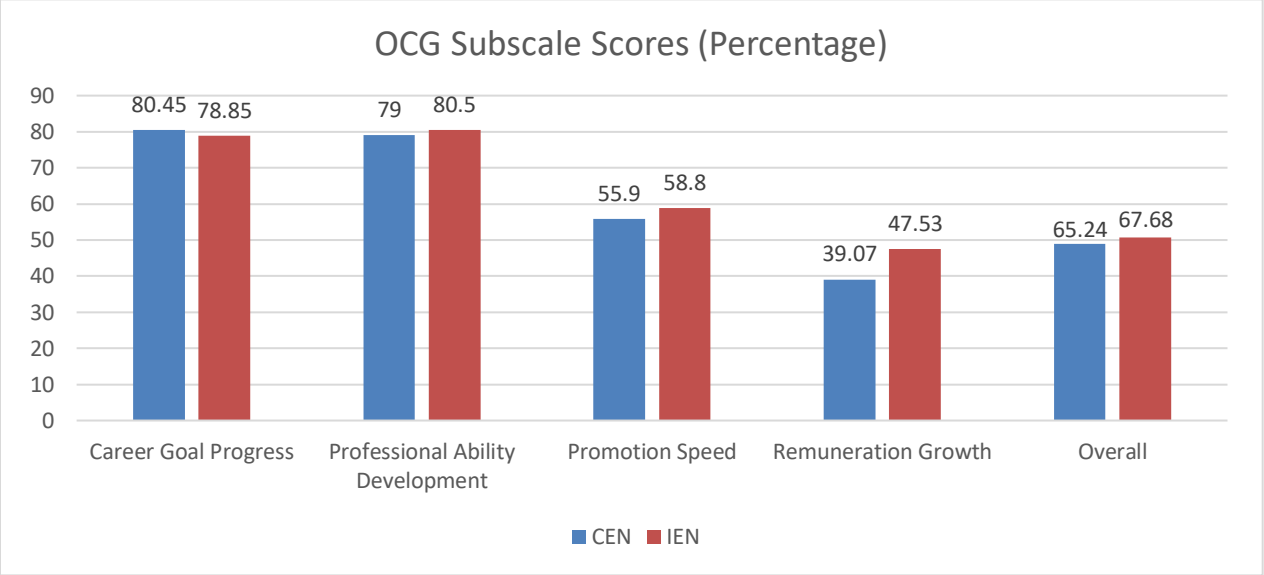
Scale	Education Groups	*N*	Minimum	Maximum	Mean	Std. Deviation	*t*	Significance
CGP	CEN	44	4	20	16.09	3.05		
	IEN	83	4	20	15.77	3.73	0.52	0.60
	Total	127	4	20	15.88	3.50		
PAD	CEN	44	4	20	15.80	3.65		
	IEN	83	4	20	16.10	3.40	-0.45	0.65
	Total	127	4	20	15.99	3.48		
PSD	CEN	44	4	20	11.18	2.93		
	IEN	83	4	20	11.76	3.50	-0.99	0.33
	Total	127	4	20	11.56	3.31		
RG	CEN	44	3	15	5.86	2.03		
	IEN	83	3	15	7.13	3.02	-2.81	0.01*
	Total	127	3	15	6.69	2.78		
OCG Total Score	CEN	44	15	75	48.93	9.46		
	IEN	83	15	75	50.76	10.6	-0.99	0.32
	Total	127	15	75	50.13	10.26		

Note. The total score possible is 75, and the minimum score is 15.

IENs had a higher overall score, higher score in PAD, PSD and RG subscales. CENs had a higher score in CGP subscale as indicated in Figure 1.

Figure 1

Scores for OCG subscales



Objective 2

The second objective was to determine the current level of perceived social support. The overall mean score for IENs was 61.87 (SD 13.14), and the overall mean score for CENs was 64.36 (SD 11.69). However, these differences were not statistically significant. No statistically significant differences between IENs and CENs on significant-other or family support existed. On friend support, CENs scored higher than IENs, which was statistically significant ($t = 2.49$, $p < .01$), as indicated in Table 6. Skewness and kurtosis are within the permissible range of 2 to +2, demonstrating that the data is normally distributed and that the fundamental presumption of parametric testing is met.

Table 6

Social Support Scale Scores (n = 127)

Subscales	Education Groups	N	Minimum	Maximum	Mean	Std. Deviation	*t*	Significance
SO	CEN	44	11	28	21.86	4.60	1.62	0.11
	IEN	83	4	28	20.40	5.28		
	Total	127	4	28	20.91	5.08		
FR	CEN	44	11	28	21.66	4.10	2.49	0.01*
	IEN	83	4	28	19.66	4.63		
	Total	127	4	28	20.35	4.54		
FM	CEN	44	6	28	20.84	5.35	-1	0.33
	IEN	83	4	28	21.81	5.04		
	Total	127	4	28	21.47	5.15		
Total Score	CEN	44	28	84	64.36	11.69	1.1	0.28
	IEN	83	12	84	61.87	13.14		
	Total	127	12	84	62.73	12.67		

Note. The minimum score is 12, and the maximum score is 84.

Objective 3

The third objective was to measure the mentorship available to IENs and CENs. As indicated in Table 7, the overall mean score for IENs was 31.10 (SD 7.91), and the overall mean score for CENs was 35.03 (SD 5.20). This difference was statistically significant ($t = 2.85$, $p < .01$). The career support between CENs and IENs was statistically significant ($t = 2.10$, $p < .05$), with CENs scoring higher. The psychological support between CENs and IENs was also statistically significant ($t = 2.10$, $p < .05$), with CENs scoring higher. Role modeling between CENs and IENs was also statistically significant ($t = 3.33$, $p < .05$), with CENs scoring higher.

As indicated in Table 7, Skewness and kurtosis are within the permissible range of 2 to +2, demonstrating that the data is normally distributed and that the fundamental presumption of parametric testing is met.

Ninety participants answered the questions related to MFQ 9, out of whom 59 (65.56%) were IENs, and 31 (34.44%) were CENs. Out of 127 respondents, only 90 had had one or two mentors in the past. The subscales showed a similar pattern, with the CENs scoring higher than the IENs, and the differences were statistically significant. Of the 90 respondents, 71% had had either one or two mentors, and 29% had had none. Most of the mentors were females, had a bachelor's degree in nursing, had an RN title, met with the mentees at least once a month, and were not formal mentorships.

Table 7

Mentoring Functions Questionnaire Scale Scores (n = 127)

Item	Education Groups	N	Minimum	Maximum	Mean	Std. Deviation	*t*	Significance
	CEN	31	3	15	11.74	1.86		
	IEN	59	3	15	10.69	2.84		
CS	Total	90	3	15	11.06	2.59	2.10	0.04
	CEN	31	3	15	10.71	2.76		
	IEN	59	3	15	9.37	3.06		
PS	Total	90	3	15	9.83	3.01	2.10	0.04
	CEN	31	3	15	12.58	1.59		
	IEN	59	3	15	11.03	2.82		
RM	Total	90	3	15	11.57	2.56	3.33	0.00
MFQ 9	CEN	31	9	45	35.03	5.10		
Total	IEN	59	9	45	31.10	7.91		
Score	Total	90	9	45	32.46	7.29	2.85	0.01

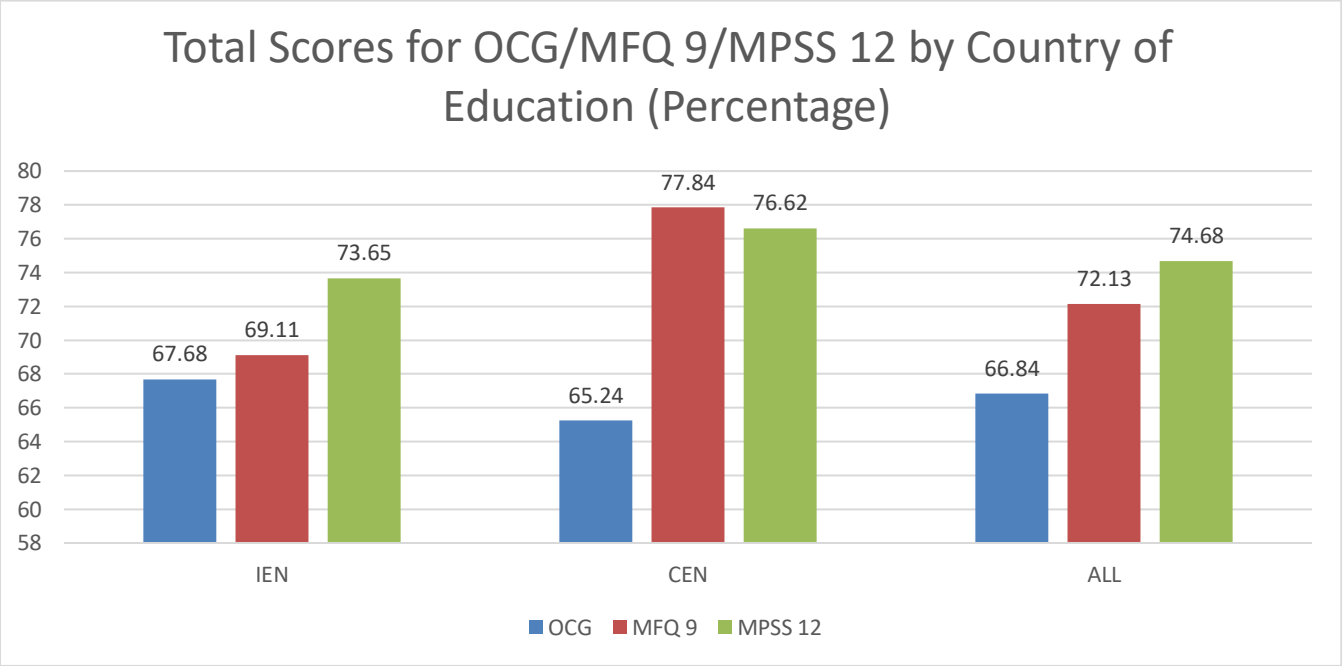
Note. The maximum score is 45, and the minimum score is 9.

IENs had a higher OCG score than CENs. Both MFQ scores and MPSS scores were lower for IENs than for CENs. Despite scoring higher in MFQ 9, mentorship did not have a statistically significant impact on the OCG scores for CENs.

The following figure (Figure 2) depicts the scores in percentages on all three scales:

Figure 2

Total Percentages of OCG / MFQ 9 / MPSS 12 scores by Country of Education



Appropriateness of Measurement Tools

All three data collection tools (OCG, MPSS, and MFQ 9) were reliable, with a Cronbach's alpha above 0.80. These tools have been used extensively in nursing.

Before regression analyses were conducted, correlation analyses were done between the scores for all three scales and their subscales. There was a positive correlation between the scores for OCG, MPSS (r = .34), and MFQ 9 (r = .39). All the correlations were statistically significant at .05, except the remuneration growth subscale, social support from friends, and mentorship's role-modeling function. The scores and their correlations are presented in Table 8.

The same analysis was done for each group separately and is presented in Tables 9 and 10.

Table 8

Correlations between Combined OCG, MFQ 9, and MPSS Scores

Correlations		MPSS Subscales and Total Scores				MFQ 9 Subscales and Total scores			
		Family	Friends	Significant Others	Total score	Career Support	Psychosocial Support	Role Modeling	Total Score
CGP	Pearson	0.27	0.26	0.28	0.31	0.31	0.24	0.32	0.32
	Significance	<.05	<.05	<.05	<.05	<.05	<.05	<.05	<.05
	N	127	127	127	127	90	90	90	90
PAD	Pearson	0.29	0.22	0.28	0.31	0.27	0.21	0.3	0.29
	Significance	<.05	<.05	<.05	<.05	<.05	<.05	<.05	<.05
	N	127	127	127	127	90	90	90	90
PSD	Pearson	0.2	0.19	0.28	0.26	0.34	0.2	0.3	0.31
	Significance	<.05	<.05	<.05	<.05	<.05	<.05	<.05	<.05
	N	127	127	127	127	90	90	90	90
RG	Pearson	0.22	0.05	0.2	0.19	0.32	0.19	0.19	0.26
	Significance	<.05	>0.05	<.05	<.05	<.05	>0.05	>0.05	<.05
	N	127	127	127	127	90	90	90	90
OCG total score	Pearson	0.31	0.23	0.33	0.34	0.41	0.27	0.36	0.39
	Significance	<.05	<.05	<.05	<.05	<.05	<.05	<.05	<.05
	N	127	127	127	127	90	90	90	90

Note. The number of respondents who had a mentor was 90.

Although CENs had a positive correlation with OCG and MPSS (r = .10) and MFQ (r = 0.23) scores, only the role-modeling function on PAD of the OCG subscale was statistically significant, as indicated in Table 9.

Table 9

Correlations between OCG, MFQ 9, and MPSS Scores Among CENs

Correlations		MPSS Subscales and Total Scores				MFQ 9 Subscales and Total scores			
		Family	Friends	Significant Others	Social score	Career Support	Psychosocial Support	Role Modeling	Mentorship score
CGP	Pearson	0.04	0.03	0.14	0.09	0.06	0.23	0.12	0.18
	Sig	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05
	N	44	44	44	44	31	31	31	31
PAD	Pearson	0.18	0.07	0.18	0.18	0.21	0.22	0.36	0.31
	Sig	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	< 0.05	> 0.05
	N	44	44	44	44	31	31	31	31
PSD	Pearson	-0.06	-0.07	0.05	-0.03	-0.08	0.08	0.06	0.03
	Sig	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05
	N	44	44	44	44	31	31	31	31
RG	Pearson	0.19	0.22	0.10	0.20	0.08	0.19	0.02	0.14
	Sig	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05
	N	44	44	44	44	31	31	31	31
OCG Total score	Pearson	0.11	0.06	0.15	0.13	0.10	0.24	0.21	0.23
	Sig	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05	> 0.05
	N	44	44	44	44	31	31	31	31

Among IENs, there was a positive correlation between the scores for MPSS (r = .45) and MFQ (r = .49) with those of OCG. They were all statistically significant at a p < .05 level except

in the psychological support function of MFQ with the CGP and PAD subscales of OCG, which was not statistically significant (as indicated in Table 10).

Table 10

Correlations between OCG, MFQ 9, and MPSS Scores Among IENs

Correlations		MPSS Subscales and Total Scores				MFQ 9 Subscales and Total scores			
		Family	Friends	Significant Others	Social score	Career Support	Psychosocial Support	Role Modeling	Mentorship score
CGP	Pearson	0.35	0.34	0.35	0.39	0.37	0.24	0.36	0.36
	Sig	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	> 0.05	< 0.05	< 0.05
	N	83	83	83	83	59	59	59	59
PAD	Pearson	0.35	0.31	0.34	0.38	0.35	0.25	0.37	0.35
	Sig	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	> 0.05	< 0.05	< 0.05
	N	83	83	83	83	59	59	59	59
PSD	Pearson	0.31	0.33	0.38	0.39	0.49	0.28	0.40	0.43
	Sig	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05
	N	83	83	83	83	59	59	59	59
RG	Pearson	0.28	0.06	0.22	0.22	0.45	0.26	0.33	0.38
	Sig	< 0.05	> 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05
	N	83	83	83	83	59	59	59	59
OCG score	Pearson	0.42	0.34	0.42	0.45	0.54	0.33	0.47	0.49
	Sig	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05	< 0.05
	N	83	83	83	83	59	59	59	59

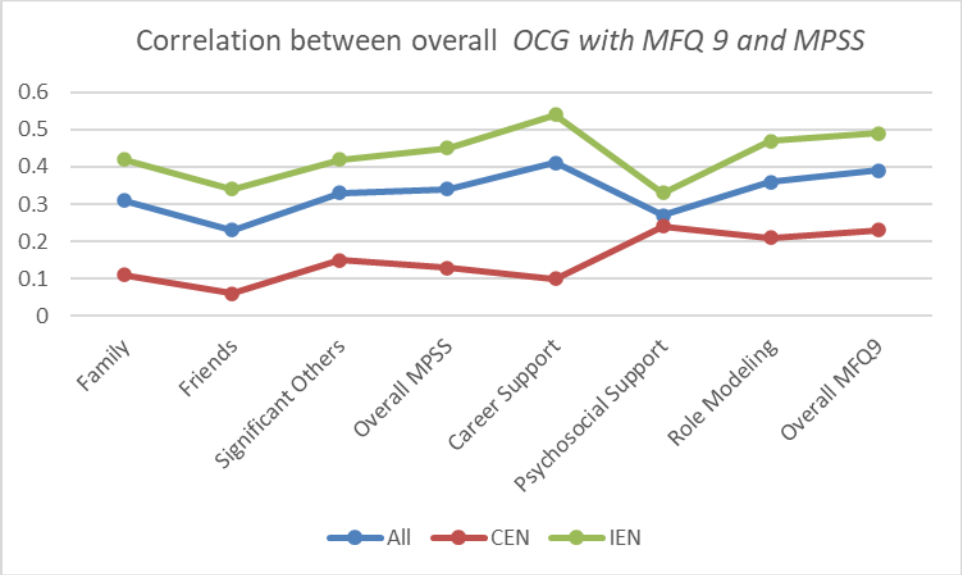
For both IENs and CENs, the overall scores for MFQ 9 positively correlated with the overall scores for OCG (dependent variable). The differences were statistically significant at the $p < .05$ level. The scores for the subscales of MFQ 9 and the scores for the subscales of OCG also had a statistically significant positive correlation in most domains except in remuneration growth. The positive correlations in remuneration growth were not statistically significant.

For IENs, the results indicate that the overall scores for MFQ 9 positively correlated with the overall scores for OCG and were statistically significant at a $p < .05$ level. However, with the scores on the subscales, the psychological support scores for MFQ 9 did not have a statistically significant correlation with the subscale score of CGP and PAD.

Although there was a positive correlation between the scores for MPSS and MFQ and that of OCG among all the participants, the correlation is stronger among IENs, as indicated in Figure 3.

Figure 3

Correlation – Overall Scores for OCG with MFQ 9 and MPSS 12



Regarding the mentors, 71% of the respondents had one or two current/past mentors, and 29% had no mentors, as shown in Table 11.

Table 11

Number of Mentors by Province

# Mentors	Ontario		Others		Total	
	#	%	#	%	#	%

One Mentor	48	37.80	17	13.38	65	51.18
Two Mentors	20	15.75	5	3.94	25	19.69
No Mentors	23	18.11	14	11.02	37	29.13
Total	91	71.66	36	28.34	127	100

Table 12 shows that 29.55% of CENs did not have a current or past mentor, and among the IENs, 28.92% did not have a current or past mentor. Among those who had mentors, most had only one mentor.

Table 12

Number of Mentors by Country of Education

	CEN		IEN		Total	
	#	%	#	%	#	%
One Mentor	23	18.11	42	33.07	65	51.18
Two Mentors	8	6.30	17	13.39	25	19.69
No Mentors	13	29.55	24	28.92	37	29.13
Total	44	34.65	83	65.35	127	100

Table 1 in Appendix D shows the selected characteristics of mentors. Most of the mentors were female, Caucasian, had a bachelor's degree in nursing, had an RN title, met with the mentees at least once a month, and were not formal mentors.

Regarding whether having a mentor influences scores for OCG, both IENs and CENs who had mentors scored higher in all the subscales of OCG and they were statistically significant ($p < .05$; Table 13). The same analysis was done for each group and are presented in Tables 14 and 15, respectively.

Table 13

Comparison of OCG scores with having a mentor or not (Both CENs and IENs)

OCG SCALE	Mentor	N	Min	Max	Mean	SD	Skewness	Kurtosis	t	Significance
	Yes	90	4	20	16.49	2.86	-1.01	3		
CGP	No	37	4	20	14.41	4.42	-0.89	0.58	-2.65	< 0.05
	Total	127	4	20	15.88	3.5	-1.23	2.47		
	Yes	90	4	20	16.66	2.87	-1.38	3.88		
PAD	No	37	4	20	14.38	4.27	-0.8	0.4	-2.98	< 0.05
	Total	127	4	20	15.99	3.48	-1.3	2.33		
	Yes	90	4	20	12.03	3.18	0.18	0.26		
PSD	No	37	4	16	10.41	3.39	-0.36	-0.57	-2.51	< 0.05
	Total	127	4	20	11.56	3.31	-0.04	0.19		
	Yes	90	3	15	7.04	2.86	0.62	0.16		
	No	37	3	12	5.84	2.41	0.62	-0.21	-2.43	< 0.05
RG	Total	127	3	15	6.69	2.78	0.66	0.2		
	Yes	90	15	75	52.22	9.02	-0.36	2.45		
OCG Total	No	37	15	66	45.03	11.39	-0.39	0.1		
SCORE	Total	127	15	75	50.13	10.26	-0.55	1.38	-3.43	< 0.05

Overall, career growth scores showed a statistically significant difference in having a mentor ($t = -3.43$, $p < .05$). The same pattern was observed with the subscales, CGP ($t = -2.65$, $p < .05$), PAD ($t = -2.98$, $p < .05$), PSD ($t = -2.51$, $p < .05$), and RG ($t = -2.43$, $p < .05$).

Subsequent analyses were done to explore career advancement among CENs. Those with mentors scored higher in all the subscales of OCG. However, the differences were statistically significant with only the RG subscales ($t = 2$, $p < .05$), as indicated in Table 14.

Table 14

Comparison of Scores for OCG and having a mentor Among CENs

OCG	Mentor Yes/No	N	Min	Max	Mean	Std. Deviation	t	Sig
CGP	Yes	31	12	20	16.58	2.11	-1.68	0.1
	No	13	4	20	14.92	4.48		
	Total	44	4	20	16.09	3.05		
PAD	Yes	31	8	20	16.23	3.13	-1.03	> 0.05
	No	13	4	20	14.77	4.66		
	Total	44	4	20	15.80	3.65		
PSD	Yes	31	6	18	11.68	2.69	-1.78	0.08
	No	13	4	16	10.00	3.24		
	Total	44	4	18	11.18	2.93		
RG	Yes	31	3	10	6.19	2.17	-2	< 0.05*
	No	13	3	8	5.08	1.44		
	Total	44	3	10	5.86	2.03		
OCG Total Score	Yes	31	36	66	50.68	7.42	-1.95	0.06
	No	13	15	61	44.77	12.52		
	Total	44	15	66	48.93	9.46		

Analyses were done for IENs only, and those with mentors scored higher in all the subscales of OCG. The differences were statistically significant in CGP ($t = -2.66$, $p < .05$), PAD ($t = -3.52$, $p < .05$), and overall scores ($t = -3.22$, $p < .05$), as indicated in Table 15.

Table 15

Comparison of Scores for OCG and having a mentor Among IENs

OCG	Mentor Ye/No	N	Min	Max	Mean	Std. Deviation	t	Sig
CGP	Yes	59	4	20	16.44	3.196		
	No	24	4	20	14.13	4.456	-2.66	< 0.05
	Total	83	4	20	15.77	3.73		
PAD	Yes	59	4	20	16.88	2.723		
	No	24	4	20	14.17	4.135	-3.52	< 0.05
	Total	83	4	20	16.1	3.402		
PSD	Yes	59	4	20	12.22	3.414		
	No	24	4	16	10.63	3.512	-1.91	0.07
	Total	83	4	20	11.76	3.498		
RG	Yes	59	3	15	7.49	3.081		
	No	24	3	12	6.25	2.739	-1.8	0.08
	Total	83	3	15	7.13	3.023		
OCG Total Score	Yes	59	15	75	53.03	9.718		
	No	24	25	66	45.17	11.009	-3.22	< 0.05
	Total	83	15	75	50.76	10.662		

Comparison of Means (ANOVA)

To answer whether any of the demographic variables influenced the scores for these scales, the mean scores were compared using select demographic variables. The scores for OCG with the select variables and the results of an ANOVA are presented in Table 16. Analysing the gender differences on the scores of OCG, MFQ 9 and MPSS 12 revealed that there were no statistically significant differences between males and females. Males had higher overall scores than females on OCG and MFQ 9 scales and females had a higher score in MPSS 12 scale. Further analysis reveals that among both IENs and CENs, Females had a lower score on OCG and MFQ 9. However, with social support scale scores, among IENs and CENs females had a higher score than males. The differences in educational qualifications, living status, residency, and the number of years in Canada, were not statistically significant.

Table 16

Organizational Career Growth Scale Scores and Select Demographic Variables

Demographic Variables		N	Occupational Career Growth Scale Scores (min 15 and max 75)					
			Scores		95% CI		ANOVA	
			Mean	Std Deviation	Min	Max	F	Significance p
Province	Ontario	91	49.82	10.603	47.62	52.03	0.027	0.600
	Others	36	50.89	9.444	47.69	54.08		
Gender	Male	17	51.82	10.279	46.54	57.11	0.535	0.466
	Female	110	49.86	10.281	47.92	51.81		
Age in years	35 years or under	41	50.93	11.005	47.45	54.40	0.203	0.817
	36–50 years	44	49.52	10.728	46.26	52.78		
	> 50 Years	42	49.98	9.148	47.13	52.83		

Country of Birth	Canada	37	49.27	8.329	46.49	52.05	0.936	0.445
	Europe	13	50.62	9.768	44.71	56.52		
	Philippines	27	53.33	9.731	49.48	57.18		
	India	31	48.52	12.310	44.00	53.03		
	Others	19	49.53	11.112	44.17	54.88		
Educational Qualification (Nursing)	Diploma	16	51.94	9.650	46.80	57.08	0.738	0.480
	Bachelor's degree	87	48.94	10.375	46.73	51.15		
	Graduate degree	17	50.76	8.258	46.52	55.01		
Living Status	Living Alone	10	51.10	12.12	42.43	59.77	0.193	0.662
	Living with family/friends	105	49.64	10.03	47.91	51.62		
Residency	Permanent Resident	35	47.94	11.780	43.90	51.99	1.520	0.220
	Canadian Citizen	87	50.39	9.080	48.46	52.33		
Number of years in Canada	1–10 years	32	50.56	12.231	46.15	54.97	0.322	0.725
	11–20 years	33	49.85	9.897	46.34	53.36		
	Over 20 years	50	48.76	8.875	46.24	51.28		

The impact of selected demographic variables on the scores for MPSS is presented in Table 17. Although there were differences in the mean scores for MPSS between males and females based on their educational qualifications, living status, and years in Canada, the differences were not statistically significant. There was a statistically significant difference in the

scores on the social support scale based on residency, with Canadian citizens having a higher mean than permanent residents ($p < .05$).

Table 17

Social Support Scale Scores and Select Demographic Variables

Demographic Variables		N	Social Support Scale Scores (min 12 and max 84)					
			Scores		95% CI		ANOVA	
			Mean	Std Deviation	Min	Max	F	Significance (p)
Province	Ontario	91	62.82	12.62	60.20	65.45	0.02	0.897
	Others	36						
Gender	Male	17	63.12	9.669	58.15	68.09	0.018	0.893
	Female	110	62.67	13.102	60.20	65.15		
Age in years	35 years or under	41	64.71	13.006	60.60	68.81	0.739	0.480
	36–50 years	44	61.93	14.345	57.57	66.29		
	>50 Years	42	61.64	10.309	58.43	64.86		
Country of Birth	Canada	37	64.76	10.180	61.36	68.15	1.348	0.256
	Europe	13	59.92	6.601	55.93	63.91		
	Philippines	27	65.93	12.241	61.08	70.77		
	India	31	59.81	16.274	53.84	65.78		
	Others	19	60.95	13.460	54.46	67.43		
Educational Qualification (Nursing)	Diploma	16	60.63	8.770	55.95	65.30	0.466	0.629
	Bachelor's degree	87	62.53	13.666	59.62	65.44		
	Graduate degree	17	64.88	10.629	59.42	70.35		
Living Status	Living Alone	10	60.00	19.41	46.12	73.88	0.565	0.454
	Living with family/friends	105						
Residency	Permanent Resident	35	58.11	14.866	53.01	63.22	6.342	0.013*

	Canadian Citizen	87	64.33	11.182	61.95	66.72		
Number of years in Canada	1–10 years	32	61.53	15.433	55.97	67.10	0.139	0.870
	11–20 years	33	63.09	12.902	58.52	67.67		
	Over 20 years	50	61.88	10.546	58.88	64.88		

The impact of select demographic variables on the scores for MFQ 9 is presented in Table 18. Although there were differences in the mean scores for MFQ 9 between males and females, based on their educational qualifications, living status, residency, and years in Canada, they were not statistically significant. There was a statistically significant difference in the mentorship scale scores based on age, with those 35 and under having a higher mean score than the other age groups ($p < .05$).

Table 18

Mentorship Scale Scores and Select Demographic Variables

Demographic Variables		N	Mentorship Functioning Questionnaire Scores (min 9 and max 45)					
			Scores		95% CI		Anova	
			Mean	Std Deviation	Min	Max	F	Significance p
Province	Ontario	68	32.51	7.200	30.77	34.26	0.018	0.893
	Others	22	32.27	7.722	28.85	35.70		
Gender	Male	12	33.50	9.298	27.59	39.41	0.282	0.597
	Female	78	32.29	6.988	30.72	33.87		
Age in years	35 years or under	29	35.38	6.079	33.07	37.69	4.024	0.021*
	36–50 years	32	31.78	7.529	29.07	34.50		

	>50 Years	29	30.28	7.401	27.46	33.09		
Country of Birth	Canada	26	34.96	5.422	32.77	37.15	1.887	0.120
	Europe	8	27.38	9.855	19.14	35.61		
	Philippines	17	31.71	8.091	27.55	35.87		
	India	25	31.96	7.738	28.77	35.15		
	Others	14	32.50	5.828	29.14	35.86		
Educational Qualification (Nursing)	Diploma	10	28.10	9.758	21.12	35.08	2.350	0.102
	Bachelor's degree	60	32.72	7.181	30.86	34.57		
	Graduate degree	15	34.27	4.935	31.53	37.00		
Living Status	Living Alone	8	31.00	10.650	22.10	39.90	0.332	0.566
	Living with family/friends	74	32.58	6.976	30.96	34.20		
Residency	Permanent Resident	22	30.41	10.017	25.97	34.85	2.057	0.155
	Canadian Citizen	65	32.97	6.052	31.47	34.47		
Number of years in Canada	1–10 years	22	31.45	7.123	28.30	34.61	0.477	0.622
	11–20 years	24	33.33	6.722	30.49	36.17		
	Over 20 years	34	31.62	8.195	28.76	34.48		

The scores for the MFQ 9 and the select demographic factors were explored using an ANOVA and a *t*-test for specific mentor characteristics. The results are presented in the following

tables. The impact on both CENs and IENs combined is shown in Table 19. The same analysis was done for each group separately and are presented in Tables 20 and 21, respectively.

Comparing the combined mean scores for the MFQ 9 revealed that the mentor characteristics of having the title of manager/educator, having a graduate degree in nursing, meeting with mentees within the last year, and knowing the mentor for 4–10 years showed a statistically significant difference in the MFQ 9 scores ($p < .05$), as indicated in Table 19.

Several mentor characteristics were statistically significant in the mean scores for the MFQ 9: participants who met their mentors within the last year had a higher mean score than those who met their mentors a year ago; participants with mentors with a graduate degree had higher scores than those with a diploma in nursing or a bachelor's degree; mentors with the job title of managers/educators are perceived to provide better mentorship than those with RN titles; and participants who had known their mentors for four to ten years scored higher than those who had known their mentors for less than three years or more than ten years. The other characteristics—gender, ethnicity, number of mentors, and the frequency of meetings—did not significantly impact the mentorship scores. Majority of them had informal mentorship (54%). Participants who received informal mentorships have had a higher score in OCG than those who had a formal mentorship. However, this was not statistically significant.

Table 19

Combined Mentorship Functioning Scale Scores and Selected Mentorship Characteristics

Demographic Variables	N	Mentorship Functioning Questionnaire Scores (min 9 and max 45)					
		Scores		95% CI		ANOVA	
		M	Std Deviation	Min	Max	*F*	*p*

Current/Past Mentors	Current or past 2 mentors	25	31.04	10.204	26.83	35.25	1.311	0.255
	Current or past 1 mentor	65	33.00	5.807	31.56	34.44		
Gender	Male	6	32.83	4.355	28.26	37.40	0.015	0.904
	Female	83	32.46	7.510	30.82	34.10		
Ethnicity	Caucasian	37	32.46	7.136	30.08	34.84	1.302	0.280
	Other Canadian	15	32.00	7.955	27.59	36.41		
	Indian/Filipino/other Asians	23	30.83	8.021	27.36	34.29		
	African Origin	7	37.14	5.581	31.98	42.30		
Last time met the mentor	Recently, within a year	42	34.19	7.721	31.78	36.60	4.711	0.033*
	More than a year ago or more	46	30.85	6.723	28.85	32.84		
Mentor Educational Qualification (Nursing)	Diploma	22	29.95	9.863	25.58	34.33	3.362	0.039*
	Bachelor's degree	40	32.05	5.139	30.41	33.69		
	Graduate degree	25	35.32	7.336	32.29	38.35		
Mentor Job Title	RN	60	31.13	7.754	29.13	33.14	6.611	0.012*
	Manager/Educator	27	35.41	5.638	33.18	37.64		
Frequency of meetings	At least 1 time a week	58	32.71	7.079	30.85	34.57	0.731	0.396
	Not weekly regular	13	34.62	8.150	29.69	39.54		
	3 years or under	34	30.26	7.341	27.70	32.83	3.639	0.031*

Number of years known	4–10 years	31	35.06	5.291	33.12	37.01		
	Over 10 years	22	32.18	9.048	28.17	36.19		

Among the CENs, the mentor characteristics of meeting the mentor within the past year and having a graduate degree had a statistically significant influence on the scores ($p < .05$), as indicated in Table 20.

Table 20

Mentorship Functioning Scale Scores and Select Mentorship Characteristics Among CENs

Demographic Variables		N	Mentorship Functioning Questionnaire Scores (min 9 and max 45)					
			Scores		95% CI		ANOVA	
			M	Std Deviation	Min	Max	*F*	*p*
Current/Past Mentors	Current or past 2 mentors	8	35.88	7.220	29.84	41.91	0.288	0.596
	Current or past 1 mentor	23	34.74	4.298	32.88	36.60		
Gender	Male	1	31.00					
	Female	30	35.17	5.127	33.25	37.08	0.639	0.430
Ethnicity	Caucasian	21	34.38	5.133	32.04	36.72	1.641	0.205
	Other Canadian	2	33.00	0.000	33.00	33.00		
	Indian/Filipino/other Asians	2	34.50	4.950	-9.97	73.97		
	African Origin	4	40.25	5.500	31.50	49.00		

Last time met the mentor	Recent, within a year	16	37.00	4.967	34.35	39.65	5.146	0.031*
	More than a year ago or more	14	33.00	4.641	30.32	35.68		
Mentor Educational Qualification (Nursing)	Diploma/BSc	18	32.56	3.682	30.72	34.39	17.797	0.000*
	Graduate degree	12	39.00	4.671	36.03	41.97		
Mentor Job Title	RN	21	34.00	5.128	31.67	36.33	3.705	0.064
	Manager/Educator	9	37.78	4.381	34.41	41.15		
Frequency of meetings	At least 1 time a week	18	34.94	4.808	32.55	37.34	2.1961	0.153
	Not weekly regular	5	38.60	5.011	33.57	37.91		
Number of years known	3 years or under	12	34.00	5.847	30.29	37.71	0.601	0.555
	4–10 years	12	36.33	4.292	33.61	39.06		
	Over 10 years	06	35.00	5.621	29.10	40.90		

Among the IENs, the title as the nurse manager/educator and the number of years known had a statistically significant impact on the scores ($p < .05$), as indicated in Table 21.

Table 21

Mentorship Functioning Scale Scores and Selected Mentorship Characteristics Among IENs

Demographic Variables	N	Mentorship Functioning Questionnaire Scores (min 9 and max 45)					
		Scores		95% CI		ANOVA	
		M	Std Deviation	Min	Max	*F*	*p*

Current/Past Mentors	Current or past 2 mentors	17	28.76	10.779	23.22	34.31	2.122	0.151
	Current or past 1 mentor	42	32.05	6.332	30.07	34.02		
Gender	Male	5	33.20	4.764	27.28	39.12	0.367	0.547
	Female	53	30.92	8.225	28.66	33.19		
Ethnicity	Caucasian	16	29.94	8.668	25.32	34.56		
	Other Canadian	13	31.85	8.581	26.66	37.03		
	Indian/Filipino/other Asians	21	30.48	8.250	26.72	34.23		
	African Origin	3	33.00	1.732	28.70	37.30		
Last time met the mentor	Recent, within a year	26	32.46	8.650	28.97	35.96	1.485	0.228
	More than a year ago or more	32	29.91	7.319	27.27	32.55		
Mentor Educational Qualification (Nursing)	Diploma/BSc	44	30.80	8.163	28.31	33.28	0.195	0.661
	Graduate degree	13	31.92	7.847	27.18	36.67		
Mentor Job Title	RN	39	29.59	8.515	26.83	32.35	4.336	0.042*
	Manager/Educator	18	34.22	5.927	31.28	37.17		
Frequency of meetings	At least 1 time a week	40	31.70	7.733	29.23	34.17	0.019	0.891
	Not weekly regular	8	32.13	8.951	24.64	39.61		
Number of years known	3 years or under	22	28.23	7.380	24.96	31.50	3.091	0.054*
	4–10 years	19	34.26	5.801	31.47	37.06		
	Over 10 years	16	31.13	9.986	25.80	36.45		

The impact of the select demographic variables on the scores for OCG was also tested using an ANOVA. Although there were differences in the mean scores for OCG between males and females, between different educational qualifications, living status, residency, and several years in Canada, they were not statistically significant.

The impact of selected demographic variables on the scores for MPSS revealed that Canadian citizens scored higher than permanent residents, which is statistically significant ($p < 0.05$). This may be because those who are citizens might have established social networks and would have access to social support due to their longevity of being present in Canada.

The impact of the select demographic variables on the MFQ 9 revealed statistically significant differences in the mean scores for the MFQ 9 and the age of the respondents. Respondents under age 35 had a higher mean score on the MFQ 9, and respondents over age 50 scored lower. A possible explanation for this discrepancy is that young people can establish successful friendships at the workplace or that these nurses are considered new (owing to their age) and can access mentorship support.

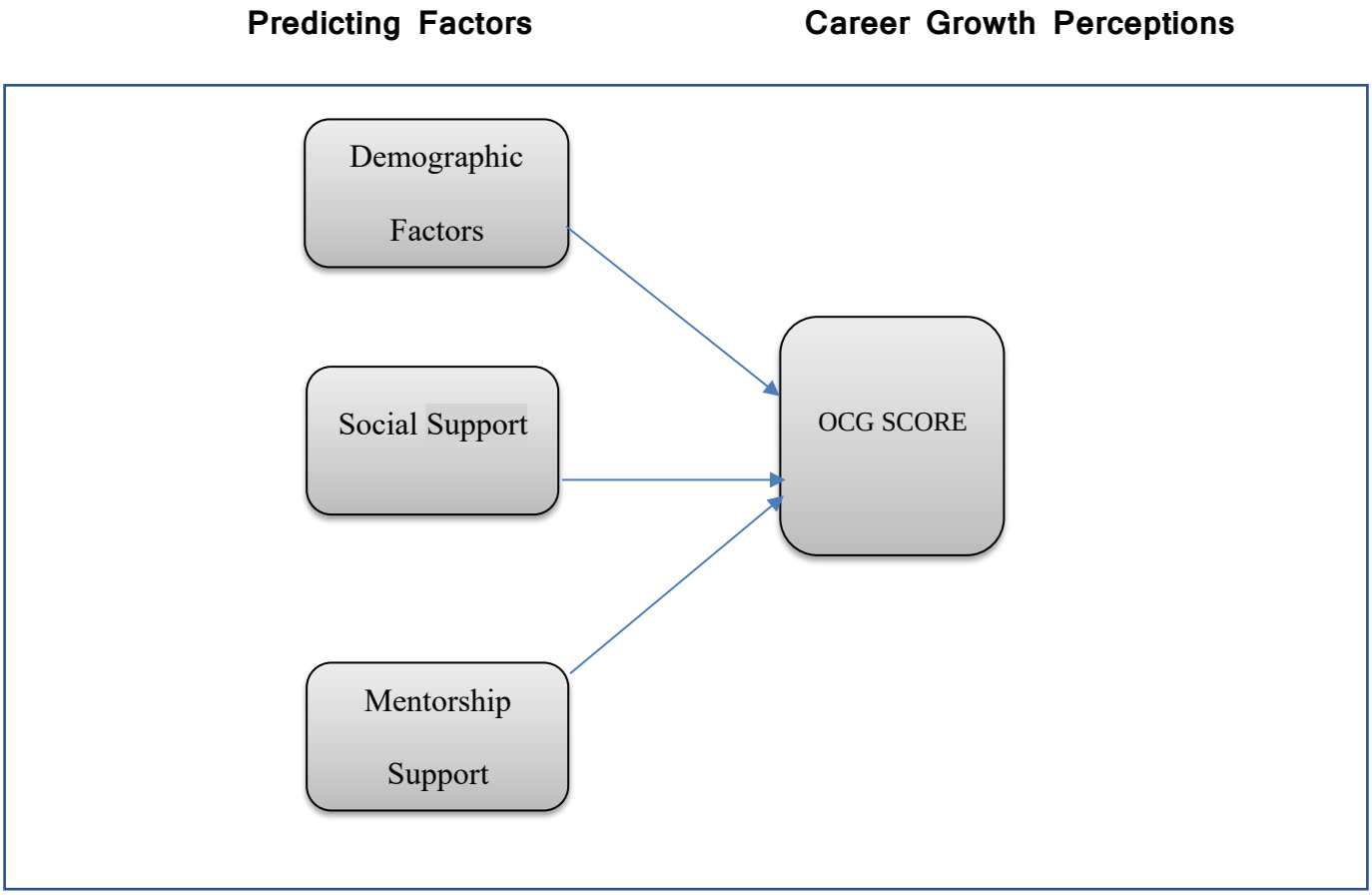
Comparing the mean scores for OCG with the selected demographic variables, the MFQ 9 and MPSS scores reveal that having a mentor and social support show a statistically significant difference in the mean scores for OCG.

Results of Multiple Regression Analysis

A multiple regression model was used to assess the influence of the independent variables on the scores for the OCG scales. Figure 4 presents the models used for regression. The power analysis was done using the G* power analysis tool (Faul et al., 2009), which yielded a power of 0.80, indicating that the sample size is adequate for regression analysis, with a moderate effect size.

Figure 4

Regression Analysis Models Used



Note. Predictors were country of origin, mentorship, educational qualifications, social support, age in years, and emotional support. When computing multiple regressions, only these predictors yielded a significant result and were included in the regression analysis. IBM SPSS version 28 was used to conduct regression analysis. Multiple regressions were run using the OCG scale score, with the subscale scores (PAD, RG, PSD, and CGP) as dependent variables with the country of origin, mentorship, educational qualifications, social support, age in years, and emotional support.

Table 22 shows that, among the CENs, the multiple regression model of the OCG score with all predictors produced $R^2 = .38$, $F = 3.074$, $p < .05$. In addition, the predictors significantly impacted the PAD and CGP subscales.

Table 22

Summary of the Regression Models and the ANOVA Results for CENs

Dependent variable	R	R Square	Adjusted R Square	Std. Error of the Estimate	*F*	Sig.
OCG Total Score	.617	0.381	0.257	8.142	3.074	.012
CGP	.626	0.392	0.271	2.634	3.229	.010
PAD	.574	0.330	0.196	3.282	2.463	.036
PSD	.488	0.238	0.086	2.775	1.562	.179
RG	.505	0.255	0.106	1.886	1.711	.138

Among the IENs (as indicated in Table 23), the multiple regression model of the OCG total score with all predictors produced $R^2 = .32$, $F = 4.309$, $p < .001$. In addition, the predictors significantly impacted the PAD, PSD, and RG subscales. The R^2 indicates that these predictors accounted for 32% of the variance on the dependent variable.

Table 23

Summary of the Regression Models and the ANOVA results for IENs

Dependent variable	R	R Square	Adjusted R Square	Std. Error of the Estimate	*F*	Sig.
OCG Total Score	.566	0.320	0.246	9.007	4.309	<.001
CGP	.427	0.183	0.093	3.665	2.041	.063
PAD	.469	0.220	0.135	3.285	2.584	.021
PSD	.506	0.256	0.175	2.858	3.151	.006
RG	.486	0.236	0.152	2.676	2.821	.013

The regression analysis also revealed that, among the CENs, social support and emotional support had a statistically significant impact on OCG (Table 24).

Table 24

Regression Coefficients for the OCG Total Score Model for CENs

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	12.612	11.360		1.110	0.274	-10.45	35.674
Country of Origin	-1.220	3.869	-0.045	-0.31	0.754	-9.075	6.635
Mentorship	4.745	2.805	0.233	1.691	0.100	-0.950	10.440
HIGH_ED_BSN	0.767	4.266	0.038	0.18	0.858	-7.894	9.428
HIGH_ED_MSN	-0.186	5.280	-0.007	-0.04	0.972	-10.90	10.533
Social Support	17.089	4.930	0.532	3.467	0.001	7.081	27.097
Age in Years	-0.012	0.116	-0.017	-0.10	0.918	-0.248	0.224
Emotional Support	17.832	6.888	0.402	2.589	0.014	3.848	31.816

The regression analysis also revealed that, among the IENs, mentorship and social support had a statistically significant positive impact on OCG, and age and level of education had a statistically significant negative impact on OCG (Table 25).

Table 25

Regression Coefficients for OCG Total Score Model for IENs

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	46.370	13.427		3.454	0.001	19.55	73.19
Country of Origin	4.160	4.003	0.127	1.039	0.303	-3.84	12.15
Mentorship	5.034	2.525	0.219	1.994	0.050	-0.009	10.07
HIGH_ED_BSN	-7.901	3.274	-0.344	-2.413	0.019	-14.44	-1.36
HIGH_ED_MSN	-9.678	4.351	-0.311	-2.224	0.030	-18.37	-0.98
Social Support	12.768	3.611	0.390	3.536	0.001	5.55	19.98
Age in Years	-0.259	0.109	-0.277	-2.374	0.021	-0.476	-0.04
Emotional Support	-0.277	4.193	-0.007	-0.066	0.948	-8.653	8.09

Multiple Regression

Multiple regressions were run using the OCG scale total score, with the subscale scores (PAD, RG, PSD, and CGP) as dependent variables, including country of origin, mentorship, educational qualifications, social support, age in years, and emotional support. The variables that produced the most significant association with the dependent variable were chosen. Power analysis using G The power analysis was done using the G* power analysis tool (Faul et al., 2009) and yielded a power of 0.80.

Among the CENs, the multiple regression model for the OCG total score with all predictors produced $R^2 = .381$, adjusted $R^2 = 0.257$, $F = 3.074$, $p < .05$. In addition, the predictors significantly impacted the PAD and CGP subscales.

Among the IENs, the multiple regression model for the OCG total score with all predictors produced $R^2 = .320$, adjusted $R^2 = 0.246$. $F = 4.309$, $p < .001$. In addition, the predictors significantly impacted the PAD, PSD, and RG subscales.

Generally, R^2 values between 0.20 to 0.50 are considered to have moderate strength in explaining the dependent variable's variance (Plonsky & Ghanbar, 2018). The R^2 values in the present study indicate that the predictors for the independent variable caused 32–38% of the variance in the dependent variable. Thus, other factors that may impact the dependent variable must be explored.

A review of the regression analysis of the IENs revealed that mentorship (with a beta value of 0.219) and social support (with a beta value of 0.390) were positively correlated with OCG. The correlation was statistically significant.

The result of multiple regression revealed that several factors impact career growth among nurses but that social support is an essential facilitator of career growth, evident among both IENs and CENs.

Appendix D depicts the normal P-P plot of the regression standardized residual of the dependent variable, total OCG score.

Chapter 5

Discussion

The current study aimed to identify the perceived impact of social support and mentorship on the career advancement of IENs compared to CENs in Canada. For nurses to thrive in the profession, there needs to be a concerted effort to provide opportunities for professional growth. Nurses must continuously upgrade their professional skills and competencies, as this is a professional licensing body requirement. The healthcare organization's responsibility is to provide opportunities for career advancement through professional development sessions, promotional avenues, skill-building workshops, and other opportunities (Sheikhi et al., 2016b). With career advancement, nurses often feel motivated and loyal to the organization (Sheikhi et al., 2016a).

The struggles of IENs in obtaining licenses to practice in Canada have been well-documented. If this is the case, career advancement and professional retention may also be jeopardized. However, the challenges experienced by IENs in the workplace and whether they have equal opportunities to thrive in the profession have yet to be studied in detail (Covell et al., 2014).

The fundamental question is whether all nurses have equal opportunities to advance their careers in healthcare organizations. The sheer lack of opportunities, in general, affects all nurses, and the lack of opportunities due to racism/discrimination is an added layer of difficulty for IENs. The current study aimed to identify whether all nurses have opportunities for career advancement and to identify the role of social support and mentorship in career advancement and determine whether these supports are equally available to CENs and IENs. To do so, comparisons of perceived CA were studied. The comparison will help identify ways of

promoting career advancement among nurses. With this aim, the current study has shed light on several key findings.

There are several similarities and critical differences between IENs and CENs. Both IENs and CENs have a moderate level of perceived career advancement. At a time when Canada is facing an acute shortage of nurses compounded by the demands of the COVID-19 pandemic, this is an important finding. A moderate level of perceived career advancement existed even before the pandemic, and the pandemic has only worsened this (Hussain et al., 2019). However, IENs scored higher than CENs on career advancement. This is surprising, because IENs and CENs perceive and interpret career advancement differently. For both groups, mentorship and social support positively affected their career advancement. Those with higher levels of perceived social support from friends, family, significant others, and mentors had a higher level of perceived career advancement, suggesting that social support and mentoring are critical to CA, and this finding is supported by the literature (Wang et al., 2018).

There are several key differences between the groups as well. Social support and mentorship are not available to both groups equally. CENs have more social support from their friends and significant others. In terms of mentorship, CENs scored higher than IENs. Although there is a difference in the scores between IENs and CENs in terms of social support and mentorship, the impact of these supports is different for both groups. There is a strong positive correlation between social support and career advancement among IENs, suggesting that, even with a moderate level of support, IENs perceive an increase in their career advancement opportunities. This finding indicates that several factors influence the career advancement of IENs, including social support and mentorship. If adequate supports are available to IENs, they will have better opportunities for career advancement; if these supports are not available, nurses

will not grow in their profession and may not continue to stay in the profession, as CA is a motivating factor in retention.

These findings are similar to what is published in the literature. Career advancement in nursing has always been an important issue that gets little attention. The few available studies demonstrate an extreme shortage of nursing personnel across the world, and one of the main reasons nurses leave the profession is the lack of career advancement opportunities (Marć et al., 2019). A cross-sectional survey of 526 Chinese nurses reported a similar result. The nurses had low scores on the OCG scale (48%). However, the subscales' lowest score was in remuneration growth (Yang et al., 2015). Researchers who studied the oncology nursing workforce shortage highlighted that workforce recruitment and retention are hampered by low wages, resource-constrained work environments, limited career advancement opportunities, and a lack of community respect (Challinor et al., 2020).

The current study's finding that IENs have higher scores than CENs in CA is consistent with the literature. However, in reality the career growth of IENs is much slower than that of CENs. Although there were differences in the scores between IENs and CENs, there was a significant difference with the remuneration growth subscale; IENs felt that they had a better remuneration growth than CENs. Owing to the initial struggles with registration, simply becoming an RN is a goal for most IENs.

When IENs migrate to Canada, they typically go through three phases. The hope of starting to practice as an RN is the first one. Soon, they realize that it is a difficult task and feel a sense of disillusionment, after which they try to navigate through the disillusionment to become an RN and be able to practice in Canada (Singh & Sochan, 2010). On average, it takes around three years for an IEN to become an RN. Just becoming an RN is perceived as career growth by

many IENs. In a study to assess the career advancement and educational opportunities of IENs in Alberta, it was reported that the IENs are interested in participating in career advancement opportunities. However, IENs prioritize re-establishing family's financial security over their personal and occupational growth (Salma et al., 2012).

This is an important finding at all levels. Nurses in general were not motivated to pursue nursing only for financial reasons. However, nurses across the globe have realized that their work needs to be compensated adequately. Nurses getting involved in job actions for better pay worldwide is evidence of this. Employers and policy makers must take note of this and adequately compensate nurses for their work.

Becoming an RN in Canada means that individuals with a high level of education from developing nations are reaching Canada, increasing their income and lowering their social status (Salami & Nelson, 2014). The majority of IENs in the current study were from India, the Philippines, and Africa. Nurses who migrate from these countries have reported that economic gain is one of the motivators of immigration. Several factors such as delays in credentialing and differences in salaries between home and host countries may explain IENs higher scores on remuneration growth and career advancement. The differences in pay between the current RN role in Canada and RNs in their home country are significant, and IENs may perceive this as remuneration growth. The economic compensation they receive in Canada is significantly higher than what they received in their home countries (Salami et al., 2014). IENs often struggle to become valued professionals in the countries they migrate to. Although finding a job after going through a long credentialing and registration process appears to be a career growth, IENs often feel that they are stuck in their positions and lack further career growth due to various reasons (Walton-Roberts, 2020). Most IENs migrate to other countries in pursuit of obtaining jobs that

pay well. There is a gross difference in the wages of the IENs between their home country and their country of migration (Covell et al., 2017).

Roth et al. (2021) noted that there are differences in the perception of burnout and work-life balance between internationally trained and locally trained nurses in Germany. Roth et al. (2021) identified that the internationally trained nurses had lower levels of burnout than the locally trained nurses. The authors also indicated that IENs have generally evaluated their growth opportunities better than locally educated nurses (Roth et al., 2021). This is similar to the current study's findings, in which IENs had a higher level of CA than CENs. IENs considered remuneration growth as a significant career advancement whereas CENs considered career goal progress, or the degree to which there are opportunities to achieve their career goals, as a significant career advancement.

Questions continue to emerge, such as whether IENs are satisfied with remuneration growth alone. Why can IENs not grow in their careers to occupy leadership positions? Are there other factors beyond their control that hinder their progress? Adeniran et al. (2013) reported mixed results in a study assessing the differences between United States–educated nurses (UENs) and IENs. UENs reported receiving promotions significantly more frequently than IENs. They were significantly different from IENs in their practice role (p =.03). Around a third of participants had never received a promotion. Two UENs out of every five had been promoted at least once in the previous three years.

In contrast, only two of eight IENs in that study had received a promotion in the prior three years. Being marginalized, facing racism, feeling undervalued, a shortage of leaders who look like them, and stigmatization and exclusion are reasons for this difference. It takes around three years for nurses to move up in their careers, and there are few opportunities in general for

nurses. Despite the reported similarity of practice areas, practice roles varied between groups. IENs in that study worked primarily as staff nurses. In contrast, the UEN practice roles were more varied. Over one fifth of UENs worked as executives, nurse managers, clinical nurse specialists, or nurse practitioners (Adeniran et al., 2013), and a similar trend may also be occurring in Canada.

The differences in scores for the other subscales of CA in this study—mainly the career goal progress subscale, which measures the perceived level of progress toward a career goal—are also noteworthy. In this subscale, the CENs had higher scores than the IENs. The CENs felt that there were opportunities to realize their career goals. This is similar to the findings of a study by Adeniran et al. (2013), who reported that UENs felt that their organization provided opportunities to realize their career goals. The critical difference between these two groups is that IENs are often satisfied with just becoming registered professionals, after a long and frustrating journey and the current burnout and retention issues will likely change this.

In contrast, CENs have career aspirations and may be optimistic of career growth. In addition to financial opportunities, CENs feel entitled to leadership opportunities, such as becoming managers, senior clinicians, and educators within an organization. Similar findings were also observed in other literature. In a study of Chinese and Korean employees, the authors reported that Korean employees scored higher than Chinese employees in career goal progress (Kim et al., 2016), demonstrating that host country employees often feel entitled to career growth.

There was a difference in the perceived career advancement scores between men and women; men had a higher perceived CA score. However, this was not statistically significant. This may indicate that the glass ceiling concept still exists in the nursing profession (although the

scores were not statistically different). In other words, men can use glass escalators (Punshon et al., 2019). Though there is a gender imbalance in the profession, with most nurses being women, men have better career advancement opportunities than women (Punshon et al., 2019). It is not unique to nursing but common to many healthcare occupations, including physicians (Jorge et al., 2021).

Developing social support networks is also a challenge for many IENs. The present study measured the social support provided by family, friends, and significant others. Both groups scored low in perceived social support. CENs had significantly higher levels of perceived social support from friends than did IENs. Despite the low scores, there was a statistically significant positive correlation between social support and career advancement among IENs. Among CENs, although there was a positive correlation, the correlation was not strong or significant. In the current study, social support was limited to the perceived emotional and informational support received from friends, families, and significant others. However, friends included peers and colleagues at work. Further research is needed to identify what type of support are currently provided by the organization.

The importance of social support is reported in a study identifying the moderating role of social support on anxiety and psychological distress among nurses in Israel. The authors collected data from 795 nurses using the MPSS tool. The findings suggested that the perceived social support score was high, 5.69 out of 7 (SD 1.28), which is 81.29% (Kagan, 2020). However, in the current study, the participants scored low in social support. CENs scored higher than IENs in all the social-support subscales except for family. IENs scored lower than CENs in social support received from friends and significant others. The low scores for IENs could be attributed to the challenges of IENs in establishing social networks in a new country. As new

immigrants, IENs are similar to skilled immigrants who face challenges in establishing social networks that facilitate social integration and promote economic independence (Kaushik & Drolet, 2018).

In a study among Syrian refugees new to Canada (similar to IENs migrating to a new country, particularly with their age), Hanley et al. (2022) reported that less than one-fourth (24%) had people they could rely on and trust when they had problems or felt they needed support. Only 27% of participants indicated that they had four or more emotionally close friends. Younger Syrians, particularly those between ages 18 and 30, reported having few emotionally close friends, with 26 % of those ages 18–25 and 38% of those ages 26–30 reporting no close friends. In contrast, those 51 years and older had more close friends than younger ones (Hanley et al., 2022). IENs being immigrants and nurses at a younger age are faced with a similar situation. This could be attributed to the biological and social differences that exist among different age groups and lacking knowledge of local culture and practices.

The present study's findings that IENs and CENs had a low level of perceived social support are similar to the other published literature. In a large-scale correlational study to assess the factors affecting frontline workers, the authors recruited 2,014 nurses from two hospitals in China during the COVID-19 outbreak. The perceived social support of the respondents was measured using the MPSS tool. The findings showed that the mean score of perceived social support was 5.57 out of 7 (79.57%) from family members and 5.38 out of 7 (76.86%) from friends and significant others (Hu et al., 2020).

Similar findings were highlighted in a study that aimed to assess the resilience of nurses and the factors that contributed to resilience. In a descriptive study, the authors recruited 242 nurses from three public hospitals in Turkey. Data on social support was collected using the

MPSS tool, which revealed that the Turkish nurses also had a moderate level of perceived social support (Öksüz et al., 2019).

There were also gender differences in the perceived level of social support. Although the sample size was small, males scored higher on perceived social support than females in the current study. However, in a study conducted among university students that included international students, the authors identified that social support is an important predictor of depressive symptoms. They also reported that female students had higher social support than males, which was attributed to the help-seeking behavior of females. The authors added that females are more likely to face stressors that necessitate help-seeking behavior (Alsubaie et al., 2019). This is relevant to nurses, as most nurses are females. The present study yielded mixed results in this regard. Most participants were females, and help-seeking behavior was higher among the CENs. This may have been due to the challenges in communication faced by IENs.

The low levels of social support that nurses experience may be attributed to several factors. The current study was conducted during the COVID-19 pandemic and accessing social support may have been challenging due to lockdowns and social distancing. These challenges would have been greater for IENs. Second, nurses work a lot and may not spend sufficient time with their social support networks and immigrants often face the challenge of losing social support networks. Immigrants must leave their extended families in their home countries, which increases their fear of separation from their loved ones. In a phenomenological study of 12 mental healthcare providers with experience providing mental health services to immigrants, the authors concluded that immigrants often face losing social support networks due to immigration (Pallaveshi et al., 2017).

The present study has identified a strong relationship between social support and CA for CENs and IENs, and the relationship is stronger for IENs. This suggests the importance of IENs accessing key social support through personal and professional networks to support CA. This is an essential finding in developing policies and including social support as a significant factor that will help IENs thrive. Strengthening social support networks is beneficial to both CENs and IENs. Adequate work-life balance and opportunities to network with others are some of the possibilities of strengthening social support.

Healthcare organizations have the responsibility to raise awareness of the importance of social support and its impact on CA. Although the current study measured only the perceived social support from family, friends, and significant others and not supervisors or work colleagues, IENs may often lack social support from colleagues and supervisors in Canada. Babenko-Mould and Elliott (2015) reported that some colleagues were unwilling to work with IENs, were not aware of the needs of IENs (owing to cultural differences) and were not willing to pay attention to the practices of IENs, assuming that the host country nurses' practices were the best (Babenko-Mould & Elliott, 2015). Professional support may come in different forms, such as formal and informal mentorships or social support (Lee & Wojtiuk, 2021).

IENs are often considered new graduates in healthcare environments, and their experience is often not given due consideration (Lee & Wojtiuk, 2021). Resilience among professionals is often linked to retention and optimism in the profession. Hence, social support can play an important role in increasing resilience among IENs, which can help them thrive in the profession (Wang et al., 2018).

The healthy immigrant effect (HIE) is a well-documented phenomenon that shows that immigrants arrive in Canada healthier than the native population. However, over time, this health

advantage declines, possibly as a result of difficulties adjusting to a new environment, stress, and the adoption of risky health behaviours (Lu & Ng, 2019). HIE applies to IENs, as IENs also face the stressors of adjusting to a new environment. Social support has also been studied extensively among various professionals. One of the critical effects of social support is promoting employee health and well-being (Broetje et al., 2020).

Further review of the regression analysis reveals that, among CENs, social support (with a beta value of 0.530) and emotional support (with a beta value of 0.402) significantly impacted OCG scores ($p < .05$), suggesting a positive correlation. This finding is similar to the findings in the literature. In a study to explore the differential effects of social support on the job performance of nurses, the authors gathered data from 639 nurses in Malaysia and reported that social support positively affects work engagement (Nasurdin et al., 2018). Emotional support has also been positively associated with employee flourishing. In a series of qualitative and quantitative studies, the authors proposed that emotional support enhances job satisfaction and helps employees thrive. Emotional support is an essential function of relationships (Colbert et al., 2016).

Because social support positively impacts career advancement for IENs, it is vital to ensure its availability. In a cross-sectional study among male nurses, authors reported that social support significantly influenced career development (Chen et al., 2020). Support from family members may help IENs continue their professional development activities (Hadziabdic et al., 2021.

The effect of mentorship was also found to be essential for CA. In the present study, CENs scored higher than IENs in mentorship in all the subscales, and the differences were statistically significant. There was low score particularly in role-modeling, and in the

psychological support subscale. The explanation for this may be that the participants were not receiving adequate psychological support from their mentors, or that the relationships remained formal. There are few opportunities to share their psychological problems with mentors. This area requires further exploration.

The findings of this study are similar in terms of the scores—a higher score in role-modeling, and a lower score in psychological support—to a study conducted in Taiwan. In a study conducted among 306 new nurses from three regional hospitals in Taiwan, the authors used MFQ 9 and collected data to examine the effects of mentoring. The results revealed that the scores on the role modeling sub-scale were 3.90 out of 5 (78%), and the mean scores for career support and psychological support subscales were 3.49 out of 5 (69.8%; Weng et al., 2010). In another study using the MFQ 9 tool, the researchers collected data from college students, intending to assess the impact of mentorship on future work selves and job-search behaviors. The students were provided with a mentor who was a professor at the college. The professors met with their mentees three times a week for 50 min per session to provide mentorship. After six weeks, data were collected from the mentees. The researchers measured the mentorship function in only two domains, career support and psychological support. The mean score in the career function was 3.33 (66.6%) and 3.20 (64%) in the psychological function. Although the scores were low, there was a positive correlation between future work and job-search behaviors (Kao et al., 2022).

Published literature suggests that mentorship buffers the stressors faced by nurses in general and IENs in particular. Mentoring influences career advancement, professional development, constructing and maintaining a professional network, and boosting competence

and self-esteem (Hafsteinsdóttir et al., 2017). The current study's findings reveal a significant difference in the amount of mentorship available to IENs compared to CENs.

The differences in the level of mentorship available to IENs may be attributed to the challenges faced by IENs in establishing meaningful networks and a lack of formal mentorship programs in the workplace. This finding is similar to that of a study conducted in the USA among Black nurse leaders. The authors reported that Black nurses faced several challenges in obtaining leadership or faculty positions and did not have mentorship access (Iheduru-Anderson, 2020).

Mentoring is an essential factor in facilitating CA. However, the quality of mentorship that is available to individuals differ significantly based on ethnicity and gender. People of color who are already marginalized based on ethnicity have additional barriers based on gender and social class. In a study conducted among the teaching faculty, Davis et al. (2022) reported that the faculty of color experienced more challenges in receiving quality mentorship compared to their White counterparts. They also noted that mentees often felt unsupported due to their mentors' paternalistic attitudes, who did not value the mentees. This is an important finding, as it relates well with the IENs, as IENs are often marginalized based on their immigration status, ethnicity, and gender (majority are being females).

The current study also sheds light on select mentor characteristics. Most mentors were female (92.22%) and Caucasian (45%). The finding that mentors with the job title of managers/educators are perceived as providing better mentorship than those with RN titles and that working longer with a mentor increases the mentor's positive impact is similar to the findings in the literature. Mentees expect mentors to be active in helping them achieve their goals. In addition, mentees prefer mentors to be role models and spend time with their mentees

(Hale, 2018). Many published articles on mentorship do not specify the number of mentees per mentor, the duration of contact, or the frequency of their meetings (Hoover et al., 2020). However, the articles establish that mentorship has a positive influence on career advancement in nursing. In another longitudinal study to assess the career mobility of healthcare professionals in entry-level positions in the US, the authors reported limited evidence of career progression in healthcare over a ten-year period (2003–2013). The authors also recommended that employers and educators plan employee career growth opportunities and suggested incorporating mentorship programs (Snyder et al., 2018).

Mentorship has also been identified as an act of caring. Like caring moments, there exist mentoring moments as well. Mentoring relationships are like caring relationships (Wagner & Seymour, 2007). Based on the current study, IENs would benefit from such caring relationships. The benefits include thriving in the profession, career advancement, and reduced turnover. Mentorship and coaching effectively enable nurse leaders to acquire foundational leadership skills (Goodyear & Goodyear, 2018). Mentorship is beneficial for employees and employers. A successful mentorship may help find the next set of leaders (Gruber-Page, 2016). Although the values of mentorship programs are well-established in the literature, many employees often do not have the advantage of mentorship support. In a study among Ugandan nurses, the authors reported that the respondents reported a lack of mentoring opportunities (Zuyderduin et al., 2010).

IENs are often considered new graduates, so extended orientation and mentorship help are needed to transition successfully into a professional role. In a cross-sectional study of 2,369 nurses, the authors established statistically significant differences between the groups of nurses who participated in the transition program with nurses who did not. Critical components of care

delivery, such as decision-making, communication, care management, system integration, and dedication, received higher ratings from participating nurses (Baumann et al., 2018). Although the benefits of a mentorship program are well-established in the literature, IENs often do not have access to such mentorship programs in Canada.

Career advancement was also found to be related to educational status and age. Education status (BSN, MSN) and age in years had a significant impact. However, the correlation was negative. The negative correlation revealed that IENs with a diploma in nursing qualification score higher in OCG than others with a BSN or MSN. This may be because IENs feel there are not enough career advancement opportunities for those with a graduate degree in nursing. The present study also revealed that younger nurses score higher in OCG. Again, this may be because younger IENs are optimistic about their career advancements.

Several other factors may help or hinder career advancement opportunities for IENs. Interprofessional communication that differs from the nature of communication in their home country, the scope of practice, and the independence given to Canadian nurses in their practice may be perceived as barriers to career advancement (Covell & Sands, 2021). IENs face challenges in both oral and written communication. Oral communication challenges involve overcoming cultural shock and understanding the nuances of communicating with patients and their families. The challenges in written communication include gaining academic literacy skills (Lum et al., 2016). Personal and family commitments are other factors that hinder career growth among IENs. Many IENs spend 3–4 years waiting for their registration, and once completed, they face the challenges of workplace integration. In a study that assessed the facilitators and barriers faced by IENs in completing competency assessments, 34.6% listed personal and family commitments as barriers (Stanhope-Goodman et al., 2014).

Gender differences observed in this study could be because of the fact that the nurses are still experiencing gender discrimination at workplace in spite of them having a higher score in social support. This trend is similar to the published literature where women score less than their male counterparts (Spagnoli et al., 2020). Establishing gender equity is also important when placing support that will promote the CA of nurses.

In addition to these individual factors, there are systemic challenges that IENs must overcome to progress in their profession. The perceived racism and discrimination are so subtle that they often go unnoticed. Limited opportunities to participate in career advancement activities due to discriminatory practices make it almost impossible to secure leadership positions (Ramji & Etowa, 2018). IENs are also faced with prejudicial treatment and comments from patients and their families that affect their motivation (Baptiste, 2015).

Integrating IENs into the workforce and enabling them to thrive in the profession is a two-way process between IENs and organizations. The initiative requires a commitment to equity and diversity from management. Ensuring that supports are in place and providing growth opportunities may enhance the leadership journey of IENs (Ramji & Etowa, 2018). The leadership style adopted by nurse managers goes a long way in positively influencing career growth among nurses. In a cross-sectional study of 131 nurses from 11 health centers, the authors reported that the transformational leadership style of managers enhances structural empowerment and positively impacts engagement in the workplace (García-Sierra & Fernández-Castro, 2018). Several intersectoral factors affect the career advancement opportunities of IENs, including lack of social support and mentorship, being female and an immigrant in a new country, and facing racism and discrimination.

The current study was guided by Kanter's theory of empowerment, and the findings suggest that organizational and power structures are critical in enabling career advancements. The moderate level of perceived OCG is an indicator of low support from organizational structures, and a lack of proactive growth in the profession indicates the influence of power structures. Structural empowerment measures—such as equitable access to resources, delegation of power, informational support, and other supports required for growth—would facilitate positive career growth that would result in empowered nurses. The power structures related to the psychological empowerment of nurses is based on how an individual feels about their work environment. The employee's ability to overcome challenges and find meaning and purpose in the workplace are essential factors in promoting psychological empowerment (Jafari et al., 2021). Social support and mentorship positively impact organizational and power structures.

Limitations

Although this was one of the first studies to assess the impact of social support and mentorship on career advancement among IENs and CENs, there were many limitations. Recruiting participants was difficult due to the COVID-19 pandemic, which resulted in a smaller sample than expected. Using a cross-sectional design, the data was collected via an online platform. Due to the pandemic, the response rate was low, which was another limitation. Data was collected from 127 participants, and the groups were not represented equally.

Further, the data were collected from participants from mainly Ontario and Manitoba, and only five participants from British Columbia. Another limitation was that the study yielded only quantitative data, and supplementing this with a qualitative component would have strengthened the study's findings. In addition, mentorship can be seen as a form of social support and therefore the measurement could be confounding the results of social support.

Chapter 6

Conclusion and Recommendations

This study is the first attempt to determine the impact of social support and mentorship on career growth among CENs and IENs. Using well-established measurement scales to collect data from participants in three Canadian provinces, this quantitative study identified the unique challenges faced by IENs and CENs. Key findings indicate that CENs and IENs have a moderate level perceived OCG, and both CENs and IENs differ in their career aspirations. IENs often are satisfied with becoming registered professionals, and CENs are optimistic about their career progression. Regarding remuneration growth, IENs scored higher than CENs, and it was statistically significant. Only in one subscale, CGP, did the CENs score higher than IENs, which was not statistically significant.

Social support and mentorship have been found to correlate positively with organizational career growth for both CENs and IENs. However, the impact was statistically significant for IENs. Both CENs and IENs have had challenges that hinder their career growth. These challenges were different for CENs and IENs. Significant differences existed in the level of these perceived supports available to both IENs and CENs. The perceived level of mentorship and social support available to CENs was higher than IENs.

Migrating to a new country is often stressful. In addition to the stressors common among immigrants, IENs face additional stressors in getting their credentials validated. The wait time for credential assessments and the complex process associated with the process of becoming a registered professional drain energy. The delay in becoming a registered professional and continuing professional practice adds stress and anxiety. Once IENs become registered professionals, they face challenges that hinder their ability to thrive and advance their careers.

It is well established that IENs are faced with racism, discrimination, and workplace incivility much more than their counterparts. Establishing mentoring or supportive relationships at work is challenging. This important finding can help facilitate workplace policies that will promote a positive career growth and thriving. In a system in which individual professionals are supposed to be considered equal, IENs often feel less valued and experience a lack of organizational support. The differences in the mentorship and social support levels available to both groups shed light on the inequity faced by IENs.

This study also yielded important information about available support, especially to IENs, and the need to establish supports that facilitate CA. Empowering nurses, particularly IENs, through appropriate mentorship programs and organizational support will help IENs overcome some structural challenges and thrive in the profession. IENs often stay longer in an institution and a province and investing in their welfare would enhance the accessibility of quality patient care to all Canadians. This requires a fundamental change in existing practices wherein IENs are offered only regular onboarding and orientation sessions. There are no mentorship programs, and IENs struggle to establish social networks. Thus, employers, policy makers and the government must invest in establishing programs that facilitate CA. Establishing mentorship programs for all nurses will facilitate career growth among nurses, and nurses who have positive CA will provide quality patient care.

Addressing the real challenges faced by IENs will help improve their potential and their CA, which will benefit the organization and the host country's people. Organizations must be aware that there are intersectional factors—such as inequitable access to information, lack of inclusiveness, discrimination, racism, and workplace incivility—that require a paradigm shift in designing policies that will facilitate a positive integration and growth among IENs. In addition,

organizations must improve the formal support available to nurses, particularly IENs. This can be done by establishing formal mentorship programs. There should be a coordinated effort between all the agencies that help with immigration, recruitment, and training of IENs.

Policy and Practice Implications

Information gathered from the participants in this study revealed that nurses have a moderate level of perceived career growth. At a time when healthcare institutions are facing an acute shortage of nurses, this is a significant finding that can help facilitate employee retention. Providing opportunities for career advancement will help in improving the perceived level of career growth. Career growth opportunities must be structured, planned, and accessible to all staff. Structural barriers, racism, and discrimination negatively impact career advancements; hence, employers should implement inclusive policies that consciously facilitate career growth. Interventions may include periodically assessing the career growth needs of nurses, facilitating participation in professional development activities through dedicated time allowances, delegating managerial and leadership functions to potential nurses, providing mentoring supports (formal and informal) and opportunities for promotion, and moving up in the career ladder. In addition, employers and policy makers must revaluate the impact of pay and other benefits provided to nurses. Historically, nurses have not been motivated by pay to either enter an organization or stay in an organization. However, the landscape is changing, and nurses everywhere are recognizing the need for appropriate monetary compensation in addition to opportunities for professional growth.

Social support and mentorship are important factors that positively influence career advancement. Investing in establishing support systems, including mentorship programs, will help IENs and CENs stay in the profession and thrive. These programs will also help in

identifying future leaders in the nursing profession. This study also identified certain demographic variables and mentor characteristics that facilitate career advancements. Managers and administrators of healthcare organizations must ensure structured mentorship programs for nursing staff. When choosing mentors, paying attention to the demographic similarities with the mentees is essential. Making mentorship available to IENs is important and ensuring the quality of such mentorship is also crucial. In addition, the employers have to be cognizant of the fact that sometimes reverse mentorship is also possible. Reverse mentorship denotes that IENs will be able to orient the mentors to the needs of the IENs taking the cultural, social, and environmental aspects into consideration (Madhavanprabhakaran et al., 2022).

The first initiative would be to recognize that there is a perceived need for support to overcome the challenges in advancing careers. The second initiative would be establishing a formal mentorship program within all the organizations where nurses are employed. Healthcare organizations could adopt any model of mentorship depending on their institutional requirements. Establishing a one-on-one mentorship, appropriately choosing a mentor, facilitating, and providing opportunities for mentors and mentees to meet regularly, and periodically soliciting feedback from nurses will help in facilitating CA among nurses. The finding that those who had informal mentorship had a higher score in OCG is also supported by other literature (Wang et al., 2010).

Employers must be aware of the perceived need for support. Establishing formal mentorship programs, supportive leadership, and ensuring equitable pay are some of the essential takeaways from this study. There are also variations in the subscale scores of OCG. The variations in the subscale scores demonstrate differences in the needs of IENs and CENs. In particular IENs score high in remuneration growth, whereas CENs scored high in career goal

progress. While planning for supportive services to facilitate CA, employers must be mindful of these differences. The study findings also reveal that IENs are often not optimistic about career growth. This is an opportunity for employers to orient, educate and support nurses in general and IENs in particular towards achieving their goals in CA.

Establishing social networks and accessing social support may be different for each nurse. Social support is primarily received from family, friends, and significant others. Policymakers should therefore focus on establishing policies and strengthening social support through appropriate newcomer services, such as providing childcare, job searching, and preparing IENs for the job market. In addition, employers can establish appropriate professional social support that peers, supervisors, and mentors could provide. Healthcare organizations and employers must understand that this is not available automatically; often, peers, supervisors, and mentors do not know the nuances of communication, especially with IENs, and may not appreciate the differences in practice. Social support provided by supervisors and coworkers is fundamental to preventing burnout among nurses (Velando-Soriano et al., 2020). Peers, supervisors, and mentors also need training in understanding the support needs or requirements of IENs which can be achieved through reverse mentorship as well. Helping coworkers, peers, supervisors, mentors, and other healthcare professionals who understand the valuable contributions and skills brought forward by IENs is critical to establishing satisfying, long-lasting relationships at the workplace.

Implications for Future Research

The COVID-19 pandemic has impacted the nursing profession in many ways. This study has yielded some information that could serve as a basis for future research. The attempt in this study was to collect data from respondents from Ontario, Manitoba, and British Columbia

through in-person interviews. However, the data had to be collected virtually due to the pandemic, and the response rate was low. At the time of data collection, frontline workers—especially nurses—were short-staffed and experiencing emotional exhaustion. A future study could be planned to include participants from all Canadian provinces. Barriers and facilitators of career advancement require further exploration, and in-depth qualitative interviews may yield results to these questions. A study designed to explore the facilitators and barriers of career advancement among nurses at all levels and comparing their perception with actual career growth could also be planned. Exploring mentorship and the characteristics of ideal mentors will help managers identify mentors with such traits.

Further, perceived racism and discriminatory practices require attention. A study to understand the experiences of IENs in a culturally diverse healthcare environment, such as the experiences of IENs after obtaining licences and their ability to advance their careers despite discriminatory practices, would unearth structural challenges. The meaning of successful integration into workplace from the perspective of IENs could also be studied to identify the essentials that are either present or absent during the current work environment.

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Appendix A

Keywords of Literature Search

IENs, IEHPs	**Nurses, Healthcare professionals**	**Immigration**	**Professional advancement,**
MeSH	**MeSH**	**MeSH**	**MeSH**
Foreign Professional Personnel/ or Nurses, International/	Advanced Practice Nursing/ or Cardiovascular Nursing/ or Clinical Nursing Research/ or Community Health Nursing/ or Critical Care Nursing/ Nursing/ or Emergency Nursing/ or Evidence-Based Nursing/ or Faculty, Nursing/ or Family Nurse Practitioners/ or Family Nursing/ or Forensic Nursing/ or Geriatric Nursing/ or Holistic Nursing/ or "Hospice and Palliative Care Nursing"/ or Home Health Nursing/ or Licensed Practical Nurses/ or Maternal-Child Nursing Medical-Surgical Nursing/ or	Disaster Victims/ "Emigration and Immigration"/ Human Migration/ Undocumented Immigrants/ Refugees/ "Transients and Migrants"/ "ethnic and racial minorities"/ or minority groups/	Absenteeism/ or Career Mobility/ or Employment, Supported/ or Job Application/ or Job Description/ or Job Satisfaction/ or Organizational Culture/ or Organizational Policy/ or Personnel Downsizing/ or Personnel Management/ or Personnel Selection/ or Presenteeism/ or Return to Work/ or Unemployment/ or Workplace/ or Remuneration/ or "Salaries and Fringe Benefits"/ or Sick Leave/ or Staff Development/ or

	Midwifery/ or Military Nursing/ or Neonatal Nursing/ or Nephrology Nursing/ or Neuroscience Nursing/ or Nurses/ or Nurse Administrators/ or Nurse Practitioners/ or Nurse Specialists/ or Nurse Anesthetists/ or Nurse Clinicians/ or Nurse Midwives/ or Nurses, Pediatric/ or Nurses, Neonatal/ or Nurses, Community Health/ or Nurses, International/ or Nurses, Male/ or Nurses, Public Health/ or Nursing Assistants/ or Nursing, Practical/ or Nursing Staff/ or Nursing Staff, Hospital/ Obstetric Nursing/ or Occupational Health Nursing/ or Oncology Nursing/ or		Women, Working/ or Social Change/ or Social Mobility/ or Employment/ or Income/ or Industry/ or Occupations/ or Workplace/ or Work/ or Education, Special/ or Educational Status/ or Efficiency/ or Poverty/

	Operating Room Nursing/ or Orthopedic Nursing/ or Parish Nursing/ or Pediatric Nurse Practitioners/ or Pediatric Nursing/ or Perioperative Nursing/ or Postanesthesia Nursing/ or Psychiatric Nursing/ or Public Health Nursing/ or "Radiologic and Imaging Nursing"/ or Rehabilitation Nursing/ or Rural Nursing/ or School Nursing/ or Specialties, Nursing/ or Transcultural Nursing/		
KW	**KW**	**KW**	**KW**
(((international* or foreign* or migrant* or immigrant*) adj4			(((career* or job* or employ* or work*) adj4 (advanc* or thriv* or success* or succeed* or promot* or satisfaction)) or

nurs*) or IEN).mp.			salaries or salary or pay* or income* or remuneration* or benefit* or poverty or poor or absentee* or presentee*).mp.
MENTORSHIP	**CANADA**	**Social Support**	
MeSH	**MeSH**	MeSH	
Inservice Training/ Mentors/	canada/ or alberta/ or british columbia/ or manitoba/ or new brunswick/ or "newfoundland and labrador"/ or northwest territories/ or nova scotia/ or nunavut/ or ontario/ or prince edward island/ or quebec/ or saskatchewan/ or yukon territory/	social support/ or community support/ or psychosocial support systems/ or social isolation/ or loneliness/ or ostracism/ or social alienation/ or social deprivation/ or social marginalization/ or social vulnerability/ or socialization/	
KW		((social or communit* or psychosocial*) adj4 (support* or system* or	

		isolat* or alienat* or marginaliz* or vulnerab*)).mp.	
coach* in-service mentor* orientation			

Appendix B

Invitation to Participate in Research

Hello,

Thank you very much for indicating your willingness to participate in nursing research. I received your name and mailing address from the College of Nurses of Ontario (CNO).

My name is Ramesh Venkatesa Perumal, a Ph.D. student in nursing at York University, Toronto, Ontario. I am the principal investigator of the following research (approved by the Research and Ethics Board of York University):

Title: Impact of Social Support and Mentoring on Career Advancement of Nurses

Purpose: This research aims to assess the impact of social support and mentorship on career advancement among Internationally Educated Nurses (IEN) and Canadian Educated Nurses (CEN). The study results will help nurses, nurse educators, and nurse administrators put supports in place that will benefit both IENs and CENs in advancing their careers. Nurses moving up the career ladder will be active members of the profession, ensuring excellence in patient care, education, and leadership in nursing.

I am looking for: **Nurses (both Canadian Educated and Internationally Educated) to participate in this research.** Participation is **voluntary**.

Your Role: In this research, I am requesting you to complete a survey questionnaire that will take approximately 20 -25 minutes. Your contribution to this research is very much appreciated. Please use the following link to access the survey.

https://yorkufoh.ca1.qualtrics.com/jfe/form/SV_41OfhNbFucerJwa

Please find below a shortened version of the same link. You can use either one of them.

https://tinyurl.com/y6axyrjs

Or You can reach the website using the following QR code

If you would like this **link to be sent electronically**, please **send me an email,** and I will share the link via email. My email is vramesh@yorku.ca.

If you have any questions about the research in general or about your role in the study, please feel free to contact me at vramesh@yorku.ca**.** or my supervisor, **Dr. Mina Singh, at** minsingh@yorku.ca**.**

Thank you,

Ramesh Venkatesa Perumal, RN, MSc N, CCNE, CNCC(C)®

Ph.D. Student (Nursing)

*** vramesh@yorku.ca, (647-268-8804.**

Appendix C

Survey Questionnaire

Thank you very much for your consent to participate in this study. Before answering the actual study questions, I kindly request you to answer the following screening questions.

Screening Questions:

1. Are you a Registered Nurse? Yes/No
2. Do you have three years of experience working as an RN at the bedside? Yes/No
3. Are you currently employed as a Registered Nurse? Yes/No
4. Are you comfortable communicating in English? Yes/No
5. Do you consent to participate in this research?

If you have answered yes to all the above questions please proceed to the next part, if not, I am sorry you will not be eligible to participate in this study.

Thank you for your interest in this study.

This survey has four parts. Kindly answer all the parts of this survey.

Part 1- Career Advancement: Organizational Career Growth Scale

Please choose the most appropriate response to each of the items

Domains	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Career goal progress	My present job moves me closer to my career goals.					
	My present job is relevant to my career goals and vocational growth.					
	My present job sets the foundation for the realization of my career goals					
	My present job provides me with good opportunities to realize my career goals					
Professional ability development	My present job encourages me to continuously gain new and job-related skills					
	My present job encourages me to continuously gain new job-related knowledge					
	My present job encourages me to accumulate richer work experiences					

	My present job enables me to continuously improve my professional capabilities					
Promotion speed	My promotion speed in the present organization is fast					
	The probability of being promoted in my present organization is high.					
	Compared with previous organizations and attainable jobs, my position in the present one is ideal.					
	Compared with my colleagues, I am being promoted faster.					
Remuneration growth	My salary is growing quickly in my present organization.					
	In this organization, the possibility of my current salary being increased is very large					
	Compared with my colleagues, my salary has grown more quickly.					

Part 2 – Mentoring - Please choose the most appropriate response to each of the items

Do you have a mentor now/currently in your professional life? Yes/No

(Mentorship is a process through which an experienced individual helps the less experienced to achieve their goals)

If no, have you had a mentor in the past? Yes/No

If yes,

Characteristics of the mentor

Mentor characteristics	Mentor 1	Mentor 2	Mentor 3
Gender Male/Female/other			
Ethnicity			
Highest qualification			
Job Title			
Number of years known			
How often do you meet your mentor in a week?			
Is it formal (initiated by the organization) Yes/No			
When was the last time you contacted your mentor (face to face or online)			

Please read the following statements and choose the most appropriate response.

Domains	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Career Support	My mentor takes a personal interest in my career					
	My mentor helps me coordinate professional goals.					
	My mentor has devoted special time and consideration to my career.					
Psychosocial Support	I share personal problems with my mentor.					
	I exchange confidences with my mentor.					
	I consider my mentor to be a friend.					
Role Modeling	I try to model my behavior after my mentor.					

	I admire my mentor's ability to motivate others					
	I respect my mentor's ability to teach others.					

Part 3 – Social Support

This tool has seven responses. Please choose the most appropriate response to each of the items

Items	Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree
There is a special person who is around when I am in need.							
There is a special person with whom I can share my joys and sorrows.							
My family really tries to help me							
I get the emotional help and support I need from my family							
I have a special person who is a real source of comfort to me.							

My friends really try to help me							
I can count on my friends when things go wrong.							
I can talk about my problems with my family							
I have friends with whom I can share my joys and sorrows.							
There is a special person sin my life who cares about my feelings.							
My family is willing to help me make decisions							
I can talk about my problems with my friends.							

Part 4: Demographic Data

The information collected in this section will be confidential. They will only be used for statistical purposes and will help the researcher to describe in general terms without revealing any identity of the participants.

1. Gender Male Female Do not wish to disclose

2. Date of Birth: Month/ Year (optional)

3. Current Province of Residence: (please circle one of the following)
   Ontario

   British Columbia

   Manitoba

4. Country of birth:

5. Are you an Internationally Educated Nurse or Canadian Educated Nurse (this applies only to your first degree or diploma in Nursing)? Please circle one:

   Internationally Educated Canadian Educated

6. Educational Qualification (Include all degrees/diplomas- Postsecondary)

a. Nursing:

Year of completion	Country of education	Degree/Diploma

b. Non- Nursing:

Degree/Diploma	Country of education	Year of completion

7. Current citizenship/ Immigration Status (please circle one)
   Permanent Resident

Work Permit

Canadian Citizen

Not Applicable

If Canadian Citizen, skip 8 and 9 and move to Question 10.

8. Date of landing in Canada YYYY/MM/

9. Living in Canada since YYYY/MM

10. Did you ever live in any other province other than the current province: Yes/No

If Yes,

Where

How long Months/Years

11. Immigrated from City/Country

12. Have you ever worked as an RN in any country? Yes/No

13. If Yes, Years of Experience as an RN

Years of Experience	Title/Designation (Primary)	Second Title/Designation	Concurrent Yes/No
Less than 1 Year			
1-5 Years			
6-10 Years			
11-15 Years			
16-20 Years			
More than 20 Years			

14. Are you currently working? Yes/No

15. What is your title----------

16. What is your current family structure?

    a. Living alone
    b. Living with family
    c. Living with friends
    d. Living with relatives

17. Do you have someone to go for Emotional support?
    Yes

    No

    If Yes,

    Is that person:

    a. A family member

b. Teacher

c. Colleague

d. Friend

e. Any other category: ----------

18. Do you have someone to go for Informational support?
Yes

No

If Yes, Is that person:

a. A family member

b. Teacher

c. Colleague

d. Friend

e. Any other category: ----------

19. Do you have someone to go for Mentoring?

Yes

No

If Yes, Is that person:

a. A family member

b. Teacher

c. Colleague

d. Friend

e. Any other category: ----------

Appendix D

Additional Tables and Figures

Table 1

Mentor Characteristics

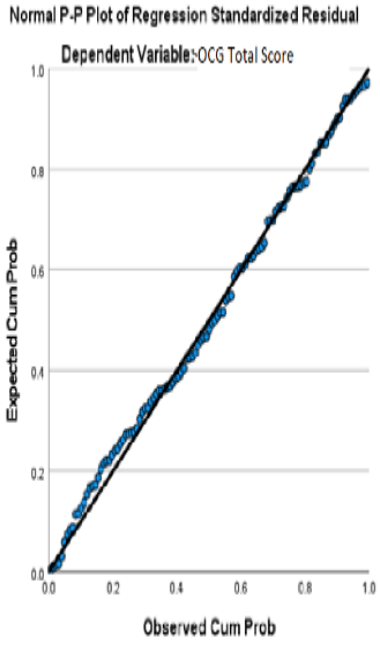
Mentor Characteristics		Mentor 1 (n-90)		Mentor 2 (n=25)	
		#	%	#	%
Gender	Female	83	92.22	22	88
	Male	6	6.67	2	8
	Missing	1	1.11	1	4
Ethnicity	African	7	7.78	3	12
	Asian	6	6.67	2	6
	Canadian	15	16.67	5	20
	Caucasian	36	40	10	40
	European	1	1.11		
	Indian	6	6.67	2	8
	Korean	1	1.11		
	Middle East	1	1.11		
	Oriental	1	1.11		
	Filipino	7	7.78		
	South Asian	1	1.11		
	Missing	7	7.78		
Highest Qualification	Diploma	22	24.44	4	16
	BSCN	40	44.44	13	52
	Master or above	25	27.78	6	24

	Missing	3	3.33	2	8
Job Title	BPSO lead	1	1.11		
	Clinical Resource Nurse	2	2.22		
	General Surgeon	1	1.11		
	Manager	11	12.22	6	24
	Nurse Educator	6		1	4
	Nurse Practitioner	1	1.11		
	PHN	3	3.33		
	Professor	5	5.55	4	16
	Registered Nurse	56	62.22	12	48
	Wound/geriatric nurse specialist	1	1.11		
	Missing/No info	3	3.33	1	4
Frequency of Meetings	Once a week	3	3.33	9	36
	Once a month	31	34.44	4	16
	As required	8	8.88	2	8
	Two times a week	2	2.22	4	16
	Three times a week	10	11.11	2	8
	Four times a week	10	11.11	1	4
	Five times a week	3	3.33		
	Missing	23	25.56	3	12
Latest Contact with Mentor	Less than a year	39	43.33	15	60
	More than a year	42	46.67	8	32
	Missing	9	10	2	8

Formal Mentorship (Initiated by the organization)	Yes	40	44.46	11	44
	No	47	52.21	13	52
	Missing/No Info	3	3.33	1	4

Note. The number of respondents varies (Some information is missing).

Figure 1


Normal P-P Plot of Regression Standardized Residual
Dependent Variable: OCG Total Score
Expected Cum Prob
Observed Cum Prob
0.0
0.2
0.4
0.6
0.8
1.0