Experiences and needs of certified nursing assistants regarding coaching by bachelor educated nurses in nursing homes: A qualitative study

Master Thesis

Name:	M. van Kuppenveld
Student number:	6228852
Status:	Final
Date:	19-06-2020
Lecturer:	Dr. A. Rieckert
Supervisor:	Dr. A. Persoon
Internship institution:	Universitair Kennisnetwerk Ouderenzorg Nijmegen
Journal for publication:	Journal of Advanced Nursing
Criteria used for reporting:	Consolidated Criteria for Reporting Qualitative Research
Number of words:	3.800
Number of words English abstract:	300
Number of words Dutch abstract:	269

Nursing Sciences, program in Clinical Health Sciences, University Medical Center Utrecht, Utrecht University

Author Information

Marieke van Kuppenveld RN; UKON junior nursing researcher, Department of Primary and Community Care, Radboud Institute for Health Sciences, Nijmegen, the Netherlands. Bachelor educated nurse employed in a nursing home, female.

Anke Persoon RN, PhD; UKON nursing researcher and coordinator, Department of Primary and Community Care, Radboud Institute for Health Sciences, Nijmegen, the Netherlands. Former bachelor educated district nurse, female.

Abstract

Title: Experiences and needs of certified nursing assistants regarding coaching by bachelor educated nurses in nursing homes: A qualitative study.

Background: Dutch nursing home care has become increasingly complex. Quality of nursing home care is endangered since certified nursing assistants are expected to provide high complex care while being educated to provide low complex care. For certified nursing assistants to remain competent, coaching by bachelor educated nurses is required. However, knowledge is lacking on how bachelor educated nurses can provide valid coaching explicitly to certified nursing assistants. Insight into experiences and needs of certified nursing assistants enables bachelor educated nurses to achieve coaching validity.

Aim: The aim of this study was to gain insight into experiences and needs of certified nursing assistants regarding coaching by bachelor educated nurses in nursing homes.

Method: A generic qualitative multicenter design was applied. Certified nursing assistants were purposively selected from five nursing homes. Semi-structured face-to-face and telephone interviews were conducted in March and April 2020. Analysis relied on Braun and Clarke's thematic analysis.

Results: Two main themes emerged: bachelor educated nurses prerequisites and value of bachelor educated nurses. Certified nursing assistants (*n* = 9) defined prerequisites within the scope of: retaining autonomy, being visible and reachable, adapting communication style, clarifying job description, participating in care, and being equal. Certified nursing assistants perceived bachelor educated nurses as valuable when bachelor educated nurses fulfill coaching needs of certified nursing assistants through empowering, educating, and being an intermediary between management and certified nursing assistants.

Conclusion: When bachelor educated nurses meet the described prerequisites with the support of nursing home managers, bachelor educated nurses can demonstrate their value and provide valid coaching to certified nursing assistants. Future research is necessary on the perspectives of bachelor educated nurses and nursing home managers to gain a comprehensive understanding of coaching.

Keywords: certified nursing assistants, bachelor educated nurses, coaching, nursing homes, qualitative research

Samenvatting

Titel: Ervaringen en behoeften van verzorgenden IG met coaching door hbo-verpleegkundigen in verpleeghuizen: Een kwalitatief onderzoek.

Achtergrond: Nederlandse verpleeghuiszorg is complex en wordt naar verwachting nog complexer. De kwaliteit van de verpleeghuiszorg wordt bedreigt doordat verzorgenden IG hoog complexe zorg dienen te verlenen terwijl zij opgeleid zijn om laag complexe zorg te verlenen. Om verzorgenden IG competent te laten blijven is coaching van hbo-verpleegkundigen benodigd. Echter, kennis ontbreekt over hoe hbo-verpleegkundigen expliciet aan verzorgenden IG valide coaching kunnen bieden. Inzicht in de ervaringen en behoeften van verzorgenden IG stelt hbo-verpleegkundigen in staat coachingsvaliditeit te bereiken.

Doel: Het doel van dit onderzoek was het verkrijgen van inzicht in de ervaringen en behoeften van verzorgenden IG met coaching door hbo-verpleegkundigen in verpleeghuizen.

Methode: Een generiek kwalitatief multicenter design is toegepast waarin verzorgenden IG doelbewust zijn geselecteerd binnen vijf verpleeghuizen. Semigestructureerde face-to-face en telefonische interviews hebben plaatsgevonden in maart en april 2020. Thematische analyse volgens Braun en Clarke werd toegepast.

Resultaten: Twee hoofdthema's werden geïdentificeerd: voorwaarden aan hbo-verpleegkundigen en meerwaarde van hbo-verpleegkundigen. Verzorgenden IG (*n* = 9) definieerden voorwaarden aan hbo-verpleegkundigen binnen de onderwerpen: behouden van autonomie, zichtbaar en bereikbaar zijn, communicatiestijl aanpassen, functie verduidelijken, participeren in zorg en gelijkwaardig zijn. Verzorgenden IG beschouwden hbo-verpleegkundigen als waardevol wanneer hbo-verpleegkundigen coachingsbehoeften van verzorgenden IG vervullen doormiddel van empowering, scholing en een intermediair te zijn tussen het management en verzorgenden IG.

Conclusie: Hbo-verpleegkundigen kunnen hun meerwaarde demonstreren en valide coaching bieden aan verzorgenden IG wanneer zij met ondersteuning van verpleeghuismanagers voldoen aan de beschreven voorwaarden. Toekomstig onderzoek is nodig naar de perspectieven van hbo-verpleegkundigen en verpleeghuismanagers om een volledig begrip te genereren van coaching.

Trefwoorden: verzorgenden IG, hbo-verpleegkundigen, coaching, verpleeghuizen, kwalitatief onderzoek

Introduction

Nursing home care in the Netherlands has become increasingly complex[1-2]. This increase is caused by residents with higher levels of impairment and multi-morbidity due to population ageing; residents with higher levels of care-dependency due to stricter admission requirements since 2015 (i.e., a need for 24-hour care or permanent supervision); higher expectations of residents and their relatives regarding person-centred care; financial deficiencies; and understaffing[1,3-4]. The complexity of nursing home care is expected to keep rising as the demand for long-term care is growing, the diversity of care services is increasing, and technological innovations continue to be introduced[3,5-6]. To secure quality of care (QoC) for nursing home residents, the Dutch government published the Quality Framework for Nursing Home Care in 2017[7]. This framework constitutes the statutory basis for QoC in nursing homes, containing standards and descriptions on how these standards can be attained[7]. A personnel standard was added in 2018, in which employment of bachelor educated nursing staff is emphasized as a manner to improve QoC[8]. The Dutch government offered a *quality budget* to nursing homes, making it possible to employ bachelor educated nurses (BNs)[9].

BNs make up 7% of the nursing staff in Dutch nursing homes. In addition, the majority of the nursing staff received vocational education; 60% are certified nursing assistants (CNAs), 17% are nurses, and 11% are nurse aides[10]. Although the relationship between the presence of BNs in nursing homes and QoC has not yet been significantly established[2,4], BNs are – unlike vocational educated nursing staff members – educated to coordinate complex care processes, apply evidence-based practices, and approach complex problems systematically[11-12]. Preceding studies indicate that BNs can improve QoC by having influence on staff and ward environment characteristics (e.g., organizational culture, team climate)[13-16]; coordination of care[17-18]; and collaboration between nursing staff and nursing home medical specialists or allied health professionals[18]. Moreover, BNs might indirectly add value to QoC by acting as a clinical leader and coach for other nursing staff members[19-20].

Coaching by BNs is required for CNAs to remain competent nursing staff members; nursing staff members who possess the skills, knowledge, and attitudes that meet the care needs of nursing home residents[2,20-21]. CNAs are educated to provide care and psychosocial support in low complex situations and act mainly on tradition, routine, and personal experience[11,22]. QoC is endangered since CNAs, who constitute the majority of the entire nursing staff, are now confronted with increasingly complex care needs[2,11]. BNs are eligible to coach CNAs considering BNs are qualified to address high complex care[2,20].

Coaching within healthcare can be defined as: "The interactive, interpersonal processes that involve the acquisition of appropriate skills, actions, and abilities that form the basis of professional practice"[23,p.47]. BNs equip CNAs with competences while being readily

available as a model or resource[21,24]. Four situations are distinguished in which BNs can provide coaching: 1) to improve the performance of CNAs; 2) to construct or stimulate effective workplace cultures; 3) during implementations; and 4) for recently employed or student CNAs[21]. Coaching can differ in method (e.g., informal coaching, mentoring, individual coaching, group coaching), context (e.g., daily care, appointments), and frequency[21]. For coaching to be successful, BNs have to achieve coaching validity; find the right method for the right CNA and the situation they are in, with the right frequency in the right context[21]. Despite numerous literature on coaching[21], knowledge is lacking on how BNs can achieve coaching validity explicitly for CNAs. The educational profile of BNs, Bachelor of Nursing 2020, does however state that improving and maintaining the expertise of others are core concepts of BNs and BNs should be acquainted with theory on effective coaching[25].

This study is a first step in creating a body of knowledge on coaching CNAs by BNs in nursing homes, by exploring the experiences and needs of CNAs. Insight into the experiences and needs of CNAs is necessary to enable BNs to achieve coaching validity. When valid coaching can be provided to CNAs, investments can be made in the future of nursing home care and QoC can be preserved for nursing home residents[2]. Furthermore, insight into coaching validity of CNAs prevents waste of efforts and time of BNs, who constitute a minority within nursing homes.

Aim

The aim of this study was to gain insight into experiences and needs of certified nursing assistants regarding coaching by bachelor educated nurses in nursing homes.

Methods

Design

A generic qualitative multicenter design was applied[26], conducting semi-structured face-to-face and telephone interviews with CNAs. This method was chosen for its ability to obtain an in-depth understanding of experiences and needs of CNAs regarding coaching by BNs[26].

Setting and Population

The study took place in five nursing homes of four healthcare organizations, chosen for their employment of BNs. The nursing homes are located in the south and the east of the Netherlands, in both rural and urban environments. The healthcare organizations are part of UKON (in Dutch: Universitair Kennisnetwerk Ouderenzorg Nijmegen). UKON is a collaboration between the Radboud Institute for Health Sciences and fifteen healthcare organizations, conducting research to improve QoC for the elderly[27].

CNAs were eligible for inclusion if they received coaching of a BN for ≥ 3 months (to be able to say something meaningful); were ≥ 18 years old; and had adequate command of the Dutch language. Maximum variation was sought by including CNAs who provided care to residents with various care needs (i.e., somatic care, psycho-geriatric care, rehabilitation care) and who received coaching from different BNs. CNAs were selected purposively by nursing home managers and BNs. The sample size was guided by data saturation; CNAs were included until new obtained information did not provide further insight into themes or no additional themes emerged[28].

Data Collection

Data were collected in March and April 2020 by means of one-time, individual, semi-structured face-to-face and telephone interviews. It was intended to conduct merely face-to-face interviews. However, during data collection the COVID-19 pandemic manifested and the method for data collection altered to telephone interviewing.

An interview guide was used to focus the data collection. Due to a lack of literature concerning coaching of CNAs by BNs, the interview guide was developed through expert consultation. The researcher (MK) consulted two experts, associates of UKON. The opening question was: Can you tell me how you experience your work as a CNA? This question was intended to start the interview easy and to give the researcher the possibility to ask about coaching by BNs when hindering factors were expressed. The topic list is displayed in Table 1.

[TABLE 1]

All interviews were audio-recorded and conducted by the researcher. Face-to-face interviews were conducted in a private room on the wards of the nursing homes. During telephone interviews, CNAs were at work and occasionally in the presence of non-participating CNAs. With the exception of one CNA who was at home. Observational memos were written during or soon afterwards the interviews to capture the behaviour of CNAs and linguistic and atmospheric elements[26].

Data Analysis

Data analysis relied on Braun and Clarke's (2006) six-phase thematic analysis, in order to establish meaningful patterns[29]. ATLAS.ti 8.4.20 (Scientific Software Development GmbH Berlin) supported data analysis[30].

In the first phase, the researcher transcribed the interviews verbatim and thoroughly read the transcripts several times becoming familiar with the content. The researcher wrote theoretical memos of emerging ideas for coding. In the second phase, transcripts were screened to identify relevant text fragments. The researcher named the text fragments with *in*

vivo codes, obtaining theoretical sensitivity[26]. The co-researcher (AP) repeated the process of coding independently for interviews four and eight, increasing inter-rater reliability[26]. Codes were discussed until consensus was reached. In the third phase, codes were assigned to potential themes by the researcher, resulting in a thematic map. In the fourth phase, themes were revised five times by the researcher and the co-researcher. At last, themes were defined and named in the fifth phase, and the final report was produced in the sixth phase.

Constant comparison was practiced after every third interview; incoming data were compared to existing codes and themes, after which new codes were formulated, themes changed, and new questions or topics arose for upcoming interviews[26]. Analysis revealed that questions containing the term coaching yielded no relevant data. The term coaching was therefore replaced by the terms collaborating, learning, and helping, after which relevant data were generated.

Demographic data were analyzed descriptively using SPSS Statistics 25 (International Business Machines Corporation New York)[31].

Trustworthiness

The trustworthiness of the study findings was based on the quality criteria credibility, dependability, confirmability and transferability[32].

Credibility was ensured through member checking. After each interview, the CNA received a summary of the interview from the researcher by e-mail. All CNAs confirmed that the summary was an adequate representation of their viewpoint. Furthermore, the co-researcher peer reviewed the interview guide and the interview techniques of the researcher by means of a pilot interview with a CNA not related to the study. The researcher had limited experience with conducting face-to-face interviews and no experience with telephone interviewing, and was therefore guided by Farooq's (2015) study ''Qualitative Telephone Interviews: Strategies for Success''[33]. To strengthen dependability and confirmability, an audit trail was kept by the researcher, enabling others to judge the decision-making process and objectivity of the researcher[34]. The audit trail contains observational memos, methodological memos, theoretical memos, and critical reflections on the researchers own role[34]. Descriptions of the sample and setting are presented to facilitate readers' judgments regarding transferability. With respect to the trustworthiness of this study, it is important to address that the researcher was not employed by any of the participating healthcare organizations. No relationships with CNAs existed prior to study commencement.

Guidelines for conducting qualitative studies established by the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed[35].

Ethical Issues

This study was carried out according to the principles of the Declaration of Helsinki, version 2013[36]. The research ethics committee of the region Arnhem Nijmegen declared this

study not to be subject to the Medical Research Involving Human Subjects Act (registration no. 2019-6019). Handling and storage of data complied with the EU General Data Protection Regulation and the Dutch Act on Implementation of the General Data Protection Regulation[37-38]. Data was stored on secured servers of the Radboud Institute for Health Sciences.

If CNAs agreed to participate in this study, their contact information was handed over to the researcher. CNAs received an information letter from the researcher, explaining the aim of this study, the interview procedure, and the confidentiality of the data[39]. CNAs were assured that participation did not compromise their personal situation, considering CNAs were recruited by nursing home managers. Written informed consent was obtained prior to face-to-face interviews and verbal audio-recorded informed consent was obtained prior to telephone interviews.

Results

Sample

Of 48 CNAs approached for recruitment, nine CNAs agreed to be interviewed. The main reason for not participating was the low priority of research during the COVID-19 pandemic. The median age of the nine interviewed women was 48 years (IQR 31 - 55). Demographic data is presented in Table 2. Three face-to-face and six telephone interviews were conducted. Interviews lasted 18 - 46 min (mean face-to-face interviews 37 min; mean telephone interviews 27 min).

[TABLE 2]

Themes

Two main themes emerged from the analysis: BNs prerequisites and value of BNs. The main themes and sub-themes are outlined below and illustrated in Figure 1.

[FIGURE 1]

BNs Prerequisites

Retaining autonomy. CNAs expressed the need for BNs to retain the autonomy of CNAs within the competences they already possess.

> ''She didn't came here to learn me how to wash and dress, I already know that … they're here to coach us in the areas we're struggling'' (CNA1).

‘’That are the fun things, to contact a doctor myself. Now they are taking it over and I think that’s a cutback of my job’’ (CNA4).

CNAs did however have positive experiences with BNs that incidentally took over their tasks when CNAs were busy or emotionally affected.

‘’I entered the room of a resident who passed away. He lied dead in bed. She let me calm down and contacted the doctor, because I was so shocked’’ (CNA8).

Moreover, several CNAs felt appreciated when they taught BNs or took over tasks of BNs.

Adapting communication style. Some CNAs expressed the need for BNs to simplify their vocabulary, enabling CNAs to immediately understand what is meant.

‘’I really am a practical person, so for me it could be a bit simpler. Sometimes I see words of which I think ok those we will have to look up on Google’’ (CNA6).

CNAs experienced follow-up communication by BNs as positive, both on a personal level and on the residents level. On a personal level, BNs showed interest in CNAs work- and private life after talking to them earlier. On the residents level, BNs asked and informed CNAs about the effects of previously initiated interventions. A lack of follow-up communication was experienced negatively.

‘’When he called a doctor, he didn’t tell me what that doctor exactly said and what the advice was for that resident. I told him you can be the nurse here, but I’m the one who provides care. So I need to know what’s going on’’ (CNA2).

Furthermore, CNAs used the following terms to express their needs concerning communication of BNs: summarizing the division of tasks out loud, listening, in-depth and open-ended questions, unforced, giving and receiving feedback, and motivational.

Being visible and reachable. CNAs appreciated the physical presence of BNs, during reoccurring moments (e.g., change of shifts of CNAs) and unannounced. Merely contact by e-mail or phone was experienced negatively.

''I always value it when someone is visible. Not that you just know that such persons exists … and I think it's easier to make contact when someone regularly shows up, even if we don't need help. That you stay in touch'' (CNA9).

CNAs expressed the need to know when and how they can reach BNs; on what days BNs work, if BNs can be reached by phone, whether BNs are present in their nursing home and where BNs are within the nursing home.

Clarifying job description. Most CNAs did not know what the job description of BNs entailed and in what circumstances they could appeal to BNs. When this is clear, CNAs are more likely to approach BNs in case of learning opportunities. CNAs also prefer that BNs share what they do on a daily basis.

''The only thing that I find difficult is that it's not one hundred percent clear to everyone what exactly her job entails and when we can consult her'' (CNA9).

Participating in care. Most CNAs required participation of BNs in direct care for residents. Participation of BNs occurred regularly for several hours or shifts per week or incidentally by providing care to complex cases, exploring what happens on a ward, and substituting in case of staff shortages. CNAs perceived BNs who participated in care as colleagues and felt that their participation contributed to QoC.

''Who just collaborates, who thinks along. Not afraid to get tired. Someone who isn't behind her laptop all day, but just collaborates'' (CNA5).

A few CNAs had negative experiences with BNs participating in care or had no experiences with BNs participating in care and did not miss it. Negative experiences encompassed an inappropriately dressed BN (i.e., on heels) and a BN with a slow pace. One CNA perceived a non-participating BN as objective and having a helicopter view.

Being equal. CNAs strongly expressed the need for BNs to treat them equally, defined as: taking CNAs seriously, having time and patience, formulating sentences from the perspective of 'we' instead of 'I', and having fun together.

''Although he might not think that it was important, he still took me seriously because I did find it important'' (CNA4).

Value of BNs

Educating.

Clinical reasoning. CNAs had positive experiences with BNs who supported them with clinical reasoning using fictional and non-fictional cases. CNAs expressed the need for BNs to further improve their clinical reasoning skills by: sharing their own thinking process, asking how CNAs think about cases or how they would act, letting CNAs search literature, and discussing cases during clinical lessons.

''A nurse thinks about what she does and what she measures, why do I do what I do? She can also transfer that to colleagues. Especially since the complexity of care is rising'' (CNA9).

Implementations. CNAs perceived BNs to be the ideal persons to implement innovations and recent knowledge. Some CNAs participated in implementations at the invitation of BNs and experienced this positively.

''You could work here for twenty years without receiving education. Because they're here now, we continue to learn. It's just good'' (CNA1).

''I'm developing a script with her for colleagues that maintain contact with the residents' relatives. I really like to do that'' (CNA2).

Care related topics. CNAs want to learn from BNs within the following care related topics: dealing with aggression, being a first contact person, composing quality improvement plans, familiarizing with jargon, medical math, mentoring students, technical nursing skills, and disease knowledge.

''People are admitted because they have dementia, but they are often also physically ill. You can just call her if you experience difficulties, for more expertise'' (CNA9).

Facilitate learning from colleagues. CNAs positively experienced learning with colleagues, and in particular learning from colleagues. BNs facilitated herein by: organizing and structuring meetings, suggesting topics, arranging equipment (e.g., catheters, tablets), inviting other disciplines, and providing knowledge.

''We usually discuss something that someone struggles with. She uses that and shows us for example something in the resident records. And then we try to learn it ourselves'' (CNA1).

Empowering. CNAs valued being empowered by BNs; when BNs recognized and developed strengths of individuals and teams. BNs empowered CNAs by: searching together for challenging and joyful tasks, and giving CNAs responsibility for these tasks; pointing out rights and encouraging CNAs to utilize these rights; discussing learning aims (e.g., letting everyone mention a learning aim at the start of a shift); advising to consult others when BNs themselves could not help; and developing a joint vision on care.

''She gave me tips from her personal experience. Because of that I dare to give tasks to someone else instead of doing it all myself … I notice that when I'm at work, I'm much calmer than I have ever been'' (CNA8).

Intermediary between CNAs and management. CNAs considered BNs to be intermediaries between them and the management. BNs were perceived more accessible than managers because BNs are more acquainted with CNAs and BNs are caregivers themselves. BNs explained policy in an understandable manner, resulting in acceptance and uniformity among CNAs.

''It's nice that there's someone who can clearly explain the policy in a normal way, what you should and shouldn't do … it's always very nice described on paper but it's not clear to everyone'' (CNA4).

Some CNAs had mental health issues and preferred BNs to talk to and to be part of the reintegration process instead of managers.

''Last time when I didn't felt good she talked to me instead of the manager … that's very pleasant because you also work with her and she knows better how I'm doing than a manager'' (CNA8).

Discussion

This study aimed to gain insight into experiences and needs of CNAs regarding coaching by BNs in nursing homes. Two main themes were identified: BNs prerequisites and

value of BNs. CNAs defined prerequisites within the scope of: retaining autonomy, being visible and reachable, adapting communication style, clarifying job description, participating in care, and being equal. CNAs perceived BNs as valuable when BNs fulfill coaching needs of CNAs through empowering, educating, and being an intermediary between management and CNAs.

The results of this study show similarities with Cardiff's (2014) person-centred leadership framework for nurse leaders[40]. Person-centred leadership is a relational style of leadership and is considered an essential characteristic of effective workplace cultures[40]. According to Cardiff's (2014) framework, nurse leaders should focus on wellbeing, empowerment, and development of other nursing staff members[40-41]. In this study, wellbeing was emphasized when BNs supported CNAs with mental health issues, BNs empowered CNAs, and BNs contributed to the development of CNAs through education. These similarities imply that BNs who provide person-centred coaching have a dual role as leaders, enhancing effective cultures of nursing home wards. The current Dutch educational profile of BNs, Bachelor of Nursing 2020, lacks information on how BNs can provide coaching[25]. The previous educational profile of Pool et al. (2001) however contained a coaching role for BNs and provided generic information on coaching nursing staff members by BNs[42]. Our results correspond with Pool et al. (2001) for the sub-themes adapting communication style and implementations[42]. The contents of the remaining sub-themes were not mentioned.

In order to appreciate the results of this study, strengths and limitations need to be considered. The interviews were short in duration due to a high workload during the COVID-19 pandemic. At the start of the interviews, the researcher asked CNAs what their preferred interview duration was and took their answers into account. It is possible that CNAs provided relatively less detail or elaboration[43]. Thereby, the sample size was small and achievement of data saturation was doubtful. Ideally two more interviews would have been conducted to confirm data saturation. However, the richness of the data implies that the most typical aspects of experiences and needs of CNAs regarding coaching by BNs were captured. Perhaps that by discussing the preferred interview duration, the focus lied on effective use of time. Maximum variation within the sample was not achieved for gender and care provision; CNAs were female and provided psycho-geriatric care or rehabilitation care. The results are therefore not immediately transferable to male CNAs and somatic wards. However, the study is strengthened by its multicenter design, the diversity of BNs the CNAs received coaching from, and the inclusion of negative experiences. The inclusion of negative experiences advocates no severe influence of recruitment by BNs.

In daily nursing home practice, BNs should participate in care; be visible, reachable, and equal to CNAs; adapt their communication style to CNAs; retain the autonomy of CNAs;

empower and educate CNAs; and be an intermediary between management and CNAs. Nursing home managers should facilitate BNs herein and clarify the job description of BNs. Upcoming curriculums and job competency profiles of BNs should address coaching of vocational educated nursing staff members, such as CNAs. When BNs acquire knowledge about coaching vocational educated nursing staff members, coaching validity can be achieved. First however, further qualitative research is needed on the perspectives of BNs and nursing home managers to yield a comprehensive understanding of coaching vocational educated nursing staff members.

To our knowledge, this is the first study that provides insight into experiences and needs of CNAs regarding coaching by BNs. When BNs meet the described prerequisites with the support of nursing home managers, BNs can demonstrate their value and provide valid coaching to CNAs.

References

1. Verbeek-Oudijk D, Van Campen C. Ouderen in verpleeghuizen en verzorgingshuizen. Den Haag: Sociaal en Cultureel Planbureau; 2017.
2. Hamers JPH, Backhaus R, Beerens HC, Van Rossum E, Verbeek H. Meer is niet per se beter: De relatie tussen personele inzet en kwaliteit van zorg in verpleeghuizen. Maastricht: Maastricht University; 2016.
3. Meijer A, Van Campen C, Kerkstra A. A comparative study of the financing, provision and quality of care in nursing homes. J Adv Nurs. 2000;32(3):554-561.
4. Backhaus R. Thinking beyond numbers: nursing staff and quality of care in nursing homes. Maastricht: Maastricht University; 2017.
5. Backhaus R, Verbeek H, Van Rossum E, Capezuti E, Hamers JPH. Future distinguishing competencies of baccalaureate-educated registered nurses in nursing homes. Geriatr Nurs. 2015;36(6):438-444.
6. Sloane PD, Zimmerman S, D'Souza MF. What will long-term care be like in 2040? N C Med J. 2014;75(5):326-330.
7. Moerkamp A. Kwaliteitskader verpleeghuiszorg: Samen leren en verbeteren. Diemen: Zorginstituut Nederland; 2017.
8. Actiz. Infographic personeelsnorm: Mogelijkheden en verplichtingen. [Internet]. 2019. Available from: https://www.actiz.nl/web/ouderenzorg/kwaliteit/onderwerp/pag/kwaliteitskader/open/infographic-personeelsnorm-mogelijkheden-en-verplichtingen. [Accessed March 21, 2020].
9. Zorg voor beter. Verpleeghuizen kunnen extra kwaliteitsbudget aanvragen. [Internet]. 2018. Available from: https://www.zorgvoorbeter.nl/nieuws/verpleeghuizen-extra-kwaliteitsbudget. [Accessed March 21, 2020].
10. Brink M, Joldersma C. Personeel en opleiden in verpleeghuizen. Kiwa Carity, CAOP; 2016.
11. Terpstra D, Van den Berg A, Van Mierlo C, Zijlstra H, Landman J, Schuurmans M et al. Toekomstbestendige beroepen in de verpleging en verzorging: Rapport stuurgroep over de beroepsprofielen en de overgangsregeling. NFU; 2015.
12. Versteeg S, De Veer A, Brinkman M, De Groot K, Francke A. Aantrekkelijkheid van de intramurale ouderenzorg voor de hbo-opgeleide verpleegkundige. Utrecht: NIVEL; 2018.
13. Schwendimann R, Zúñiga F, Ausserhofer D, Schubert M, Engberg S, De Geest S. Swiss nursing homes human resources project (SHURP): Protocol of an observational study. J Adv Nurs. 2014;70(4):915-926.
14. Colon-Emeric CS, McConnell E, Pinheiro SO, Corazzini K, Porter K, Earp KM et al. CONNECT for better fall prevention in nursing homes: results from a pilot intervention study. J Am Geriatr Soc. 2013;61(12):2150-2159.

15. Bower P, Campbell S, Bojke C, Sibbald B. Team structure, team climate and the quality of care in primary care: An observational study. Qual Saf Health Care. 2003;12(4):273-279.
16. Van Beek AP, Gerritsen DL. The relationship between organizational culture of nursing staff and quality of care for residents with dementia: Questionnaire surveys and systematic observations in nursing homes. Int J Nurs Stud. 2010;47(10):1274-1282.
17. Temkin-Greener H, Zheng N, Katz P, Zhao H, Mukamel DB. Measuring work environment and performance in nursing homes. Med Care. 2009;47(4):482-491.
18. Van Bogaert P, Timmermans O, Weeks SM, Van Heusden D, Wouters K, Franck E. Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events - a cross-sectional survey. Int J Nurs Stud. 2014;51(8):1123-1134.
19. Dellefield ME, Castle NG, McGilton KS, Spilsbury K. The relationship between registered nurses and nursing home quality: An Integrative Review (2008-2014). Nurs Econ. 2015;33(2):95-108.
20. Damen N, Koopmans L, Van de Steeg L, Wagner C. Evaluatieonderzoek proeftuinen ouderenzorg. Utrecht: NIVEL; 2015.
21. Van der Ham H, Vermeij T. De verpleegkundige als coach. 4th ed. Amersfoort: ThiemeMeulenhoff; 2013.
22. Hamers JPH. De ouderenzorg verdient beter: (p<0, 001). Maastricht: Maastricht University; 2015.
23. Morton-Cooper A, Palmer A. Mentoring and preceptorship: A guide to support roles in clinical practice. 1st ed. London: Blackwell Scientific Publications; 1993.
24. Broscious SK, Saunders DJ. Peer coaching. Nurse Educ. 2001;26(5):212-214.
25. Lambregts J, Grotendorst A, Van Merwijk C. Bachelor of nursing 2020: Een toekomstbestendig opleidingsprofiel. Landelijk Overleg Opleidingen Verpleegkunde; 2015.
26. Boeije H. Analysis in qualitative research. 1st ed. London: SAGE publications; 2010.
27. UKON. UKON. [Internet]. Available from: https://www.ukonnetwerk.nl/english/. [Accessed April 24, 2020].
28. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. 2nd ed. London: SAGE Publications; 2014.
29. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2008; 3(2): 77-101.
30. ATLAS.ti. Legal info. Available from: https://atlasti.com/legal-info/. [Accessed April 24, 2020].
31. IBM. IBM SPSS statistics. [Internet]. Available from: https://www.ibm.com/products/spss-statistics. [Accessed April 24, 2020].

32. Lincoln YS, Guba EG. Naturalistic inquiry. Beverly Hills: Sage; 1985.
33. Farooq MB. Qualitative telephone interviews: Strategies for success. Annual Waikato Management School Student Research Conference, 12 June 2015, Hamilton, New Zealand. Waikato: University of Waikato; 2015. p. 1-30.
34. Holloway I, Galvin K. Qualitative research in nursing and healthcare. 4th ed. Chichester: John Wiley & Sons; 2017.
35. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-357.
36. World Medical Association. Declaration of Helsinki. Fortaleza: WMA; 2013.
37. Moraes C. General data protection regulation. Brussels: Council of the European Union; 2015.
38. Schermer BW, Hagenauw D, Falot N. Handleiding algemene verordening gegevensbescherming en uitvoeringswet algemene verordening gegevensbescherming. Ministerie van Justitie en Veiligheid; 2018.
39. CCMO. Informatiebrief en toestemmingsformulieren proefpersonen. [Internet]. Available from: https://www.ccmo.nl/onderzoekers/standaardonderzoeksdossier/e-informatie-proefpersonen/e1-e2-informatiebrief-en-toestemmingsformulier-proefpersonen. [Accessed October 12, 2019].
40. Cardiff S. Person-centred leadership: A critical participatory action research study exploring and developing a new style of (clinical) nurse leadership. PhD thesis, University of Ulster; 2014.
41. Vermeulen H, Van Oostveen C. Persoonsgericht leiderschap: een participatief actieonderzoek over verpleegkundig leiderschap. Ned Tijdschr Evid Based Pract. 2017;15(3-4):23-24.
42. Pool A, Veltman-Van Vugt F. Met het oog op de toekomst: Beroepscompetenties van hbo-verpleegkundigen. Utrecht: NIZW; 2001.
43. Irvine A. Duration, dominance an depth in telephone and face-to-face interviews: A comparative exploration. Int J Qual Methods. 2011;10(3):202-220.

Tables and Figures

Table 1. Topic list for interviews

Opening question
Can you tell me how you experience your work as a CNA?
Subsequent topics
Complexity of care
Collaborating with the BN
Learn from the BN
Be empowered by the BN
Team influence of the BN
Communication of the BN
Attitude of the BN
Future learning goals

Table 2. Demographic data (*N* = 9)

Age (in years)	
Median (IQR)	48 (31-55)
Gender, *n*	
Female	9
Work experience as a CNA* (in years)	
Median (IQR)	14 (9-31)
Working hours per week	
Median (IQR)	32 (24-32)
Care needs of residents, *n*	
Somatic care	0
Psycho-geriatric care	7
Rehabilitation care	2
†Amount of BNs* who provide coaching, *n*	
1 BN	5
2 BNs	3
3 BNs	1
Mean time receiving coaching of BN(s) per week, estimated	

by the CNA, *n*	
≤ 15 minutes	1
>15 minutes to <60 minutes	4
≥ 60 minutes	4
Participation in daily care of BN(s) who provide coaching, *n*	
Yes	6
No	3

*CNA: certified nursing assistant, BN: Bachelor educated nurse

†Three CNAs received coaching of the same two BNs and six CNAs received coaching of different BNs.

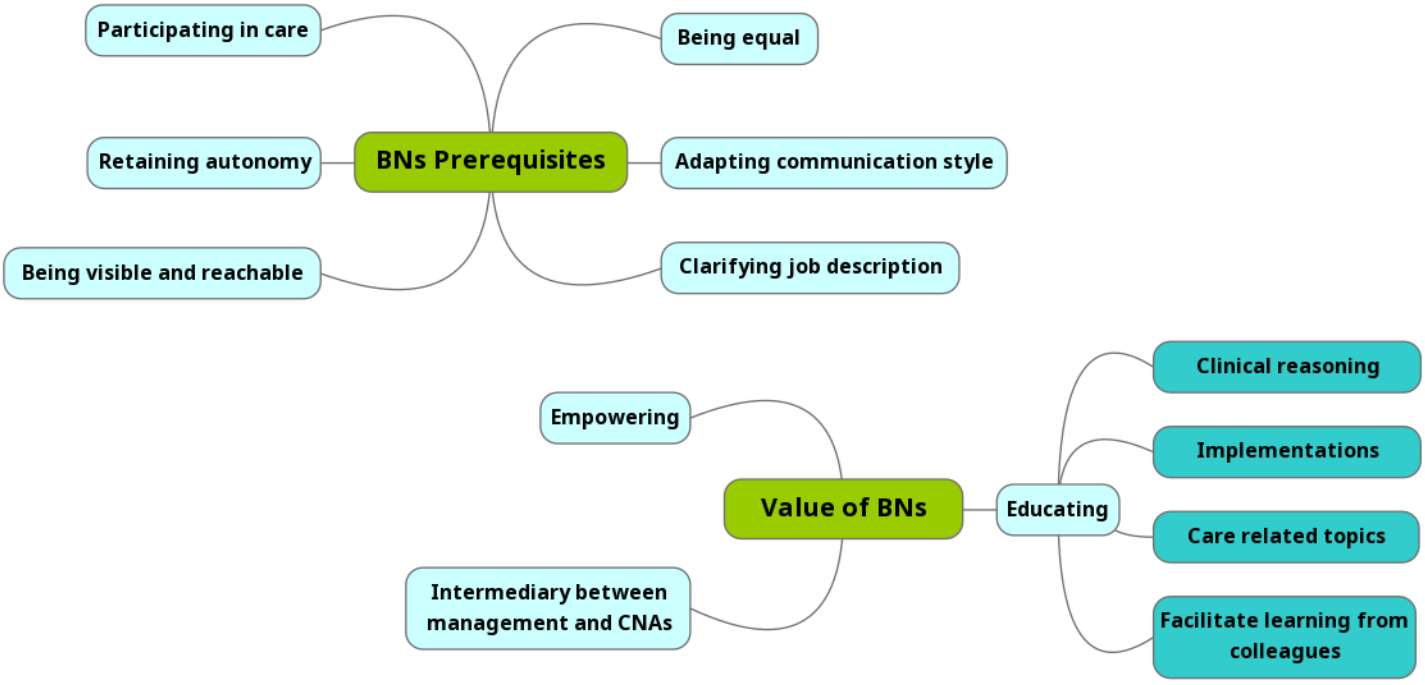

Figure 1. Thematic map of experiences and needs of certified nursing assistants regarding coaching by BNs