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

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## Abstract

**Aims and objectives:** This study aimed to gain insight into the experiences and needs of certified nursing assistants regarding their coaching by bachelor-educated registered nurses in nursing homes.

**Background:** Certified nursing assistants are key in providing day-to-day nursing home care. They are, however, not trained to meet the increasingly complex needs of nursing home residents. For certified nursing assistants to respond to high-complexity care, coaching by bachelor-educated registered nurses may be appropriate. Yet, knowledge of how bachelor-educated registered nurses can provide valid coaching is lacking.

**Design:** An explorative qualitative design was adopted.

**Methods:** Certified nursing assistants ($n = 13$) were purposively selected from 10 Dutch nursing homes. Semi-structured interviews were conducted in 2020 and 2021, and thematic analysis was applied.

**Results:** Two main themes emerged: connecting with certified nursing assistants, and the coaching activities themselves. Certified nursing assistants deemed several aspects important for bachelor-educated registered nurses to connect with them: respecting the autonomy of certified nursing assistants, being visible and reachable, adapting communication, clarifying own job description, and participating in care. Certified nursing assistants perceived coaching by bachelor-educated registered nurses as valuable when they fulfil their needs through activities such as empowering, teaching, and mediating between management and certified nursing assistants.

**Conclusions:** Valid coaching of certified nursing assistants appears possible and requires specific competencies of bachelor-educated registered nurses.

**Relevance to clinical practice:** Coaching certified nursing assistants is one way of addressing complex care needs in nursing homes, and coaching can contribute to both professional and team development. As coaching requires specific competencies of bachelor-educated registered nurses, nursing education profiles should be enriched with this most important role. Management can facilitate coaching by providing bachelor-educated registered nurses with a clear job description.

**Patient or public contribution:** Experts on coaching in nursing home settings informed the topic list. Furthermore, member check was performed.

**KEYWORDS**
bachelor nurses, certified nursing assistants, coaching, empowerment, nursing homes, qualitative research, registered nurse

## 1 | INTRODUCTION

Worldwide, nursing home care has become increasingly complex due to higher levels of impairment and multi-morbidity among residents, higher expectations regarding person-centred care, financial deficiencies, and understaffing (Backhaus, 2017; Handor et al., 2022; Meijer et al., 2000). This complexity is compounded by trends such as the growing demand for long-term care, the ageing workforce, the increasing diversity of care services, and the ongoing introduction of technological innovations (Backhaus et al., 2015; OECD, 2020; Sloane et al., 2014). Although highly skilled nurses are needed to address the present and future challenges of nursing home care, the vast majority of nursing staff are trained to provide low-complexity care (Backhaus et al., 2015; Katz, 2011). Immediate professional development for nurses, both at the individual and team level, is therefore pivotal (Handor et al., 2022).

### 1.1 | Background

In Dutch nursing homes, nursing staff make up 74.8% of the total workforce. Nursing staff consist of nurse aides (23%), certified nursing assistants (CNAs; 41.5%), vocationally educated registered nurses (10%), and, like in many countries, an utterly small percentage of bachelor-educated registered nurses (BRNs; 0.3%) (Backhaus et al., 2015; Rommets & Roelvink, 2021). BRNs hold a registration level 6 for health care professionals, conforming to the European Qualifications Framework (EQF) (Handor et al., 2022), whereas other nursing staff members are vocationally educated. Unlike vocationally educated nursing staff, BRNs are educated to coordinate complex care processes, apply evidence-based practices, and approach complex problems systematically. In a recent systematic review, Tuinman et al. (2021) demonstrated that a skill mix with more BRNs had a positive impact on nursing-sensitive outcomes such as pain and pressure ulcers. Although the relationship between BRNs in nursing homes and quality of care (QoC) has not yet been significantly established like in hospitals (Backhaus, 2017; Backhaus et al., 2015), several studies have indicated that BRNs can improve QoC through their influence on staff and ward environment (e.g., organisational culture, team climate) (Bower et al., 2003; Colon-Emeric et al., 2013; Schwendimann et al., 2014; van Beek & Gerritsen, 2010), coordination of care (Temkin-Greener et al., 2009; van Bogaert et al., 2014), and collaboration between nursing staff and nursing home medical specialists or allied health professionals (van Bogaert et al., 2014). Moreover, BRNs might indirectly add value to QoC by acting as clinical leaders and as coaches for other nursing staff members (Dellefield et al., 2015).

**What does this paper contribute to the wider global clinical community?**

- Early knowledge on the nature of coaching CNAs by BRNs. Coaching of CNAs has proven to require specific competencies of BRNs, and coaching should thus be an element of professional nursing profiles and nursing educational curricula.
- Indications that coaching enables the professional development of CNAs and contributes to team development.
- Recommendations for nursing homes to provide clear BRN job descriptions and to articulate their position.

Coaching by BRNs may be an effective pathway for CNAs (also known as 'licensed practical nurses' or 'licensed vocational nurses' in the US) to remain competent nursing staff members who possess the skills, knowledge, and attitudes necessary to meet the care needs of nursing home residents. CNAs - who make up the majority of the nursing staff and carry out most of the day-to-day care (Hamers et al., 2016) - are educated to provide care and psychosocial support in reasonably uncomplicated situations and act mainly on tradition, routine, and personal experience. As CNAs face residents' increasingly complex care needs, the need for high QoC increases likewise. BRNs are qualified to perform highly complex care and are thus assumed to be capable of providing coaching to CNAs.

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" (Morton-Cooper & Palmer, 1993, p. 47). BRNs equip CNAs with competences while being readily available as a model or resource (Broscious & Saunders, 2001). Van der Ham and Vermeij (2013) distinguish four situations in which BRNs can provide coaching: (1) to improve the performance of CNAs; (2) to construct or stimulate effective workplace cultures; (3) during implementations of innovations; and (4) for recently employed or student nursing staff members. Coaching can differ in method (e.g., informal coaching, mentoring, individual coaching, group coaching), context (e.g., daily care, appointments), and frequency. For coaching to be successful, BRNs have to achieve coaching validity: they must find the right

method for the right CNA and the situation they are in, with the right frequency (Van der Ham & Vermeij, 2013). Despite an abundance of literature on coaching, explicit knowledge is lacking on how BRNs can achieve coaching validity for CNAs. Even the Dutch educational profile of BRNs, Bachelor of Nursing 2020, does not specifically include coaching as a competency; it does however state from a more general perspective that improving and maintaining the expertise of others are core concepts for BRNs (University of Applied Sciences Groningen, 2018).

By exploring the experiences and needs of CNAs, this study was a first step towards creating a body of knowledge on the coaching of CNAs by BRNs in nursing homes. Understanding the experiences and needs of CNAs is necessary for BRNs to achieve coaching validity and thus equip CNAs to provide care in a changing healthcare landscape. Furthermore, insight into coaching validity contributes to a clear job profile for BRNs employed in nursing homes and prevents wasted time and effort for these underrepresented members of the nursing staff.

### 1.2 | Aim

The aim of this study was to gain insight into the experiences and needs of CNAs regarding coaching by BRNs in nursing homes.

## 2 | METHODS

### 2.1 | Design

An explorative, qualitative multi-centre design was adopted by means of semi-structured interviews. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed (Tong et al., 2007).

### 2.2 | Sample

The study was carried out in 10 nursing homes located in both urban and rural areas in the Netherlands. The nursing homes were operated by different Dutch healthcare organisations. Each of the organisations was a member of the UKON, a collaboration between the Radboudumc and 19 healthcare organisations conducting research and implementing research results to improve QoC for the elderly.

Certified nursing assistants were eligible for inclusion if they had received coaching by a BRN for ≥3 months 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, psychogeriatric care, rehabilitation care), who had received coaching from different BRNs, and who had both positive and negative experiences with coaching by BRNs. CNAs were selected purposively by nursing home managers and BRNs via email. Each eligible CNA received an information letter explaining the goal of the study, the rationale, the interview procedure, and the confidentiality of data. The sample size was guided by data saturation: CNAs were included until newly obtained information provided no further insight into themes or no additional themes emerged (Charmaz, 2014).

### 2.3 | Data collection

Data were collected by means of one-time, individual, semi-structured interviews. Our original intention was to conduct only face-to-face interviews. However, during data collection, the COVID-19 pandemic emerged and the method for data collection altered to telephone interviewing. To avoid burdening CNAs, data were collected during periods when COVID-19 infections were not peaking: in March and April 2020 and in September and October 2021.

An interview guide was used to focus the data collection. Due to a lack of literature concerning coaching of CNAs by BRNs, the interview guide was developed in consultation with two experts on coaching in the nursing home setting. The experts were 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 easily and to give the researcher the opportunity to ask about coaching by BRNs when hindering factors were expressed. The subsequent question was related to the CNAs experiences with the BRN as a coach. Analysis after the first three interviews 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. The topic list is displayed in Table 1.

All interviews were conducted and audio-recorded by researcher MK (female, junior scientist). Face-to-face interviews were held in a private room in the nursing homes. Participants interviewed by telephone were either at work or occasionally in the presence of non-participating CNAs. One CNA was at home during a telephone interview. Observational memos were written during or immediately following the interviews, to capture the behaviour of CNAs and the linguistic and atmospheric elements (Holloway & Galvin, 2017).

**TABLE 1** Topic list.

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

## 2.4 | Data analysis

Data analysis relied on Braun and Clarke's (2006) six-phase thematic analysis, in order to establish meaningful patterns. Constant comparison was performed 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 (Holloway & Galvin, 2017). ATLAS.ti 9.1.6 (Scientific Software Development GmbH Berlin) supported data analysis.

In the first phase, the researcher transcribed the interviews verbatim and thoroughly read and re-read the transcripts to become 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 assigned the text fragments in vivo codes, obtaining theoretical sensitivity (Holloway & Galvin, 2017). Researcher AP (female, senior scientist) independently repeated the coding process for two interviews. Codes were discussed until a consensus was reached. In the third phase, codes were sorted into potential themes resulting in a thematic map. In the fourth phase, themes were revised multiple times by researcher MK and researcher AP. At last, themes were defined and named in the fifth phase, and the final report was produced in the sixth phase.

Demographic data were analysed descriptively using SPSS Statistics 25 (International Business Machines Corporation New York).

## 2.5 | Rigour

The study's rigour was based on the quality criteria credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985).

Credibility was ensured through member checking. After each interview, the participating CNA received a summary of the interview by e-mail. With the exception of one CNA who did not respond, CNAs confirmed that the summary was an adequate representation of their expressed views. Furthermore, researcher AP peer-reviewed the interview guide and researcher MK's interview techniques by means of a recorded pilot interview with a CNA not related to the study. Data from the pilot interview were not used in this study. 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 (Holloway & Galvin, 2017). The audit trail contained observational memos, methodological memos, theoretical memos, and critical reflections on the researcher's own role (Holloway & Galvin, 2017). The sample and setting are presented in such a way that the reader can judge the transferability. With respect to the trustworthiness of this study, it is important to address that researcher MK was herself a BN in a nursing home not related to this study. The researchers MK, AP, and ML (female, senior scientist) were unfamiliar with both the participants and the managers prior to study commencement. Researchers AP and ML were familiar with several BRNs responsible for recruitment.

# 3 | RESULTS

Thirteen CNAs participated in this study (demographic data are presented in Table 2). Three face-to-face and 10 telephone interviews were conducted. As BRNs and nursing home managers were responsible for recruitment, the researchers did not know how many persons refused to participate. Interviews lasted 18–46 min; the mean duration of telephone interviews and face-to-face interviews was 27 and 37 min, respectively. The interviews were short in duration due to the high workload the CNAs had during the COVID-19 pandemic.

## 3.1 | Themes

Two main themes were identified: (1) connecting with CNAs and (2) coaching activities. These themes were interrelated, meaning that BRNs were only capable of providing valuable coaching when they connected with CNAs. The main themes and sub-themes are outlined below and illustrated in Figure 1.

**TABLE 2** Demographic data ($N = 13$).

| | |
|---|---|
| Age (in years) | |
| Median (IQR) | 43 (31–54) |
| Gender, *n* | |
| Female | 13 |
| Work experience as a CNA (in years) | |
| Median (IQR) | 13 (9–26) |
| Working hours per week | |
| Median (IQR) | 32 (24–32) |
| Care provided, *n* | |
| Somatic care | 1 |
| Psychogeriatric care | 8 |
| Rehabilitation care | 4 |
| Amount of BRNs who provide coaching[a], *n* | |
| 1 BN | 7 |
| 2 BRNs | 3 |
| 3 BRNs | 3 |
| Mean time contact with BN(s) per week, as estimated by the CNA, *n* | |
| ≤15 min | 1 |
| >15 min to <60 min | 7 |
| ≥60 min | 5 |
| Participation in care of BN(s) who provide coaching, *n* | |
| Yes | 9 |
| No | 4 |

Abbreviations: ABN, Bachelor-educated nurse; CNA, certified nursing assistant.

[a]Three CNAs received coaching from the same two BRNs and six CNAs received coaching from different BRNs.

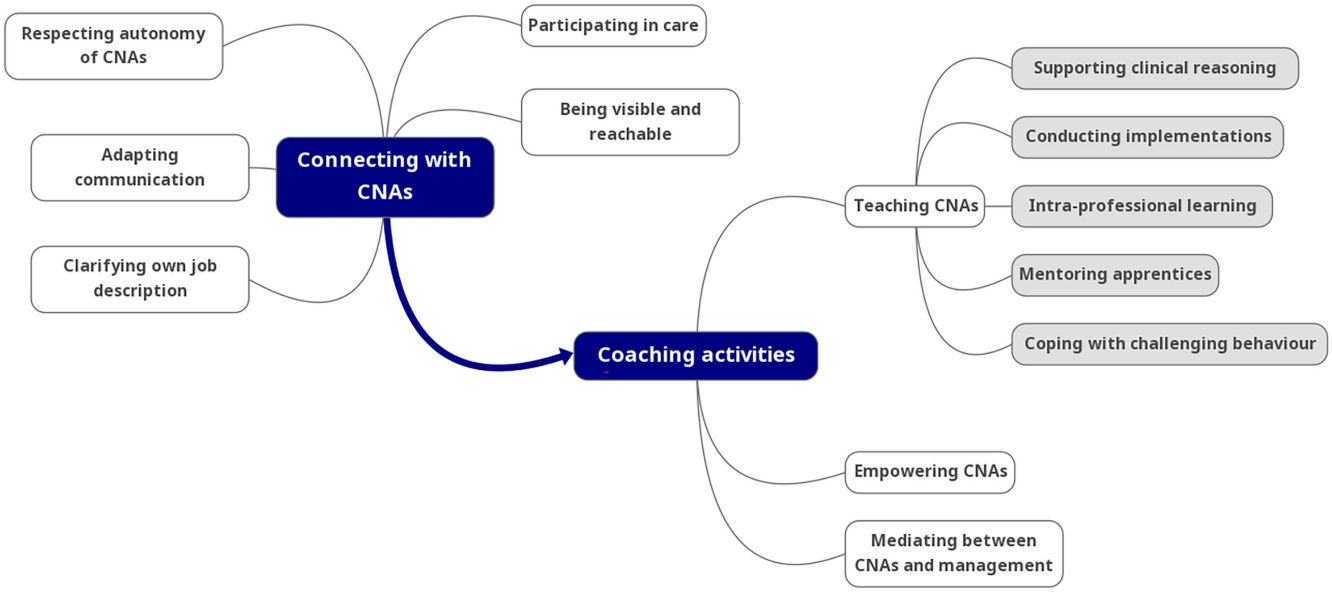


**FIGURE 1** Thematic map of experiences and needs of certified nursing assistants regarding coaching by BRNs. BRN, bachelor-educated registered nurse; CNA, certified nursing assistant.

## 3.2 | Connecting with CNAs

The first main theme, connecting with CNAs, was grouped into five subthemes: (1) respecting autonomy of CNAs, (2) adapting communication, (3) being visible and reachable, (4) clarifying own job description, and (5) participating in care.

### 3.2.1 | Respecting autonomy of CNAs

Certified nursing assistants strongly expressed the need for BRNs to respect their professional autonomy; BRNs should not interfere with skills CNAs already possess and with tasks CNAs feel competent to perform.

> She didn't come here to teach me how to wash and dress [the residents], I already know how to do that … they're here to coach us in the areas in which we're struggling.
>
> (CNA1)

> Contacting the doctor myself is the fun part. Now they are taking over, and I think that's a cutback of my job.
>
> (CNA4)

Nevertheless, CNAs also had positive experiences with BRNs who incidentally took over their tasks in cases where CNAs were busy or emotionally affected.

> I entered the room of a resident who had passed away. He was lying there dead in the bed. She let me calm down and she contacted the doctor herself because I was so shocked.
>
> (CNA8)

Certified nursing assistants felt it was important for BRNs to adopt an attitude of equality, which was variously defined as: taking CNAs seriously, aligning with the CNA's actual knowledge, having time and patience, formulating sentences from the perspective of 'we' instead of 'I', showing interest in CNAs' personal lives, 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)

> If you are equal and you also behave that way, you can achieve far more than if you position yourself above the group.
>
> (CNA4)

### 3.2.2 | Adapting communication

Certified nursing assistants expected BRNs to keep them in the loop about matters related to residents. Lack of information provision was seen as a disruption to the continuity of care.

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

Several CNAs indicated that BRNs should simplify their terminology, enabling CNAs to immediately understand a given message.

> I'm really practical, so for me it could be a bit simpler. Sometimes I see words of which I think: *okay, we will have to look those up on Google*.
>
> (CNA6)

### 3.2.3 | Being visible and reachable

Certified nursing assistants appreciated the physical presence of BRNs on the unit. This could be during recurring moments (e.g., shift changes), unannounced, or by having an office on the unit. Contact merely through e-mail or telephone was perceived as impersonal.

> I think it's easier to make contact when someone regularly shows up, even if we don't need help – just to stay in touch.
>
> (CNA9)

Certified nursing assistants expressed the need to know when and how they can reach BRNs: what days BRNs work, whether BRNs can be reached by phone, whether BRNs are present in their nursing home, and, if so, where the BRNs are within the nursing home. CNAs felt that they could rely on BRNs that were visible.

> When she arrives in the morning, even if she is not scheduled to work in resident care, she lets us know that she is there. If we need her, we know where we can find her.
>
> (CNA1)

### 3.2.4 | Clarifying own job description

Most CNAs were unfamiliar with the BRN's job description and did not know in what circumstances they could consult BRNs. When this is clear, CNAs are more likely to approach BRNs for learning opportunities. CNAs also prefer BRNs to share their activities on a daily basis.

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

### 3.2.5 | Participating in care

Most CNAs required BRNs to participate in daily care. BRN participation occurred with different purposes and at different frequencies: regularly for several hours or shifts per week; incidentally by providing care in complex cases; regularly or incidentally to explore what happens on a unit; substituting for CNAs in case of staff shortages. CNAs perceived BRNs who participated in care as peers 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 couple of CNAs offered contrasting points of view. They perceived a non-participating BRN as objective or as peers anyhow. Additionally, negative experiences involving BRNs participating in patient care were expressed, regarding an inappropriately dressed BRN and a slow-paced BRN.

> Even though she doesn't provide care, she's still part of the team … she's just there for us.
>
> (CNA12)

## 3.3 | The coaching activities

The second main theme, coaching activities, was grouped into three subthemes: (1) teaching CNAs, (2) empowering CNAs, and (3) mediating between managers and CNAs. The subtheme teaching comprised five elements.

### 3.3.1 | Teaching CNAs

*Supporting clinical reasoning*

Certified nursing assistants valued BRNs who supported them with clinical reasoning, using fictional and non-fictional cases. CNAs expressed the need for BRNs to help them further improve their clinical reasoning skills by sharing their own thought process, challenging CNAs to express their thoughts, asking CNAs to think about useful resources within the organisation, and discussing cases during clinical lessons.

> Ask questions, like *what could you have done differently* and *who else could you have turned to*? That you go out there, that you can hire an external psychiatrist, for example.
>
> (CNA10)

*Conducting implementations*

Certified nursing assistants wanted BRNs to coach them in designing and conducting small-scale implementations, such as composing a quality improvement plan. CNAs who participated in implementation processes at the invitation of BRNs felt that their practical knowledge was beneficial for the project.

> I developed a script with her for colleagues who act as the contact person for residents' relatives. I really enjoyed doing that.
>
> (CNA2)

> But you can also, for example, if you notice that a team makes a lot of medication errors or something, discuss this and create a plan for improving the situation. Those are the sorts of things that you can ask for her help on: h*ow do I go about it*, *what are we doing wrong*, and *what is the solution*?.
>
> (CNA9)

*Intra-professional learning*

Certified nursing assistants reported that BRNs enabled them to learn from each other. BRNs facilitated this by organising educational meetings, for which they collected meeting topics from CNAs, arranged equipment (e.g., catheters, tablets), invited other disciplines, and provided knowledge and stimulated dialogue among CNAs during the meetings.

> We usually discuss something 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)

*Mentoring apprentices*

Certified nursing assistants expressed the need for BRN participation in the process of mentoring CNA apprentices. CNAs regularly experienced difficulties mentoring their CNA apprentices, particularly when they underperformed, when they were verbally challenging, or when they lacked interest in nursing home care. CNAs appreciated for example that the BRN incidentally assessed the apprentices together with them.

> That I really do have to ask further about what's going well. She keeps me sharp.
>
> (CNA11)

*Coping with challenging behaviour*

Certified nursing assistants were increasingly confronted with situations in which a resident's challenging behaviour affected other residents. There was a need for BRNs to guide CNAs in assessing challenging behaviour triggers, finding interventions, and monitoring the situation. An example of finding an appropriate intervention was discussing the resident's life course with relatives in an attempt to understand that resident's challenging behaviour. BRNs also played a key role in inviting external experts for consulting on challenging behaviour. One CNA wanted BRNs to offer video interaction guidance (i.e., using video clips of residents as the basis of a reflective dialogue with caregivers about how to develop care).

> Usually we sit together, the case is presented, and everyone is asked: *Gosh*, *what do you see happening*, *how does it affect you*, *how do you act*, *and what do you think is effective?* … and eventually we come to a solution.
>
> (CNA9)

### 3.3.2 | Empowering CNAs

Certified nursing assistants valued feeling empowered in their role through BRNs' encouragement and support. BRNs empowered CNAs by giving them responsibility for new tasks, discussing learning aims (e.g., asking CNAs to mention a learning aim at the start of the shift), acting as role models, 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 now, I'm much calmer than I have ever been.
>
> (CNA8)

The BRNs also raised the CNAs' awareness of available resources (e.g., materials, time, individuals) to advocate for good quality of care in the organisation.

> And then she also says, 'hey, you have the right to use some time to work on your client's file, and you should take that time!'.
>
> (CNA2)

Additionally, the BRNs recognised CNAs' individual qualities and encouraged them to develop these qualities further.

> Hey, that's something you find enjoyable, and that's where your strengths lie, can't we do something with that? Yes, to what extent can we help each other?
>
> (CNA10)

### 3.3.3 | Mediating between CNAs and management

Certified nursing assistants saw BRNs as intermediaries, serving as a bridge between themselves and management. On the one hand, BRNs explained policy using understandable language, resulting in acceptance and compliance among CNAs. On the other hand, BRNs, who were perceived as easily approachable, passed on signals from CNAs to management.

> It's nice that there's someone who can explain the policy in a normal way, what you should and shouldn't

> do … it's always very nicely described on paper but it's not clear to everyone.
>
> (CNA4)

Rather than managers, BRNs had daily contact with CNAs and participated in the delivery of care. As a result of their closer, more colleague-like relationship, some CNAs preferred to discuss personal issues with BRNs or preferred that BRNs be part of a reintegration process instead of managers.

> Last time when I didn't feel well, she [the BNR] talked to me instead of the manager … that's very pleasant because you also work with her and she has a better idea of how I'm doing than a manager does.
>
> (CNA8)

## 4 | DISCUSSION

As far as we know, this is the first study conducted from the perspective of CNAs to gain insight into their experiences and needs with regard to coaching by BRNs in nursing homes. Two main themes were identified. The first theme, although not an item on the interview topic list, was connecting with CNAs by respecting their autonomy, being visible and reachable, adapting communication, clarifying the BRN job description, and participating in care. CNAs saw BRNs as valuable when they fulfilled the CNAs' coaching needs through teaching that focused on clinical reasoning, implementing innovations, facilitating learning, mentoring students and coping with residents' challenging behaviours. CNAs also considered BRNs valuable in helping them feel empowered in their duties and for mediating between management and CNAs.

Our results underline the findings of Best (2020) and Trevillion (2017) who argue that respecting the coachee's autonomy is crucial and that coaching primarily occurs within a trusting non-hierarchical relationship. When a coach takes a top-down approach, newly acquired skills fail to be adopted by the coachee (Best, 2020; Grant & Hartley, 2013). It is important to highlight that an established connection between the CNAs and BRNs is a prerequisite for providing coaching. Coaching seems to be a delicate activity that requires specific competencies of the BRN to overcome the perception of hierarchical distance and to earn the trust of CNAs. One of the specific competencies BRNs will need to deploy to enable coaching is tailored communication. Interestingly, during the first two interviews, we noticed that using the word 'coaching' did not yield any relevant data, even though these respondents were included specifically because they had coaching experiences.

Our findings can also be considered in the context of three concepts concerning professional and team development, namely, an effective workplace culture, practice development, and person-centred leadership. An effective workplace culture is "the most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders. This is the culture that impacts directly on the delivery of care" (Manley et al., 2013, p. 1994). Within Manley et al.'s (2011) framework of an effective workplace culture, the BRNs' coaching activities in our study can be regarded as 'essential attributes' and the professional relationship between CNAs and BRNs as an 'enabling factor' (Manley et al, 2011). Furthermore, the coaching of CNAs by BRNs probes into principles of skilled facilitation and the role of the internal facilitator as mentioned in the concept of practice development (Manley et al., 2013; Shaw, 2013). Because of its focus on the well-being of staff members, the coaching activities can also be considered in relation to Cardiff's concept of person-centred leadership, a relational style of leadership considered an essential feature of effective workplace cultures (Cardiff, 2014).

Debate is ongoing about the general role of BRNs in nursing homes and their assumed contribution to QoC. Backhaus et al. (2015) opined that BRNs will contribute to QoC in the more complex care needs in nursing homes. In an international Delphi study, they revealed four main competency areas for future BRNs: leadership and coaching, communication, commitment to continuous quality improvement, and client assessment/geriatric expertise. In reviewing the coaching activities found in our study, we noticed that BRNs already demonstrate several required competencies. The importance of our finding that BRNs should clarify their role to CNAs as an enabling factor to coach teams is in adherence with other literature (Backhaus, 2017; Manley et al, 2011). Management also has an important role to play in positioning and promoting the BRN in a clear and exceptional way. Backhaus et al. (2015) advocate allocating BRNs in a way that allows them to act as intermediaries.

A recurrent discussion in the Dutch nursing homecare setting concerns the BRNs' contribution to the residents' direct physical care (Backhaus et al., 2020; Van den Schoor, 2016). Proponents argue that BRNs should deploy their role as clinical nurse expert by providing the nursing staff coaching on the job (Hamers et al., 2016). Opponents suppose that direct patient care (e.g., washing, dressing) is unchallenging for BRNs. BRNs are believed to be more needed, and better positioned from a cost perspective, in care-transcending areas such as quality improvement (Backhaus et al., 2020). In our study, the majority of the BRNs that provided coaching to CNAs participated to some degree in direct patient care, and CNAs mentioned its value, although not unanimously. We suggest that CNAs benefited from coaching and support from BRNs in clinical reasoning and from the trusting non-hierarchical relationship. We believe that the BRNs' participation in direct physical care directly contributed to this outcome.

As mentioned in the introduction, literature specifically related to BRNs coaching CNAs is currently lacking. This is harmful first because the BRNs' task remains invisible, and second because without an adequate description of coaching, we are unable to teach the BRNs coaching-specific competencies. Subsequently, we are

unable to evaluate coaching performance and cannot implement optimal coaching into daily practice. More research is needed on all aspects of the coaching trajectory. Relevant research areas include the needs of CNAs, successful coaching strategies, criteria for evaluating coaching quality, acquiring coaching competencies, and implementation of workplace culture. When we have achieved a more comprehensive understanding of coaching, upcoming job competency profiles and the educational curriculum of BRNs should address the coaching of CNAs more explicitly.

### 4.1 | Strengths and limitations

In order to interpret the results of this study, strengths and limitations need to be considered. The study was limited by the short duration of the interviews. To avoid unintentionally burdening CNAs during the COVID-pandemic, we took the individual CNA's preferred interview duration into account. That is, we asked questions as described in the topic list, but with limited follow-up questions, and we ended the interview at the time preferred by the interviewee. Conceivably, this may have led to CNAs providing relatively less detail or elaboration (Irvine, 2011). Yet, after the second wave of data collection, we noticed that data saturation had occurred and, although we stuck to the topic list questions, an unexpected new theme had emerged: Connecting with CNAs. We, therefore, argue that we have captured the most relevant features of coaching CNAs by BRNs. However, in a follow-up study, we would further explore the perspective of CNAs regarding BRNs participation in care, as this matter is subject to debate in the Dutch nursing home context whilst thorough empirical research to support this debate is lacking.

As all participants were female, maximum variation was not achieved for gender. The findings are therefore not immediately transferable to male CNAs. Maximum variation was however achieved for other characteristics, with a special interest in the type of care provided, the number of BRNs that provided coaching, and the BRNs' participation in care. In addition, transferability was strengthened by the multicentre design of this study.

## 5 | CONCLUSION

During qualitative interviews, CNAs described their experiences and needs with respect to coaching by BRNs. CNAs described a wide range of experiences, both positive and negative, of collaborating with BRNs. Based on their experiences, CNAs asserted that to enable valid coaching, BRNs must first find a way to connect with them. Once that connection had been made, CNAs experienced BRNs as valuable teaching, empowering, and mediating resources. As such, BRNs displayed the competencies expected of them and contributed to an effective workplace culture. BRNs can thus elevate nursing home care to highly complex care.

## 6 | RELEVANCE TO CLINICAL PRACTICE

The CNA's experiences and needs were the starting point of this study. The research question was raised in the context of a daily practice characterised by staff shortages, unqualified personnel, severe workloads, and increasing demands for high-quality person-centred care. In addition, the knowledge and skills required of CNAs can change rapidly and innovations are constantly being introduced and implemented. The most obvious way to empower and strengthen CNAs is to appoint BRNs who possess the knowledge and skills required to handle more complex geriatric care situations, who are clinical experts, and who can function as a bridge between management and CNAs. However, coaching CNAs requires specific coaching competencies, and efficiency can be improved by optimally preparing BRNs for this delicate job. Up to now, nursing-specific coaching knowledge has been lacking and criteria for valid coaching competencies insufficient.

Nursing home organisations will need to become teaching organisations in order to meet the needs of an increasingly ageing population with a diminishing supply of qualified nursing personnel. Providing person-centred care to residents requires a person-centred practice, with staff well-being as an additional important outcome. Coaching is one way to care for the well-being of CNAs and should therefore be promoted. Coaching may also contribute positively to team development. Management can help facilitate coaching by providing a clear job description and clear communication about the role of the BRN as a coach. In addition, a programme should be developed for introducing BRNs to staff. Other facilitators include providing a workplace for BRNs in the unit and allocating time for BRNs to spend with CNAs, including time for conducting clinical lessons. In view of the above-mentioned societal situation, nursing home organisations have the difficult task of finding the resources necessary to employ the relatively more expensive BRN and create a good skill mix. However, this is not management's responsibility alone, but also the responsibility of BRNs. BRNs can promote and support organisations in becoming teaching organisations. We suggest that BRNs demonstrate the leadership needed to ensure that the role of the coach becomes part of the more general role of facilitator as outlined in the concept of practice development. CNAs and BRNs can collaborate, each in their own unique role, to look for ways of adapting the organisations to meet future demands of nursing home care.

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### CONFLICT OF INTEREST STATEMENT

None.

## ETHICAL APPROVAL

The research ethics committee of the region Arnhem-Nijmegen, the Nederlands 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 General Data Protection Regulation and the Dutch Act on Implementation of the General Data Protection Regulation (Moraes, 2015). Data were stored on secured servers of the Radboudumc. Written informed consent was obtained prior to face-to-face interviews and verbal audio-recorded informed consent was obtained prior to telephone interviews.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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