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Joyce Young

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Walden University
2015

Abstract

Nurse Aides' Perspectives on Training

by

Joyce L. Young

MSN, Walden University, 2007

BSN, Elmira College, 1991

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

February 2015

Abstract

In 2008, the Institute of Medicine recommended increasing CNA training programs to 120 hours of training. In accordance with that change, the Pennsylvania Department of Education recommended that the Pennsylvania's CNA training program of a required 80 hours be increased to 120 hours of training. This increase was intended to improve CNA job performance and job satisfaction, as well as the quality of patient care. The purpose of this phenomenological research study was to understand how Certified Nurse's Aide (CNA) graduates of 100-hours or fewer training programs in Lancaster, Pennsylvania, perceived their clinical training as related to effectively performing clinical duties in a skilled nursing facility. Roger's learning theory served as a basis for analysis due to its approach of student-centered learning. Through the voices of seven CNA participants, data were collected through the implementation of in-depth interviews, surveys, and observation field notes. Data were analyzed through manual coding of themes combined with peer reviewers and record review to triangulate data. Three themes emerged: (a) CNAs perceived they were inadequately prepared to effectively complete clinical tasks, (b) a mentoring or shadowing program prior to employment reduced the physical and mental stressors and improved the quality of patient care they provided, and (c) CNAs voiced little desire to attend continuing education courses other than those provided by the nursing facility. These results may improve state curricular standards, provide insight for skilled nursing facility administrators relative to effective CNA patient care, and facilitate increased CNA job satisfaction and retention.

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Dedication

I dedicate this dissertation to my friend and partner Michael E. Harris, PhD, DBA who has believed in me and has taken my hand to help navigate me through the rough waters to reach my dreams. I also dedicate it to my two sons, Raymond and Scott, who have been the wind beneath my wings and keep reminding me that I was the ‘little train that could’.

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I acknowledge and thank the administrators, nurses, and nurses' aides who participated in the research for trusting that their voices would be shared.

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Section 1: The Problem

Introduction

Due to the increase in the number of aging American individuals, most healthcare workers will care for the elderly sometime in their careers (Health Care Work Force to Small, 2008). The Institute of Medicine's (2008) report suggests that strategies improving the effective training of direct caregivers are critical. Inadequate or the lack of, training of healthcare workers may lead to a high turnover rate, a shortage of healthcare workers, and the feeling of incompetency by the healthcare worker.

According to Castie, Engberg, Anderson, and Men (2007), Certified Nurse's Aide (CNA) direct caregivers performed their duties with more competency and confidence when they perceived their CNA training program as adequate. Castie et al. (2007) findings suggest that CNA healthcare caregivers' perception of their training directly impacts CNA workers' ability to meet patient needs. Further, Castie et al. (2007) identified that job satisfaction, and job retention was also tied to the CNAs perceptions of whether their training was adequate. Hence, CNAs' voices will provide insight into CNA job competency, job satisfaction, as well as role clarity as a healthcare professional. The study explores how CNA graduates of 100-hours or fewer training programs in Lancaster, Pennsylvania, perceived their clinical training, and whether they felt prepared to effectively perform clinical duties in a skilled nursing facility.

Background

In 1987, the Nursing Home Reform Act was federally mandated, in the United States, relative to CNA training curriculum and clinical components. In the 1990s, the

Bureau of Labor Statistics (BLS) and Employment and Training Administration (ETA) (2003), focused its policy research agenda on the long-term care workforce (Bureau of Labor Statistics (BLS) and Employment and Training Administration (ETA), 2003). The National Nursing Assistant Survey (NNAS) was the largest and most visible research finalized in this area. It administered the first national probability sample survey used in nursing homes for CNAs (Bercovitz, Branden, Remsburg, Rosenoff, & Squillace, 2007). The survey study was designed to provide an evidence base for understanding what draws individuals to nurses' aide careers; what draws individuals to be employed in a nursing home; and what contributes to their job satisfaction and longevity.

The report, *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation: Report to Congress* in 2003, was a collaboration response between Health and Human Services (HHS) and Department of Labor (DOL) to the U.S. Congress. One recommendation from these two governing bodies was to inform policymakers in government relative to the quality and availability of the workforce in the long-term. This would include wages and benefits, trends among caregivers, understanding the effect of their training, the effects of workplace culture on retention, and understanding how characteristics relate to health caregivers' recruitment and job satisfaction (Report to Congress, 2003).

In 2003, the office of the Assistant Secretary of Planning and Evaluation (ASPE) contracted with an independent research organization to develop a series of design options for a national survey of paraprofessional workers in institutional and community settings. ASPE then designed a National Survey of Certified Nursing Assistance in

Nursing Homes to identify what changes in CNA positions would make employment more attractive, and further, to identify reasons that CNAs left the profession. ASPE sponsored the NNAS through the collaboration of two independent research organizations, a national advisory group, private consultants, and a sustained partnership with the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC; Bercovitz et al, 2007). Upon completion, the survey identified primary points that would make CNA positions more desirable and increase retention. The identified points are wages, receipt of public benefits, health benefits, and injuries. The results of this survey were applied by the National Nursing Assistant Survey (NNAS) to a sub-sample of nursing homes participating in the National Nursing Home Survey (NNHS) in 2004.

The aforementioned survey assisted in strengthening the federal, state, and provider recruiting efforts of a qualified and committed CNA work force. An important outcome because of this survey was the development and initiation of the President's New Freedom Initiative on February 1, 2001 by President George W. Bush. The New Freedom Initiative recognized securing additional direct health care workers as critical if a goal of developing a plan for staffing an effective and adequate healthcare continuum of care for America's patients. In turn, the development of a staffing continuum of care would maximize consumer independence by providing a plethora of consumer health care choices (Bercovitz et al., 2007).

The literature (Bercovitz et al., 2007; Castie et al., 2007; NNHS, 2004) overwhelmingly concluded that CNA curricular training components required revision.

Further, the literature suggests that CNA training programs should reflect an increased in education and clinical practicum total hours to prepare CNA candidates adequately to care for the increasing elderly population.

The Local Problem

Evidence of the Problem at the Local Level

Since the passage of the 1987 Nursing Home Reform Act, researchers have been seeking a method to measure the adequacy of federal nurses' aide training requirements of and its effectiveness thereof. The Institute of Medicine (IOM; 2008) has recommended that federal and state governments, in collaboration with consumers, improve the quality healthcare for the elderly by developing CNA training programs with competency standards based on consumer-centered long-term care. The IOM (2008) training to make increased care efficiency and alleviate the current CNA shortage in the United States. report also called on health care professions, policy makers, and regulators to consider expanding the roles and responsibilities of CNA health care providers at various levels of training to effectuate increased care efficiency and alleviate the current CNA shortage in the United States.

In response to the IOM, the State of Pennsylvania is strongly recommending a need for additional hours of training to train CNAs adequately to address the higher level of critical care required by patients currently admitted to hospitals, residing in skilled nursing facilities, and patients who are homebound. Presently, the CNA training program in Pennsylvania consists of 80 hours. This number of hours of training currently is being examined by the State of Pennsylvania as to its efficiency of providing adequate training.

A lack of training hours, and/or ineffective training program could leave healthcare workers unprepared to meet the challenges of the elderly, which may lead to a high turnover rate and a shortage of CNA healthcare workers (News from the National Academies, 2008).

In an attempt to meet this challenge, The Centers for Medicare & Medicaid Services (CMS; 2011) examined the Affordable Care Act (ACA), passed by Congress and signed into law by President Obama on March 23, 2010. The purpose of the ACA was to improve and secure qualified health care professionals to meet the needs of all patients, especially elderly patients. Specifically, the ACA, Title I and V, sought to provide guidelines for securing Medicaid benefits for America's seniors and ensuring quality health care services, as well as securing and maintaining qualified healthcare professionals. The ACA also mandates enhanced annual nurse aide in-service training, specifically in the areas of dementia care and resident abuse prevention. The ACA codes for the Interpretive Guidelines for F-tag 497 (Regular In-Service Education) have been updated by the CMS to include these two topics as a required part of each aide's yearly 12-hour training. The rationale for additional dementia education is the inability for patients with dementia to communicate their wants and needs clearly; hence, these patients are at a higher risk for neglect and abuse than others are (U.S. Department of Health & Human Service, 2010).

Similarly to the findings of the CMS and ACA, the State of Pennsylvania also recognizes difficulties in adequately training, and subsequently, maintaining, CNA

workers. How CNAs perceive their training program and job effectiveness, satisfaction and retention; is important for local, state, and national nursing homes' ability to provide a quality continuum of health care (Bercovitz, Branden, Remsburg, Rosenoff, & Squillace, 2007). CNA perceptions may help to underscore and explain retention concerns identified at a local 120-bed nursing home located in central Pennsylvania**.**

Rationale

According to the Omnibus Budget Reconciliation Act (OBRA) of 1987, Federal Regulations, Section 483.152 states nurses' aide training and competency evaluation programs that are to be approved by the States must consist of a minimum of no fewer than 75 clock hours of train (Legal Information Institute, 2011). Supervised practical training is defined as training in a laboratory or other setting in which the student demonstrates knowledge while performing tasks on an individual, under the direct supervision of a registered nurse (RN) or a licensed practical nurse (LPN).According to the Institute of Medicine (2008), it has been recommended that CNA training be increased from 80 to 120 hours. The dichotomy of an increasing elderly population and inadequate preparation of nurses' aides is the impetus for a need to retool America's healthcare and education (Institute of Medicine, 2008, The Nursing Home Reform Pennsylvania Code, 1989). According to the Pennsylvania Administrative Code, Title 55, 1181.521 (2009) of Pennsylvania, nurses' aides are required to have a minimal of 80 training hours of instruction and a minimal of 37.5 hours of clinical training hours to be in acted in 2010 (State Nurses' Aides Training Requirements, 2009). The class

curriculum consists of communication skills, personal care skills, interpersonal skills, basic nursing skills, and resident rights.

Definitions

Special terms that are associated with the problem are defined in the following section. These terms may have multiple meanings depending on the context; thus, their definitions are provided to the reader for clarification.

Active training: a training approach that includes active participation of the learner. Adult learner-centered methods that engage students with discussions, role-plays, and small group work may be used in this approach (Paraprofessional Healthcare Institute [PHI] Policy Works, 2012).

Certified Nurse's Aide (CNA): CNAs are individuals who have received a minimum Federal and State training hours in a State approved nurses' aide training program. Federal regulations require the individuals to have 75 hours of training hours and a training program that must include 16 hours of clinical or "hands-on" training, in which the trainee demonstrates knowledge while performing tasks for an individual under the direct supervision of a nurse. State education requirement for the individuals may vary from state to state. CNA students must complete the training and pass a state certificate exam and skills test within four months of starting work at a nursing facility (Moore, 2011). For the purpose of the study, CNA and nursing assistant will be used interchangeably.

Clinical practicum: training experience to build clinical skills "practical" application of the theory studied (State Nurse's aide Training Requirements, 2009).

Direct care worker (DCW): Direct care workers are individuals who give personal care to others of all ages who have disabilities or a chronic illness and need assistance (Ejaz, Noelker, Menne, and Bagaka; 2008, Mittal, Rosen, and Leana, 2009).

P*assive training:* a training approach that involves little or no active participation from the learner. Lectures, readings, and video tapes, with a limited amount of supervision hands-on practice or with a combination of the above may be used in this approach (Paraprofessional Healthcare Institute (PHI) Policy Works, 2012).

Skilled Nursing Facility (SNF): Refers to “an institution or part of an institution that meets criteria for accreditation established by the sections of the Social Security Act that determine the basis for Medicaid and Medicare reimbursement for skilled nursing care. Skilled nursing care includes rehabilitation and various medical and nursing procedures” (Elsevier, 2009).

Supervised practical training: means training in a laboratory or other setting in which the student demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse (Legal Information Institute, 2011).

Significance of the Problem

This problem is significant because the State of Pennsylvania CNA training program-hour increase is a key factor in providing quality healthcare to patients requiring CNA services in all levels of medical care. Through an increase of clinical hours of CNA candidates, nursing home facilities in Pennsylvania hope to realize a benefit through an increase in CNA efficiency and effectiveness while improving CNA retention.

The financial decisions made by administrators often determine the continuum of educational operation in their facility. The significance of this problem is important in the funding of continuing CNA education in a facility. It is important that the administrators of healthcare facilities understand that the facility funding is relevant to the development of nurses' aides' training programs; and further, to those involved (i.e., administrators and instructors) in the implementation of improved CNA programming. Consequences of healthcare administrators' decisions affect the expansion and improvement of healthcare services within a healthcare facility, and must be considered carefully to successfully accommodate the increasing numbers of senior citizens in America requiring skilled nursing care (Business Wire, 2008).

This study has the potential to contribute to the existing body of practice that is needed to improve certified nurse aide training. Through the CNA participants' voices, expectations of the State of Pennsylvania CNA training programs will be explored in correlation with CNA duties in skilled nursing facility. Phenomenology is the qualitative research strategy that I selected for this study. Hatch (2002) stressed that phenomenological research is at the basis of all qualitative research. In this study, I planned to provide information on improving the quality of the nurses' aides training and assist in bridging significant gaps of CNA training and the clinical implementation of their duties within a skilled nursing facility.

Research Questions

The questions that guided this study are the following:

1. How do CNA graduates of the 100-hour or fewer programs perceive their clinical

training as it relates to effectively performing their clinical duties in a skilled nursing facility?

2. How do CNA graduates of the 100-hour or fewer programs perceive their classroom training/curriculum as it relates to effectively performing their duties in a skilled nursing facility?
3. How do CNA graduates of the 100-hour or fewer programs perceive their desire/motivation to acquire or not acquire additional education in the healthcare system as related to their training program?

Literature Review

I used Boolean search engines such as Walden University and Google to find articles related to the research subject, such as CNA training, Care Givers training, CNA surveys, and perceptions. Current research and peer-reviewed literature specific to CNA perceptions of CNA education training programs have been found to be limited. Saturation has been reached in this literature review.

In this section, I examine the current peer-reviewed journals and professional literature in relationship with the recommendations from the IOM (2008). I introduce and explore their recommendations on retooling healthcare education by the use of Roger's learning theory, expanding the roles and responsibilities of healthcare providers, and on the research that is being conducted to prepare healthcare workers. I also examine teacher centered vs. student centered training and the CNAs perceptions of their training being inadequate to prepare them for their duties. Next, I examine the retention of CNAs

on a local and national level that may be significantly influenced by inadequate preparation.

The current research and peer-reviewed literature revealed consistent themes of CNAs disinterest given teacher centered vs. student centered training (PHI Policy Works, 2012), perception of training as inadequate preparation for CNA duties (Castie et al, 2007), and poor retention of CNAs on a local and national level due to inadequate preparation (Bercovitz et al., 2007).

Recommendations from the IOM

The IOM is an organization, independent of the United States government, which provides unbiased recommendations for the American public law makers relative to healthcare. In 2008, the IOM recommended that CNA training be increased to 120 hours, whereas States training programs ranged from 75-100 hours (Paraprofessional Healthcare Institute, 2009). The dichotomy of an increasing number of the elderly populations and inadequate preparation of nurses' aides is the impetus for the need to retool America's healthcare and education (Institute of Medicine, 2008, The Nursing Home Reform Pennsylvania Code, 1989). Recommendations from the IOM (2008) were: (a) retool education so that training programs will deliver a more efficient healthcare system and relieve the shortage of adequately trained workers, (b) healthcare regulators should consider expanding the roles and responsibilities of healthcare providers at the various levels of training, (c) research should be conducted on preparing healthcare workers to assume expanded roles (News from the National Academies, 2008).

Retooling of Healthcare Education

There is a need for nurses' aides to give care that is more technical because as hospital stays become shorter nursing home patients are increasing (News from the National Academies, 2008). Hence, upon returning to the nursing home, these patients will be in need of advanced and more frequent skilled nursing care.

The minimal federal requirements for a nurses' aides' training and competency evaluation program are described in the Omnibus Budget Reconciliation Act (OBRA) of 1987, Federal Regulations, and Section 483.152.(U.S. Department of Health & Human Service,2010). CNAs are typically taught these requirements through a combination of passive training techniques of lectures, readings, and video tapes, with a limited amount of supervision hands-on practice (Paraprofessional Healthcare Institute (PHI) Policy Works, 2012).

Many educators rely heavily on passive training techniques, such as lectures, readings, and video tapes, rather than that of active training techniques of adult learner-centered methods that engage students with discussions, role-plays, and small group work. Often there is a disconnection between the classroom and the workplace, with inadequate on-the-job support for new workers to continue their learning and perfect their skills (Paraprofessional Healthcare Institute (PHI) Policy Works, 2012). According to the Paraprofessional Healthcare Institute (PHI) Policy Works (2012), these methods often fail in conveying the information to the learner because the method is not student -learner centered.

These limitations from this type of training often leave CNAs feeling unprepared for the challenges of caring for patients with complex emotional and physical needs. These feelings of unpreparedness and disconnect, from theory to application, often leads to a high turnover rate for direct care workers (Paraprofessional Healthcare Institute (PHI) Policy Works, 2012). New direct care workers often cite inadequate preparation as one of the reasons they leave the healthcare field for other positions (PHI Policy Works, 2012). When instruction is very teacher centered, many students become disinterested in learning (Weimer, 2002). In this case, control of the class remains firm, and almost exclusively, in the hands of the teachers.

To prevent teacher-centered classrooms, educators are implementing a student-centered learning method for reallocation of power in the classroom. This method requires that faculty give students limited control over those learning processes that directly affect them. Student-centered learning allows the teacher to share the control of the classroom with students, as students are able to explore and experiment independent of the teacher's directive. In this teaching format, students are encouraged to work with their peers and engage in learning versus passive rote memorization of information presented (Nanney, 2004).

The main concept of student-centered learning is incorporating topics that are relevant to the students' lives, needs, and interests' so that learning becomes a more meaningful experience. In student-centered classrooms, students become actively engaged in creating, understanding, and connecting to knowledge. Hence, students

become invested stakeholders in their learning environment and experience, thus, demonstrating a higher motivation (Nanney, 2004).

In a learner-centered classroom, course content is taught utilizing differential learning strategies and methods to accommodate individuals who learn differently and require multi-modalities of learning to include visual- perceptual learning, auditory and manipulative learning strategies (Baume & Fleming, 2006). Methods utilized in the learner-centered classroom are taught through a variety of problem-solving activities that involve role-plays, case studies, small group discussions, and any number of interactive exchanges. The more the learners participate in these learning methods in the classroom, the more likely they will be able to integrate and apply their new knowledge into their work and into any new situation in their work (Paraprofessional Healthcare Institute, 2005).

Student-centered learning benefits both the learner and the instructor by shifting the power in the classroom to the students. Instruction requires students take an active, versus passive, role in the classroom. In student-centered learning, students are encouraged to bring their diverse thoughts and perspectives to class for class input. Students are also included in the decision-making processes throughout the instruction. Options are the focus of these classrooms, rather than uniformity. The learners are the co-creators of learning in this process, with ideas and issues that deserve attention and consideration (Nanney, 2004).

The instructor must first consider the students rather than the content when designing the lesson in order to meet the students' needs. Student-centered learning

shifts the power of learning from the teacher to the student. This shift makes the student more responsible for their learning. It helps the teacher become more familiar with the students learning abilities and helps the teacher to know their students as people. Student-centered learning also creates an environment of caring which promotes an atmosphere of comfort and ownership for the student (Nanney, 2004). Nanney (2004) points out that student-centered teaching helps the instructor design instruction that is effective for each student that will meet each one of his or her needs. It can be adapted to meet each student's diverse needs.

In order to accomplish an implementation of increased student-centered learning, an expansion of training hours will be required. CNAs' perceptions of student-centered learning may be examined by examining the Roger's learning theory, as a conceptual framework. Roger's learning theory of "client-centered is often equated with student-centered learning" (Merriam, Caffarella, & Baumgartner, 2007, p. 283). Roger believes that some characteristics of student-centered education demand personal involvement, self-initiation, and pervasiveness, learner evaluation and meaningful learning exchanges. These characteristics fit into his theory of learning as a practice.

Personal involvement within one's lesson assists helps him/her to own it so that it makes sense to him/her. Self-initiation means that the student has to want to do it in order to get it done. Perseverance occurs when the student is serious about learning and is willing to meet the goals and objectives of the course. Finally, the student's learning should be evaluated to see if his/her needs have been met, and further, to determine if the. student's lesson was meaningful and integrated their entire learning experience (Merriam,

Caffarella, & Baumgartner, 2007) "The process of learning, which is centered on learner need, is seen as more important than the content; therefore, when educators are involved in the learning process, their most important role is to act as facilitators or guides" (Merriam, Caffarella, & Baumgartner, 2007, p. 284)

Expanding the Roles and Responsibilities of Healthcare Providers

Presently, the role of the nurse's aide is to assist the nurse in caring for the patient. Their duties include patient comfort by increasing time spent with the patient, carrying meals to patients, answering call lights when patients signal they need help, and assisting in the positioning of patients. Their duties also include making beds, giving baths, filling water pitchers, ice bags, and performing routine tests, such as taking a patient's temperature, pulse, and blood pressure (Moore, 2011).

CNAs are able to perform a variety of jobs in a medical facility. Their job descriptions may vary depending on the type of facility where they are employed. They may be employed as a hospital CNA, Rehabilitation Centers Nurses' Aide, Adult Care Center Nurse Assistant, Hospice CNA, Nursing Home CNA., Physician's Office Nurses' Aide, Long-Term Care Facility CNA., and Mental Health Care Center Nurses' Aide. They may also work as a Home Health Aide, Travel Nurses' Aide, Private Duty CNA., or School Nurses' Aide (Wilson, 2011).

Because of the increased number of the aging, most healthcare workers will care for the elderly sometime in their careers. The Institute of Medicine (2008) has recommended that a competence test for caring for the elderly should be given to all CNAs to ensure their competence. Further, as it was also recommended that this

competence test be given to all healthcare givers that maintain a CNA license or certification (News from the National Academies, 2008).

Research conducted on preparing Healthcare Workers

Training, rewards, and workload are particularly important aspects of nurses' aides' jobs (Castie, Engberg, Anderson & Men, 2007). Castie et al (2007), examined the relationship between CNA job satisfaction and turnover, and found there was a connection between overall job satisfaction and job retention. Data was obtained by Castie, et al (2007) survey of 72 nursing homes from five U.S. states in Colorado, Florida, Michigan, New York, and Oregon, of which 1,779 surveys were collected from nurses' aides' respondents (a response rate of 62%). A job satisfaction instrument was developed for use with the nurses' aides, along with previously validated measures of intent to leave and turnover. Components of the survey contained the following categories and correlation thereof: 1) high overall job satisfaction was associated with low scores on thinking about leaving, 2) contemplating engaging in a job search, 3) searching for employment, and 4) CNA resignation or turnover. In examining the association between the job satisfaction subscales and intent to leave and turnover, Castie et al. (2007) found that high Work Schedule subscale scores, high Training subscale scores, and high Rewards subscale scores were associated with high scores on the Quality of Care subscale. Further, overall high Quality of Care scores were associated with a low turnover after one year of employment (Castie et al, 2007).

The implications of Castie et al. (2007) study were that inadequate preparation of CNAs may result in job dissatisfaction and frustration; hence, high turnover of staff

results. Survey analysis suggested the inadequate preparation of nurses' aides is an issue of concern for healthcare educators, as healthcare workers' perceptions of job preparedness and their ability to meet the challenges of an aging population is critical CNAs' commitment to employment (Castie et al, 2007). Castle (2006) proposed that NA satisfaction is associated with promotional opportunities, superiors, and compensations.

Castle (2007) proposed that CNA satisfaction is associated with promotional opportunities, superiors, and compensation. Bishop, Weinberg, Leutz, Dossa, Pfefferle, and Zincavage (2008), in part, agreed with Castle's (2007) findings relative to CNA job satisfaction being somewhat dependent upon the CNAs relationship with his/her superior. Bishop et al (2008) conducted a qualitative study with the intent to understand what factors motivated CNAs to retain his/her job the investigation of management and philosophy techniques within Massachusetts' nursing homes. Through the voices of 225 CNAs employed in 15 different Massachusetts nursing home, Bishop et al (2008) concluded CNAs' intent to stay employed at a facility was not primarily determined by tangible rewards (i.e. benefits, wages, and opportunities for advancement); but rather was determined by the primary factors of fair, attentive supervision. Further, Bishop et al (2008) paired the investigation of CNAs job satisfaction to the response of nursing home residents. Results indicated that not only did fair supervision and mentoring influence CNA retention; but also, that nursing home residents perceived CNAs as satisfied with his/her job as also being more committed to providing a better quality of care for residents. The consequences of CNA job satisfaction were further explored by Thompson, Horne, and Huerta (2011).

Thompson et al. (2011) conducted a similar study that replicated and extended Castie et al (2007) study. Thompson et al. (2011) examined factors related to satisfaction of nurse aides at a 120-bed skilled nursing facility in Lubbock, Texas. They adapted the Nursing Home Nurse Aide Job Satisfaction Questionnaire to allow for the collection of qualitative responses of nursing staff. The results of this study suggest that job satisfaction among nurses' aides are related to rewards, workload, and the team environment created among coworkers. These findings may differ from Castle et al (2007) because of the related higher-than-average satisfaction rating of nurse aides at this facility.

Yeatts, Cready, Swan, and Shen (2010) purported there was a relationship between the certified nurse aides' (CNAs) perception of training and continuing education and CNA performance, turnover, attitudes, burnout, and empowerment. A self-administered survey instrument was utilized. Survey responses of 359 CNAs working in 11 large nursing homes in the North Texas region were retrieved. Participation in decision-making, information exchange, the procedures used, and satisfaction/commitment was associated with the perceived training availability were evaluated by study participants. CNAs surveyed identified several concerns: 1) they may not have received substantial training related to the depersonalization of residents, 2) self-esteem was impacted by the overall success in treating patients, and 3) direct decision-making by CNAs was often required on the job. Additionally, the study results suggest that an employment component for CNAs relative to training is the need for on-going assistance in transference of CNA skills and knowledge to hands-on resident care.

Resnick, Cayo, Galik, and Pretzer-Aboff (2009) furthered this notion of CNA perceptions relative to success through continuing facility and/or resident care education. Resnick et al (2009) concluded that the quality of patient care improved with additional training for nurses' aides. This conclusion arose following a 6-week restorative care educational program (30 minutes weekly) conducted for 523 nursing assistants and implemented in 12 nursing homes recruited. The mean age of the participants was 38.1 years (SD = 12.0). The majority were female (486; 93%) and African American (466; 89%). The nursing assistants had an average of 14.7 (SD = 3.8) years of education and 11.5 (SD = 8.6) years of experience. Control sites had a single 30-minute in-service on managing behavioral problems commonly associated with dementia. Of the nursing assistants, 33% who consented to participate at the treatment sites attended all six classes. Of those, 53% who did not attend at least three classes received one-on-one review of the class content. Overall, 86% of the nursing assistants who consented to participate attended the 6-week educational program. At the control sites, 18% of the nursing assistants who consented to participate attended the in-service training. There was a significant increase in restorative care knowledge in treatment group participants. The techniques used in this intervention were effective in helping to expose nursing assistants to educational sessions and increase their knowledge of nursing care practices (Resnick, Cayo, Galik, Pretzer-Aboff, 2009).

Seery and Corrigall (2009) state in the study, *Emotional Labor: Links to Work Attitudes and Emotional Exhaustion*, that job satisfaction, affective commitment, emotional exhaustion, and intentions to quit were linked to self-focused emotional labor

(surface acting) and other-focused emotional labor (emotional enhancement). The study employed a cross-sectional survey of 363 nurse's aides and childcare workers. Surface acting, a type of self-focused emotional labor, was related to negative work outcomes (lower job satisfaction and affective commitment as well as higher turnover intentions and emotional exhaustion). Emotional enhancement, a form of other-focused emotional labor, was related to positive outcomes (lower turnover intentions and emotional exhaustion) when performed for clients' family members, but not for clients. The cross sectional design of this study limits the ability to map the temporal ordering of these relationships, and thus to determine if emotional enhancement is a job resource or response to positive work experiences. In addition, two helping occupations – nurses' aides and childcare workers - were sampled; hence, the findings may not generalize to other types of occupations. This study adds to the research about job-related emotional labor because other-focused emotional labor largely has been neglect in previous research. In addition, it is the first to differentiate workers' emotional labor with different groups of clients (patients/children; family members).

In the home care services, there is a noticeable trend towards increased psychosocial strain on employees at work. For health promotion in the workplace, not only factors relating to the absence of injury and the physical health of the workers, but also psychological aspects and all potential resources needs to be taken into consideration. Larsson, Karlqvist, Westerberg, and Gard, *Identifying work ability promoting factors for home care aides and assistant nurses* (2012), purported there is a dynamic balance between the resources of the individual employees and the demands of

work. As a result, there is a high frequency of work-related musculoskeletal disorders and injuries, and a low prevalence of sustainable work ability.

Larsson et al (2012) sought to identify factors promoting work ability and self-efficacy in care aides and assistant nurses within home care services. The method in this study is based on cross-sectional data collected in a municipality in northern Sweden. Care aides ($n = 58$) and assistant nurses ($n = 79$) replied to a self-administered questionnaire (response rate 46%). Hierarchical multiple regression analyses were performed to assess the influence of several independent variables on self-efficacy (model 1) and work ability (model 2) for care aides and assistant nurses separately. The results of the study was that perceptions of personal safety, self-efficacy and musculoskeletal wellbeing contributed to work ability for assistant nurses (R2adj of 0.36, $p < 0.001$), while for care aides, the safety climate, seniority and age contributed to work ability (R2adj of 0.29, $p = 0.001$). Self-efficacy was associated with the safety climate and the physical demands of the job in both professions (R2adj of 0.24, $p = 0.003$ for care aides), and by sex and age for the assistant nurses (R2adj of 0.31, $p < 0.001$). The conclusion of the study was that the intermediate factors contributed differently to work ability in the two professions.

Self-efficacy, personal safety, and musculoskeletal well-being were important for the assistant nurses, while the work ability of the care aides was associated with the safety climate, but also with the non-changeable factors age and seniority. All these factors are important to acknowledge in practice and in further research. Proactive

workplace interventions need to focus on potentially modifiable factors such as self-efficacy, safety climate, physical job demands, and musculoskeletal wellbeing.

Ejaz, Noelker, Menne, and Bagaka's , *The impact of stress and support on direct care workers' job satisfaction* (2008), a study implied that it is important to target both direct care workers' (DCW), level and organizational, level factors to increase DCW job satisfaction. A stress and support conceptual model is applied in this study to investigate the effects of background characteristics, personal and job-related stressors, and workplace support on DCW job satisfaction. Ejaz et al (2008) collected survey data by researchers from 644 DCWs in 49 long-term care (LTC) organizations. The DCWs included nurse assistants in nursing homes, resident assistants in assisted living facilities, and home care aides in home health agencies. The influence of components of the LTC stress and support model on DCW job satisfaction was examined and an analysis of individual-level DCW predictors in correlation with job satisfaction.

Subsequently, Ejaz et al (2008), through a hierarchical linear model, examined the influence of organizational factors on DCW job satisfaction after controlling for significant individual-level DCW variables of background characteristics, such as age and education. The composed model explained 51% of the variance in DCW job satisfaction. Background characteristics of DCWs were less important than personal stressors (e.g., depression), job-related stressors (e.g., continuing education), and social support (e.g., interactions with others) in predicting job satisfaction. The results from the hierarchical linear modeling analysis evidenced that nursing homes, when compared to the two other types of LTC organizations, had lower DCW job satisfaction rates. Further,

organizations offering lower minimum hourly rates had higher DCW job satisfaction than those reporting turnover problems.

Mittal, Rosen, and Leana, (2009), researched the effects of the background characteristics, personal stressors, job-related stressors and workplace support on job satisfaction of direct care workers' (DCW). Mittal et al, (2009) used a stress and support conceptual model to collect and analyze survey data from 644 DCWs in 49 long –term care (LTC) organizations. The DCWs included nurse assistants in nursing homes, resident assistants in assisted living facilities, and home care aides in home health agencies. In this study, researchers examined the influence of components of the L.T.C stress and support model on DCW job satisfaction. In the beginning, the researchers ran a multiple regression analysis by entering individual-level DCW predictors with job satisfaction as the outcome. Subsequently, the researchers used hierarchical linear modeling to examine the influence of organizational factors on DCW job satisfaction after controlling for significant individual-level DCW variables. Results identified five major themes that are associated with turnover: (1) lack of respect, (2) inadequate management, (3) work or family conflicts, (4) difficulty of the work, and (5) job openings. Themes associated with retention were as follows: (a) being “called” to service, (b) patient advocacy, (c) personal relationships with residents, (d) religion or spirituality, (e) haven from home problems, and (f) flexibility. The themes that were associated with turnover were different from those associated with retention.

Rubin, Balaji, and Barcikowski (2009), attributed job dissatisfaction, nurse staffing, and turnover to faulty communication between nurses and nursing aides. Rubin

et al (2009) identified barriers to nurse-nursing aide communication. Focus group session data revealed that insufficient communication methods between nursing supervisors and nurses aids were often found to produce job dissatisfaction for nurses' aides. In addition, Rubin et al (2009) assisted in determining the effectiveness of job satisfaction-related outcomes by interviewing two (2) registered nurses (RNs), ten (10) licensed practical nurses (LPNs) and 19 certified nursing aides. The respondents' voices produced narrative themes that guided focus group discussions. A job satisfaction survey was also distributed in a pre-test/post-test format to triangulate data findings. Rubin et al (2009) concluded: (1) anger and condescension in communication; and (2) lack of mentoring, empathy, and respect were significant contributors to CNA job dissatisfaction. The job-satisfaction survey data indicated that these attitudes decreased significantly among participants in the focus group when validation of respondents' concerns was provided by the nursing facility administration. Conclusively, Rubin et al (2009) purport that nurse supervisors, both RN and LPN, are key to educational reform and the use of collegial communication methods when delegating authority are key to CNA job satisfaction.

Additional research supporting the notion of improved supervisor-CNA collegial communication was that of Siegel, Young, Michell, and Shannon (2008). The notion that nursing supervision of routine patient daily care (e.g., grooming, feeding, and toileting) delegated to unlicensed assistive personnel (UAP), critical to efficient nursing home service delivery was supported through the work of Siegel et al (2008). Siegel et al (2008) explored the organizational, managerial, and nurse-level factors associated with

the nurse's role as supervisor of UAP in nursing homes. The design and study was an ethnographic approach to data collection that included 31 interviews, 170 hour of observation, and organizational document review at three nursing homes. Analysis included micro coding and content analysis. The results revealed (a) considerable variation in organizational resources, systems, and processes to support organization and operational of the supervisory role; and (b) limited evidence of nurses' estimation of the potential benefits of training and organizational systems to support supervisory practice and the complexity of the supervisory role. These findings suggest that action from nursing home leaders in policy, academia, ownership, and management positions is warranted. It is important for nurses to be equipped with competencies and skills that reflect the complex matter of the delivery of high-quality nursing home care of organizational environments in which nurses work. In addition, to support nurses' role enactment, nursing home administrators and managers must be equipped with the competencies, skills needed to be efficiently in organizing, and operational care.

Practices to improve Training Effectiveness

The number of Long Term Care (LTC) residents is projected to triple by 2031 (O'Brien, 2010). Implementing management initiatives that enable formal caregivers to provide quality, individualized care to older adults in long-term-care (LTC) facilities is increasingly important and can be improved through the empowerment of it care givers.

The relationships between the care provider access to structural empowerment and the provision of individualized care in LTC are explored by Caspar, Sienna, O'Rourke, and Norm, (2008). Structural empowerment is defined as informal power,

formal power, information, support, resources, and opportunity. Caspar et al (2008) computed structural equation models for registered nurses, licensed practical nurses and CNAs to examine the relationship between access to empowerment structures and the provision of patient care. Access to structural empowerment had a statistically significant, positive association with provision of individualized patient care for both groups. Hence, both registered nurses/licensed practical nurses and CNAs appeared to provide better patient care when empowerment structures were available to the study respondents. Of the empowerment structures, support, educational opportunities and recognition for job performance was rated most highly by both groups as motivation to provide quality patient care. Findings from this study suggest that provision of individualized care in LTC may be enhanced when formal caregivers have appreciable access to empowerment structures.

The effects of access to an empowerment structure on caregivers are further described by Häggström, Engström, and Barbro (2009), through the perceptions of nurses and CNAs working in a SNF. Häggström et al (2009) provided a series of role awareness training which focused on structural empowerment. The goal of the training was to assist participants in developing their self-image and professional role. The qualitative design consisted of semi-structured interviews of 14 nurses and 14 nurses' aides' pre and post training course participation. Results evidenced nurses and CNAs perceived their professional role as enhanced following the structural empowerment-training course. Themes derived were: (a) the move from passivity to activity, (b) previous participant complaints became points of understanding, (c) unrealistic expectations and frustration

levels decreased, and (d) and participants no longer kept discontent silent, but began to speak up. Hence, the series of role awareness sessions resulted in improved perception of one's nursing and/or CNA professional role. Subsequently, this improved perception translated into improved quality care within the nursing facility in which the study participants' worked.

Medvene and Louis (2012) furthered the notion of Häggström et al (2009) relative to CNA perception of his/her role and the impact their perceptions have on providing quality patient care. The quality of CNA-resident relationships was explored using the theoretical framework of "interdependence theory." Medvene and Louis (2012) attempted to code CNAs' responses relative to relationships with residents, and further, factors that promoted or limited these relationships using interdependence theory. Interdependence theory defines closeness of any relationship in terms of outcome interdependence. The theory provides an explanation of the process of trust and commitment development between two parties. Seventeen CNAs, from nine long-term care facilities in the United States, participated in structured in-depth interviews. CNAs unanimously stated they had developed close relationships with some residents, and further, that they were thinking "relationally" about their interactions with residents.

The implication of this study is that in-service training programs for CNAs should encourage CNAs to think about their interactions with residents in a relational, as well as dispositional, term. Person-centered care philosophy encourages CNAs to develop close relationships with their residents. CNA training programs should normalize the appropriateness of such relationships. However, if the in-service training programs

normalize close CNAs to patient relationships, such programs should also provide CNAs guidance in dealing with boundary issues, personal relationships, and multiple roles.

Quality of Care

Adding to the notion of quality of care provided to patients, the quality of care of skilled nursing home residents was examined in terms of CNA role perception. Chung (2011) proposes that quality of CNA-resident care is influenced by CNAs' opinions, and CNAs' role perception within the skilled nursing facility (Chung, 2011). Chung (2011) explored the impact of social workers mentoring CNAs. Chung (2011) noted that when CNAs are mentored with a social worker, they are more able to address, and resolve, daily patient care (both formal and informal) dilemmas. Through the mentoring, CNAs evidenced increased ability to discuss acceptable and appropriate patient relationships within nursing home care.

The beliefs and assumptions of CNAs, according to Chung (2011), contributing to reduced resident quality of care are those of (a) CNAs feeling of being overburdened, (b) workload fatigue, (c) inter-staff miscommunication, (d) lack of adequate training, (d) inadequate staffing, (e)lack of continuity of care, and (f) depersonalized care. These findings support that of other literature (Castie et al, 2007, Häggström et al, 2009) which has established the relationship between staffing levels and care outcomes of nursing homes residents.

Based on the literature (Castie et al, 2007; Chung, 2011), turnover adversely affects continuity of care and care recipient relationships that can prevent or interfere with the development of the client and caregiver relationship. Caregivers play an

important part in monitoring the everyday physical and mental health of their clients; hence, CNAs' patients receive more individualized and efficient quality of care (Casper et al, 2008). High staff turnover can also cause a staff shortage that may result in a rushed, depersonalized, or unsafe care for the resident (Castie et al, 2007).

While few studies have made a direct link between work force turnover and the quality of care received by long-term care residents, there are strategies that can be used to retention nurses' aides and improve the quality of residential care in a long-term care setting. These strategies are assessments of the nurses' aides' attitudes, regular training programs in dementia care, adequate staffing and equipment, performance-based pay rises, and subsidized training.

Call for measurable CNA Efficiency Clarification

Lerner, Resnick, Galik, and Russ (2010), measured the impact of continuing education provided to CNAs in relation to CNA motivation to participate in higher learning experiences within the nursing field. Lerner et al (2010) examined a full-day advanced nursing assistant training course implemented in Maryland. Lerner et al (2010) initiated their research with the following three goals: (a) Identify if CNAs had interest in participating in continuing education experiences, (b) the extent to which CNAs' supervisors supported CNA participation in the course, and (c) the extent to which classroom learning and theory was applied to CNA practice.

The training format was that of a daylong training program, and was provided for forty-four experienced CNAs to supplement their basic CNA certification education requirements. To test the effectiveness of the training for knowledge acquisition and

application, a pre- and posttest design were implemented. Results suggested that study participants experienced a significant improvement in knowledge upon completion of the training program. The participants requested additional education on dementia and infection control following the training completion. A direct benefit from the training, per Lerner et al (2010), was that 100% of CNA participates was able to plan a detailed intervention, as well as develop outcome measures of the proposed intervention, that specifically met the needs of the participating CNAs' workplace. Conclusively, this study revealed that when CNAs were enrolled in this advanced training program, an expressed desire for additional caregiver education occurred. Lerner et al (2010 purported that an advanced training program is one method to increase job satisfaction among nursing assistants that can improve the quality of care for nursing home residents.

While Lerner et al (2010) discussed the impact of CNA continuing education in the workplace, Chuang, Dill, Morgan, and Konrad (2012) identified additional factors that impacted CNA-patient care. Using a **c**ross-sectional survey, data from 661 frontline health care workers (FLHWs) in 13 large health care employers, was collected from the United States between 2007 and 2008. Both regression and fuzzy-set qualitative comparative analysis suggested that supervisor support and team-based work practices were necessary for high job satisfaction and high quality of patient care to be realized. However, supervisor support and team-based practices were not sufficient were not sufficient to achieve favorable quality patient care outcomes. When the aforementioned was implemented in tandem with other HPWP, the result was either job satisfaction or high quality CNA-patient care. Several configurations of HPWP were associated with

either high job satisfaction or high quality of care. Such configurations were supervisor support combined with performance based incentives, performance based incentives combined with team based work, and a flexible CNA work environment. However, Chuang et al (2012) found only one configuration of HPWP to be sufficient for the combinations of supervisor support, performance-based incentives, team-based work, and flexible work.

These findings, consistent even after controlling for FLW demographics and employer type, suggests additional research is needed to clarify whether HPWP have differential effects on quality of care in direct care versus administrative workers. In conclusion, high-performance work practices that integrate FLWs in health care teams, and provide FLWs with opportunities for participative decision-making, can positively influence job satisfaction and perceived quality of care when implemented as bundles of complementary policies and practices.

Similar to Chuang et al (2012), CNA job satisfaction was examined by Bishop, Weinberg, Dana Beth, Leutz, Dossa, and Pfefferle (2008). Specifically, Bishop et al (2008) investigated the commitment levels of CNAs employed in 18 Massachusetts nursing homes based on their perceptions of job autonomy, use of knowledge, and teamwork. Conversely, this study also investigated CNA job commitment relative to nursing home resident satisfaction. Through the implementation of a qualitative exploration of management philosophy and practice, and of 255 CNAs' job perceptions and survey responses, and 105 resident questionnaire survey respondents, CNA quality care and patient perception of care was examined. Results indicated that CNA levels of

commitment were dependent upon (a) the effect of personal characteristics, (b) satisfaction with tangible job rewards, and (c) aspects of job design. A further analysis derived from the survey data, enabled a general linear model that estimated the effect of job commitment on residents' satisfaction with their relationship to nursing staff. The following components appeared to be most critical in predicting CNA-patient quality of care: (a) satisfaction with wages and benefits, (b) advancement opportunities, and (c) good basic supervision. These aforementioned components were perceived by CNAs based on data collected as impacting CNAs' intent to retain employment.

Job enhancements were identified as not being significantly related to intent to stay. Conversely, resident respondents were more satisfied with their relationships to nursing staff and their quality of life on units where a higher proportion of CNAs were committed to their jobs. Hence, Bishop et al (2008) correlate the greater job commitment of CNAs with improved quality of CNA – patient relationships, as well as improved quality of life for residents as a direct result of CNA employment commitment. Thus, the implication is that increased job satisfaction leads to, and equates with, improved care. However, what is notable is that culture change transformation that increases CNA autonomy, knowledge input, and teamwork, may not increase workers' commitment to jobs without improvements in basic supervision.

Coogle, Parham, and Rachel (2011) further the understanding of CNA job satisfaction and job retention in their recent research. Coogle et al (2011) examined the relationship between CNA job satisfaction and career commitment. Two hundred sixty-two Alzheimer's CNAs employed in long-term and community-based care setting

attended dementia-specific training. Upon completion of the training, they completed two short work-related questionnaires measuring job satisfaction and career commitment. The results of stepwise regression revealed interrelations between the two constructs. Congruence appeared to be reciprocal with respect to the overall scale scores and the intrinsic job satisfaction measure. Unexpected relations appeared in analyses of the extrinsic job satisfaction measure and the career planning subscale. The results are indicative of the fundamental distinction between job satisfaction and career commitment. Conversely, Coogle et al (2011) purport efforts to reduce turnover is correlated with improved staff empowerment.

Recruitment and Retention

Long-term care providers face a challenge of retention of direct-care workers, CNAs, who provide patient hands-on care. CNAs are key players in determining the quality of paid long-term care because they provide the hands on care to their clients. Rosen (2008) purported retention of nurses’ aides is higher when CNAs perceive their job training fails to meet the needs of their job requirements. Hence, high turnover of staff and subsequent poor patient care is provided (Rosen, 2008).

This issue, as well as efforts to reduce turnover among these workers, is a major concern recognized by both policy makers and provider organizations. Currently, there are no standardized methods of measuring CNA retention, neither is the scope of the problem defined nor is CNA intervention effectiveness. Barry, Kemper, and Brannon (2008), addressed retention accountability through the incorporation of the Better Jobs Better Care Demonstration (BJBC) to explicate some important issues in measuring and

interpreting turnover related to interventions designed to improve DCW jobs. Retention data, derived from nine BJBC providers was analyzed to develop a turnover tracking system for BJBC. Barry et al (2008) careful analyzed BJBC and revealed differences in definitions of turnover and the data elements used to construct the measure that can have large effects on turnover, data elements relative to turnover rates, how retention data is used, and what data means to CNA employers. Barry et al (2008) retention data analysis infers that policy makers, researchers, and managers who utilize retention data driven policies, must consider measure variances and definitions thereof. An unintended consequence of high retention rates may be (a) disruption of continuity of patient care, (b) residents at risk due to inexperience and/or lack of knowledge of rookie CNA, (c) an increase in patient-nurse and/or patient-CNA ratios, and (d) decreased time for CNAs and nursing staff to perform individual patient care. Finally, Barry et al (2008) identified that decreased CNA retention presents need for increased pressure of family members to care for loved ones who would have been admitted to long term care facilities.

Ejaz and Noelker (2008) expanded on the definition of the high turnover of CNAs citing the training of CNA replacements as the most visible direct cost of high staff turnover. The extent of the training varies according to the different providers and is connected to the number of hours of training required for the different positions. In addition, the costs for recruiting and training new direct-care workers may be impacted by government reimbursement rates (i.e., Medicare, Medicaid, and private pay). These rates often determine the quality of care that can be provided for the patient (Ejaz & Noelker, 2008).

Turnover of Direct Care Workers (DCWs) has reached alarming proportions in the long- term care (LTC) industry (Ejaz &Noelker, 2008) in the United States. F.K. Ejaz and Noelker (2008) conducted a cross-sectional designed study consisting of 644 DCW interviews relative to job commitment. DCW participants represented 27 nursing homes, 14 assisted living facilities and 8 home care agencies from five (5) Ohio counties. Guided by the LTC stress and support conceptual model, DCW background characteristics of personal and job-related stress, and workplace support were considered. Job commitment was defined as whether or not CNA workers were planning on remaining at their current employment facility DCW 3 years from the time of the research. Study participant DCWs, averaged 39 years old, of which 55% of all participants did not anticipate remaining in their place of employment in the capacity of a DCW.

When examining predictors associated with job commitment, Ejaz and Noelker's (2008) findings revealed that background characteristics of were most powerful in predicting job commitment. For example, DCWs who were in the minority, younger, more educate, worked fewer hours, and had more dependents, reported they would most likely exit employment as a DCW. The other factors related to job commitment were health insurance and hearing racist remarks. In a follow-up question in the study, it was discovered that those who wanted to leave desired to advance their career by moving into professional nursing or other healthcare fields. Thus, background characteristics were critical to define those who aspired to move out of low-paying positions, such as those who were younger age and better educated. Organizations could help in promoting

retention and the reduction of staff turnover in the healthcare industry by developing career advancement programs and addressing racism on the job.

In an effort to decrease turnover and improve quality of care in North Carolina's nursing homes an ongoing workforce development intervention, WIN A STEP UP, was developed to improve the working situation of CNAs. The program is a partnership between the North Carolina Department of Health and Human Services and the University of North Carolina Institute on Aging. A pilot program (funded by the Kate B. Reynolds Charitable Trust) enabled the program team to assess the situation of CNAs in North Carolina and develop a workforce intervention for CNAs to improve their job satisfaction and retention. Using concepts from North Carolina's successful TEACH® Early Childhood Project, WIN A STEP UP provided a 33-hr curriculum covering clinical and interpersonal skills and distributed financial incentives to participants as they proceeded through the curriculum and completed their retention commitments. The pilot program-implemented in nursing homes, adult care homes, and home health/home care agencies, demonstrated improvements in job satisfaction and retention of participating CNAs, with the most promising improvements seen in nursing homes (Morgen & Konrad, 2008).

Morgan, Craft, Konrad, and Thomas (2008) evaluated the effectiveness of the WIN A STEP program utilizing longitudinal semi-structured interviews and survey data collected from certified nursing assistants (CNAs), supervisors, and managers of eight nursing homes (NHs) and ten comparisons nursing homes (NHs). To control for selection bias, 77 CNA program participants were matched to 81 participating site and

135 comparison site controls using propensity scores in a quasi-experimental design supplemented by qualitative assessments. The results were managers at seven of eight participating NHs wanted to repeat the program. At three months after baseline, participants differed from controls by having (a) more improved nursing care and supportive leadership scores, (b) greater improvement in team care, and (c) stronger ratings of career and financial rewards. Nurse supervisors participating in supervisory skills training reported positive changes in management practices for themselves and peers. Modest three-month turnover reductions occurred in six settings where the program was fully implemented without incident. The implications of this study was that managers', supervisors', and participating NAs' consistent perceptions of improved quality of care and job quality, along with a promise of increased retention, suggest that interventions like WIN A STEP UP are beneficial (Morgen & Konrad, 2008).

Another suggestion to improve the quality of care for the patient and job quality for the CNAs was investigated by Singh (2008). This study investigates the change in earnings trajectories of direct-care workers working in Massachusetts nursing homes and home health agencies who received career ladder training through the Extended Care Career Ladder Initiative (ECCLI) in Massachusetts. The design and method of the study retrieves data from Round 4 of ECCLI grants that received funding between November 2002 and December 2003. The report is based on an analysis of earnings data obtained by matching social security numbers of 985 employees, of whom 467 were direct-care workers receiving training, with unemployment insurance wage records in Massachusetts. Findings indicated that direct care workers participating in the career

ladder training, of which 92% were women; more than half had a high school diploma; and 24% were born outside the US. On average participants received about 32 hours of training. The participants of the study were on a relatively flat earnings trajectory prior to ECCLI. The participants' earnings were on a much steeper trajectory during ECCLI. This was partly due to the mandated wage increases associated with ECCLI. The participants in the three quarters after the end of ECCLI were again on a relatively flat trajectory but at a level of earnings, that was about 30% higher than prior to ECCLI.

Implications for Future Nurse Aide Training

This study data results may facilitate new curriculum standards within the CNA training programs offered within the United States. Results of this study may prove sufficient to implicate ongoing conversations among Health Care administrators and educators relative to increased implementation of relevant, hands-on curriculum. The implications for this study are consistent with the Institute of Medicine’s report (2008) in which it is suggested that it is important to improve the training for CNAs (direct care workers), to better prepare them to give quality care to an increased aging population. The tentative recommendations from this study of client-centered learning may result in that which parallels the IOM panel’s recommendations of (a) enhancement of geriatric competence of the general workforce in common problems, (b) increasing recruitment and retention of geriatric specialists and caregivers and (c) implementation of innovative models of care (News from the National Academies, 2008).

The Paraprofessional Healthcare Institute (2009) has recommended that the following tentative changes should be made to improve the future of CNAs’ classes and

direct-care workers' training. The policymakers recommended taking action in three areas: these actions could help CNAs in the future to be adequately prepared for employment; hence, they would be less likely to exit their place of employment and/or the CNA career path. They suggest that there are three areas of the CNAs training that should be improved. These three areas are curricula and training support, federal training requirements, and state training infrastructure (Paraprofessional Healthcare Institute, 2009). These recommendations of the PHI could tentatively be used to direct the following projects of curricula and training support, federal training requirements, and state training infrastructure. These implications are based on the PHI recommendations and the anticipated findings of the data collection and analysis of my study.

Curricula could be enhanced by identifying additional competencies that will be required for workers caring for the elderly and those with disabilities in any setting (State Nurse's aide Training Requirements, 2009). Career paths could be created to allow level-entry caregivers to advance through taking advanced levels of competencies tests that would advance nurses' aides for the care of consumers who need additional healthcare. The curricula could include more on the job training with mentors and in-service training.

The curricula could be Federal and state training requirements could be made to align with competencies that set consistent standards across occupations that require similar skills. Federal training requirements could be developed to consensus training standards for personal care workers based on the core competencies. CNA applicants should be screened for English fluency prior to enrollment in a training program and enrollment in English remedial classes should be required if necessary. To assist the

caregiver in providing more person-centered service, the competencies could place greater emphasis on communication and interpersonal problem solving (State Nurse's aide Training Requirements, 2009). The curricula could be made to align with the Federal and state training requirements competencies to set consistent standards across occupations that require similar skills. Federal training requirements could be developed to consensus training standards for personal care workers based on the core competencies. CNA applicants should be screened for English fluency prior to enrollment in a training program and enrollment in English remedial classes should be required if necessary. To assist the caregiver in providing more person-centered service, the competencies could place greater emphasis on communication and interpersonal problem solving (State Nurse's aide Training Requirements, 2009).

Summary

The purpose of this qualitative study was to examine the perceptions of practicing CNAs relative to their preparedness and effectiveness in completing job tasks. Using qualitative research methods, I identified how CNA graduates of a program with a 100-hour or fewer of training perceived their clinical training relative to effectively performing clinical duties in a skilled nursing facility. In addition, I wanted to understand if the CNA training program has encouraged them to seek additional health education. The voices of CNA participants will be recorded, and themes analyzed, in an effort to assist development of CNA training program that meet expectations of both the CNA, as well as the CNA educator. Through the voices of CNAs, organizations may exhibit higher retention rates, and increase patient quality of care.

CNA education has been examined in terms of their perceptions relative to employment preparedness (Ejaz & Noelker, 2008; Ejaz, 2008), job satisfaction (Castie et al., 2007), retention (Bishop et al., 2008; Chuang et al., 2010), CNA empowerment in the workforce (Häggström et al., (2009), and opportunity for advancement (Greco, 2011). Understanding the CNA's perceptions relative to components of CNA employment, role and effectiveness of patient care, may benefit from CNA training program educators' knowledge of learning theories such as application of classroom applications, developmental stages, and theories of development.

Currently, the State of Pennsylvania is examining the CNA training program for its reverence in providing adequate training for their CNAs. A possible lack of training could leave healthcare workers unprepared to meet the challenges of the elderly (O'Brien, 2010), which can lead to a high turnover rate and a shortage of healthcare workers (News from the National Academies, 2008). The present federally-required minimum number of hours of training for direct-care workers is 75 hours. At the federal level, the recommendation is to raise this number to 120 hours (News from the National Academies, 2008). Extending the CNAs' training program by the State of Pennsylvania was recommended to meet the federal recommendations to meet the increasing needs of direct care workers and to improve the quality of healthcare (Paraprofessional Healthcare Institute (PHI) Policy Works, 2012).

However, there are still financial concerns that the price of the program would have to be increased to cover the increased cost of the instructors' time, extra material needed, and available space that might be needed for the extra instruction. This increase

in the cost of the program would have to be passed on to the students in the form of a tuition increase. This tuition increase could then make the program less appealing to individuals who are interested in becoming nurses' aid.

The remaining sections are organized as following: In Section 2, I will detail the methodology that I used in this study, in Section 3, I will present my data analysis from interviews of CNAs in a skilled nursing home, and Section 4, I will present the major themes results that will be found in the interviews.

Section 2: The Methodology

Introduction

Qualitative research is instrumental in the identification of areas for improvement. It also discovers how individuals interact with their social world, and is instrumental in developing new themes (Creswell, 2009; Merriam & Associates, 2002), thus qualitative research was used for this project. In healthcare education, qualitative methodologies are also used to support facilitating positive change that is based on different cultures, and the voices of those within those cultures. In this section, I will describe the selection criteria, number of study participants, access to suitable study participants, participant-interviewer relationship, and ethics.

Qualitative Research Design and Approach

This tuition increase could then make the program less appealing to individuals who are interested in becoming nurses' aid. utilization of in-depth interviews, observation field notes, and record review. Qualitative research is instrumental in the identification of areas for improvement. It also allows

Qualitative research has been primarily accepted in the field of anthropology and sociology. Qualitative inquiry is growing legitimacy in the applied fields, including education (Merriam & Associates, 2002). According to Creswell (2007), a qualitative research design should be utilized when a detailed understanding of the research problem is required. Qualitative research methods also assist the researcher to understand the social dynamics participants experience through the eyes of the participants. Unlike quantitative methods that can only derive empirical data, the main focus of qualitative

research is driven by the participants' responses, allowing for a deeper investigation of the research problem (Creswell, 2007). When considering the aforementioned rationale for the choice of qualitative research, a quantitative approach with a focus on numerical data would not efficiently make understanding of CNA perceptions. An essential part of understanding qualitative research rests in the meaning participants' experience in their interaction with their world (Merriam, 2002). Merriam (2002) stated, "Reality is not the fixed, single, agreed upon, or measurable phenomenon that is assumed to be positivist, quantitative research" (p. 3). Each participant develops his or her own meaning through interaction with his or her environment (Merriam, 2002).

Description of the Qualitative Tradition and Research Design

In the qualitative research design for this study, I focused on the perceptions of practicing CNAs relative to their preparedness to be effective in completing job tasks. Through the qualitative research method, I sought to identify how CNA graduates of a 100-hour or fewer training program perceive their clinical training relative to effectively performing clinical duties in a skilled nursing facility. In an effort to assist educational development of CNA programs that evidence effective training components, the voices of CNA participants were recorded. Through the identified themes of CNA interviews, an understanding of the role of the CNA, efficacy and efficiency of patient care, and job satisfaction were examined.

Phenomenology is the qualitative research strategy that I selected for this study. Hatch (2002) stressed that phenomenological research is at the basis of all qualitative research. Phenomenology expresses "the essence of the human experience" (Van Manen,

1990, p. 4). Hatch found that phenomenological researchers strive to understand this meaning by exploring the phenomenon with participants (2002, p. 30).

Participants

In this next section, I describe the selection criteria, number of study participants, access to suitable study participants, participant-interviewer relationship, and ethics.

Criteria for Selecting Participants

The first step of conducting this proposed research study was to send correspondence (see Appendix A) to the administrator of a suburban Pennsylvania 120-bed nursing home in Eastern Pennsylvania, introducing myself as the researcher and describing my proposed research. Upon receipt of administrative approval (see Appendix D) of a nursing home meeting research criteria, a description of the research project as explained by me to the Assistant Nursing Home Adminstrator. The facility administrator then explained it to CNA graduates of a 100-hour training program as potential research candidates though an informative flyer at a CNA meeting held within the facility. I provided candidates for this research with a detailed description of the study, informed there is no remuneration, no employer incentives or rewards, benefits, or compensation as a result of choosing to participate in this study. Further, CNA participants were informed of the voluntary nature of this research, and that they could have withdrawn from participating in the research at any time.

While risks of participation were minimal to none to participants, I provided the participants with information of any risks that may be associated with participation or that participation may incur. Participants were required to sign an informed consent (see

Appendix B) that outlined the research project and participant responsibilities, detailed project description, describe potential risks, explained the voluntary nature of the study, and provided a confidentiality statement assuring anonymity of participants. This research project engaged seven CNA graduates of a 100-hour CNA training program, currently providing CNA services within a skilled nursing facility in Eastern Pennsylvania, to participate in in-depth interviews. Interested CNA participants were given instruction within the informed consent letter, as to how to contact the researcher to secure his/her participation (Lodico, Spaulding, & Voegtle, 2006).

Justification for the Number of Participants, Balanced with Depth of Inquiry

According to Seidman (2006), there are two criteria that can be used to aid researchers in identifying adequate participants for qualitative studies: sufficiency and saturation. *Sufficiency* is defined as the number of participants with whom the readers can connect relative to the participants' experiences (Seidman, 2006). Saturation of information is defined as reaching a point wherein participants provide similar information and responses to interview questions, surveys, and data collection methods (Seidman, 2006). When new themes are no longer revealed through participant data, saturation of data is met. As this is the case, there is no one definite quantity of participants required to conduct qualitative research.

I employed seven participants who satisfy the 100-hour training criteria in this study. Participants were required to speak English as this researcher speaks only English. Engaging seven participants allowed for in-depth interviews to be conducted until both the participant and researcher has exhausted data possibilities. The goal was to obtain

data that is rich in detail, not in quantity, so that readers can connect with participant responses and the participants recorded experiences. I required the flexibility to probe deeply into the perceptions, attitudes and feelings of the participants, and, further, have sufficient time to reflect on the issue. Limiting the number of participants assisted the researcher in achieving this goal.

Qualitative researchers do not test hypotheses, like that of researchers who use the quantitative method. Hence, a qualitative research approach does not demand specific participant quantity criteria, but rather seeks to maximize the number of participants that suffice the specific research study criterion for participant selection. Researchers Glaser and Strauss (1967), Lincoln and Guba (1985), Rubin and Rubin (2005), have affirmed the notion of saturation of information in a study is derived by the richness of the data collected, regardless of number of participants. Specifically, the researchers relate selection of participants to selection of those participants who will connect the readers with the participants' experience. This method of selection is referred to the employment of purposeful sampling. This researcher followed the purposeful sampling approach, as the number of CNA participants who qualify for this study's criterion may be limited as this study is limited to participation of only one Lancaster, PA, skilled nursing facility.

Procedures for gaining access to Participants

Lodico, Spaulding, and Voegtle (2006) present several ways of employing purposeful sampling. These include such strategies as extreme case, homogeneous, intensity, purposeful random, maximum variation, typical case, criterion, critical case, convenience and snowball or chain, and theory based on these qualitative approaches.

Maximum variation is primarily utilized strategy in qualitative studies because it documents diverse variations and identifies important common patterns (Creswell, 2007, p. 127). “Maximum variation sampling includes individuals with different views on the issue being studied or who represent the widest possible range of characteristics being studied” (Lodico, 2006, p.141). According to Seidman (2006), it provides “the most effective basic strategy for selecting participants for interview studies” (p. 52).

The research site was a suburban Pennsylvania nursing home in Lancaster County with 120 beds (see Table 1). The population of the study was CNAs currently employed at the Lancaster County nursing facility at the time of this study. The sample of the population studied was chosen through the use of maximum variation purposeful sampling. The sample consisted of seven CNA participant volunteers, who had 100 hours or fewer of training and were employed at aforementioned research site. The number of participants was determined by the saturation of information provided by the participants, the maximum number or participants may also not be reached due to a lack of a qualified study participant pool. Further, it was anticipated that some participants could have dropped out of the study at some point of the study’s implementation. Finally, participants all took their training and CNA test in English; hence, the participants’ English comprehension and fluency was eliminated as a concern that could have otherwise impacted this project study data-collection or transcription.

Methods of establishing a Researcher-Participant working Relationship

Establishing, nurturing and maintaining productive relationships with participants are important. Despite researchers’ efforts in a qualitative research design, various

circumstances or reasons may result in participants exhibiting or expressing doubts, reservations and/or suspicions relative to interviews and/or the interviewer (Hatch, 2002; Rubin & Rubin, 2005). Hence, these tenuous feelings may contribute to shortened, guarded, or false responses during participant interviews (Hatch, 2002; Rubin & Rubin, 2005). As a result, researchers are often prevented from achieving their goals. Such goals that may be prevented are success in interviewing, fluid researcher-participant communication, and the construction of sharing a joint referent about a particular topic (Janesick, 2004). These reasons may also prevent the researcher from further inquiry that interferes with securing information respondents may wish to reveal (Hatch, 2002).

I provided an invitation letter (see Appendix A) prior to the interviews in addition to consent forms (see Appendix B) to avoid such issues and to build trusting relationships as Rubin and Rubin (2005) have indicated as best practice. Essential information, such as my introduction, the purpose of the study, my role as the researcher, the time commitment, setting of the study, and my guarantee of confidentiality were indicated in the letter. According to Rubin and Rubin (2005), the participants wish to know how the interviewer identifies them and the criteria from which they were selected. The invitation letter from the researchers should clarify the above aspects. In the invitational letter, researchers should also address questions and concerns, such as questions about confidently and amenity should be addressed with the participants before the interviews. According to Janesick (2004), a copy of the interview questions should be given to allow participants to preview the questions and topic provided this previewing method is

mutually comfortable for both interview and participant. Appendix C lists the guided interview questions asked during the in-depth interviews.

The researcher's success of the interviewing may be ensured by providing sensitive invitation letters that would convey the researcher's intentions clearly. I have been open to any methods of communication before and after the interviews, through the methods of e-mail, telephone, and face-to-face meetings to answer participants' questions. There is no right or wrong answer that from the participant that the interviewer is interested in (Hatch, 2002; Rubin & Rubin, 2005). In addition, the answers they provide will be used to improve the CNA training in this particular nursing home. As a researcher, I have conducted my study and in consideration and approaches that will assist to minimize the issues that are inherent in interviewing and collecting meaningful data.

Measures for Ethical Protection of Participants

When collecting data for a research study, Lincoln and Guba (1985) and Halpern (1983) purported the thought of "trustworthiness" that remains relevant in any qualitative research project. Trustworthiness consists of four components: credibility, transferability, dependability, and confirmability. Credibility is defined as an evaluation of whether or not the research findings represent a "credible" conceptual interpretation of the data drawn from the participants' original data (Lincoln & Guba, 1985). The degree to which the findings of this inquiry can apply or be transferred beyond the bounds of the project is defined as transferability. Dependability is defined as an assessment of the quality of the integrity processes of data collection, data analysis, and theory generation.

In the final step, Conformability is defined as a measure of how well the researcher's findings are supported by the data collected (Lincoln & Guba, 1985). The goal of trustworthiness in a qualitative study is to support the argument that the researcher's findings are "worth paying attention to" (Lincoln & Guba, 1985, p.290).

The qualitative data collection methodology included in-depth interviews, interview observation notes, and record review. An interview is a purposive conversation with a person or a group of persons. Participant interview completion was anticipated by the end of September 2013, but was completed in February 2014. Observations consisted of researcher notes taken during the in-depth face-to-face interviews. Observations described the CNA participant's body language displayed during interviews, the "ethos," or culture, of the participants as displayed through pragmatic gestures and researcher-participant interactions. Record review was determined through CNA responses. Records of CNA absences, job performance evaluations of participants and general facility data such as patient census were reviewed.

A researcher functions in a qualitative study as a primary instrument for data collection and analysis (Merriam & Associates, 2002). As a solo researcher, I have carried out the research from the stages of constructing interview questions, conducting interviews, transcribing, to analyzing the data. To recruit the participants for a qualitative study, I have used purposeful sampling to conduct the study. I have gained contact information relative to potential participants by contacting the administrator of a 120-bed suburban Pennsylvania nursing home in Lancaster County. Following Rubin and Rubin (2005) practices for developing trustworthy relationships, I contacted pivotal

administrators and personnel at the nursing home when the study commenced, and discussed the research goals, focus, importance of the research project, and participant involvement of the research process, which included potential future involvement.

Before data collection commenced, I reflected upon my personal beliefs as a former nurse aide instructor, as well as my nursing home supervisor experiences that may have influenced data collection. I have reduced my bias and enhanced my credibility by recording an audit trail before and after each interview. To keep a reflective stance in my data analysis, I have reviewed the research process regularly. An audit trail is defined as a transparent description of the research steps taken from the start of a research project to the development and reporting of the findings. According to Lincoln and Guba (1985) and Halpern (1983), there are six information categories that comprise an audit trail: raw data, analysis notes, reconstruction and synthesis products, process notes, personal notes, and preliminary developmental information for establishing dependability. Audit records are the documentation kept when doing an investigation.

For this qualitative study, an in-depth, semi-structured, open-ended interview design was implemented. The participants were recruited by purposive sampling. According to Creswell (2007), the qualitative approach can better answer the how and why questions. This project study's goal was to explore an issue within its social context and to gain an in-depth understanding of the problem being investigated (Rubin & Rubin, 2005). Janesick (2004) defined interviewing as "joint construction of meaning about a particular topic" (p. 72) so that qualitative interviewing is an optimal data collection method for this study. To avoid imposing predetermined notions upon participants;

strategies of inviting detailed dialogue of the topic, obtaining rich description, and asking open-ended questions assisted in avoiding predetermined notions. Open-ended interviews permitted the researcher to explore statements or topics of interest, inquire for additional details, clarify and/or expand explanations received, encourage participants' thoughts, feelings, and actions. They also validated the participant's humanity, perspective, or action, and utilized observational and social skills to further the discussion (Charmaz, 2006). Thus, this study benefited from the approach of an in-depth, semi-structure and an open-interview design.

I consulted with professionals who worked with CNAs at a suburban Pennsylvania nursing home in Lancaster County with 120 beds to ensure the quality and clarity of the questions for the interviews. I reviewed the quality and clarity of my initial interview questions to further gain insight regarding my interview content. I also developed and utilized an interview protocol (see Appendix C).

Data Collection

Interviews

The goal of data collection from interviews should be "characterized by respect, interest, attention, good manners, and encouragement" (Hatch, 2002, p. 107). The purpose of the interviews was to collect data from multiple participants. I observed and recorded the reactions of the participant as the interview proceeded. I allowed participants to have control over the interview informing each participant he/she did not have to answer each question asked in the survey interview. Developing and establishing a trustworthy relationship in initiating interviews is pivotal in gathering honest and in-

depth responses from the participant (Hatch, 2002; Rubin & Rubin, 2005); hence, the aforementioned strategies assisted in establishing trustworthiness.

To obtain contact information of CNAs who have had 100 hours or fewer of training, and who were employed at a suburban Pennsylvania nursing home in Lancaster County with 120 beds, I contacted the administrators of a suburban Pennsylvania nursing home in Lancaster County with 120 beds. After obtaining the permission of the administrator, I gained permission from the administrator to send potential participants an information letter with a consent form attached with a directive for potential participants to contact me via phone or email. This initial correspondence provided an opportunity to introduce myself, the goals of this study, and the face-to-face or e-mail participation.

It is essential throughout the research process to provide different methods that will compliment and allow for participants' communicative preferences so that initial and follow-up participation is fostered and encouraged (Hoffman, 2009). As practical methods of qualitative interview, the literature acknowledges the use of technology to mediate interviews, such as telephone, e-mail, and instant messaging interviews (Hoffman, 2009; Kazmer & Xie, 2008). Any of these modes of interaction can be valuable for a qualitative interview. However, the pros and cons of each modality, as well as the researchers' preferences and abilities, contribute toward successful completion of a study (Kazmer & Xie, 2008).

Face-to-Face Interviews

The traditional, synchronous methods of interview are the face-to-face interviews. Researchers in face-to-face interviews have an opportunity to observe nonverbal cues.

These nonverbal cues include facial expressions and body language. In addition to adapting questions and providing prompts, the researchers can also clarifying participants' responses. Telephone interviews, a synchronous interview method, inhibit researchers to examine participants' underlying thought processes exhibited through pragmatics of language, namely facial expressions and body language. The researcher must depend upon the respondent's tone of voice; hence, natural conversational interactions and reactions are not visible when conducting telephone interviews. This lack of face-to-face interaction may result in a lack of contextual naturalness, especially with strangers (Shuy, 2002). Because visual cues and fast pace dialogue is lacking within to telephone interviews, participants may or may not provide thoughtful responses. Thus, the choice to engage in telephone interviews must be made with caution. Sturges and Hanrahan (2004) compared face-to-face, telephone interviewing, and found that participants primarily chose face-to-face methods over others because of time constraints and a need for convenience.

Face-to-face interviews may have some anticipated difficulties. An example of one such difficulty is the difficulty of scheduling interviews for synchronous methods as compared to asynchronous interaction modes, such as interviewing through e-mail or instant messaging methods (Kazmer & Xie, 2008). Another difficulty in obtaining quality recordings during face-to-face interviews is technological and environmental factors that may impact recordings. According to Riach (2009), a researcher with a tape recorder in a researcher-centered mode of face-to-face interviews may inhibit participants' responses and communication of knowledge. Participants may attempt to

connect with the researcher and the research topic to rationalize through constructing responses based on the researcher's position or appearance. As a result, contradictions may emerge throughout the coding stages of data. Biases by the disposition of the researcher and interviewer-participant may also occur in face-to-face interviews as a result from visual and nonverbal cues or status differences between a researcher and participants (Meho, 2006). Finally, face-to-face interviews demand significant time for transcribing, comprehending, and organizing the recorded data. More time is required because the participants respond actively processing his/her thoughts in response to questions. This necessary processing time can distort or incur incomplete data at time of transcription.

For longitudinal research, face-to-face interviews, some researchers (Meho, 2006; Young, Persichitte, & Tharp, 1998) have found that better results are in retained from participants than other modes of interview. Riach (2009) purports that those who utilized face-to-face interviews, exhibited increased reluctance to participate in post-interview discussions when compared to those participants who participated in e-mail interviews. The most popular mode of data collection is that of face–to-face interviewing, although it remains to a challenging mode for conducting data analysis and presenting the data.

Preparation is the key for successful interviews. I contacted each participant to confirm our meeting and answered all questions that the participants had a day prior to the interview. The interview took place at a convenient time for the participants. To put the participants at ease with the interview, a comfortable and familiar location that was a place of neutrality for both participants and the researcher was chosen. I discussed my

interests and professional background that directly related to the participants to put them at ease prior to commencing the interview. This process of sharing a common background with the participants according to Rubin and Rubin (2005) increased the trust between each participant and myself as interviewer. Once a rapport was established, I reviewed the interview procedures and gained participant permission for audio recording of interviews, and subsequent note taking. Participants were informed that they could stop or discontinue the interview at any time. Instructions to discontinue audio recording and “off the record remarks” were provided. I assured participants that their responses would remain confidential and utilized only to improve nurse-aide training programs on a local and State level. An initial interview for each participant lasted a duration of 20 minutes. I thanked participants orally for their time. Interview data was one source from which triangulation was achieved, and was compared to data obtained from field notes and record review per best practices described by Lodico, Spaulding, and Voegtle (2006).

Field Observation Notes

I engaged in field observation notes. These notes were manually recorded in a journal. Field observation notes were provided as additional opportunities to discern if the CNAs transcribed interview text corresponded to observations of individual participant interviews as it related to their assignments and duties at the research site. A description of the participants, the interview content and setting, my feelings and thoughts regarding the interview pragmatics (observation of body and facial gestures), and potential probing questions for future participant interviews were transcribed during and after each data collection.

When referring to the process of understanding a phenomenon, Lincoln and Guba (1985) proposed that understanding is time and content dependent, that is to understand the nature of the data, data must be derived from the environment which supports it. Field observation and analysis of CNA's behaviors assisted in revealing underlying assumptions about their training, that is, if it was adequate or not to meet their expectations of their duties as a CNA. Field observation also assisted in contributing to the validly of the data by revealing participants' assumptions relative to their training and relationship(s) with their nursing instructors.

Interpretive Approach

Confidentiality

Data analysis began as soon as the first piece of data was collected. The identity of the participants was kept confidential in a safe location known only to me. Data will be stored for five years upon completion of this study. Shredding of data records and tape erasing will then occur. To ensure confidentiality, I transcribed all interviews. This kind of data collection enabled me to analyze new information, compare and contrast new data with existing data, and seek patterns and themes across the data. Through transcribing the data, I was able to move forward to the next step of coding.

Interviews

Face-to-face interviews were conducted in a quiet location of each participant's choice. Explanation of the interview was provided. The research site administration stated recording interviews would be a barrier to obtaining honest answers from

participants. Hence, I did not record participant interviews by using a tape recorder. Rather, I manually scribed each interviewee response.

Field Observations Notes

Qualitative researchers can transform data in different ways. The three main elements of qualitative research design are description, analysis, and interpretation (Wolcott, 1994). I used phenomenological research to explore the effects of the CNA perspective of their training on their clinical duties and their desire to advance their knowledge of the health field. I manually have written field notes of my observations specific to interviews and these observations will be kept in a journal for which only I have access. Phenomenological research examines the individual's interruption of his or her experiences. This method of research attempts to understand, the meaning of an experience from the perception of the participant.

Transcription

To use this method of research, I employed an interpretive qualitative approach. To enhance participates confidentiality and anonymity, I am the sole transcriber of their interviews. According to Merriam and Associates (2002), an interpretive qualitative approach allows researchers to learn about individuals' experience, interactions with their social world, and what their experiences and relations mean for them. Hatch (2002) further explained that interpretive analysis is a process of "making inferences, developing insights, attaching significance, refining understandings, drawing conclusions, and extrapolating lessons" (p. 180) that help people make sense of the social phenomena of what is being studied. Steps in interpretive analysis are provided by Hatch (2002). They

are as follows: 1) read the data for a sense of the whole, 2) review impressions previously recorded in research journals and/or bracketed in protocols and record these in memos, 3) read the data, 4) identify impressions, 5) record impressions in memos, 6) study memos for salient interpretations, read data, 7) coding places where interpretations are supported or challenged, 8) write a draft summary, 9) review interpretations with participants, 10) write a revised summary, and 11) identify excerpts that support interpretations (Hatch, 2002, p. 181).

In order to follow this process, I kept a research journal comprised of field observations and thoughts. Even though an interpretive approach may be implemented in any qualitative study, the amount of detail that an in-depth interview provides can increase the creative aspects of interpretation and assist readers to make sense of what is being studied (Hatch, 2002).

Coding Process

According to Saldana (2009), a qualitative coding process involves words or phrases whose characteristics embody summative, salient, or evocative attributes concerning language-based or visual data. The researchers, using codes, look for the concepts and themes in several ways. One way to find the important concepts or themes in the interview begins with identifying certain words that are explicitly raised by the interviewer or the participant (Rubin & Rubin, 2005). In following the practices set forth by Rubin and Rubin (2005), data was coded manually. By taking the words and phrases directly from what the participants say, this approach is a substantive approach (Creswell, 2009).

Individual codes will be identified through color-coding techniques to enable locating patterns or interactions in the data, and understand interwoven relationships between codes more easily. In addition, I used the words from the transcription for each coding definition in order to ensure that I allow participants to generate patterns, concepts, and themes and I do not alter the thoughts initiated by the participants when creating a coding table (Rubin & Rubin, 2005). An exploratory method that assists in intuitive and empathic understanding of the native members' daily lives, beliefs, and attitudes (Lett, 1996), while producing "a rich description of an inter-connected system" (Shordike, et al, 2010, p. 336) is referred to as an *emic* approach. Utilizing an emic approach, I examined the data for subtle codes that reflect upon the meanings of participants' responses upon completion of the initial coding categories.

According to Tesch (1990), the coding process is a complex, multi-step process. The first, is to obtain a sense of the "whole" by determining the main idea or the "So what?" of the most interesting interview. The second step is to make a list of all topics revealed in the interviews and then cluster similar topics. Thirdly, organize a schema by abbreviating the topics as codes, and further, write the codes next to the appropriate segments of the text. A fourth step involves reducing the total list of categories by grouping topics that relate to one another. Follow this with step five, alphabetizing the codes of categories. Continue with step six, performing a preliminary analysis, and finally, complete the last step, record existing data if necessary.

Similarly, Creswell (2009) identifies the steps for qualitative data analysis: 1) organize and prepare the data for analysis; 2) read through the data thoroughly, 3) begin a

detailed analysis implementing a coding process, 4) generate a description of the setting, people, categories, or themes for analysis, 5), describe how themes will be represented in the qualitative narrative, and lastly, 6) interpret the meaning of the data.

Rubin and Rubin (2005) recommended creating a coding outline to state the findings after extensive reading and rereading of the interview transcripts. A coding outline will allow the researcher to see the relationships among the coding categories (Rubin & Rubin, 2005). Finally, I will create a table to show themes that emerged across the interviews and their relations to assist readers in understanding a framework of findings from the study. I have strived to engage in the text throughout the coding process for coding accurately. In addition, I have engage in the text throughout the coding process to make sure that the participants did not present repeated instances of concepts and themes or explicit the interviews.

Validity and Reliability

To ensure trustworthiness in a qualitative research, validity and reliability have to be present, this can be challenging. Creswell (2009) explained, “Qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures, while qualitative reliability indicates that the researcher’s approach is consistent across different researchers and different projects” (p. 190). There are four criteria that 1) proposed by Guba in 1981 that qualitative researchers should consider in the pursuit of a trustworthy study, these four criteria are the following: credibility, transferability, dependability, and confirmability.

There are a variety of strategies for ensuring trustworthiness in qualitative research. There are eight validation strategies presented by Creswell (2007, 2009). They are as follows: 1) spend time in the field, 2) triangulate different data sources of information, 3) use peer debriefing to enhance the accuracy of the account, 4) present negative or discrepant information that runs counter to the themes, 5) clarify the bias the researcher brings to the study, 6) use member checking to determine the accuracy of the qualitative findings, 7) use rich, thick description to convey the findings, and 8) use an external auditor to review the entire project. Creswell recommended that qualitative researchers engage in at least two validation strategies to achieve qualitative validity and reliability. I will use multiple methods, including (a) triangulation, (b) member checking, (c) rich, thick description and reflective commentary, (d) peer debriefing, and (e) document reviews (d) observations of interviews conducted throughout my study.

Triangulation

According to Creswell and Miller (2000), "Triangulation is a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study" (p. 126). I will employ different methods of data collection: semi-structured face-to-face interviews, e-mail interviews, record review analysis in this study. After data collection, I will use member checking, peer debriefing, and record review to add validity for the data gathered from participants. Triangulation reduces the effect of the researcher bias while ensuring real objectivity (Shenton, 2004). According to Guba (1981), researchers' objectivity is referred to as

confirmability and that qualitative researchers should consider conformability in the pursuit of a trustworthy study.

Member Checking

According to Lincoln and Guba (1985), member checking is "the most crucial technique for establishing credibility" (p. 314). I will ask for participant in my study for clarification following transcription of data and coding of themes on an individual basis after their interview to ascertain whether they agree with my interpretations. I will also share my interpretations of 25% of the responses that I have collected with the participants for clarification after I have collected 75% of the data. I will encourage them to comment upon my interpretations of the data. This is an important step, according to Merriam and Associates (2002), because the participants should be able to identify their experiences described by the researchers' words or suggest some fine-tuning to improve the accuracy of the researchers' expressions. Besides this method of checking, the researchers can ask participants questions regarding the adequacy of the themes or categories, sufficiency of evidence, and accuracy of the participants' accounts (Creswell & Miller, 2000).

Rich, Thick, Descriptive, and Reflective Commentary

Rich, thick description is important in assisting member checking and establishing credibility in a qualitative study. This type of description "creates verisimilitude, statements that produce for the readers the feeling that they have experienced, or could experience, the events being described in a study" (Creswell & Miller, 2000, p. 129). I penned field notes specific to each interview, which included a detailed description of the

environment, attitude, moods, and body language to enhance the applicability, practicability, and validity of the findings (Creswell, 2007, 2009). The researcher's reflective commentary also should be employed to record the researcher's initial impressions of data analysis when providing a rich, thick description, as well as to evaluating the study (Shenton, 2004). Reflective commentary discloses the researchers' own assumptions, beliefs, biases, and subjectivity. It is critical in establishing credibility in a qualitative research study (Creswell & Miller, 2000; Shenton, 2004).

Peer Debriefing

According to Creswell and Miller (2000), peer debriefing is defined as "the review of the data and research process by someone who is familiar with the research or the phenomenon being explored" (p.129). This type of review increases credibility and deeper understanding of the study. It also challenges the researchers' assumptions and interpretations and provides support and encouragement. Finally, peer debriefing offers researchers the opportunity to develop the research design further (Lincoln & Guba, 1985). Peer debriefing is equivalent to the interrupter reliability in quantitative research (Creswell, 2007) because it can be applied as a solidification strategy in a qualitative analysis (Marques, 2005). According to Marques, the researcher's bias is difficult to eliminate when the researcher is perceived as a primary instrument, thus employing peer debriefing is an important credible verification tool in a qualitative study.

I provided twenty-five percent of the data from interviews in my study, in addition to analysis of coding and my interpretation of the data, to two practicing medical professionals. Debriefer one, a supervisory registered nurse (R.N.) employed in a skilled

nursing facility; and debriefer two, a CNA also working in a skilled nursing facility both had two year's experience working within their field. After establishing themes and codes from the data, each was emailed 25% of the data as email attachments with instructions to review the data and return impressions via email utilizing the data-coding sheet also provided. There was only one instance when a discord between my impression and an outside reader's coding of themes occurred. This facilitated opportunity for further examination of the data and considering varied perspectives.

Records/Documents Reviews

Researchers use the term documents and records based on different criteria. According to Hatch (2002), "documents" referred only to official written documentation. He also made a distinction with unofficial or personal documentation, records, photographs, and archives. This study has followed the practice of Creswell (2009) of making a distinction between public, private documents or records that were accessible and convenient. Hatch (2002) purports that the record review methodology component provides "a sense of history" (p. 117) concerning a topic, while also providing insight into the social phenomenon that is being studied. To validate data that was obtained from the interviews, I conducted a record review of pertinent information related to CNA training, LC SNF CNA Employee Handbook and job description, and participant case load assignment records and continuing education opportunities provided.

Dissemination of Study's Results to Participants and Facility Administrators

A PowerPoint presentation of this study's results will be presented to the LC SNF facility administrator(s) and study participants at a mutually agreeable time. A time for

questions and answers will conclude the presentation. Attendance to this study's presentation will be voluntary. A copy of a power point will be available via email upon request.

Ethics

Studying how persons react and perceive a specific idea requires a respectful attitude, sensitivity, and adequate preparation. The culture can be beyond the difference in nationalities, that is, it can be the culture of the CNAs versus the culture of teachers and administrators, or the culture of general education versus the culture of healthcare education. Thus, I have given careful ethical consideration to this study. To ensure no language barrier existed between the participants and myself, all participants were graduates of a 100-hour program taken in an English-speaking education institution; hence, it was assumed that the participants were fluent in English and devoid of significant disabilities that would have impeded participation in this study. In this research study, I implemented five principles suggested by Trochim (2006) to eliminate any ethical issues throughout the study: 1) voluntary participation, 2) informed consent, 3) risk of harm, 4) confidentiality, and 5) anonymity. Anonymity of participants was established by random assignment of a letter from the American alphabet, which was kept confidential, and known only to myself. Additionally, participants' letter-name correlation was kept in a home with location of the safe known only to myself.

According to Hatch (2002), benefits relative to research participants and researcher are an important issue in the interview process. Hatch (2002) encourages qualitative researchers to explore all those who are research stakeholders and understand

to what extent each stakeholder benefits. To this end, I maintained a neutrality of disposition toward all participants and administrators throughout my research project. Additionally, I invited participants and administrator(s) with the opportunity during interviews and throughout the duration of data collection to clarify, rescind, or revise information each provided optimally to minimize any bias, inaccuracies or potential risks perceived by study participants. Hence, all were provided with my contact information to discuss data provided via email, cell phone or in-person. No participants, CNAs or administrator(s) chose to contact me for such reason(s). In addition to the group opportunity to attend a presentation providing an overview of this study's rationale, methodology and results, participants may ask for his/her individual transcript to ensure full disclosure of his/her data provided.

Section 3: The Project

Introduction

I have provided the description and goals of the project, as well as its rationale in the following section. The literature that I describe throughout this section supports the project and subsequent data collection analysis. I have explored the perceived gap between a certified nurse assistant (CNA) educational training and CNA job requirements. Finally, in this section, I have provided the project's evaluation and conclusion.

Description and Goals

The goal of this qualitative research study was to gain an understanding of CNA perceptions relative to an increased 100-hour educational CNA certification program through utilization of interviews, observation field notes, and record review. Gaining insight relative to CNA training programs, and subsequent clinical performance, was also a goal of this project study.

Participant Recruitment

Participant recruitment within an Eastern Pennsylvania suburban skilled nursing facility (SNF) was achieved through correspondence to skilled nursing facility (SNF) administrators throughout the Lancaster County, PA, area. Correspondence (see Appendix A) was sent via the U.S. Postal Service to fifteen administrators of suburban Pennsylvania SNFs within a fifty square mile radius of Lancaster County, PA. In the correspondence, I introduced myself as the researcher and detailed the rationale, research questions, and methodology of the proposed research.

Within 2 weeks, I sent 15 letters for research approval to potential SNF facility administrators; however, only one response was returned from the facility, LC SNF. The LC SNF administrator identified potential CNA participants who qualified for the research project and subsequently, held an information meeting within their facility. Interested CNAs who met the research criteria were then provided with my contact information and were asked to contact me via email or cell phone. The aforementioned method of participant selection ensured potential CNA participants anonymity.

The LC SNF administration introduced my project though an informative flyer at a CNA meeting held within the facility. After 2 weeks, I received no CNA participant responses. Hence, I received permission from LC SNF's administrator to meet with each potential participant for an approximate fifteen minutes to explain my project. At these individual potential participant meetings, I discussed my project's significance and potential risks, delineated the voluntary nature of the study, and provided a statement assuring confidentiality of the participants. Upon completion of the informational meetings, seven out of eight participant CNAs employed at LC SNF volunteered for this project study. Upon receipt of each individual participant's signed consent, in-depth interviews were scheduled through email and/or phone correspondence. A second opportunity to review the consent form was provided prior to beginning the scheduled interview with each participant. All seven participants stated they understood the participation consent conditions and none chose to opt out of the study.

Seven participants gave in-depth interviews, ranging from 15 to 20 minutes, that were conducted and guided by facilitating questions (see Appendix C). After each

interview, field notes specific to the individual participant's mood, language pragmatics (i.e. body language, facial expressions, and tone of voice), environment and ethos were completed. Triangulation of data was accomplished through the use of interpretive analysis methodology techniques, member-checking**,** peer debriefing and participant follow –up meetings, all of which were designed to clarify data interpretations and themes. Upon request of the administrator, results of the project were provided in a power point format to present upon this research project Walden Committee approval. The LC SNF administrator plans to present the research results to the CNAs at the next LC SNF meeting.

Rationale

As qualitative research is instrumental in the identification of areas for improvement (Creswell, 2009; Merriam & Associates, 2002), this research project explored how CNAs interact with their social world in a meaningful way. The rationale for this research stems from Pennsylvania's CNA proposed revision of the training program regulations that would increase training hours from 80 to 120 hours. This increase is reporting by Pennsylvania State as intended to improve CNA job performance and job satisfaction; thus, increasing the quality of care for their patients.

The Pennsylvania Administrative Code, Title 55, 1181.521, mandated nurses' aide requirements to be a minimum of 80 training hours of instruction and a minimum of 37.5 hours of clinical training hours (State Nurses' Aides Training Requirements, 2009). The new regulations, enacted in 2010, revised the CNA curriculum of communication skills, personal care skills, interpersonal skills, basic nursing skills, and resident rights.

The dichotomy of an increasing number of the elderly populations (Institute of Medicine, 2008) and inadequate preparation of nurses' aides (Institute of Medicine, 2008) was the impetus for a need to retool America's healthcare and education.

This project methodology was chosen to give a voice to CNA perceptions relative to CNA training as it is relates to clinical job duties.

Review of the Literature

Justification of the Choice of Research Design

The justification for the qualitative phenomenology approach in lieu of a quantitative approach is that the phenomenology approach seeks to understand the underlying meaning. Historically, Polkinghorne (1989) emphasized the conscious experiences of humans and how they give meaning to their experiences. In this study, the phenomenology approach sought how CNAs derive meaning from their educational experience. In addition, this approach facilitates a strategy to address how CNAs apply that meaning within their workplace environment.

Creswell (2003) emphasized that phenomenological research was the preferred qualitative approach to evaluate feelings and attitudes. As this study engaged seven (7) participants, the literature affirmed the most appropriate approach for a small, limited number of participants is the phenomenology approach (Creswell, 2003, Hoffman, 2009). The essential aspect of this type of methodology is the extended interaction between the researcher and participants. The experiences between the two parties provide insights into the relationships and patterns of the phenomenon being examined (Creswell, 2003).

It is apparent that the quantitative type of approach will not suffice when considering the focus on empirical data outcomes and the goal to give voice to CNA perceptions relative to SNF clinical duties. The quantitative research method relies on data to test hypotheses, provide fixed response options, and analyze numerical data (Creswell, 2003). Quantitative data cannot sufficiently define the CNAs role clarification, job satisfaction, or perception of job preparedness. An exploration of certified nurses' aides' (CNA) perceptions of their training, as it relates to their duties, is best suited for qualitative data collection through in-depth, detailed description guided by CNA participant insights relative to the research problem. Therefore, a quantitative approach to this study would t prove effective in developing an initial understanding of CNA perceptions. Whereas, Hoffman (2009) supported the use of a qualitative research method as a general approach when striving to ascertain participant reactions, feelings and/or attitudes, as statistical explanation of the problem appears inappropriate, impossible, and irrelevant in understanding more abstract human concepts.

The goal of this qualitative research study was to understand certified nurse assistant perceptions relative to an increased 100-hour educational CNA certification program through in-depth interviews, observation field notes, and record review. The goals and results of this research are important because they may assist healthcare administrators in bridging CNA training components and the clinical implementation of CNA duties. Through the CNA participant voices, expectations of CNA training will be explored and related to their training and subsequent duties. Administrators and healthcare supervisors within a SNF will have a more in-depth understanding of how

CNAs perceive their role within the CNA daily expectations of patient care. Hence, the research themes that I identified may be relevant to the development of nurses' aides training program specifically in the State of Pennsylvania.

Current Themes in the Literature

The last two years, research and peer-reviewed literature revealed three consistent themes relative to CNA perceptions and training programs: (a) CNAs perceptions that student-centered training is preferable to teacher-centered training (PHI Policy Works, 2012), (b) training programs are perceived as inadequate preparation for CNA duties The last two years, research and peer-reviewed literature revealed three consistent themes relative to CNA perceptions and training programs: (a) CNAs perceptions that student-centered training is preferable to teacher-centered training (PHI Policy Works, 2012), (b) training programs are perceived as inadequate preparation for CNA duties (Castie et al., 2007), and (c) poor retention of CNAs on a local and national level due to inadequate preparation (Bercovitz et al., 2007). I introduced and explored the current peer-reviewed journals and professional literature in consideration of the recommendations from the IOM (2008). Recommendations from the IOM (2008) were: (a) retool education so that training programs will deliver a more efficient healthcare system and relieve the shortage of adequately trained workers, (b) healthcare regulators should consider expanding the roles and responsibilities of healthcare providers at the various levels of training, (c) research should be conducted on preparing healthcare workers to assume expanded roles (News from the National Academies, 2008).

Barriers to CNA Training

CNA training program and continuing education programs, while a necessary requirement, are also reported as a barrier for potential CNA candidates. CNA course availability and scheduling have been attributed to CNA employment retention and job dissatisfaction. According to a 2005 survey by the Iowa Better Jobs Better Care (BJBC) Coalition, CNAs perceived three main barriers to their training: (a) cost of the program, (b) knowledge of course provision, and (c) lack of evening class availability (Greco, 2011). Greco (2011) reported that the average cost of CNA training programs in U.S. major cities is as high as $1,300 in 2010. He further stated, the tuition cost, program registration fees, and related transportation costs would most likely inhibit potential students from participating in CNA training, and/or perceive it as a worthy investment (Greco, 2011). Additionally, the average CNA salary in the US earned is reportedly less than $25K annually (Greco, 2011), hence, negatively impacting prospective student enrollment.

Lines (2011) expanded this notion of CNA training availability through an examination of education reimbursement programs for CNA training. Despite every U.S. state having a CNA training tuition reimbursement program, the lag time between actual tuition reimbursement and the training program tuition requirements become a barrier many potential CNA students could not overcome (Lines, 2011). Greco (2011) expanded on this idea of CNA tuition reimbursement inaccessibility, stating that while it is possible CNAs and CNA potential candidates may be aware of reimbursement opportunities, they often lack knowledge on how to access grants or reimbursements. According to the Iowa

Caregivers (2005) survey, many SNF administrators perceive prospective CNAs as being unaware of local training course availability and/or access thereof.

Greco (2011) identified the additional barrier to CNA student's experience as a difficulty in scheduling classes conducive to potential CNA students' personal and employment needs, and various other obligations. For lower income students, taking time off from work or hiring childcare or elderly care are less likely to be an option (Greco, 2011). Financial and scheduling concerns are offten barriers associated with CNA participation in initial certification programs and/or continuing education opportunities.

However, these are not only barriers associated with CNA participation in initial certification programs and/or continuing education opportunities. Language can also be a barrier for a prospective CNA student, as a requirement for CNA certification is the ability to read and write English with fluency. Lines (2011) purports that while some CNA classes are offered in Spanish and a few other languages (e.g., Haitian Creole, French); CNA applicants enrolling in such schools must still possess English competency as evidenced by enrollment testing (Linis, 2011).

Implementation

The efficacy and efficiency of CNA training were expressed through the voices of CNAs. CNA participants' voices provided insight into CNA practical training and CNA practical experiences and the gap thereof. Initial participant recruitment was conducted by my self via letter correspondence introducing the research project to skilled nursing facilities within Lancaster, Pennsylvania. Upon receipt of administrator permission to

conduct the study at LC SNF, information flyers were introduced by the administration to potential participants. Hence, the LC SNF administrator distributed the information. flyers, outlining this research project and requesting CNA volunteers (see Appendix E), during a CNA meeting

After 2 weeks, I received no response to my flyers. Therefore, I acquired permission from the administrator to meet with each potential CNA participant for a brieften-to-fifteen minute meeting to explain my research project. As a result of these participant responsibilities. Further, the consent provided a detailed project description, potential risks, explained the voluntary nature of the study, and provided a statement assuring confidentiality of the participants.

Prior to the face-to-face in-depth interviews, I reviewed the signed consent form with each participant to answer any questions and provide an additional opportunity to withdraw. All participants stated they understood participation terms. Hence, face-to-face interviews commenced at the approved LC SNF research nursing home facility located within Eastern Pennsylvania. Each participant within this research project was then assigned a random letter to preserve anonymity and only the researcher knows which letter corresponds to each participant.

Upon completion of coding the data into themes, or patterns, as voiced by participants, analysis of themes, record review, and peer member checks were completed. Finally, a PowerPoint presentation of this study's results was subsequently developed to be presented to the administrator of LC SNF nursing home for the administrator's distribution to nursing and CNA staff at her discretion.

Project Evaluation

Findings

Upon completion of my data collection, I began data organization, development of themes, and coding. To simplify the analysis process, a participant chart and coding categories were developed as indicated in Table 1 and 2. The themes are represented in the qualitative narrative by participant voices and charts, and lastly, the meaning of the data will be interpreted in the narrative.

Patterns and Themes of Meanings

Patterns emerged during the in-depth interviews with the CNAs as they responded to questions that were relative to each of their likes and dislikes about their jobs. These patterns were then developed into themes. Four major themes emerged: (a) number of training hours proved insignificant relative to perceptions of training adequacy, (b) need for mentoring and shadowing, (c) time management and large CNA caseload, and (d) continuing education training perceived as sufficient through employer. An overarching theme, that CNA participants perceived the job as demanding both physically and emotionally, despite enjoying working with patients, evolved. Hence, overall participants identified their job as stressful. One positive theme, participants' perception that continuing educational training opportunities provided within the LC SNF were sufficient, also clearly emerged from the data collection.

Evidence of Research Quality Procedures

Introduction

Qualitative research discovers how individuals interact with their social world, and is instrumental in developing new themes (Creswell, 2009; Merriam & Associates, 2002).The qualitative research in this study was designed to understand certified nurse assistant perceptions relative to an increased 100-hour educational CNA certification program through utilization of interview observation field notes, and record review. This project was conducted within the LC Skilled Nursing Facility (SNF) in Lancaster County, PA.

The demographics of Lancaster, PA is evidence that the U.S. trend of a growing elderly population is increasing with the rate of 15% (Retooling of America. 2000). The State of Pennsylvania, as well as Lancaster County, PA, reports a consistent 15% yearly increase of persons age 65 and older. In contrast, Lancaster County reports that while 81.9% of Lancaster's youth are high school graduates, only 23% continue in higher education earning a Bachelor of Arts degree.

Profile of LC SNF

Not only is important to view the scope of the education availability when analyzing the data, but profiling the research site will also assist in understanding the data. According to the LC SNF website, it is located on 50+ acres in rural Lancaster County, PA. It is a continuing care retirement community consisting of 114 licensed health care beds**,** 74 licensed personal care beds, 12 residential living residences, 58 apartments, and 45 cottages. The retirement community is located on two adjoining

campuses. LC SNF, a nonprofit, church related facility, was founded in 1968 and is governed by a nine-member Board from a faith based Conference of a faith based church. LC SNF is licensed to receive Medicare and Medicaid funding. A review of LC SNF's policy revealed all residents without regard to race, color, national origin, ancestry, age, sex, religious creed, handicap, or disability will receive needed services. The facility affords residents a panoramic view of the farming community that is typical of Lancaster County. While within easy driving distance of surrounding towns, residents of LC SNF live in a quiet, country setting.

I reviewed the mission statement of LC SNF and noted that it indicates an emphasis on meeting residents' spiritual and medical needs. The Christian ministry of LC SNF's staff and volunteers are active on a daily level within the facility. Additionally, the administrator stated that local church groups and pastors visit LC SNF residents with weekly consistency.

Observations of LC SNF

The LC SNF nursing home is two-story building located on a hill overlooking the surrounding town. As you enter, the nursing home has an information desk to the left of the entrance. Upon stopping to introduce myself to the receptionist, I was meet by the assistant administrator .She directed me though a very large patients' lounge that was very simply decorated. She then escorted me to an elevator to go to the second floor where the nurses' lounge was located. The break room was small with a table and chair, couch, chair, refrigerator, and a small sink. She then informed me that I could interview the CNAs as they came in for their lunch breaks. She then left the room. Then, as

lunchtime approached, the staff started to come into the room. I introduced myself to each one, and as the CNAs introduced themselves, I introduced my research study to each CNA. I asked them individually if they would be willing to participate in my study. While one CNA declined, the other seven that I ask agreed to participate. Each interview lasted 15-20 min. While participates A, B, C, and E where very outspoken, participates D, F, and G where a little nervous, shy and less forthcoming in their responses.

Profile of CNA Study Participants

Mittal, Rosen, and Leana, (2009), researched the effects of the background characteristics, personal stressors, job-related stressors and workplace support on job satisfaction of direct care workers' (DCW). When examining predictors associated with job commitment, Ejaz and Noelker's (2008) findings revealed that background characteristics of were most powerful in predicting job commitment. For example, DCWs who were in the minority, younger, more educate, worked fewer hours, and had more dependents, reported they would most likely exit employment as a DCW.

I interviewed seven individuals. When asked to complete basic personal attributes of age, number of children and marriage status, the following was submitted. All participants were female. Four participants were between 19 and 35 years old. One patient was older than 35, but chose not to state her age. Two other participants chose not to reveal their ages or age range. One participant was married and had two children and another was a single mother. The remaining five participants chose not to answer marriage and parental status questions. Based on these data, relative to personal attributes of the participants, no conclusive statement can be made relative to stressors

outside LS SNF employment and job satisfaction such as that of Mittal et al. (2009) who identified the effects of the background characteristics, personal stressors, job-related stressors and workplace support on job satisfaction of direct care workers' (DCW).

Table 1 provides CNA study participants' background information relative to native language spoken, the number of years employed as a CNA, occupations and employment prior to their employment at LC SNF and the impetus from which they chose a career as a CNA.

Table 1

Background Information

Participant (represented by letter of aph)	Number of years as a CNA	First language spoken	Previous employment	Reasons for seeking CNA certification
A	9	English	None	Childhood dream and mother's encouragement
B	7	English	CNA and Photographer	Job after high school
C	2	English	None reported	Initially employed in nursing home in another capacity
D	1	English	None reported	No specific reason given.
E	28	English	None reported	Became aware through Votechnical School
F	2	English	Housekeeping	Worked as housekeeper in nursing home.
G	5	English	Retail and Woodshop	No specific reason given.

While Table 1 data does not suggest a conclusive correlation between the literature relative to CNA job retention factors, the following information presented in Table 2: Information on Training, provides data supporting Castie et al. (2007) research suggesting that CNA training and workload are key to CNA job satisfaction. Specifically, 71% (5 out of 7) participants identified frustrations they experience in the workplace. Research is clear that workplace stressors correlate with high turnover and job dissatisfaction (Castle, 2007; Castie et al., 2007). Further, CNA adequate preparation and staff mentoring was identified by Bishop et al. (2007) as impacting CNA job retention. In this study, 86% (6 out of 7) participants voiced frustrations and concerns that impact the provision of patient care. Hence, this study's data affirm that of Bishop et al. (2007) findings.

Table 2

Information on Training and Testing

Participant	Do you feel you were adequately prepared for employment as a CNA	Hours of CNA training received	Problems identified in current CNA position	Topics missing or lacking in participant CNA training program
A	Yes	105	New trainees have inadequate on-the-job training	Practicum – more on-the-job training
B	Yes	One month	Caseload – number of residents assigned	Practicum- on the-job training
C	Yes	3.5 Weeks	Not informed of State SNF rules and policies	None reported
D	Yes	100	None identified	None reported
E	Yes	Not aware	Lacking strategies to address patient behavioral issues	None reported
F	Yes	Not aware	Workplace confrontation	None reported
G	Yes	105	None	Time Efficiency

While data presented in Tables 1 and 2 affirms literature themes of CNA inadequate training and preparation, as well as personal and workplace stressors, participant voices also presented some conflicting information relative to adequate preparation. While a record review confirmed all participants passed the Red Cross standardized test required for CNA licensure, only 5 out of the 7 participants perceived their CNA training program was instrumental in passing the Red Cross test. In fact, during participant interviews, 100% (7 out of 7) participants stated they passed the Red Cross on their first attempt. This high rate of exam success suggests that the CNA

training was adequate in meeting standards for CNA licensure recognized by Pennsylvania as critical for the provision and delivery of quality CNA patient services. However, the 100% pass rate by this study's participants did not eliminate participants' perceptions that they were inadequately prepared for various aspects of patient care.

Another consensus 100% of participants voiced was the satisfaction their caregiver role provided. Despite this unanimous perception of satisfaction as caregiver, two participants were not satisfied with their overall abilities and role as caregiver voicing a desire for additional continuing education opportunities. This perception of possessing inadequate CNA training was in opposition to participant consensus that continuing education was unnecessary for the execution of CNA duties.

This denial of needing continuing education is also in direct conflict with all seven participants' perceptions that their job as a CNA is stressful and demanding. Six out of seven (85%) participants stated that sufficient continuing educational training opportunities are provided through the LC SNF facility. However, 100% of participants did not state that the continuing education provided by LC SNF decreased the physical and mental stressors of the job. When asked what could be done to relieve some of the job stress, Participant G stated, "more training on the job before going out on your own" was needed. Participant A stated, "I do not enjoy the physical or mental stress at times." affirming previous research citing job stress and dissatisfaction impacts CNA job retention. While the CNAs perceived facility provided in-service training met their professional needs, participants also voiced job related complaints suggesting that additional in-service training is warranted. Participant G and F stated, heavy lifting needs

to better addressed and identified as a job stressor. Overall, participant record review and interview data affirmed researchers' Castle, (2007), Castie et al. (2007) and Bishop et al.'s (2011) findings that CNA perceptions of job satisfaction are directly linked to quality patient care and job retention.

Outcomes: Survey Themes

Research Question 1: How do CNA graduates of the 100-hour or fewer programs perceive their classroom training/curriculum as it relates to effectively performing their duties in a skilled nursing facility?

Theme Number 1: Number of Training Hours

The CNA participants perceived that the number of hours of training they received was irrelevant. When participants were presented with the question relative to the number of hours of training received, only 43% (3 out of 7) had knowledge of the exact number of training hours received. While this perception was validated, it may also be unfounded as it was also revealed that 57% of the participants were unaware of the number of hours received for certification. Hence, the lack of awareness by participant relative to the number of their training hours, may suggest that training and educational strategies utilized may be more important than the number of hours of training. Further, no participant indicated that the amount of hours was, or should be, an issue relative to how well they perform their job.

One possible explanation for participants' concern as to required number of training hours, may be due to the lack of CNA schools in the Lancaster, PA area offering CNA certification programs. It may also be the participants' lack of knowledge of State

CNA schools program requirements. Participants A and G stated that they both had 105 hours of training while participant D stated she had 100 hours of training. Participants B and C measured their training in week, while participants E and F did not know how long they attended their training. The length of training was not an issue for participants E and F.

Because the participates had graduated 3 years after their programs had changed, I was unable to obtain a record review of their training program to affirmed the accuracy in the participants' recall of the number of hours of training. That two participants had no knowledge of how many hours of training they attended, and yet felt they were adequately prepared for employment as a CNA further affirms that training quality is not measured in hours or weeks but by ability to perform the job when hired.

Data in this study did not affirm the findings of past research examining participants' perceptions of CNA training preparedness for employment (Ejaz & Noelker, 2008; Ejaz, 2008). In fact, participants in this study felt they were inadequately prepared to complete their clinical duties at LC SNF. Hence, this study's results were unlike that of Ejaz and Noelker's (2008) research suggesting there is a relationship between adequacy of job preparedness and the amount of hours of training.

Job satisfaction (Castie et al., 2007) and retention (Bishop et al., 2008; Chuang et al., 2010) were also correlated with the amount of training hours; however, the participants' responses in this study indicated no correlation of training hours to job satisfaction and retention. When further exploring the themes of job preparedness and job satisfaction, this research questioned how CNA graduates of the 100 hour or fewer programs

perceived their ability to effectively complete clinical duties. CNAs' voices were clear that a need for mentoring and shadowing when accepting a new CNA employment position would be beneficial.

Theme Number 2: Mentoring and Shadowing

Participant CNAs voiced that new CNA trainees would benefit from being mentored or provided with a shadowing component prior to, or immediately upon accepting, a CNA position in the LC SNF facility. This request for an employee mentoring or shadowing program was supported by 40% of participants interviewed. Despite participants' voicing they were adequately trained, participants A, B, G and E stated: “something was missing”, “having chances to shadow (a CNA) before taking the job”, “get a showing time” and “add something like shadowing” when asked what would benefit them in their CNA certification program training. Participant A stated, “I feel that I was adequately trained. The best training after being taught proper skills is on the training and shadowing.” Participant B responded to the question of improving CNA training programs by stating she “wished she had (had) more job shadowing.”

According to the LC SNF facility assistant administer, all new CNAs at the facility are provided with orientation to the facility. This orientation program includes mentoring with an experienced CNA. Mentoring is defined by this facility as the pairing of an experienced CNA with the newly employed CNA employee. The mentor, ideally, assists the new CNA employee in patient care, reviewing patient care plans for a percentage of the new employee's patient caseload. The Charge Nurse (the nurse supervisor for that floor or unit within the SNF) determines the mentor-mentee match, as

well as the patient caseload for which the mentor and mentee will be responsible. Once the new CNA mentee completes patient care rounds with his/her CNA mentor to the satisfaction of both the Mentor and Charge Nurse, the newly employed CNA will be permitted to complete CNA duties without mentor accompaniment.

In the LC SNF mentor program, there is no provision for on-going mentoring by the mentor and new employee – mentor relationships have no defined parameters. The LC SNF administrator stated that the mentoring program is tailored to meet the individual needs of the new employee as deemed by the mentor and administrative staff. \While 40% of the participants indicated a specific mentoring or shadowing program should be a required component of CNA training programs, the remaining 60% of participants did not comment or voice concerns relative to improvement of the CNA training program.

Chung (2011) proposes that quality of CNA-resident care is influenced by CNAs' opinions, and CNAs' perception of his/her role within the skilled nursing facility (Chung, 2011). Chung (2011) explored the impact of social workers mentoring CNAs and found that when CNAs are mentored by a social worker, CNAs are more able and confident in addressing and resolving daily patient care dilemmas. Through mentoring, CNAs evidenced an increased ability to discuss acceptable and appropriate patient relationships within nursing home care. Castle (2007) proposed that CNA satisfaction is associated with promotional opportunities, superiors, and compensation. Bishop, Weinberg, Leutz, Dossa, Pfefferle, and Zincavage (2008), in part, agreed with Castle's (2007) findings relative to CNA job satisfaction being somewhat dependent upon the CNAs relationship with his/her superior. Similar to Bishop et al. (2008) findings that facility management

and philosophy techniques contributed to CNA job retention, this study found that facility management extended to CNA caseload or the number of patients assigned to each CNA.

Theme Number 3: Time Management and Large CNA Caseload

Not only did participants identify mentoring and shadowing as a needed component of the CNA training program to increase their job satisfaction; but participants also identified time management on the job as a concern. Adding to the notion of quality of care provided to patients, the quality of care of skilled nursing home residents was examined in terms of CNA role perception.

Participant CNAs perceived that time management was a problem due to their individual assigned patient caseloads for which they were responsible. This theme emerged when asking the question relative to the types of problems CNAs encountered within their workplace. .

Interview Question: What types of problems do you feel you encounter as a CNA working in a skilled nursing facility?

According to participants B, C, E, and G, a contributing theme in this research project is time management difficulties due to the large number of patients assigned to them. While participants reported being assigned one or two patients while they are in the clinical training portion of their CNA program, the data is clear that participants were not prepared for a caseload of 10 patients or larger. After CNA program graduation, participants reported an increase in caseload of patients to be 10-15 patients per CNA. Despite record review, verifying the LC SNF CNA caseload is within the guidelines of in

accordance with Pennsylvania State Regulations, it became clear that participants did not feel prepared to handle the patient caseload given.

Duties that the CNAs' reported that that they were required to do was provide patient personal hygiene care, meal assistance and some housekeeping chores. Participant B stated, "I was not ready for how many residents I had to take on." and further indicated that all "the things I do for each patient is so much it causes more stress." Participant G responded to the same question by stating she "felt that time efficiency" was a problem for her. Participant C stated, "not having enough staff was very stressful in giving good caring for her patients because there isn't enough time for just me to do it." While Participant E stated that "not having enough time to interacting with the resident is stressful."

Data in this study confirms the findings of past research examined in terms of CNAs' perceptions relative to employment preparedness (Ejaz and Noelker, 2008; Ejaz ,2008), job satisfaction (Castie et al, 2007; Chung ,2011) and retention (Bishop et al, 2008; Chuang et al, 2010).

According to Chung (2011), the beliefs and assumptions of CNAs, contribute to a reduced resident quality of care. These believes are the following; 1) CNAs feeling of being overburdened, 2) workload fatigue, 3) inter-staff miscommunication, 4) lack of adequate training, 5) inadequate staffing, 6)lack of continuity of care, and 7) depersonalized care. These findings support that of other literature (Castie et al, 2007, Häggström et al, 2009) which has established the relationship between staffing levels and care outcomes of nursing homes residents.

Castle (2007) proposed that CNA satisfaction is associated with promotional opportunities, superiors, and compensation. Bishop, Weinberg, Leutz, Dossa, Pfefferle, and Zincavage (2008), in part, agreed with Castle's (2007) findings relative to CNA job satisfaction being somewhat dependent upon the CNAs relationship with his/her superior. Bishop et al (2008) conducted a qualitative study with the intent to understand what factors motivated CNAs to retain his/her job the investigation of management and philosophy techniques within Massachusetts' nursing homes.

Yeatts, Cready, Swan, and Shen (2010) purported there was a relationship between the certified nurse aides' perception of their training and continuing education and their performance, turnover, attitudes, burnout, and empowerment. To explore if the participants in this study affirmed or refuted the findings of Yeatts, et al. (2010), the following research question was asked: "How do CNA graduates of the 100-hour or fewer programs perceive their desire/motivation to acquire or not acquire additional education in the healthcare system as related to their training program?

Theme Number 4: Continuing Education Training is Sufficient through Employer

CNAs perceive that they have sufficient continuing educational training provided through their facility; however, it has been established that a mentoring or shadowing program was also perceived as being valuable when transitioning from training program to employment expectations. The majority of participants were satisfied with in-services provided by the LC SNF. This finding of satisfaction relative to continuing education opportunities was in direct opposition of Resnick, Cayo, Galik, and Pretzer-Aboff's (2009), who examined the notion of CNA perceptions relative to successful patient care through continuing facility and/or resident care education. All except one participant, or

86% (six out of seven), stated that sufficient continuing educational training opportunities are provided through the LC SNF facility. The one participant, Participant G, who did not feel she had adequate training to successfully treat patients stated, “There needs to be more training on the job before going out on your own”. Despite the majority of participants voicing no need for further continuing education, there is evidence that perceptions of job satisfaction is dependent upon the like or dislike of clinical tasks given. For example, Participant A stated, “I do not enjoy the physical or mental stress at times…need help with this part of my job”. Participant F stated, “I did not enjoy the heavy lifting…this is not a good part of my job.” Hence, there is a disconnect between the participants’ perceptions of adequate facility training and job satisfaction when job tasks proved difficult or disliked.

Data in this study did not confirm the findings of past research examined in terms of their perceptions of in-services relative to employment preparedness by Resnick, Cayo, Galik, and Pretzer-Aboff (2009). Resnick et al’s (2009) data concluded that the quality of patient care could be improved with additional training for nurses’ aides. The research participants in this project, overwhelmingly, did not indicate the need for continuing education or in services to feel prepared for the job of a CNA despite the rhetoric of difficulty with time management.

Peer Reviewers and Participants’ Perceptions

Table 2, Peer Reviewers, provides the responses from this study’s two peer reviewers interpretation of 25% of the in-depth interview data collected. Peer Reviewer 1, a Registered Nurse (RN), and Peer Reviewer 2, a Certified Nurses’ Aide, reported their

interpretations of the data in a narrative format and returned their interpretations of the data via email.

Both Reviewer 1 and 2 were in agreement of the following three themes: 1) CNA participants did not view the number of hours of training within their certification program as an indicator for job satisfaction or successful clinical task completion; 2) there was a need for a mentoring or shadowing program during the initial months when hired as a CNA, 3) no continuing education was needed other than that of the LC SNF facility provided inservices. Reviewer 2 identified a disconnect between the CNAs' voiced satisfaction of continuing education and their voiced discontent relative to dealing with "difficult patients" and "behavior problems with patients".

Conclusion

Though the voices of seven (7) CNAs employed in Lancaster County in Pennsylvania, the following perceptions were expressed: 1) the number of training hours received was irrelevant and directly correlated with job satisfaction or preparedness; 2) new CNA graduates should be mentored or shadowed by the facility in which he/she is employed; 3) time management is problematic due to the number of patients per CNA caseload when compared to training program caseload, and 4) continuing educational training provided by employment facility is perceived as sufficient.

In healthcare education, qualitative methodologies utilized in research may assist in facilitating positive change based on the participant voices of CNAs working within the skilled nursing facility culture. Qualitative research is instrumental in the identification of areas for improvement, such as how educators could improve CNAs

training by adding the state and feudal recommended clinical and class room hours to their already existing 80 hours of training.

Section 4: Reflections and Conclusions

Introduction

In this section, I have provided the project strengths, recommendations for remediation of limitations, scholarship project development and evaluation, leadership and change, analysis of self as scholar analysis of self as practitioner, analysis of self as project developer, the project's potential impact on social change, implications,

Also in this section, further research targeting the involvement of CNA students and their perceptions regarding CNA training programs to effectuate improve training programs on a local and national level is discussed. This future research might also provide an insight into a potential positive impact on the educational healthcare training of the State of Pennsylvania's healthcare service

Project Strengths

The project had much strength. One of the strengths of the study was that one hundred percent (7/7) of the participants' described their job duties the same as the LC SNF written job description. Another strength noted was that the CNA participants'

responses reflected individual perceptions based on experiences as an employee of the LC SNF nursing home free of administrator influence. In addition, a good rapport was developed with the CNA participants; hence, providing an environment in which participants freely responded to research questions. Also, it was noted that CNAs did not alter their duties for the benefit of this research. Finally, the CNAs identified a need for mentoring or shadowing programs for new CNA employees; thus, providing a strategy for all nursing home facilities to utilize to improve CNA job performance, retention and satisfaction

Project Limitations

This project included several limitations in addressing the research problem relative to the efficacy and efficiency of the Pennsylvania 120-hour CNA training program. This study was limited to the perception of a small group in a localized area. Only seven CNAs of one nursing home in Lancaster County, Pennsylvania were engaged in the study; therefore, limiting the diversity of responses and shared experiences of all CNAs. Also, the data collected from the participating nursing home was not limited to only those CNAs who had a 100 hours or less of training during the time of this study, and therefore, no correlation or interpretations can be made relative to CNAs who receive, or have received, greater than 100 hours of training prior to employment as a CNA.
Finally, data collection opportunities were limited to 15 min of each CNAs brake time.

Recommendations for the Remediation of the Limitations

This study could be expanded to CNAs of other nursing homes in Lancaster County, Pennsylvania, and therefore, the results of the data collected and subsequent analysis

could be generalized to that of all CNAs.in nursing homes in Lancaster County, PA. The data collected from the participating nursing homes should be limited to only those CNAs who had a 100 hours or less of training during the time of this study, and therefore, it would represent only CNAs that had 100 hours or less of training of in the participating nursing homes. Finally, due to the CNAs daily schedules, data collection opportunities could be made available for each CNA's participation at the beginning or ending of their shift.

The Problem Approached Differently

Different approaches to the problem of increasing CNA certification training program hours as presented in this study may result in a varied data collection. One different approach would be to expand the project to include additional nursing homes in, and outside, of Lancaster, Pennsylvania. Another approach would be to conduct a comparison study of CNAs who attended 100 hours of training or less and CNAs who attended 120 hours of training. Finally, the problem could be approached differently though data collection, by reversing this study's methodology to include technological strategies such as email, social media or texting in combination with focus groups, while continuing the method of face-to-face interviews.

Alternatives Addressing this Problem

Alternatives that might be considered in addressing this type of problem would be to expand this study's methodology to include CNA participant from additional nursing homes in Lancaster, PA, as well as additional states to allow for possible data generalization on a national and/or global level. Another alternative would be to do a

comparison study of CNA graduates of 100 and those of 120-hour programs. This study might provide more of a direct insight into the efficacy of increasing hour requirements to attain nurse aide certification. Finally, data collection opportunities might increase if CNA's participation included interview conversations and more detailed appropriate survey methods were exchanged via e-mail; thus, replacing in-depth face-to-face interviews.

Scholarship

In Schulman's study (as cited in Atkinson, 2009, p 96), "Scholarship properly communicated and critiqued serves as the building block for knowledge growth in a field." Schulman further identified three guidelines to judge scholarship: (a) the information available to the public, (b) the information reviewed by peers, and (c) the information can be built upon by the community (1998). These guidelines summarize what I have learned, as I now have a better understanding of qualitative research methodology strategies designed to increase obtaining rich, descriptive data. It has become clear that an analysis of data obtained through the voices and perspectives of others allow for multiple interpretations. Furthermore, as a result of this study, my professional goal is to continue engaging in scholarly research and incorporating best practices within my professional career.

I chose to study a project using qualitative research methods of in-depth interviews, record review, and peer data review, as an instrument to identify areas of improvement in the Certified Nursing Assistant training program in Pennsylvania. In accordance with qualitative literature, through my research project, understanding how

individuals interact with their social world was instrumental in developing new themes (Creswell, 2009; Merriam & Associates, 2002). In healthcare education, qualitative methodologies support a framework from which to facilitate positive change within skilled nursing facility and various medical setting cultures. The voices of medical paraprofessionals and professionals are critical within medical facility cultures if quality and efficient patient care is to be realized.

The goal of this qualitative research was to understand certified nurse assistant perceptions relative to an increased 100-hour educational CNA certification program to a 120-hour education program. This goal was sought through interviews, observation field notes, and record reviews that revealed that, while there is no direct correlation between a 120-hour program increasing CNA job preparedness and patient quality care in this study, participant voices revealed a need for mentoring employer programs and a need for more on-site training by the employing facility.

Project Development and Evaluation

In 2008, the IOM made the recommendations relative to retooling CNA education training programs to effectuate efficient healthcare service delivery system wide. In addition, the CNA education revisions were intended to relieve the shortage of adequately trained workers. Healthcare regulators were encouraged to expand the roles and responsibilities of healthcare providers at the various levels of training, and conduct research targeting healthcare worker preparation (News from the National Academies, 2008). The goal of this qualitative research study was to explore the CNA) perceptions relative to the recommended 120-hour educational Pennsylvania CNA certification.

The development of this research project was important as results may assist healthcare administrators in bridging CNA training components and the clinical implementation of CNA duties. Through the voices of CNA participants, expectations of CNA training programs were explored and themes relative to effective program training and the ability to effectively carry out clinical duties emerged. Hence, administrators and healthcare supervisors within a SNF may benefit from a deeper understanding of how CNAs perceive their abilities to execute daily expectations of patient care. Identified research themes of implementing a mentoring or shadowing program was voiced as a specific strategy to incorporate in nurses' aides training program specifically in the State of Pennsylvania.

Leadership and Change

The Assistant Nursing Home Administrator of this project's research site has held the position for the past five years. In response to a brief overview of themes that emerged from this research, the LC SNF Administrator stated, "While change is challenging and requires time, most of the nurses' aides hired needed additional hands on experiences." She further stated, "The new hire CNAs did not receive enough hands-on training in their training programs."

Thus, validating the perceptions of CNAs interviewed that they are lacking in hands-on training. The LC SNF was clear that she is eager to embrace the themes identified in this research to facilitate CNA job satisfaction, as well as effective patient care through the implementation of a new hire CNA mentoring program. .

Analysis of Self as Scholar

I have been employed in the field of Nursing Education for the last five years. One key element that was included in, and strongly reinforced by, Walden University was the implementation of reflection. As Walden courses often required reflection papers, I learned how to apply theory within my professional life. I have always set aside time for reflection and asked such questions as, “How can I improve my teaching?”, “What activities would help my students learn?”, and “How can I better meet the learning needs of my students?”. Mohr (2004) discussed the importance of educators taking time for reflections. She stated, “Teacher research leaders continually explore the relationships among their theories, their practice, and their reading. This characteristic provides a foundation for their leadership and credibility among their peers.” Mohr (2004, p. 127). Mohr (2004) and her associates interviewed teachers who successfully used reflection as an educational tool. The following summarizes Mohr’s (2004) reported strategies to implement reflection methods into busy teaching schedules: (a) find a quiet place at home before school begins and record your reflections in a teacher log, (b) at the end of the school day close the door and record reflections in a research journal, and (c) give your students a few minutes of journaling time at the beginning or end of class and journal along with your class. Mohr further emphasized that good teachers take the information of daily school life and “systematically reflect on their classroom and school…and see things differently or in a new light” (2004, p. 127).

Walden University has increased my awareness of the importance of becoming an actively engaged action researcher. Merle (2009) defined action research as a systematic

process that school educators follow to gain insights or information about the learning process that helps them understand their school, their teaching strategies, and their students. The most important aspect of teacher research is that the research is conducted by teachers, and this research assists the educator to examine his or .her personal practices and strategies (Johnson, 2008). Mills (2007) and Mertler (2009) outlined four steps to action research that teachers should include in this inquiry process:

1. Identify an area of focus.
2. Collect data.
3. Analyze and interpret the data.
4. Develop a plan of action to implement findings.

My goal is to continue to implement action research. and results thereof, within my workplace and field of nursing, as well as apply practical solutions while problem solving clinical dilemmas.

Analysis of Self as Practitioner

Through utilization of the conceptual framework of Roger's Learning Theory, I have examined the CNA training program from the underlying assumptions of student-centered education. Roger's learning theory of "client-centered is often equated with student-centered learning" (Merriam, Caffarella, & Baumgartner, 2007, p. 283), purports that some characteristics from student-centered learning stem from personal involvement, self-initiation, and pervasiveness, learner self-evaluation, and construction of meaning. In short, Roger's theory embraces the notion of "learning as a practice." When relating educational strategies for CNAs, personal involvement may facilitate student ownership

of course content in the classroom or clinical practicum settings and practice. Self-initiation requires that the student is motivated in order to reach task completion. Hence, my experience as a researcher affirms that one must be able to self-initiate learning to be successful. Finally, as a practitioner, the last step of Roger's learning theory – evaluation -- must be integrated within my workplace setting so that new information through traditional lesson delivery or practicum becomes meaningful. My learning experience as a researcher and medical practitioner is best summarized by the following quote: "The process of learning, which is centered on learner need, is seen as more important than the content; therefore, when educators are involved in the learning process, their most important role is to act as facilitators or guides" (Merriam, Caffarella, & Baumgartner, 2007, p. 284)

Analysis of Self as Project Developer

I learned that project planning requires resources, the help of others, and time to develop the project. While I had the support of the research site for my project, my timeline for the project required adjustment. The greatest challenge in meeting my original research timeline was the time required to complete the qualitative data analysis, and subsequent presentation of the data. I estimated that the process would take 30 days. However, the qualitative data analysis and presentation required 60 days to complete. Creswell (2003) pointed out that qualitative data analysis requires more time than quantitative analysis. Even though the data analysis was time consuming and more challenging than anticipated, I found qualitative analysis a powerful method for conducting research and unearthing the "so what" of my research question.

The Project's Potential Impact on Social Change

Meso (Community) Implications

My project revealed continued modification of CNA training programs is indicated. Through the voices of CNAs in one northeastern United States skilled nursing facility, awareness was increased that CNAs perceive their job as demanding both physically and emotionally. The voices of CNAs indicated a need for improved mentoring or shadowing upon graduation of a certified nursing assistant program. Participants' desire for employer mentoring programs did not appear to be correlated to the number of classroom training hours completed. To this end, skilled nursing facilities may benefit from regularly scheduled CNA-Administrator round table discussions to identify concerns and educational needs to improve overall patient care.

Macro (National) Implications

The Department of Health of Pennsylvania continually is reviewing the CNA training program curriculum. Specifically, they are reviewing incorporating the voices of CNA participants in addressing adding more practicums within the current 100-120 hour training programs. Mentoring programs, as well as adding practicums, should be explored as a requirement for CNAs within the first year of employment.

Implications, Applications, and Directions for Future Research

The longevity of the elderly who are in better health affects the funding of health care. Compounding the funding concern is the increase in chronic diseases among the younger population. These factors suggest that the health of the future elderly may be

worse than that of the current elderly population (Rand Health Compare, Spending, 2009).

In 2008, health spending was 16.3 percent of the Greater Domestic Product (GDP). Spending is expected to increase by an estimated 19.5% of the GDP in 2017 to equal an approximate $4.3 trillion. Hence, the GDP projected growth of an average of 4.7% per year; however, healthcare will grow faster than GDP. In 2017, it is predicted that the US economy will spend 20 cents of each dollar on healthcare. Furthermore, in 2018, healthcare spending growth is expected to exceed the GDP growth by an average of 1.9 percentage annually (Rand Health Compare, Spending, 2009).

Goldman, Shang, Bhattacharya, Garber, Hurd, Joyce, Lakdawalla, Panis, and Shekelle (2005) suggest Medicare spending in the future healthcare system will be affected by the health of the future elderly. According to Goldman, et al (2005), three possible scenarios were examined. In the first scenario, the health of new Medicare beneficiaries was predicted by using all the information available, which included the health of the younger population. In the second scenario, the researchers assumed that new beneficiaries' results were based on the same constellation of diseases and disabilities that the healthy beneficiaries had in the 1990s. In the third scenario, the research team assumed that there would be continued improvement in the health status of the entire elderly population, including new beneficiaries. The last scenario is the most favorable for implications for Medicare spending. The Medicare spending is about eight percent lower than the first scenario. Because in this scenario, healthier people live longer in which to accumulate costs, this scenario could cause an increase in the cost of

caring for an increased elderly population resulting in an. increase in Medicare spending (Rand Health Compare, Spending, 2009). The themes that emerged in this research project indicate that improved CNA education programs may well assist America's elderly in maintaining healthy lives.

The Affordable Care Act signed into law on March 23, 2010 by President Obama, will achieve these goals through a comprehensive strategy. This strategy includes investing in a new generation of primary caregivers by increasing their resources for training, giving incentives to new physicians for providing primary care to patients, and will support caregivers who choose to enter primary care in underserved areas (U. S. Department of Health & Human Services, 2010). If healthcare education is not retooled, it may result in an increase in the shortage of healthcare workers at a critical juncture when the baby boomers will be entering the healthcare system. Training for the elderly caregiver should include additional training on meeting the needs of the elderly validated by proficiency testing to ensure that the caregivers have the appropriate skills to care for the elderly (Institute of Medicine, 2008; Rosen, 2008). In addition, Rosen (2008) identified that CNAs feel they should also be compensated monetarily for any additional training and duties that will be needed to care for the increased aging population.

Since President Obama's healthcare plan was proposed in 2010, even more attention has been focused on obtaining adequate services with qualified healthcare workers. It has been estimated by the Association of American Medical Colleges that the nation will have a shortage of approximately 21,000 primary care physicians in 2015. This shortage could be prevented by taking action to increase the numbers of primary

care physicians and nurses. This would increase the accessibility to healthcare and help lower the costs of healthcare by preventing diseases and illness. This will result in ensuring the quality of healthcare for all Americans. It will also assist in preventing high turnover rates of direct care workers, hence, reducing bed availability in hospitals and nursing homes. High turnover rates may also contribute to healthcare worker recruitment, selection, and training. When adequately prepared healthcare givers become new hires, morale and group productivity may increase, thus decreasing indirect health care costs. Conversely, when inadequately trained CNAs are employed, job retention increases leading to staff shortages, and compromised patient care. To address adequate CNA training and patient care, future research is warranted.

Conclusion

In this section, I examined the positive impact of Roger's theory of student-centered learning had on seven students regarding their nurse aide training, as well as the research methodology itself. It was noted that as a researcher, I have gained insights into this project's strengths and limitations. Further, the concepts of scholarship project development and evaluation relative to implementing leadership and change within the healthcare field were investigated. A self- analysis as scholar, practitioner, and researcher was presented. Conclusively, this project has provided insight into educational healthcare training so that a potential positive impact on the State of Pennsylvania's healthcare service delivery can be provided. Further research targeting the involvement of CNA students and their perceptions regarding CNA training programs is warranted to effectuate improved training programs on a local and national level.

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Appendix A: Research Letter

Joyce Young

August 17, 2013

Dear Sir or Madam,

I am an MSN-prepared nurse, as well as a doctoral candidate in the EdD Adult Education, Walden University, Richard W. Riley College of Education and Leadership program. As you may well be aware, the Institute of Medicine, in a 2008 article, "Retooling for an Aging America", recommended he number of training hours for certified nurse aides (CNAs) training programs be increased from 75 to 120 hours. To address this change, my dissertation topic explores to what extent practicing CNAs feel adequately prepared to be effective in completing job tasks. Specifically, my qualitative study will seek to understand how CNA graduates of training programs consisting of 100 or fewer hours perceive the effectiveness in performing CNA clinical duties in a skilled nursing home.

I am writing to you to obtain permission to conduct my research in your skilled nursing facility. This study will utilize qualitative methodology to include in-depth CNA interviews with written observations, procedure and policy review of the facility's CNAs job description and their in-service requirements. Themes revealed through the voices of the CNA participants will aide skilled nursing facilities in understanding CNA perceptions relative to the training-job related duties. Additionally, perceptions relative to CNAs' desire to further post-secondary education will be explored. Hence, data will provide a framework from which effective training programs could be developed for

skilled nursing facilities (SNF). Participant feedback may be beneficial relative to skilled nursing facility funding and the expansion and improvement of healthcare facility training programs. The research questions are:

a. *How do CNA graduates of the 100-hour-or-fewer program perceive their clinical training as it relates to performing their clinical duties effectively in a skilled nursing facility?*
b. *How do CNA graduates of the 100-hour-or-fewer program perceive their classroom training as it relates to performing their duties effectively in a skilled nursing facility?*
c. *How do CNA graduates of the 100-hour-or-fewer program perceive their desire motivation to acquire or not acquire additional education in the healthcare system as related to their training program?*

I appreciate your willingness in considering my request to conduct my research within your facility. In accordance with IRB ethics and procedures, no remuneration will be provided to participants in this study. I would be happy to discuss the details of this study at your convenience. Please do not hesitate to contact me via email, xxx.xxx@xxx.xxx or via cell xxx-xxx-xxxx.

Sincerely,

Joyce Young, MSN, RN
Walden Doctoral Candidate
The Richard W. Riley College of Education and Leadership

Appendix B: Consent Form

You are invited to take part in a research study of to find out how you perceive your CNA clinical academic training as it relates to your clinical duties in a skilled nursing facility and how you perceive your training as it relates to your desire to acquire or not acquire additional education in the healthcare system.

You are invited to take part in the study because you are a CNA at a suburban Pennsylvania nursing home in Lancaster County with 120 beds who has had 100 hours or fewer of training. This form is part of a process called 'informed consent' to allow you to understand this study before deciding whether to take part.

This study is being conducted by researcher Joyce Young, doctoral candidate at Walden University, Richard W. Riley College of Education and Leadership.

Background Information: The purpose of this study is to explore how CNAs who have had 100 hours of training or fewer perceive their training as it relates to effective performance of clinical duties. Themes revealed through the voices of the CNA participants will aide skilled nursing facilities in understanding CNA perceptions relative to the training-job related duties. Additionally, perceptions relative to CNAs' desire to further post-secondary education will be explored. Hence, data will provide a framework from which effective training programs could be developed for skilled nursing facilities (SNF). Participant feedback may be beneficial relative to skilled nursing facility funding and the expansion and improvement of healthcare-facility training programs.

Procedures: If you agree to participate in this study, you will be asked to:

- Participate in a confidential, in-depth, audio recorded interview (time will vary

from 20 to 30 minutes)

- A PowerPoint presentation of the study's results will be held for participants and administrator(s) at the conclusion of study if you so choose to attend.

Voluntary Nature of the Study: Your participation in this study is voluntary. If you choose to participate, you may decline to answer any question(s) asked during the interview. You may change your decision and either enter or withdraw from the study at any time with no penalty, negative consequences or bias.

Risks and Benefits of Being in the Study: If you choose to participate, your responses and comments will be kept confidential. Your identity will not be exposed in recording data and within the data results/analysis. The benefit of your participation is that your responses may help instructors of CNA training programs to develop more-effective teaching methods within the classroom and clinical practicum for future CNA students.

Compensation: There will be no compensation for participating in his study.

Confidentiality: Any information you provide will be kept confidential .The researcher will not use your information for any purposes outside of this research project. The researcher will not include your name or place of employment within the data analysis, final written report, or scholarly papers based on the data, nor will the data be made available to outsiders, without your further, written consent. It is to be understood that excerpts taken from interviews and data regarding research site policies and procedures and CNA training programs may appear in subsequent research summaries, journals or scholarly papers and such use will be authorized.

Contacts and Questions: Feel free to ask any questions, either now or during the study, that you may regarding this study and/or your potential participation within this study. You may contact the researcher, Joyce Young, via phone xxx-xxx-xxxx or via university e-mail xxx.xxx@xxx.xxx. Further, if you wish to contact a Walden University representative to discuss any concerns or questions you may have regarding your possible participation in this study, you may contact Dr. Leilani Endicott, 1-800-xxx-xxxx, extension xxxx. Walden University's approval number for this study is **IRB will enter approval number here 12-12-13-0103711** and it expires on **IRB will enter expiration date December 11, 2014.**

Statement of Consent: I have read the above information and understand the research, as well as understand the participant requirements, the nature of my voluntary involvement, the confidential nature of my participation, and any potential risks related to my participation in the study. By my signature below, I am agreeing to participate in the study as outlined in the terms described above. I understand that I will receive a copy of my consent form for my records.

Participant's Name (Printed)____

Participant's Signature____

Date of Consent_________________________

Written or electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

Appendix C: Interview Guide

- OBJECTIVE: To learn how CNAs who graduated from a 100 hours or fewer of a training program perceive their training as it relates to their duties at a 120 bed, suburban Lancaster County, Pennsylvania skilled nursing facility, and how CNAs perceive that the CNA training program as impacting his/her decision on pursuing advanced training in the field of medical health.

Background information:

- CNA introduction of themselves: name, age, family (e.g., children, single-mothers).
- How did you begin working as a CNA? Include specific mechanism and reason.
- Previous types of jobs? Why did you leave that job(s)?
- How long have you been CNA?
- If you are an immigrant in the U.S., what is your native country and language? Do you, or have you had problems with English as a second language? How did you learn English?

Information on training and testing experiences:

- Do you feel your CNA training program adequately prepared you to be effective in your current job?
- Number of hours?
- What types of problems do you feel you encounter as a CNA working in a skilled nursing facility?
- What topics do you wished your training program had covered to better prepare

you for employment as a CNA?

- How was your experience with the CNA state certification exam? Was the test directly related to your training experience and clinical practice training? If you did not pass the state test the first time, what area(s) did you fail? In what test area(s) did you feel you were less prepared, or not at all prepared, to answer?
- How many times did you take the certification test? How many people do you think pass the test that attended your training program? That attended other training programs?
- Did you have to pay for the test? If not, who paid for it? Do you know that there is an option for you to get reimbursed through the facility?

Information on job experiences:

- What are the things you like the most about your job? What are the things you do not like about your job?
- What kind of follow up or additional training you would want to have after you start your job as a CNA (continuing education, group support, etc.)?

Appendix D: Letter of Cooperation from a Community Research Partner

Community Research Partner Name
Contact Information

Date

Dear Joyce Young,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Nurse Aides' Perspectives on Their Training within the Insert Name of Community Partner. As part of this study, I authorize you to interview CNAs before or after their shift regarding their duties at the facility and review policies and procedures books regarding CNA duties at the facility. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: a private room to interview participants. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB.

Sincerely,
Authorization Official
Contact Information

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix E: Flyer

CNAs: Stand Up and Be Counted

Did your training meet your needs as a practicing Nurse Aide? Would you like to see it improved, if so, how? If you would like to voice your opinion about your Nurse Aide training, I invite you to take part in a research survey being conducted by a Doctoral Student Researcher for Walden University. If you are interested in participating, you may contact the Researcher at 800-555-1235 or by e-mail at Researcher16901@walden.edu.

All responses will be kept confidential.

Curriculum Vitae

JOYCE L. YOUNG

EDUCATION

Walden University, Minneapolis, MN
EdD (ABD) in Adult Education 2014
Dissertation: Nurse Aides' Perspectives on Their Training

Walden University, Minneapolis, MN

MSN in Nursing 2007

Area of Concentration: Nurse Management Elmira College, Elmira, NY
BSN in Nursing 1991
Area of Concentration: Nursing

Corning Community College, Corning, NY
ASN in Nursing 1972
Registered Nurse (RN)

CERTIFICATIONS

Registered Nurse – State of Pennsylvania, New Jersey, and New York
CPR certified through American Red Cross Association
State of Pennsylvania, Trainer of Trainers for Nurses' Aides
State of Pennsylvania, Child and Youth Protection Certification
Personal Care Home Administrator Certification

TEACHING EXPERIENCE

Lancaster School of Technology Career Link, Lancaster, PA
Nurse Aide Instructor
2014March --Taught Nurses' Aides 2013January .

Immaculate University, Immaculate, PA
Adjunct Instructor 2011January
2011February
Taught RN-BSN Program—Holistic Nursing

TLC Institute, Inc., Harrisburg, PA
Nurse Aide Instructor 2010
Taught RN-BSN Program—Holistic Nursing

JFC Medical – Lancaster School of Technology Career Link, Lancaster, PA
Nurse Aide Instructor 2008
Taught RN-BSN Program—Holistic Nursing

Avysion Healthcare Services – PA Dept. of Welfare, Middletown, PA
RN-Program Coordinator/Planner 2008
Attended State Meetings for the MR Centers; conducted program planning for the State MR Centers.

LANGUAGES

English – Native Language

MEMBERSHIPS

Past member of the New York State Nurses Association
Current member of the Nurses Service Organization