Dynamics of a Peer Coaching Dialogue for Professional Development between Graduate RN and Nurse Educator

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Dedication Page

I have an awesome husband, friends who care, parents who listen, an understanding farmer's wife, family who encourage, and an advisor who coaches spot on from afar. My friend, my husband, my companion, keeps the last berries of summer awaiting my writing break, moves my outdoor editing haven into the path of the setting sun, reminds me that supper gives sustenance, and is the love of my life.

Acknowledgement Page

"The River of Learning"

Rivers are fascinating. Their mountain sources are thin trickles, cold and fresh, that merge into one as the river widens, becomes fuller and finds its way to the sea to be a rich estuary full of life and complete. Rivers meander and wind their way to the sea across all sorts of terrain, through all manner of climates. You can dip into a river anywhere and you can leave it when you will. And of course, it is not just a river-it gives birth to all manner of living things (Davis & Hase, 2001, p. 1).

I acknowledge my colleagues at Catholic Health Initiatives who believe in coaching as a forum to strengthen leadership talent and to the faculty at College of Saint Mary who brought academic excellence to my written words. I acknowledge that there where many eyes on this dissertation who provided support along the way. These individuals include the women of Integrity Builders and my daughter Jaime who is on a parallel path. Cindy my transcriptionist and Lindsay my proofreader held my hand through the tedious editing process. I am forever indebted to everyone's assistance.

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ABSTRACT

This multi-site phenomenological qualitative study examined the experience of peer coaching between Nurse Educators and Graduate RNs. Six dyads participated. This study provided an understanding to the essence of peer coaching for professional nursing practice development.

The primary source of data included participant interviews and was corroborated through videos, card sorting activities, and field notes. A phenomenological approach using Hermeneutic techniques resulted in five themes that described the essence of the peer coaching dyad engaged in professional development when reflecting on patient experiences. The coaching dyad nurtured and engaged through an accepting relationship that co-created descriptive patient experiences. Significant was awareness of professional responsibility. Graduate RNs welcomed having a confidant. The process of coaching connected the two clinicians together through reflection and probing techniques facilitated deeper understanding. The essence of peer coaching included the art of nursing. The use of safety intuition provided a compelling reason for Graduate RNs to advocate and critically look for human error, and to utilize resources to promote a culture of safety in practice. Coaching evoked an emotional response to the human condition of caring and sense of responsibility.

Because of sample size, no generalizations can be inferred. Additional research is needed to develop a coaching curriculum and a valid coaching measurement tool. Replication studies could explore how the coaching preceptor could create a coaching triad.

Chapter I: Introduction

Peer coaching is a promising strategy to support the Graduate RNs acclimation into professional practice. Coaching, as a contemporary learning strategy for professional development, has a growing body of descriptive research in the literature (Armstrong & Geddes, 2009; Baker & Lattuca, 2010; Donner & Wheeler, 2009; ICF, 2012; Marchese, 2012; Passmore & Gibbes, 2007; Passmore & McGoldrick, 2009; Walker, Cooke, Henderson, & Creedy, 2011). Coaching between a Graduate RN and Nurse Educator has been a topic without evidence in the literature. This study has provided an understanding of the essences of peer coaching between nurses engaged in professional practice competency development.

Background and Rationale

Graduate RNs are entering the workforce during tumultuous times, which could make traditional training practices obsolete. Within 15 years, half of the nursing workforce will be retiring at a time when the demand is greater than ever (Institute of Medicine (IOM), 2010). In addition, nursing professionals are being called to be collaborative partners in providing healthcare. New learning strategies are needed for nursing to be an adaptive workforce during healthcare reform (Dall'Alba & Sanberg, 2006; IOM, 2010). The healthcare environment and the aging workforce have brought urgency for a change for nurses entering the profession.

While the Institute of Medicine (IOM, 2010) testimony has clearly identified an increased role for nursing, the agency lacks specificity as to how nursing is to arrive at this role. Peer coaching could be a valid strategy to begin. The literature discusses the relevance in peer coaching for leadership transition and change in health care practice (Cilliers & Terblanche, 2010; Grealish, 2000). Peer coaching fosters innovation using reflective practice strategies and is an effective learning strategy for a multitude of disciplines (Browne, 2006; del Bueno, 2001;

Robbins, 1991; Saunders, Stuckhardt, Stuckard, & McGinnis, 2012; Xun & Land, 2004). Nursing is incorporated within many different settings across the health care compendium. Professional nurses reflecting together using a peer coaching process could provide the means to lead healthcare change.

Mentoring has been the traditional learning approach used to support Graduate RNs. Mentoring is known as one-way coaching; the mentor teaches, tells, and informs (International Coaching Federation, 2012). A mentor provides guidance based on extensive experience, but the supply of quality nurse mentors is dwindling with the aging workforce, and past experiences may not be as effective in a health care environment calling for reform (Parker, Hall, & Kram, 2008). Discussion has recently shifted from mentoring to workplace coaching as a learning strategy for professional development.

Coaches have helped others develop skills and awareness. Coaching provides an avenue for professionals to adapt to new situations, to inspire learning through guidance, and to shift paradigms and attitudes in practice (Sookane, 2006). There has been abundant testimony promoting coaching as the ideal learning method for professional development (Harvard Business Essentials, 2004; Hunt & Weintraub, 2007; International Coaching Federation, 2012; Kimsey-House, Kimsey-House, & Sandahl, 2011; Marshall, 2011; McNally & Cunningham, 2010; Smither, London, Flautte, Vargas, & Kucine, 2003; Thompson, Bear, Dennis, Vickers, London, & Morrison, 2008). Establishing a dyadic relationship for the professional RN entering practice with a Nurse Educator who has expertise in coaching could build an adaptable nursing workforce.

The widespread use of coaching for first-year teachers is unique to the education sector. Peer teachers engage in a coaching relationship to help new teachers acclimate into the

classroom (Gliessman & Pugh, 1994; Johnson, 2007; Robbins, 1991; Sookane, 2006; Van Eekelen, Boshuizen, & Vermunt, 2005). The nursing profession could consider the same model. Nursing compares to the education sector as both nurses and teachers work in a helping discipline and both work in isolation (Parker, et al., 2008). Nursing could emulate the education profession's use of peer coaching for Graduate RN's entry into professional practice with similar success.

Educators, like nurses, have a shared knowledge; a peer coaching dyad could bring newly formed insights against concrete experiences. As a coaching dyad, two teachers share instructional experiences to find ways to create positive learning experiences back in their classrooms (Robbins, 1991). A coaching dialogue of reflecting on work experience drives the two to develop a deeper meaning through consensus (Armstrong & Geddes, 2009; Baker & Lattuca, 2010; Donner & Wheeler, 2009; ICF, 2012; Marchese, 2012; Passmore & Gibbes, 2007; Passmore & McGoldrick, 2009; Walker, Cooke, Henderson, & Creedy, 2011). Coaching with someone of a similar educational background could help a nurse acclimate into the profession. The Graduate RN and Nurse Educator coaching dyad could provide for an enriched environment to explore change from their patient care experiences.

Coaching by sharing work experiences would provide a foundation for Graduate RN professional growth. Sekerka and Chao (2003) recommended that coaching can be used in settings outside the classroom, but more inquiry is needed to understand coaching as a workplace learning strategy between health care professionals. Reflection on practice helps the nurse build a knowledge base, recognize priority, and develop a sense of urgency. A skill set is drawn out of these experiences to help the Graduate RN make decisions on a particular action to be used in various future settings (Benner, Sutphen, Leonard, & Day, 2010). Nurses have to understand

multiple disease processes, to provide treatment interventions, to evaluate medication effect and health improvement, and to remediate if complications arise. The nurse has a responsibility to manage priorities between patients and coordinate the entire health care team, including physicians. The nurse's healthcare environment has high complexity. Graduate RNs would benefit from reflecting with someone who has coaching expertise to guide their perceptions into action. The peer coaching experience could make reflective practice thinking a habit.

Peer coaching establishes self-regulated learning habits. Ladyshewsky and Ryan (2002) reported that the inquisitive nature and questioning attitude of the peer coach provides a modeling effect. Practice would develop self-regulated learning. Practice with others expands capacity in self-directed learning (Fiddler, Marienau, & Whitaker, 2006). Peer coaching would help the novice be adaptive and innovative within the work environment because these learning habits would be developed.

Critical thinking allows a nurse to adapt to the workplace and is a product of self-regulated learning (Phan, 2010). A questioning mind is a learned skill. In contrast, Teekman (2000) identified that pre-perceptions affect one's view of any situation, self-questioning is common, but nurses do not demonstrate critical inquiry in isolation. Nurses are looking for action-oriented interventions within the current patient care situation and do not look for a broader implication. Critical thinking has conceptual connections with reflective judgment, problem framing, higher order thinking, logical thinking, decision-making, problem solving, and scientific methodology (Giancarlo & Facione, 2001). During peer coaching, critical thinking provides a means to develop a collective viewpoint on the topic under consideration (Gayeski & Rowland, 2005). Peer coaching would provide a natural forum for development of critical thinking beyond the context of one patient or situation.

Peer coaching provides a forum for the development of critical thinking with others (Ladyshewsky & Ryan, 2002; Parker et al., 2008; Robbins, 1991). Critical thinking is a core competency in nursing education, but the Graduate RN has difficulty in applying critical thinking skills and needs peer support in gaining this competency (Benner, et al., 2010; del Bueno, 2001; Miller, 2011). With intention, a peer coach would be able to facilitate development of this essential competency with a Graduate RN entering practice.

A measurement of critical thinking ability could set up the coaching conversation. A common Graduate RN assessment tool, Professional Behavior Developmental Systems (PBDS), measures competency in critical thinking ability, technical knowledge, and interpersonal communication (del Bueno, 2001). Recommendations are provided from the results of this tool. This tool was used as part of this study, a hospital-based Nurse Educator provided feedback through a coaching dialogue with a Graduate RN, and an action plan for continued practice development resulted. This assessment tool quantifies the critical thinking ability of the Graduate RN (Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009). These tools were developed by del Bueno (2001), based on a theoretical model, and included a ranking order summation of overall competency (Appendices A, B, C). This study used a consistent tool for professional development and provided a consistent coaching objective. A study with rigor would result.

Although not a focus of this study, emerging from the literature has been a validation of the PBDS assessment tool. Widespread utilization of the tool has attested to its validity; 15,000 individual assessments are completed on an annual basis (Ford, 2012). PBDS provides a consistent context for analysis between coaching dyads.

Problem Statement

Nurse Educators do not know how peer coaching would affect the professional development of Graduate RNs. There has been little research on peer coaching for nursing. Nursing research has not provided direction on the coaching relationship, process, or the outcomes between peers engaged in entry into professional practice development. There has been a void in the nursing research literature on peer coaching. This study can inform nursing practice.

Coaching with a peer Nurse Educator would begin the Graduate RN's journey of professional identity. Becoming a nurse has been described as a process of formation (Benner et al., 2010). A nurse's professional identity forms over time from reflection on practice experience (Benner et al., 2010). Peer coaching can be the guide; Graduate RNs would arrive into their own professional selves.

Envision the lasting impressions imprinted on a Graduate RN being coached by a skilled professional partner. According to Benner, Tanner, and Chelsea (2009), nurses place their knowledge in a plasma state, waiting to apply understanding and decisions, comparing the current with the past. Feelings of doubt and uncertainty could have a negative impact. Prolific in healthcare is complexity and these events can be dramatic for nurses who may distort their involvement in a negative way resulting in a loss in their ability to self-regulate (Gates, Gillespie, & Succop, 2011). The coach's role is to co-create understanding of events to heighten awareness, begin problem solving, and redirect negative feelings that block action (O'Broin & Palmer, 2009). Learning occurs when the feedback environment is rich and the opportunity for articulating reflection on experiential learning is planned (Benner et al., 2009). Yet, 93% of nurses reported not having enough time to collaborate with other nursing team members

(Rosseter, 2012). The Nurse Educator profession has been encouraged to consider new approaches in Graduate RN professional development.

Purpose of the Study

The purpose of this hermeneutic phenomenological qualitative study was to explore peer-coaching dialogues between Graduate RNs and Nurse Educators as lived experiences. All coaching dyads used the PBDS formative coaching feedback tool, reflecting on patient care scenarios. One voice was collected and understood from these peer nurses employed at mid-sized acute care Midwestern urban medical centers. Both the participants' perspectives and a review of the coaching event provided the foundation for uncovering the essence of peer coaching for clinical practice development in nursing.

Peer coaching has been described as an effective tool for professional development. Learning is generative; critical thinking and self-regulated learning are outcomes of successful coaching (Miller, 2011; Phan, 2010). This study has provided a description of coaching as a human science. Coaching can be developed as a primary learning strategy for Graduate RN entry into practice.

The basis of this research has been to provide a vision that coaching would significantly impact the professional growth of a Graduate RN as an adaptive practitioner. Inherent in the peer coaching dialogue would be a relationship promoting a high level of honesty, trust, and faith. Nursing peers would have clarity on work experiences that would result in trying new approaches in patient care. The process of coaching would make critical thinking and self-learning habits sustainable. This study used a phenomenological approach to understand the dynamics within the coaching dyad and to understand the impact that coaching could have on professional development.

Research Question

There has been little research on the topic of coaching between nursing peers engaged in discourse of the clinical setting. The primary purpose of this research project was to begin an understanding of peer coaching dialogues, within the context of patient care reflection, between multiple nursing dyads. For this qualitative research study, the questions explored were:

- How does the Midwestern urban acute care hospitals' peer coaching dyad contribute to professional development within the context of a formative assessment feedback session between Nurse Educator and Graduate RN?
- What was the essence of these peer coaching dyads, within the context of a formative assessment feedback session, between Nurse Educators and Graduate RNs of Midwestern urban hospital acute care settings, when professional practice development was the coaching topic?

Concepts

The concepts explored in this qualitative research study were (a) the peer coaching dyad, (b) the dialogue, (c) the process, (d) the relationship, and (e) reflection in nursing practice. A nurse as a self-regulated learner was considered the foundation to peer coaching. The context of this particular lived experience included PBDS as a feedback tool, which is why this tool has been briefly mentioned. Coaching has been the main concept for this descriptive qualitative analysis.

Definitions of Terms

Operational definitions of the coaching concepts have been provided as a supplement (Table 1).

Table 1

Coaching Terms Cited From the Literature

Term	Author	Definition
Peer Coaching	(Robbins, 1991)	A confidential process through which two work together, reflect on current practices, expand, refine, build new skills, share ideas, teach, and do research.
Coaching	(ICF, 2012)	Coaching is a thought-provoking, creative process that inspires maximization of professional potential.
Action Learning Coaching	(Kramer, 2007)	Coaching ensures psychological safety, questions demonstrate empathy, real time learning is promoted, challenging questions support reflection, learning and unlearning. The coach is fully present, with no pretense, showing unconditional positive regard, promoting action and new goal formation.
Informal Coaching	(Hunt & Weintraub, 2007)	Coaching is a spontaneous event without contract and can include brief interchanges between peers.
Internal Coaching	(Hunt & Weintraub, 2007)	Human resources (HR) typically use this process for leadership development. There may be political difficulties.
Development Professional Coaching	(Hunt & Weintraub, 2007)	This process uses tools to aid an individual's work role. It has an organizational context. Focus is split between organization and person, using many formative tools as foundation for change.
Cognitive coaching	(Dennen, 2004)	Authentic learning experiences foster relevant and transferable learning.
Consulting	(ICF, 2012)	An external advisor diagnoses, recommends change, is paid to produce outcomes, and recommends systematic regiments.
Mentoring	(ICF, 2012)	Guides from one's own perspective or from one's life experiences. Is known as one-way coaching. Telling and informing are methods employed.
Executive Coaching	(Passmore & Fillery-Travis, 2011)	Socratic dialogue where the facilitator uses open questions to bring self-awareness and personal responsibility to the participant.

Note. Adapted from Robbins, P. (1991). *How to plan and implement a peer-coaching program.* Alexandria, Virginia: Association for Supervision and Curriculum Development.

Peer nurses. The peer nurses in this study were Registered Nurses (RNs) employed by a Catholic mid-western urban hospital as colleagues. This dyad was composed of a Nurse

Educator and a Graduate RN who were engaged in a professional development discussion. There was no supervisory relationship.

Nurse Educator. The Nurse Educator was a staff RN who was accountable to orientate the Graduate RN to the hospital environment and facilitated the initial and follow-up PBDS assessment. The nurse educator is an expert clinical coach (Paniagua-Ramirez, Barone, & Torres, 2004). This RN cohort had a minimum of three years of experience in the clinical and educational nursing fields. This coaching expert was identified through supervisory referral and had verbalized coaching expertise.

Graduate RN. This RN was a BSN graduate within the last six months, had limited clinical experience, and was engaged in peer coaching discussion to enhance professional practice. The Graduate RN had completed a PBDS assessment and was aware of the purpose of the coaching event. The Graduate RN was positioned to receive feedback for the sole purpose of developing future goals for continued growth in professional practice. This RN was not previously licensed as a Practical Nurse.

Coaching relationship. The association between Nurse Educator, as coach, and Graduate RN was considered collegial and helpful. Rapport is established, trust is central, and a mutual desire to incorporate newly learned knowledge and skills into practice is present (Waddell & Dunn, 2005).

Coaching dyad. There would be a nursing partnership with a high level of confidential support and dialog about perceived problems or experiences. The two would have powerful influence on each other and would stress alliance, trust, commitment, and active involvement (Garvey, Stokes, & Megginson, 2009).

Exemplars. Examples are taken from primary or secondary data sources to illustrate the concept under discussion.

Assumptions, Limitations, Delimitations

An assumption has been made that this study evoked the typical coaching process between the dyad. Within a natural qualitative study, the design elements strengthen or weaken the results (Van Manen, 1984). Scientific rigor was applied throughout this qualitative design so that the methodology would not impart any distraction, but provided a human science description of the experience of peer nurse coaching. In this study, testing of the video and audio taping technology was completed so that any intrusion effect was eliminated prior to the coaching dialogue. There were no identified disruptions noted in the coaching dialogue, and all participants stated a feeling of ease and comfort during data collection.

Another assumption was made that the Nurse Educators' expertise was not a barrier for the Graduate RNs' engagement in learning. Power issues, such as expertise, could disrupt the rapport necessary for effective coaching relationships (Drum, 2007). Because of these factors, a purposeful sampling process was used. To be included into the study, participants had to have established a rapport. In all cases, the relationship between the two nurses was described as helpful and personal, and there were many examples of positive experiences between the two.

Two limitations were identified in this study design, but were mitigated. First, the interview tools and card sorting activities had not been thoroughly tested. These tools were reviewed during a pilot coaching session by an experienced Nurse Educator, a seasoned nurse coach, and a Graduate RN and were considered meaningful. Second, the researcher was an employee at one of the hospitals, so, to eliminate any employer-influenced effect, additional hospitals were included.

Delimiting the strength of this study was the small sample size obtained within a limited geographical area. The sample size was kept small to allow for extensive focus on the participants. The sample size of this study was decided by saturation principles that were recommended in phenomenological methodology (Creswell, 2013). In addition, the time constraints and expense of collecting and analyzing several sources of data made it unreasonable for a larger geographic region to be included. This study size provided descriptive information on the subject of peer coaching, but the study outcomes and recommendations cannot be generalized to the population as a whole.

The last delimiting factor in this study was the researcher's coaching knowledge. The researcher's knowledge informed the subject as a quality measure, but was held distant and in-check during the research process (Van Manen, 1984). The voice of the participants permeated the study.

Conclusion

This study explored the lived experience between Nurse Educators and Graduate RNs engaged in clinical discussion. A hermeneutical qualitative research approach was used. This research proposed shifting from mentoring to peer coaching as the learning strategy for Graduate RNs' entry into practice. Scientific rigor was applied to uncover the essential structure of peer coaching as a vehicle of learning transfer and professional practice development. Coaching contributes to the verve of professional development (Sekerka & Chao, 2003). Through formation stories, the Graduate RNs change their perceptions with less fear of failure (Benner et al., 2010). This study informed how a nurse dyad created learning and developed a collective view through coaching. Because nursing research has been silent on this topic, this study began

an odyssey for peer coaching as a basic educational tool engaging the Graduate RN to be an adaptive and innovative professional within the structure of a clinical practice dialog.

Chapter II: Literature Review

This literature review of coaching aims to illustrate the basic concepts of coaching as relevant for development of Graduate RNs. Beginning the review is an historical perspective of coaching followed by a discussion on learning theories and coaching discussions brought forward from other disciplines. There lacks consensus on the theoretical foundation of coaching. This discipline is emerging through a multitude of specialties, each with its own theoretical framework (Global, 2008). Peer coaching could be considered for the nursing profession. Peer coaching fosters innovation using reflective practice strategies and is an effective learning strategy for a range of disciplines (Browne, 2006; del Bueno, 2001; Robbins, 1991; Saunders, et al., 2012; Xun & Land, 2004). The literature supports the application of coaching for Graduate RN professional development.

Historical Perspectives

Coaching has been considered a new learning strategy, but with historical roots. Coaching has dated back to the classical times of Socrates in which the pursuit of knowledge and truth was obtained through debate and inquiry of differing opinions (Garvey, et al., 2009). The context of coaching with another began as a nineteenth century dated term in an English satire on the human character within the aristocratic way of life (Garvey et al., 2009). In this novel, coached students arrived at the university in horse drawn carriages ready to learn. The earliest published application of coaching in 1888 referenced athletic training for the defense of the wicket in cricket (Garvey et al., 2009). Athletic reference to coaching continues today, but Gallwey (1974) was the first to reference coaching to have an inner mental game. In the book, *The Inner Game of Tennis,* success in tennis involved overcoming your own anxiety and doubt

and has been compared to modern developmental coaching (Garvey et al., 2009). Coaching may be emerging within professions, but has had substance for a while.

Although the roots are deep, the research articles on coaching have been slow to appear. The coaching literature has been summarized as discussions, beginnings of academic research, tactics for professional development, and early in theory formation (Cavanagh, Grant, & Kemp, 2005). A seminal review of the coaching literature by Kampa-Kokesch and Anderson (2001) identified few studies of rigor. More rigorous investigation of coaching has been identified as a priority (Zellers, Howard, & Barci, 2008). This study provides a beginning for peer coaching research within nursing.

The first scientific reference to coaching productivity improvement was reported by employees, managers, and coaches (Gorby, 1937). This executive coaching study measured effectiveness through a unique application of the control group. Extrinsic business objectives outside of the coaching topics were used as the control group. Although the control group was considered nontraditional, there was a significant difference noted in meeting the coached business objectives.

Until 1994, only a sparse accounting of 50 academic papers and dissertations were published with only 71 citations added through 2004 (Garvey et al., 2009). The cause of the limited research has been attributed to the flexible nature of the coaching process that results in variable, shifting topics. The dance that occurs within coaching is fluid, varies, and is difficult to design into a structured research study (Kimsey-House et al., 2011). The study of coaching in the past ten years has generated more questions begging for answers. One of the earliest research articles on coaching measuring individual performance was by Peterson (1993). This field study of 370 participants, with missing data, contained 40,000 data points. This

longitudinal study of five years measured improved perception of change by the participants and recommended that all parties within the coaching dyad should be evaluated when measuring outcomes. This study impacted the design of the current study to be a hermeneutical approach so that a holistic perspective of coaching was garnered.

There have only been a few studies of sufficient rigor within the coaching literature (Dingman, 2004; Passmore & Fillery-Travis, 2011). Included is a brief summary of the research studies that had a control group (Table 2).

Table 2

Summary of Coaching Studies with Control Groups

Author	Key Points
Peterson (1993)	The retrospective degree of change was significant.
Olivero, Bane, & Kopelman (1997)	Coaching, compared to knowledge, had significant effect on productivity.
Smither, et al. (2003)	Compared to other strategies, coaching led to goal formation, solicitation of ideas from superiors, and increased effectiveness as measured by direct reports.
Sue-Chan & Latham (2004)	Peers with experience offer credibility when coaching for change.
Evers, Brouwers, & Tomic (2006)	Learning to be more balanced in life was significant for coaching success, but coaching did not impact self-efficacy.
De Haan, Culpin, & Curd (2011)	In comparing coaching techniques, none stood out.
De Haan, Duckworth, Birch, & Jones (2013)	The common factors of success in coaching are a working alliance, a full range of coaching techniques, and self-efficacy of the client.
Grant (2013)	Executive nurses report relevance in goal attainment, workplace wellness, resilience, depression, and stress improvement compared to control groups.

Theoretical Background

The learning theories, which underpin the foundation of coaching, present learning as a thinking process. Both learning and coaching are described similarly, driven by emotions.

Learning occurs through social interaction (Bigge & Shermis, 2004; Cilliers & Terblanche, 2010). The theorists most often referenced in the coaching literature were Dewey, Vygotsky, Argyris, Kolb, Rogers, Lewin, Schön, Bandura, Knowles, Kramer, and Mezirow and their specific contribution to coaching are illustrated.

In his famous book, *Democracy and Education*, Dewey (1938) posited that education is a reconstruction of experiences within the mind. Mentation increases people's abilities to direct the course of subsequent experiences. Dewey contributed to the foundation of critical thinking for reflective practice, which is a core nursing practice standard (Hatlevik, 2012). The process of reflection on practice for change and improvement began in the writings of Dewey. Dewey (1916) defined critical thinking as suspending judgment with healthy skepticism. This type of forum provides for professional development through reflection on experiences.

The next theorist, Vygotsky (1978), introduced the concept that learning needs to be within one's perceived ability, or zone of proximal development (ZPD), to keep the learner motivated. Learning would occur if the tasks were perceived to be within reach, and if felt to be beyond their capacity, the learner would probably quit. Challenging learning experiences, perceived as attainable, would breed motivation to try.

Both of these theorists concurred that change follows an experience of mental tension (Bigge & Shermis, 2004). Disequilibrium is felt when understandings, values, and beliefs are challenged by an experience. The learner would change behavior as a coping mechanism to restore mental equilibrium resulting in a new perspective or understanding (Argyris, 1977; Dewey, 1916; Vygostky, 1978). Changing perceptions are embedded in the process of restoring mental balance. Facilitating the learning process, changing perspective, and restoring a sense of mental balance are tenets within the coaching role (O'Connor & Kotze, 2008; Scoular & Linley,

2006). When learners experience something bothersome, the coach could facilitate the process of restoring balance. Argyris (1977) coined learning as cyclical and that the change could range from something superficial to major value-altering behaviors. At the highest level, underlying beliefs or values are reformed. Argyris defined learning to be a continuous feedback loop fed by a healthy skepticism. Within positive coaching relationship, a reflective space is created between professionals over time, conversation has respectful silences, dialogue is at a comfortable pace, and an open attitude leads to mutual understanding between the dyad (Cilliers & Terblanche, 2010). This coaching relationship infers a high level of trust and one where professional development could be formed.

The father of Humanistic theory, Rogers (1977), contributed that learning was impacted by feelings and emotions. Individuals view their world through a visual lens guided by emotion, feeling, and attitude (Rogers, 1977). Rogers connected learning to psychology and posited that both related to personal change and self-knowing. He was interested in personal growth and development as integral to learning theory. From Roger's (1977) work, the optimum self would be present when one is free from threat allowing learning without inhibitions. This freedom makes adaptable thinkers. A fully functioning individual strives to make good behavior choices. The coaching process provides an open adaptive learning space (Garvey, et al., 2009).

Kolb (1983) brought the dimensions of emotion, motivation, and affect into the understanding of learning. Kolb conveyed a humanistic view of learning to be personal and suggested that personal involvement would help change attitude, behavior, and values. Learning would be more effective when self-initiated. Emotions and affect motivate significant learning. Humanistic learning theory suggested the person as a whole comes into the learning equation. The Kolb model began the movement of understanding adult learning (Svinicki & Dixon, 1987).

In addition, this model serves as the basis for coaching as a process in which: (a) an experience has some level of concern or emotional connection, (b) the adult learner is prompted to consider many different viewpoints, (c) having a full complement of ideas formed from the experience, the adult learner looks for a logical conclusion, and (d) a decision is made to guide future action.

Both Lewin (1935) and Bandura (1977) brought environmental and social influences into the theory of learning. The social impact on learning was introduced by Lewin (1935), who proposed learning included a social paradigm. The learner experienced unmet needs and wants within the environment that produced a potential for change. Change, or learning, resolved the tension. The environment would either attract or cause avoidance to learning and change. According to Lewin (1935), the person, the psychological space, the goals that were sought, the negative goals that were avoided, and the barriers that restricted would determine the actual paths of change. This suggests a role for the coaching professional to assist the learner out of the rut of a habit that had evolved from social influence.

Bandura (1977) brought into focus how perceptions are formed and influence learning behavior. Perceptions play a key role as an intervening variable in learning (Bandura & Adams, 1977). The determining factor for change was the expectation of change. If people felt they could achieve, they would. Called self-efficacy, confidence plays a key role in learning (Bandura & Adams, 1977). With a discrepancy in perceptions, new meaning would be forthcoming, but mediated by self-efficacy (Bandura & Adams, 1977). Self-efficacy has impact on learning and change.

Most pertinent, reflection brings relevance to the clinical experiences in a nurse peer-coaching equation in align with social learning theory. Schön has been called the father of coaching for reflective practice and a cornerstone in social learning theory (Bigge & Shermis,

2004). The ideal professionals would think about their work environment and experiences without bias, ready to explore, and relate to the context of the event, looking to understand a problem or situation (Schön, 1987). This suggests that coaches could play a facilitation role. The expert's clinical knowledge could inform the discussion, but would not take a prominent role. According to Schön (1987), the gestalt of the teacher (or in this case, coach) does not dominate learning.

Kramer (2007) brought relevance to adult learning theory, or Andragogy, at the workplace setting of professional practice development. One component of adult learning theory includes a learner who wants to interact with others in order to critically reflect on relevant issues at work (Dzubinski, Hentz, Davis, & Nicolaides, 2012). In the face of complexity and ambiguity, the adult learner would appreciate the support of another to make sense of the events at work. Andragogy would be relevant within the coaching dyad. The individuals involved within the coaching dyad would come to the relationship as Adult Learners. Following are additional relevant adult-learning principles.

Emotional intelligence. Because an adult's motivation is central to adult learning, the concept of emotional intelligence (E.I.) could explain the variation seen in personal aptitude for change. E.I. has been described as the creative will to question any organizational value, assumption, or ideology embedded in the culture of self, or the organization and suggests that this motivation has individual differences (Kramer, 2007). Those high in emotional intelligence are highly perceptive in understanding the world as unique. A person with high emotional intelligence is self-aware, self-managed, and able to effectively manage relationships (Goleman, Boyzatis, & McKee, 2003). The emotional intelligence of the individual can change the direction of coaching and the success. In contrast, those low in E.I. could pose a challenge for

effective coaching (Goleman, et al., 2003). The ability to come to a collective perspective involves addressing the E.I. of the individual and a tenet for coaching an adult learner.

Self-regulation. Knowles (1970) contributed to the theoretical foundation of coaching as one who co-habits within an environment that activates inquiry, action, and learning. His theory of adult learning resonated with coaching as being situational, depending on extraneous factors. According to Knowles (1970), education cannot be defined as a simple transfer of knowledge because assumptions are constantly in flux as society and culture change. Instead, learning has been defined as a life-long process of examination, reexamination, and continued inquiry (Knowles, 1970). Self-directed learning is the goal, and a skill set of self-regulation activities is within the purview of the adult learner (Knowles, 1970). A less common discussion from Knowles (1970) has been the perspective that the adult's learning trajectory vacillates between self-directed or regulated learning based on experience. The learning environment between a novice such as a Graduate RN and Nurse Educator would suggest the process used as a coaching dyad would vacillate between both self-directed and regulated learning.

Self-regulation has been extensively researched and commonly described as a process used by an adult learner to affect learning. Zimmerman (2002) identified that coaching models self-regulation. Adult learners correct learning deficiencies through goals, aligning strategies to monitor progress, and applying different filters within the context of their learning environment (Zimmerman, 2002). The process of coaching is similar to self-regulated learning. An adult learner, within the health care profession, monitors thinking according to universal criteria such as clarity, precision, accuracy, consistency, logicalness, and significance which results in correcting oneself as appropriate in the context of caring for patients (Simpson & Courtney, 2002). The learning tactics for both self-regulation and coaching are similar.

Transformative learning. The seminal writings of Mezirow (1981) laid the theoretical foundation that a shift of beliefs results from significant learning. According to Mezirow (1981), humans learn to control their environment, to clarify and explain their conditions of living, and to seek an emancipatory response for autonomy. These motivations lead one into new territories of thinking. Under a transformative setting, learning propels forward (Flaherty, 2005). This setting of innovation and creativity invites experimentation; however, the passage to transformation is troubled with doubt, disbelief, compromise, or habit (Mezirow, 2003). With support, the challenge to reach unique growth could exist.

A theoretical foundation has been laid for a discussion on coaching for nurses entering the workforce. This foundation included learning as a process involving factors that promote and motivate transformational learning. Emotions impact successful change and perceived ability motivates forward progress. The learning curve between individuals engaged in interaction could be heightened with intentional reflection. Coaching, aligned through cognitive learning theory, has been proposed to be useful in assisting professional development of the novice nurse (Coaching, 2007; Donner & Wheeler, 2009; Haag-Heitman & Kramer, 1998; Karalis & Wiesen, 2007; McNally & Cunningham, 2010). Coaching affirms and develops critical thinking, communication, improved patient-centered care, and helps novice nurses integrate into their professional selves (Donner & Wheeler, 2009). As adult learners, a positive environment could be provided to encourage adaptive learning within the coaching dyad.

Coaching Theory

Coaching has been theorized by Anderson (2013a) to be a learning strategy where awareness is facilitated to heighten understanding. The coach helps propagate the feelings associated to the context of the conversation and provides for change through reflection and

action (Anderson, 2013a). Coaching would involve the person, the situation, the event, and the engaging tactics to change behavior and follows a hierarchy (Appendices D, E). According to Anderson (2013b), coaching would be the venue to bring "knots" into learner awareness and the process to unravel the "knots." These "knots" are considered learning opportunities and an astute coach would notice the call for help and begin the work. Blocking understanding could be an emotional, technical, or awareness-centered need (Figure 1).

Figure 1 The Coaching Model

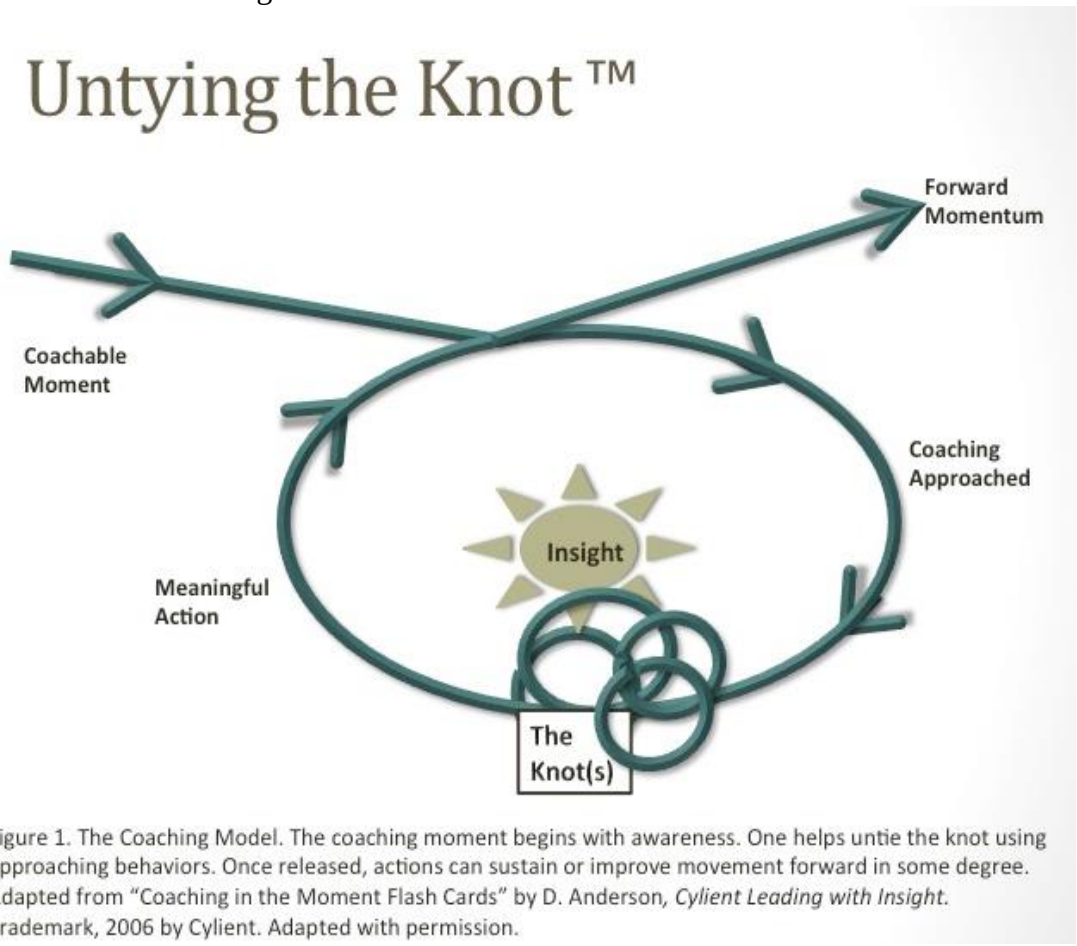

Figure 1. The Coaching Model. The coaching moment begins with awareness. One helps untie the knot using approaching behaviors. Once released, actions can sustain or improve movement forward in some degree. Adapted from "Coaching in the Moment Flash Cards" by D. Anderson, *Cylient Leading with Insight.* Trademark, 2006 by Cylient. Adapted with permission.

The coach's responsibility is to help the learner acknowledge the presence of emotion, to facilitate reflection and instruction as necessary, and to illuminate different perspectives (Anderson, 2013a). Momentum for change is a cyclical process. For example, if a coach hears

"Why didn't I know this?" this signals that awareness has begun, and fear could be in the way of learning. Rather than tell, inform, or instruct, the coach suggests, offers, tests, and listens for what is and what is not being said (Anderson, 2013a). The goal of the coach, the client, and the facilitative process is to develop momentum toward new beliefs, values, and behaviors.

Coaching Literature

A continued discussion follows for the purpose of illustrating applied coaching within the literature. Coaching research has focused primarily on leadership development and qualitative methods have been the preferred method of analysis (Greif, 2007; Passmore & Gibbes, 2007). Different applications of coaching evidence are included. Specific attention has been given to coaching concepts, professional development of nursing practice, and use of reflection on patient care experiences to augment a comprehensive understanding of the components within this study.

Peer coaching dyad. A constant theme of positive change has been documented within the few reported peer-coaching studies (Franklin, 2005; Thompson et al., 2008). Specifically, the literature discusses the relevance in peer coaching for leadership transition and change in health care practice (Cilliers & Terblanche, 2010; Grealish, 2000). Having a strategy such as peer coaching to facilitate change has promise.

In addition, peer coaching fosters innovation as a reflective practice strategy for a multitude of disciplines (Browne, 2006; del Bueno, 2001; Robbins, 1991; Saunders, et al., 2012; Xun & Land, 2004). The education sector has explained the peer coaching process, described the coaching relationship, identified attributes of successful coaching, and theorized a coaching model (Robbins, 1991). If the education sector has established coaching as an entry to practice

learning strategy, others of similar professional attributes, like nursing, could follow in these footsteps.

Knowledge acquisition has been a common outcome identified in peer coaching (Sekerka & Chao, 2003). In addition to simple learning, Browne (2006) identified peer coaching as a model for change because it affects inspiration and motivation within the participants. Knowledge acquisition is significantly impacted the closer the innovation is aligned to the experience and associated feelings of the learner (Browne, 2006; Ives, 2008). Peers working together could engage in meaningful discussions regarding healthcare. Within the health care environment, benefits of peer coaching for professional development are documented (Sekerka & Chaco, 2003). In examining the experience of 13 coaching physicians within an ambulatory care setting, two major themes emerged: reflection/teaching and personal learning/change (Sekerka & Chao, 2003). These physicians experienced positive cognition with annotation of improved ability to connect with their patients. Peers have a professional connection to engage as coaching dyads to improve patient care.

The coach brings a specific purpose to the coaching dyad. A common attitude by a coach is to maintain focus and intention within the coaching dyad (Walpole & Blamey, 2008). As the dialogue unfolds, the coach uses techniques of facilitation to keep the conversation flowing. A coaching dyad is described as “dancing within the moment” (Kimsey-House et al., 2011, p. 5). Coaches see themselves as formative observers and role-modelers (Walpole & Blamey, 2008). Coaches are cognizant of moving the coaching dyad subtly toward awareness and change.

A synthesis of several peer-coaching studies by Ladyshewsky and Varey (2005) suggested that the maturity of the coaching dyad determines the appropriate coaching intervention. The eight stages of maturity are: (1) trust is recognized; (2) consistency is critical;

(3) the coach drives a process; (4) mutual understanding leads to deep exploration; (5) with clarified assumptions, a challenging attitude would be critical; (6) new possibilities are explored and actions are driven; (7) commitment is gained and constraints are met head on; and (8) genuine caring sustains the relationship forward (Ladyshewsky & Varey, 2005). These interventions, based on the level of maturity within the coaching dyad, contradict the spontaneous and dance-like labels that have been associated with the coaching process.

Peer coaching uses a framework to engage in rich metacognitive discussions and has practical application for transition from theory to practice (Dennen, 2004; Ladyshewsky & Varey, 2005). Participants in a coaching dialogue can articulate what they know and what they do not know, shifting their understanding and perspectives into new insights and mastery; however, a question has been raised in nursing whether social persuasion would mediate peer-coaching effectiveness within the nursing student population (Kushnir, Ehrenfeld, & Shalish, 2008). Additional research needs to be done to differentiate coaching applied to Graduate RNs. As this study evaluated student-student coaching effectiveness, there is a need to differentiate the effectiveness of peer coaching in nursing when one peer is experienced and the other a novice.

Individuals participating in peer coaching could impact the organization as a whole. A study by Thompson et al. (2008) illustrated peer coaching as effective in facilitating organizational change. The importance of organizational focus when implementing coaching, as a broad based strategy, was key. When coaching was used without an organizational purpose articulated only a moderate effect was observed (Thompson et al., 2008). Trust is built when clear outlined objectives are communicated. Identifying objectives reduces any misconceptions when an organizational effort of coaching is implemented. The relationship between the successful business outcomes of customer satisfaction, profitability, market share, and revenue

growth was significant with the coaching intervention group compared to those without the coaching intervention (Thompson et al., 2008). This research was based on self-report. Coaching needs to continue to be a business strategy into the future with a call for clarity of outcome measurement (Thompson et al., 2008). These authors suggested a mature peer coaching discipline will have purpose with identified metrics as part of the strategy (Thompson et al., 2008). With broad base implementation, peer coaching could impact the profession of nursing one nurse at a time.

A research synthesis of learning strategies in the workplace (N = 3,152 experimental, N = 2,988 control) contributed to the subject of organizational learning (Trivette, Dunst, Hamby, & O'Herin, 2009). This synthesis of 79 studies concluded that learners within organizations understood and used newly acquired knowledge and skills as a cyclic process while gaining confidence. Coaching as a learning strategy provided for mutual planning, goal setting, information sharing, and modeling. Emerging from this synthesis was a learner who gathered information, practiced, and reflected on experience by a coach who drove the process through encouragement and use of knowledge (Trivette et al., 2009). Coaching, as a workplace learning strategy, would benefit organizational learning.

Van Eekelen et al. (2005) offered a different perspective on organizational learning. This phenomenological study of 89 examples gathered from 15 participants demonstrated learning in organizations as mostly non-linear, spontaneous, and with less self-regulation, planning, or reflection with others. The themes revealed that learning was accomplished by doing, through interaction, by reading, or by thinking. The clients, not the context, were the primary catalyst for learning, and the primary learning was spurred spontaneously (Van Eekelen et al., 2005). In this study, reflection on experience was not the catalyst for organizational learning.

Before organizational change could be attributed to coaching, widespread adoption and top leadership support is needed (Peel, 2006). Organizational culture has been cited to either foster coaching or derail coaching as something embraced or considered forced (Peel, 2006). Coaching as an organizational strategy would need to have a defined purpose (Thompson et al., 2008). To minimize cultural impact, this peer nursing study was designed to include participants from different cities and hospital settings.

The coaching process. Dingman (2004) contributed a literature synthesis of the coaching process to be six stages. According to Dingman (2004), a formal contract or alliance begins. Following, attention is given to establish the coaching relationship. This relationship allows for the beginning of an honest appraisal of learner competencies. With needs identified, reflection brings goals into their collective view and a pathway is established to monitor effectiveness of change. The coaching dyad would continue this process as routine or until the coaching relationship is terminated.

Bowman and McCormick (2000) reviewed the coaching process for effectiveness through a randomized control study. Evaluated were the coaching dimensions of collegiality, feedback, analysis of application, adaption, personal facilitation, and overall assessment of the coaching experience. The between group mean score comparisons of learner achievement was significant within the coaching group. In addition, many individual factors within the coaching group demonstrated significant impact, technical feedback, adaptation, and personal facilitation. Contrasting, neither collegiality nor overall satisfaction of the learning event demonstrated significant difference between the coaching and non-coaching groups (Bowman & McCormick, 2000). Peer coaching groups were more adept in achieving targeted objectives and could better integrate learning strategies, but additional research is needed to substantiate overall

effectiveness (Bowman & McCormick, 2000). This study suggested that the peer coaching process provides something more meaningful than a conversation with a supportive peer.

The coaching process has been consistently described to demonstrate effective outcomes, but is presented primarily through self-reported descriptions. The outcomes described improved confidence, organizational change, mastery of knowledge, learning alternative teaching strategies, change of values, perceived self-efficacy, and goal formation (Browne, 2006; Hannah, 2004; Ho & Ku, 2009; Ladyshewsky & Varey, 2005; Longhurst, 2006; Tschannen Moran & McMaster, 2009; Waldman, 2003). The benefits have been documented, but not substantiated.

The first outcome study on coaching effectiveness outside of descriptive analysis was completed by Olivero, Bane, & Kopelman (1997). Transfer of learning was compared between educational courses with and without coaching supplementation. Both groups were measured using a productivity index and the coaching group demonstrated a significantly higher index. The coaching group within this study had eight coaching sessions designed to explore strategies to produce successful work accuracy, and the control group had time to review progress with others who were not trained to coach. This study tied coaching to workplace productivity as effective.

One descriptive study was conducted to determine the effectiveness of coaching when personal improvement goals were not used as a focus. In this unique peer coaching study, teachers selected goals from a list pre-determined by the school's curriculum committee (Marchese, 2012). The participants completed a survey to determine effectiveness of goal completion as the method of analysis. There was higher success from topics chosen from a predetermined list by those who had trained peer coaches (Marchese, 2012). This provided an understanding that the coaching process could be directed and based on strategic initiatives.

A comparative study was conducted using GPA as a measurement of success between deployments of three different learning strategies for student education (Sue-Chan & Latham, 2004). External coaching, peer coaching, and self-coaching were the study interventions (Sue-Chan & Latham, 2004). External coaching was viewed as a significant contributor to exam success as compared to the other modalities. The use of self-reflection did not contribute significantly to success. Because the study was conducted on students, their lack of knowledge and general expertise was explained as the reason the peer group and self-reflection was not effective (Sue-Chan & Latham, 2004). This study supports considering reflective practice as a coaching dyad activity and adds intrigue to the concept of the Nurse Educator as a coaching peer with expertise.

A different perspective by Van Eekelen et al. (2005) informed organizational learning. This phenomenological study of 89 examples of learning from 15 participants demonstrated learning in organizations as mostly non-linear, spontaneous, and with less self-regulation, planning, or reflection with others. The themes revealed that learning was accomplished by doing, through interaction, by reading, or by thinking. The clients, not the context, were the primary catalyst for learning, and the primary learning outcomes were non-linear in that the problem or task was not perceived or planned, but spontaneous (Van Eekelen et al., 2005). In this study, reflection on experience was not the catalyst for organizational learning.

Coaching has been directly measured to impact business operation (Hannah, 2004). Improved competence and skill in customer satisfaction was connected to a coaching intervention. A nine month phenomenological case study (n = 350) was set up to determine if workplace coaching would positively affect customer service skills in railroad employees and thus improve customer satisfaction. This study had unique characteristics because it was an

intervention applied throughout an organization. The coaching relationship within this study was viewed overall as a positive experience and subsequent mystery shopper investigations noted an increased use of customer satisfaction skills by employees (Hannah, 2004). Coaching had a positive effect on employee competence as measured by customer service skill.

Outside of the field of qualitative research and descriptive analysis was a quasi-experimental study that demonstrated inconclusive results. Smither et al. (2003) demonstrated that manager effectiveness, measured by a formative assessment tool, improved significantly with an executive coach. Of the 1,361 senior managers enrolled in the study, 404 had received an executive coach as the intervention in this research design. The coaching group's goals were more specific, and the amount of sharing of feedback to others was significant with a moderate effect size d = .36. In addition, the formative assessment rating overall mean improved significantly in the coaching group. The manager's pre and post intervention scores were split into low, medium, and high performer groups and reanalyzed. The overall effect for the high performing group was negative, questioning the value of cost/benefit of using external coaches. These authors suggested a need for research to enhance theoretical understanding of the feedback process and the return on investment using external coaches. Coaching studies are in the earliest stages of maturation.

Can any professional be trained to coach and can poor learners be coached? A study was designed to explore this question. Peer coaches were selected on criteria of having low knowledge of peer coaching and teamed with students with low rates of engagement (Johnson, 2007). The peer coaching intervention was measured according to use of prompts, the wait time for student response, and positive performance feedback ratios. Important to this study was the long-term effects that coaching had on professional development. The teachers reported

continued use of the five-step coaching process one year after intervention, indicating a lasting effect (Johnson, 2007). Long-term retention of peer coaching teaching strategies was realized long past the intervention.

The final statistical report on coaching effectiveness has been included because the study participants were randomized to receive four coaching sessions by a coach who had received coaching education as part of the study (Grant, 2013). In addition, this study was conducted in the field of nursing. Short-term self-reported improvement was noted in senior nursing workers who received four coaching sessions (Grant, 2013). Significant self-improvement increase was identified within the intervention group to include goal attainment, resilience, depression reduction, stress reduction, and workplace wellbeing. In this study, Grant (2013) included an interesting design element, as the control group came from a waiting list of individuals who had requested to be coached. Limitations included a self-reported measurement and a concern that the Hawthorne effect was present. This study did measure a perceived broad improvement contributed to coaching practice.

Self-regulated learning. The tenet of the coaching process has been to develop learning habits that can be used frequently in different situations. Few are prepared to learn by themselves and teaching to this skill is especially relevant (Miksza, 2011; Zimmerman, 2002). Understanding self-regulated learning processes was the focus of a research synthesis study on coaching conducted by Greene and Azevedo (2007). One hundred and eleven research studies met the criteria for inclusion. Coaching facilitated self-regulation practices such as task identification, planning for change, monitoring and controlling learning strategies, reaction within reflection, and adaption to metacognition (Greene & Azevodo, 2007). This foundational

article validated that the coaching process develops the professional to be a self-regulated learner.

The coaching dialogue. The coaching conversation includes more than words. This powerful dialogue includes listening, intuition, curiosity, forward thinking, and deep discussions (Kimsey-House, et al., 2011). The conversation is designed as an alliance between parties to provide clarity and empowerment. Learning can be generative and transformational (Senge, 1991). At the heart of the coaching conversation is a focus to fulfill the potential of the learner.

The literature has not resolved the ideal length of the coaching conversation or the frequency. A non-randomized control study by Smither et al (2003) concluded that as little as two coaching interventions were significant in managers setting specific goals, soliciting ideas from others, and improving their 360 degree evaluation score as measured by direct reports and supervisors. Significant in this study was the sample size of 1,202 senior managers within a multi-national setting.

Meaningful discussion, facilitated by a peer coach using a skilled communication style, is client centered. A coach has a repertoire of skills to uncover the needs for the day, uses silence, active listening, clarifying, pressing for specifics, avoiding negative jargon, and using neutral comments (Robbins, 1991). Skillful dialogue plays a significant role in the coaching process, which includes an awareness of other elements within the learning environment (Senge, Scharmer, Jaworski, & Flowers, 2005). As Senge et al. (2005) commented,

> You totally forgot yourself . . . I was them and they were me . . . I have known with certainty that what arose was exactly what needed to arise at that moment . . . out of this profound opening of the heart . . . I discover[ed]. (p. 90)

Powerful expressions that are present during coaching conversations are the use of metaphors that represent a thousand words (McNally & Cunningham, 2010). Naturally occurring, the metaphor gives the coach clues for exploration. Coaches can incorporate metaphors into their repertoire of skills and can also actively listen for the client's use of metaphors within the conversation. Probing is an effective strategy to use when metaphors are present (McNally & Cunningham, 2010). These verbal pictures become the source for clarity or a bridge to understanding something deeper. Metaphors imply a feeling without being felt (McNally & Cunningham, 2010). These phrases are expressions of opportunity for continued dialogue to uncover understanding.

In addition to verbal cues and facilitated discourse, the body would have information to contribute to the coaching conversation. Flaherty (2005) explained the attributes of somatic coaching:

> Central to coaching practice is observing and assisting the understanding of how one's body presents. The body as a whole plays a role on how one feels, acts, and relates to others. The body navigates by habits from previous experiences and leads to adaptive or maladaptive patterns with new events. The goal of somatic coaching is to tune into one's body, to watch how the energy flows, and to redirect when needed. Work in somatic coaching includes being mindful, focusing attention to body language, and the use of breath to build capacity to learn. (pp. 99-100)

The process of somatic coaching includes watching for the body movements and other nonverbal cues that are brought into the coaching process. At times what is said does not match what is shown and this is a source of conversation. A coach notices how the muscles around the eyes change during the telling of the story or how arms are placed (Flaherty, 2005). If the words

deliver a sense of peace, yet the arms were wrapped tightly around the body, this could be a disconnected message. There presents an opportunity for deeper meaning and understanding when words and behaviors are banded together.

Another example of somatic coaching from the literature has been described as the Aha moment. This term represents somatic congruence as the feelings of elation or awareness is felt in the body as tingling body sensations (Longhurst, 2006). Everyone has had an experience of this nature. Longhurst (2006) described this bodily experience as the physical manifestation of a change in a person's belief. The Aha moment has been described as a very positive emotion, well understood when felt, but difficult to be put into words. The Aha is the body's way of knowing that change is occurring (Flaherty, 2005). The exhilaration that something profound is happening illuminates a path to action through effective coaching (Kimsey-House et al., 2011). Somatic coaches are trained to recognize this signal that action planning can begin. It has been hard to understand how something so common, powerful, and transformational has not been commonly recognized as a signal for change by most people.

Coaching relationship. When two individuals work together for the purpose of coaching, a partnership aligns. The coaching relationship permeates with feelings of support, helpfulness, trust, openness, and nurturance (Cilliers & Terblanche, 2010; Coaching, 2007; Foster & Lendl, 1996; Ladyshewsky & Varey, 2005; Laske, 2006). The typical coaching relationship has been described as supportive.

Peer coaching demonstrates effectiveness because of the feelings of collegiality in the relationship (Bell & Mladenovic, 2008; Showers & Joyce, 1996). Through 32 peer-coaching observations, collegiality demonstrated a contributory effect to practice change (Bell & Mladenovic, 2008). The spirit of this collaborative relationship promotes a desire to understand

each other's perspectives with an open-minded type of inquiry. For nursing colleagues, their commonality is to improve patient care leadership (Coaching, 2007). The coaching relationship exerts a willingness to explore differing points of view for the purpose of making a professional difference.

Feeling connected has significance in an effective coaching relationship. Cheng (2010) suggested that the goal of the coaching relationship was to create an open space for safe exploration of alternative ideas. This study by Cheng (2010) suggested that peer coaching was an effective learning strategy for a changing workplace environment because it provided a safe haven for discussion. According to Dingman (2004), the coaching relationship includes interpersonal, communication, and support skills and these skills would mediate the perceived effectiveness of the coaching. Competent coaches can establish effective relationships and be effective.

An attempt has been made to quantify the coaching relationship. Participants in a study conducted by Higgins and Kram (2001) described reciprocity and mutuality as strong, but only the emotional tie was the significant characteristic within the coaching relationship. In addition, the emotional component of the peer coaching relationship significantly enhanced future use of peer coaching by both parties, (Parker et al., 2008). Peers need a "critical friend" (Parker et al., 2008, p. 496).

Being able to express ideas and thoughts openly contributed to learning; however, Thompson et al. (2008) noted that only 30% of the respondents who used peer coaching felt that the coaching relationship was effective. The commentary requested further exploration to understand how the peer coaching relationship contributes to effectiveness.

The literature has suggested a few attributes that contribute to a positive coaching relationship. Input into the coach selection, having an accommodating coach, and an emotional tie all predicted satisfaction, course success, and professional development (Parker et al., 2008). When Scoular and Linley (2006) analyzed personality match using the Myers Briggs Personality Tool, it was the coaching dyad with opposite personalities that demonstrated effective coaching. This implies a different type of peer could be effective in coaching. The need to bring different personalities resulting in different perspectives was suggested as important. The topic on coach selection is unclear and more research would contribute to a better understanding.

The coaching relationship has been cited as transformational. Longhurst (2006) described the individual themes within the coaching moment as transformational:

> Through insight, coaching relationships awaken unconditional energy that is felt within the body and leads to action. With this experience, negative self-talk is released so thinking patterns strengthen the ego...One feels a sense of illumination and the soul experiences a connection with others...there is a loss of one's awareness of self replaced with inter-connectedness to all things. (p. 68)

This study assisted in the understanding of what is experienced when transformational thought occurs through meaningful interaction with an effective coach and illustrates the benefits that could be realized by those in a helping profession such as nursing.

The effective coach, according to Dingman (2004), understands there are ethical boundaries within the coaching relationship when coaches help others become self-aware. Some of the conversations and coaching experiences may be uncomfortable for the participants. In contrast, according to Kushnir, et al. (2008) and Sekerka and Chao (2003), the simple act of purposeful communication can build trust within coaching. There has been little debate on the

presence and value of emotional expression during coaching if there is a trusting relationship (Lyons & LaBoskey, 2002). A coaching peer could facilitate an open space for the expression of professional doubt within ethical boundaries.

Evers et al. (2006) offered a discussion that self-efficacy had not significantly improved through coaching. This quasi-experimental outcome study compared the coaching relationship to Bandura's learning theories of self-efficacy and outcome expectations. Although small and incongruent groups were sampled, the only significant outcome measured was acting in a balanced way and setting goals. Self-efficacy did not improve. These researchers posited that a heightened awareness of the participants' strengths and weaknesses resulted in feeling less confident, less sure. This study suggested caution in coaching one who is trying to blend theory into practice as a novice nurse. This study would question the relevance of coaching for Graduate RNs who are beginning a new work life.

Synergism. Coaching can bring the unique natures of two individuals into a blended relationship. Coaching could transcend above what could be accomplished alone (Miller, 2011). An unpublished dissertation by Miller (2011) explored the effect of coaching on communication, service, and knowledge generation between members. Regression analysis was performed and the presence of a positive coaching relationship enhanced the probability that there was advancement in knowledge and skill of both parties (Miller, 2011). Both participants within the coaching relationship learn.

Critical thinking. Critical thinking has been described as a purposeful, self-regulatory process, which results in interpretation, analysis, evaluation, and inference (Donner & Wheeler, 2009). Critical thinking applies criterion-based logic to contextual events. A meta-analysis of 85 studies on critical thinking demonstrates that it has been well applied to nursing practice and

an essential tool of inquiry for nursing (Donner & Wheeler, 2009). Having a critical nature brings forward integration of multiple perspectives resulting in innovation (Yanchar, Slife, & Warne, 2008). Embedded within the Professional Behavior Developmental Systems (PBDS) tool is an assessment of critical thinking; there is relevance in using this tool for a study on peer coaching in nursing.

Novice to expert. Benner (1984) coined the novice to expert term. It has been a concept that represents the process for practice assimilation upon entry into the workplace as a Registered Nurse (Benner, 1984). Commonly referred to as theory to practice, this conceptual model describes the transition that new or novice nurses make from learning concepts to applying them into the practice setting as a professional (Benner et al., 2009). The transition, from novice nurse to expert, is a developmental process in which the nurse learns to be a nursing professional, as well as being comported into the patient care environment with skill (Benner et al., 2009). Comportment involves more than action; it is the style, attitude, behavior, posture, and manners of the nurse with others. Comportment adds the component of art into nursing practice.

Nursing practice has been cited as complex, situated, and having many changing variables (Benner et al., 2010). This complexity has asked nurses to be continuously inquisitive. Nurses need to develop skillful ethical comportment using technology and clinical judgment (Benner et al., 2010). Influenced by scientific evidence, requiring logical reasoning over time, assumptions and bias are held distant when engaging with others in health care practice (Benner et al., 2010). The nurse matures in the stages. According to Benner et al. (2009):

> The novice nurse does not have experiences to draw from so follows rules. The advanced beginner nurse recognizes that rules apply differently depending on the situation. The next level of maturity portrays a competent nurse who feels responsible and aware of

> competing priorities and choices. The proficient nurse can discriminate and use intuition. The expert nurse not only sees the goals, but knows how to achieve them. Ultimately, the mature professional nurse understands subtle differences and has evolved into someone who knows what to do without thinking. (p. xvii)

The study design for this qualitative exploration includes both a novice RN as Graduate RN, and at minimum a proficient RN as Nurse Educator. The novice to expert conceptual model would not intuitively pair an expert with someone who may benefit from being told or instructed as they practice as rule-following novices. There is value in conducting a study to better understand this contradiction. Although not a focus, this nursing theorist provided a contextual understanding to the nurses engaged in clinical discourse for professional development.

Conversely, the level of experience was not a barrier for the coaching engagement (Roth & Tobin, 2001). Purposeful time spent between peers, who have a common knowledge base, provided an opportunity for learning regardless of level of expertise. The use of reflection led to planning, application, and deeper understanding of complex issues (Trivette et al., 2009). Peer coaching was a natural fit for reflective practice within this study and suggests appropriate for the Graduate RN.

Reflection for Professional Development

A qualitative study of significant rigor by Stegman (2007) contributed to the understanding of how reflection is used in coaching. A grounded theory analysis revealed four domains of reflection that guides coaching. The four domains of reflection to consider with peer coaching include: (a) technical coaching, (b) clinical coaching to the context of the event, (c) personal coaching based on feelings, reactions, and responses, and (d) critical reflection where assumptions are questioned.

Sharing experiences between peers could expand individual potential through reflective practice. Reflection with another of similar experience affords salience (Roth & Tobin, 2001). Although Roth and Tobin (2001) presented a limited case study of three subjects, a call was made for additional evidence for the value of fluidity and context for success in reflection. Having contextual knowledge has merit for matching or considering peers as reflective partners.

The education sector has informed reflective practice and has documented reflection as a professional activity. A three-year longitudinal study of professional authors identified the significance of narration as a reflection strategy between 60 education practitioners (Lyons & LaBoskey, 2002). Experiences were explained, shared, and understood. A sense of community and promotion of professionalism arose through a common focus on goals (Lyons & LaBoskey, 2002). Being within the same professional culture contributed value in reflective practice as a learning strategy.

Through reflective coaching, alternative points of view are guided through open-ended questions resulting in the appreciation of differences and change of belief (Bryant & Terborg, 2008). There could be presence of deep learning as assumptions and learner beliefs are challenged. Stegman (2007) identified that beliefs are reformed when the perspective of the learner shifts. On the surface of the conversation is change in perspective, but something deeper could be identified. A dominant theme of successful coaching is the attribute of reflection (Stegman, 2007). A coach with communicative skill can facilitate a deep discussion into the shared experience of others.

Talking to someone who is trusted and who understands someone else's circumstances could assist in learning. Hearing another's point of view leads to higher order metacognition (Ladyshewsky & Ryan, 2002). A trusting coaching dialogue encourages question of

competency, promotes reconstruction of meaning, and promotes adaptive response (Armstrong & Geddes, 2009; Hindmarch, 2008). Peer coaches provide a valuable service in bolstering confidence. When uncertainty, questioning, doubt, or need for validation arise, a dialogue with a peer coach assists learning and change (Ladyshewsky & Ryan, 2002). Perceptions are not necessarily the truth, but feel real. Self-doubt that is not grounded in reality can be more accurately expressed with the help of a trusted coaching relationship (Hindmarch, 2008; Leedham, 2005).

Reflection in nursing practice. Nursing has competency in critical thinking ability and could leverage their impact on patient care with intentional use of critical thinking as a reflective practice strategy modeled through coaching practice. Nursing has widespread influence in health care organizations. According to the Institute of Medicine, nursing will be key to healthcare transformation once all Americans have access to affordable healthcare (IOM, 2010). Nursing is the largest segment of the health care team professionals and could be the lynchpin for facilitating change (IOM, 2010). A commitment to leading the culture of learning includes teamwork, collaboration, and adaptability (Saunders et al., 2012). Positive leadership cultivates innovated thinking and critical reflection is germane to systemic transformation within organizations (Dzubinski et al., 2012). Change can begin with reflection on practice facilitated by nurses who use coaching.

Within the context of positive leadership, the nurse could facilitate critical and timely reflection within a community of others (Dzubinski et al., 2012; Freshwater, 2004; Joyce & Cowman, 2007). The environment of healthcare has been described as complex, and nursing can take a positive posture for learning and change with coaching skill in reflective practice.

Nurses have a rich workplace environment that includes high technology, high touch, and complexity. Nurse Educators can ensure that the nursing workforce engages in life-long professional learning while reflection upon the clinical setting (Porter-O'Grady & Malloch, 2007). The call to engage and re-engage in reflection on practice experiences could potentiate learning. Mediating the impact of reflective learning either positively or negatively is fear, personal involvement, experience, and patient centeredness (Fowler, 2008). There abounds opportunity for a coach to help their peer during dialogue, and being available when asked is especially important. If the learner activates the engagement for reflection, fear and anxiety are profoundly reduced (Corrigan, Hardham, Cant, & Mort, 2011). Coaching can encourage reflection within the context of the experience, with fresh eyes, and offer a new perspective within an open and honest relationship. A coaching dyad could provide for accurate expression and reflection on patient care experiences.

Reflection is a common way to evaluate nursing practice. Reflection has more widespread use in guiding nursing practice than the use of evidence-based practice for learning (Rolfe, 2010). Nurses documented using their mental energy in self-reflection rather than referring to evidence reported by professional organizations. Yet, the skill of self-reflection has been suggested as something that needs to be learned, especially for the Graduate RN (Hatlevik, 2012). The Graduate RN needs support making meaning of practice experiences through reflection. Reflection has been documented in other disciplines as generative and helpful if facilitated (Higgs, Loftus, Jones, & Christensen, 2008). A coach, through reflection, led others to look for evidence for practice change (Gipe & Richard, 1992; Waldman, 2003). Reflective thinking is important to the growth of the Graduate RN learning a way of being within their professional practice (Hatlevik, 2012).

Grounded in social science, the work of any nurse would be rich in detail for reflection and learning with another. The patient care environment is full of ambiguity and dissonance in which reflection would assist in professional development (Gipe & Richard, 1992). Flaherty (2005) asserted that reflective practice with a trusted coach facilitates development of self-directed, self-correcting, and innovative strategies in dealing with health care challenges. Nurse Educators, as facilitators of reflective practice, could begin a path to proficiency for the Graduate RN.

Most believe that the Graduate RN enters practice as a novice. There has been discussion by Benner et al. (2009) that the student's patient experiences would have potential to progress the Graduate RN forward as an Advanced Beginner upon entry into practice. Why would a student experience not add reflective value? The Graduate RN has limited availability of time and energy to engage in reflective practice to develop awareness and meaning (Nelson, Apenhorst, Carter, Mahlum, & Schneider, 2004). With intention, support could be provided. Experts provide skill to correct deficiencies and to connect the dots for learning (Zimmerman, 2002). Nurse Educators have assisted in developing coherence between theory and practice through reflection with Graduate RNs (Hatlevik, 2012). A structured mechanism for reflection could be considered for the Graduate RN.

The evidence has suggested that the novice Graduate RN can be supported through coaching by an expert Nurse Educator who is skilled in coaching for reflective practice. Nurses are called to develop a sense of salience within the patient care environment related to the significance and urgency that is presented (Benner et al., 2010). Identifying reflective coaching as a priority has the potential for advancing nursing practice. The Nurse Educator could seek to

master coaching as a learning tactic. Reflective coaching could leverage entry into practice for the Graduate RN.

Conclusion of the Literature Review

This literature review presents coaching to be a transformational learning strategy that is based on the concepts of reflective practice and produces increased competency, competence, and confidence through a relationship (Coaching, 2007; Freshwater, 2004; Stelter, 2009). Nurse Educators, as skilled coaches, have been suggested to be relevant for Graduate RNs learning to enter practice.

Chapter III: Research Methods

Peer coaching is in its infancy in terms of vetting understanding of how it works, what impacts success, and what the nuances are within the coaching dialogue. Coaching has been an emerging discipline (Global, 2008). The coaching research in the past five years has taken a myopic view from a narrow perspective and few studies have been designed to include investigating more than one of the coaching concepts. This study has taken a broad view of a very specific coaching event from a variety of perspectives.

This study focused on the coaching dyad and many data sources have been collected on both Nurse Educator and Graduate RN. Included was a somatic analysis of the coaching process and a linguistic review based on reflection of patient care experiences through a card sort activity. A complete picture of peer coaching has been collected. This collage represents how practice development occurs between Graduate RNs and Nurse Educators.

Significant to this study design has been the subject and the context. The aim of the research methodology was to complete an in-depth examination of peer nurses using a consistent coaching context. The aim of the research methodology was to examine coaching through a variety of perspectives using multiple venues, but with a common purpose. An interpretive qualitative inquiry provided the foundation for this research on the subject of peer coaching between nurses.

Close attention has been given to define a comprehensive research design methodology. Detailed data gathering procedures have been provided. These quality measures and analysis procedures have been designed with ethical consideration, so accurate attention is given to coaching from the subjects to bring understanding to the clinical practice development within the nursing profession.

Research Design

Phenomenological inquiry was used in this study of the nurse coaching dyad. Qualitative study acknowledges that individuals are conscious human beings within lived experiences (Moustakas, 1994). Phenomenologists rely upon the perceptions of human experiences within natural settings to determine meaning. The process of phenomenology preserves the context of the event (Creswell, 2013). A descriptive accounting of the data results from collecting the group experiences. According to Colaizzi (1978), the phenomenologist continually goes back to the original transcripts to assure the context remains intact and ultimately brings the essence of the experiences into a descriptive narration. Phenomenology not only describes the detail of the lived experiences preserving the context, but also exposes what is experienced and how it is experienced (Creswell, 2013). Exploring the coaching dyad through a qualitative method of study of this type has generated rich data for analysis. Both the Graduate RNs' and Nurse Educators' perceptions have been brought together to reveal the edifice in coaching for this profession.

Hermeneutics, a type of phenomenological design, was used to garner meaning. Unique to this type of inquiry, is the use of interpretive processes to uncover the underpinnings of events under review (Van Manen, 1984). Hermeneutic phenomenology methods "bring to language perceptions of human experiences" (Streubert & Carpenter, 1999, p. 43). The goal for hermeneutic interpretation is to deliver both the structure and the meaning from the event under review (Wojnar & Swanson, 2007). Phenomenological methodology brings an interpretive process to provide a holistic and linguistic restoration of events.

These methods are interpretive, rather than solely descriptive. The distinction between hermeneutics and other types is the role of the researcher (Van Manen, 1984). For the

hermeneutic researcher, a pre-understanding knowledge of the subject co-mingles with the participants to disclose meaning (Wojnar & Swanson, 2007). For example, if a researcher heard "I am lost" within an interview, it signals that there was a deeper meaning associated within this metaphor. A collaborative communication would follow. A researcher with coaching experience, for example, would know to ask additional insightful probing questions. Knowledge of the subject provides a connection with the understanding held by the participants during hermeneutic inquiry (Wojnar & Swanson, 2007). The results of hermeneutics provide for attainment of rich descriptive data.

According to Streubert and Carpenter (1999), nursing practice is relevant for qualitative research design. Nursing is a social science embedded in relationships. Nurses seek understanding and use a qualitative framework within their relationships mixing knowledge with context (Streubert & Carpenter, 1999). Both nursing members of the coaching dyad and their relationship have been studied utilizing a qualitative methodology maintaining the integrity of this experience as a social event.

Populations

The population for this study came from hospitals that utilized the Performance Based Development Systems (PBDS) setting to provide for a narrow, yet deep focus of Graduate RN coaching. The research design called for a minimum of two organizations, but three Catholic acute-care hospitals within the Midwestern United States ended up with participants. These hospitals are medium-sized institutions, use the PBDS formative assessment tool for professional nursing development of new hires, and prescribe to coaching as the learning strategy for deliberation of PBDS results with Graduate RNs (Appendices F, G).

The PBDS coaching feedback process is the setting that provided a consistent context

between the different facilities. The New Graduate candidates for the study were just beginning clinical practice employment. The hospitals selected for sampling had designated Nursing Educators who were responsible for the Graduate RNs' acclimation into practice. The Nurse Educators who enrolled into the study had responsibility for providing initial and continuing education programs within the nursing organization of the hospital. None of the educators administered the assessment tool, but did coach the Graduate RN from the results of PBDS assessment.

As part of the inclusion criteria, the coaching dyads were required to have established a relationship prior to the PBDS coaching event. All participants met this criterion. Establishing rapport is essential to an effective coaching relationship (Drum, 2007). It is easier to share and explore with someone whom you know and trust. This study was designed to explore a single coaching event and a previous relationship was included as criterion. The sampling process provided an intentional selection of participants. Specific criterion of each group follows.

Nursing Educator. Cornerstone to this study design was the assurance of the participation of a competent coach. Although an estimate, a proficient performer has three to five years of experience within a population (Benner, 1984). To be included in the study, the consenting volunteer Nurse Educator needed to have at least three years of clinical and three years of educator experience. The premise of the study was to enroll experienced Nurse Educators with coaching talents. The Nurse Educator cohort had a familiarity with coaching, used coaching tactics, and was highly recommended by their supervisor.

Nurse Educator coaching expertise was assumed to be present in this study. Coaching is a core Nurse Educator competency (Kalb, 2008). In addition, the participating hospitals did offer a coaching class (Coaching in the Moment™) as a leadership course designed to leverage

coaching between individuals (Appendices D, E). This course requires certified instructors, was offered as an elective course at the hospitals, and was intended to minimize the cultural variation inherent in a multihospital design. Even though this course was offered, none of the Nurse Educators had participated. Regardless, there was validation by the educational director that all Nurse Educators had specific training on coaching strategies. Her recommendations provided for study members who could inform the subject of coaching. In addition, their extensive background provided confidence that the essence of a coaching Dyad could be revealed (Table 4).

Table 4

Nurse Educator Cohort

Participant	Hospital	Educator Experience	Clinical Experience	Specialty
1	A	8 years	> 10 years	Obstetrics
2	B	> 10 years	> 10 years	Acute Care Oncology
3	B	> 10 years	> 10 years	Acute Care
4	C	> 10 years	> 10 years	Acute Care
5	C	> 10 years	> 10 years	Critical Care
6	A	> 10 years	> 10 years	Critical Care

Graduate RN. This study was designed for the Graduate RN who had been employed less than six months at the participating institution and held a license for less than eight months. Only four-year college (BSN) nurses without prior LPN experience were included. Clinical experience since employment had to be less than six months. Participation was voluntary. Participants who are able to inform the culture under review are best to include (Streubert & Carpenter, 1999). These subjects were all relatively new to nursing. There were demographic characteristics gathered that were used for selection criteria. If the Graduate RN had any other

licensure, they were not included, and all Graduate RNs were required to have their bachelor's degree in nursing (BSN). The goal was to provide a homologous group. This group with limited experience came from different nursing programs and, although female, represented a broad sample to study (Table 3).

Table 3

Graduate RN Cohort

Participant	Hospital	Program	Heath Care Experience	Employment	PBDS Results
1A	A	Traditional BSN	None	4 months	Unmet
2A	B	Traditional BSN	No, but Mother was RN	1 month	Unmet
3A	B	Accelerated BSN	Home aide	1 month	Unmet
4A	C	Traditional BSN	3 years CNA CMA	2 months	Unmet
5A	C	Accelerated BSN	None	3 weeks	Unmet
6A	A	Traditional BSN	Home Aide	1 month	Met Expectations

All of the Graduate RNs' names were provided by the Nurse Educators for enrollment, and both within the coaching dyad had to have expressed their relationship to be positive and in high regard to be included into the study. This enrollment criterion for the Graduate RN assisted in standardizing the cohort across several organizations.

Sampling procedures

Sampling began after IRB approval. To gain access to the study population, a broad overview of the research study was presented to nursing administration and permission was given from the Chief Nursing Officer (Appendix H). Additional written approvals were gained from the corporate members responsible for the PBDS program (Appendices I and J), from

nursing leadership within the division of each hospital, and after the Nursing Research Committee of the system reviewed the appropriateness of the study for the hospital setting.

A conference with the manager of the system's Nursing Education department occurred. Exemplar Nurse Educators were identified following the criterion for inclusion and contact information was provided. Next, the Nurse Educators were contacted through email. Personal meetings were conducted following a planned script. Consents for participation were review and study participants were formally enrolled (Appendix K).

The Nurse Educators candidates became the source for identifying candidates for the Graduate RN pool. According to Streubert and Carpenter (1999), it is important to choose applicants who inform the subject. Using a purposeful criterion expedites the research sampling process without compromising integrity (Creswell, 2013). This strategy found qualified subjects. The enrollment period lasted several months due to the timing of graduation and hire of the Graduate RNs. The candidates were contacted and none within either group declined to participate. The consenting process followed the same process as the Nurse Educators. Eligible Graduate RN participants continued to be enrolled throughout the data collection process until saturation in data analysis was completed. At that point, no more coaching dyads were included.

Sample

The plan for this study was to obtain a convenience sample size using a purposeful criterion process through permission. In this type of sampling, criterion determines where to select the participants, how participants are selected, and what strategy is used to select participants (Creswell, 2013). The desired sample consisted of at least three Graduate RNs and three Nurse Educators. It is important that the sample size offers enough complexity without diminishing the overall picture. The typical qualitative study is between three and 25

participants (Creswell, 2013). For this study, additional dyads were included until saturation of themes was achieved. Ultimately, six pairs were needed. According to Morse (1994), at least six participants are recommended for studies using phenomenological methods. This study used multiple sources and a sample of six sets or 12 individuals informed the subject.

A large sample size was impractical for this type of a qualitative design as the analysis included a variety of data sources for triangulation purposes. According to Mason (2010), who reviewed 560 Ph. D. qualitative studies, smaller sized samples are appropriate in studies with a narrow scope, multiple interviews, more than one data collection source is gathered per individual, or when the researcher is a subject matter expert. The current study meets these criteria. In addition, the researcher has practiced as a developmental coach within the field of healthcare. There were many factors included into this study, so meaningful results could be obtained.

Setting

The PBDS feedback coaching events formed the context under study between Graduate RNs and Nurse Educators. This setting was regularly and naturally occurring. It was estimated to be 30-60 minutes in length and occurred in a classroom setting without interruption, noise, or distractions, but typically lasted 45 minutes instead. The coaching events were followed by separate, individual audiotaped interviews and card sort exercises, which typically lasted 30-60 minutes.

Special precautions were taken in collecting video and audiotape data. Before the videotape screen was minimized on the laptop, both participants viewed the recording and reaffirmed consent to be videotaped or audiotaped. The purpose of minimizing the screen was to allow for a more natural setting; the researcher was not present once coaching began. Special

attention was given to eliminate negative impact from the technical components on the data collected from the participants. The PBDS feedback session was set up for optimum learning.

Administration of the PBDS feedback followed a prescribed model (Appendix A). Initially, the PBDS assessment measurement was administered via a web application format to the Graduate RNs. The rate of successful ranking of initial PBDS has been noted to be 78% (Fero et al., 2009). PBDS evaluates many factors of competency in nursing practice and follows Benner's (1984) novice to expert model. Regardless of location, an independent certified individual who was not the Nurse Educator scored the PBDS exams. An overall score was provided to the Nurse Educator prior to coaching. All Nurse Educators reviewed and planned for the PBDS feedback event prior to meeting the Graduate RN. Coaching from the results of the PBDS created a purposeful and homogeneous setting that is necessary for qualitative research (Creswell, 2013). The Nurse Educator served the role of clinical coach (Appendices F, G). The goal of the PBDS formative assessment provided focus and a consistent context for the coaching event under review.

Although the PBDS coaching event was the context of the setting, it was not the primary source of data. Following the coaching event, the researcher interviewed the participants separately, and this data became the primary data source for the study. The participants were interviewed at a location of their choice and all were interviewed in either a private lounge or office promoting reflection without interruption. A natural setting promotes a relaxed environment for the conduction of quality interviews (Creswell, 2013). Although one tornado watch and two phone call interruptions occurred, the participants voiced that there was no disruption. To avoid fatigue distraction, no Graduate RN interviews were conducted after a twelve-hour night shift. Privacy and a quiet environment were maintained within the setting.

Ethical Considerations

Prior to conducting any research, approvals were obtained by the Institutional Review Board (IRB) at the College of Saint Mary, the IRB at the community and institution boards, and two Nursing Research committees. Protection of human subjects and confidentiality were the standards set for this research study. Informed consent was utilized for all subjects (Appendix K). The researcher read aloud the consent form and asked the participants to follow along. Reading together ensured all sections of the consent were reviewed and understood. The participants were aware of their right to terminate participation at any time. They verbally acknowledged understanding that their data was for the purpose of completing a doctoral dissertation by the researcher, for public or scientific presentation, and only during oral defense would videotaped clips be presented. It is difficult to assure total anonymity using video presentations even with face altering editing. The study participants were aware, consented, and provided permission for the use of video clips for dissertation presentation as applicable. They were made aware that no data would identify the study participants. Informed consent documents were signed by the participants and witnessed by the researcher.

For every data gathering procedure, volunteer participation was readdressed. Everything was transparent to the subjects and all were treated with the same dignity and respected in a cordial manner. There is a natural concern that occurs during qualitative research because it is a more intimate type of inquiry (Van Manen, 1984). At times, the researcher needed to probe to uncover the essence within the coaching event under exploration. As perceptions were explored, the researcher maintained a demeanor of highest sensitivity and regard.

This researcher used videotaping as a data source. The uses of video clips for illustrative purposes were communicated to the participants in a transparent manner. The researcher abided

in an ethical and responsible manner in the use of clips used to support the themes. All data was protected and held in high confidence. A backup of the data has been done and will be maintained for seven years on an external hard drive with a security password.

The data gathering process presented no risk to the participants in any manner and the benefits were to inform coaching as a nursing strategy for the Graduate RNs' entrance into practice for professional development. This researcher was accessible to the participants through email or cell phone exchange. Findings of the study were made available to those interested. The participants were informed that the findings would be presented for publication without identifiable persons.

Quality Measures

A critical step in maintaining the integrity of the lived experiences is for the researcher to be distanced from any preconceived knowledge on the subject of study. Bracketing out conscious thought eliminates preconceived ideas (Moustakas, 1994). A journaling exercise helped raise the researcher's consciousness of bias. Because the researcher has professional coaching experience, this step was significant to impart credibility. The essence of phenomenology was to explore the lived experience of others, without interference, uncovering essential structures (Colaizzi, 1978). The researcher continually asked, "Was this what I see, was this what they see, was this what was seen?" The coaching dyad was the data source for this study and strict use of phenomenology was the quality method to uncover meaning without bias.

Additional quality methods included verifying meaning, validity checks, and auditing. These were applied with methodological rigor. Verification was fulfilled through a thorough review of the literature and validity was maintained through a vigorous reliance on the phenomenological method chosen for this study (Creswell, 2013). Triangulation, a means of

validation suggested by Creswell (2013), was accomplished through the compilation of the multiple data sources of videotapes, field notes, and card sorting data. Saturation techniques were utilized to reach an exhaustive exploration for content themes. The sixth coaching dyad did not reveal any new themes.

The final themes were put through additional scrutiny. The coaching videos were reviewed, the card sort data was summarized, and the field notes were reread to triangulate the findings. Two member checks were also completed to strengthen the quality of the research findings. First, a college faculty member completed a thematic coding validation on one of the transcripts. Second, a member check was completed with one of the Nurse Educator participants. She agreed with the identified themes. The final themes held up to rigorous review. All these actions provided a basis of trustworthiness.

Data Gathering Tools

Data was assembled from a variety of sources. Primary data was gathered through reading questions from a semi-structured interview tool (Appendix L). In addition, the collection of thoughts, ideas, and perceptions of the lived experience of these two were buttressed by researcher observations. The researcher made notes during the interviews, card sort exercises, and review of the videotapes (Appendices M, N, O). Field notes are considered essential for hermeneutical analysis (Van Manen, 1984). The researcher interacted within the lived experience to bring forth a meaning of the essence of the coaching Dyad. These notes, the videotapes of the coaching event, and the card sorting activities were considered secondary data sets.

The data gathered using a card-sorting technique was designed to solicit important coaching attributes from both Graduate RN and Nurse Educator. A card sorting activity

identifies concepts for web design, typically, headings for a web page (Department of Health and Human Services, n.d.). In this study, the card sorting exercise was designed to identify which coaching strategies were effective for reflective practice discussion during coaching interaction.

The semi-structured interviews and the card-sort exercises were tools that were modified from a pilot project reported by Bostwick and Chambers (2012). The semi-structured interview of open-ended questions was designed to link the research question to the coaching event in a detailed manner, and the card sort was done to solicit a sense of coaching priorities from the participants for triangulation purposes. The videos were reviewed to solidify meaning of the essence of the coaching events. The range of data was extensive and planned to inform the lived experience of nurse coaching.

Data Gathering Procedures

The study required time to enroll at least three coaching pairs, to videotape the coaching event, and to audiotape separate semi-structured interviews of about 30-60 minutes each that would include a card sorting exercise that was done alone.

A formal data collection process was followed. Prior to every data collection activity, informed written consent of the coaching dyad was assured and reconfirmed. A minimum of three data sets was compiled for phenomenological analysis. A data set included a videotape of the coaching pair, a completed interview with card sort from both participants, and field notes. Creswell (2013) recommends a minimum of at least three subjects. To be included as a whole, a complete set was required. Questions for understanding were encouraged throughout the research process.

Semi-structured interview. Perceptions of the coaching dyad were explored through the administration of a semi-structured interview of both parties independently. Open-ended

questions based on the research question were asked of all participants. Additional probing questions were asked to facilitate in-depth answers to the scripted questions. An example of a probing question was to restate the response as a question. These questions were designed to facilitate collaborative communication (Appendix P).

The interview was audio-recorded and transcribed verbatim. Audio recording helped avoid interference and assisted the researcher to focus on listening. This process included a welcome and assurance that participation was voluntary using a professional and cordial demeanor. The interview and videotape began with verbal instructions. The date and pseudonyms were recorded on separate logs to maintain a connection. The data was secured within a locked file cabinet. During the interview, questions were repeated and clarified. Field notes were made during the interview following the guidelines. Direct observation for nonverbal behaviors and environmental factors were logged. These observations maintain the integrity of the participants' stories (Creswell, 2013). Demographic questions were gathered (Table 5).

Table 5

Demographics of the Coaching Dyad

Graduate RN	Nurse Educator
Age	Age
Previous Hospital Experience as LPN	Years of Experience as Clinician
Previous Hospital Experience	Years of Experience as Educator
Length of Employment at Institution	Length of Employment at Institution
Clinical Experience with Nurse Educator	Continuing Education in Coaching
	Coaching in the Moment Training

The interview concluded by inviting additional information. The interviews were conducted separately, audiotaped, and transcribed verbatim for the purpose of answering the research

question using a hermetical methodology (Van Manen, 1984). Related relevant coaching questions were asked of the Nurse Educator and Graduate RN.

All interviews were coded with pseudonyms and matched to the videotaped recordings in NVivo version10 (Nvivo v10) software.

Videotaping the coaching event. The Nurse Educator and Researcher collaborated to schedule the coaching event. The procedure for the collection of this data was to position a camera that included both participants. The video screen was minimized to impart less distraction and the videotape was stopped when PBDS feedback was completed. Afterwards, the videotape was secured and labeled with pseudonyms; videos were imported into Nvivo v10 and password protected.

Card sort. The data from the card sorting exercise represented the perceptions of the participants' priorities in coaching for reflective practice. Individually, the participants were guided through a process of sorting and resorting a pack of 37 cards that had coaching terms written on them. Only the final sorting process was retained to represent the participants' perceptions of coaching priority. This was an exercise adapted from Bostwick and Chambers (2012), which explored self-doubt in nursing (Appendices Q, R, S). The time for this activity ranged from 10 to 20 minutes and followed the interview to eliminate bias of the primary data collection. The steps of card sorting included agreement to proceed, reading the instructions, and maintaining rapport throughout the activity. The participant was given a pile of cards and asked to sort them into three piles evaluating which were most meaningful, somewhat meaningful, and not meaningful within their PBDS feedback session. The last card was a blank. They added a label of their own to be retained. The researcher asked the participant to review their piles before moving forward. When done, a second resort was instructed. The re-sort was done picking out

those words, based on their perceptions, to be most important for reflecting on practice for professional development with a coach. The final terms are categorized (Table 6).

Table 6

Coaching Term Results: Card Sort Frequencies

Coaching Attributes	Responses
Relationship Builders	73
Communication Builders	43
Knowledge Builders	31
Identity Builders	23
Total cards/words	170

The cards were banded together and labeled, each with their unique pseudonym. The cards selected were logged into NVivo v10 and destroyed. This exercise brought insight to coaching attributes that added value to reflective nursing practice. This data set provided a source of information to confirm the data presented during interview was true.

Field notes. Detailed notes were taken while watching the videotaped coaching events, during the interviews, and as the card sorting exercise was completed. Notes were made watching for visual attributes associated to collaborative communication, visual distancing behaviors, and other somatic events (Appendices M, N, O). The enrollees were informed that notes would be taken.

Data Analysis

Collecting the data and managing it prudently were the first steps proceeding data analysis. Maintaining the anonymity of the data was foremost. Master lists of names referenced to pseudonyms have been maintained in a secured separate location by the researcher. The

videotape, transcripts, log, and card sort data were mapped to the participant's pseudonym and entered into NVivo v10. This software provided analytics to leverage an extensive analysis of the data. The efforts in this step of the research process were to assure ethical and quality measurement of the collected data.

Data analysis followed the tradition of interpretive phenomenological methods. This method requires a conscious reduction of data from multiple sources, analysis of specific statements as themes, and a search for all possible meanings (Creswell, 2013). The researcher made every effort to let the data speak without personal influence entering into the analysis. For this researcher, the entire data sources were read asking, "What is really going on here?" (Van Manen, 1984, p. 39). An open questioning mind was maintained.

Hermeneutics is described as circular (Wojnar & Swanson, 2007). The researcher continually moves back from the data, to the persons, and to the literature to ascertain meaning (Appendix T). The belief within this methodology is that the researcher and participants are shaped by their backgrounds and in the process of interaction and interpretation, an understanding is co-generated (Wojnar & Swanson, 2007). Specifically, the Van Manen (1984) and Benner (1994) approaches were employed for initial data analysis. The steps have been summarized to be: (a) reading of all the cases and associated works, (b) isolating the paradigm cases, (c) identifying repetitious themes for within and between cases, (d) selecting exemplary quotes to illustrate themes, (e) identifying cases that were similar or deeply contrasted, (f) re-reading the cases and working to isolate the repetitious themes, and (g) identifying exemplary quotes to illustrate themes. This researcher read each of the entire texts with a reflective posture, grasping for essential meanings (Creswell, 2013). The desire to uncover themes emerged through questioning the data.

Themes and subthemes were recorded through a process of uncovering topics. Examples of topics identified included setting, context, perspectives, processes, activities, strategies, and relationships. This methodology helped the researcher begin to answer the research questions. Within these topics, attributes were categorized and subthemes were added through a repetitive reading of all the transcripts. At this point repetitive themes were identified and consolidated until a final review was completed. The researcher pondered the data using a line-by-line approach (Creswell, 2013). Statements and phrases that imparted meaning were highlighted. Quotes were circled to illustrate. Themes represented those ideas of high frequency, or most surprising, or those that were unexpected. It is best practice to report themes providing details from the data (Creswell, 2013). This process continued until an understanding of the coaching event between nursing peers was understood through reflecting on two of the exemplar transcripts. NVivo v10 was the tool used for sorting, combining, and synthesizing the data.

Summary

This research had been designed with attention to a phenomenological structure, including data from those intimately involved and experienced in coaching for professional development. The perceptions and observations of both members of the coaching dyad were included in the design of this study to inform coaching within professional practice development as an organic whole event. The data sources were from multiple sources, which added rigor to a thorough and valid analysis and informative interpretation of the essence of coaching. Audiotape transcription, videotaping, card sorting, and field notes added additional trustworthiness to the design of this study.

The coaching dyad, as a lived experience between two nurses, was explored through rich data analysis using rigorous phenomenological methods. The coaching event has been described

in an organic, holistic manner, and the researcher constructed a comprehensive process for interpretation of the nature of the human experience of coaching between nurses. This research process contracted and expanded the data and arrived at an end state of uncovered essences and structure within the coaching experience. This began a foundational knowledge background for coaching as a professional practice development strategy between nursing peers.

Chapter IV: Results

This chapter presents the results from twelve peer nurses who had a coaching experience intended for professional development. The context of the interview conversations centered on the results of an assessment tool that measured professional development. One nurse was an experienced coach; the other was the coaching recipient and new to the nursing profession. The coaching dyads (Nurse Educators & Graduate RNs) have been described, summaries of the data collection timeframe have been outlined, and the processes employed have been presented.

The underlying essence of peer coaching for professional development came forward through the collection of participant stories. The methods used for data analysis preluded an enriched discussion of the emerged themes and subthemes that have arose from multiple data sets. The primary source of data in this research came from recording the Graduate RN and Nurse Educator perceptions of coaching using a semi-structured interview process. The researcher used probing questions to get enriched data. Examples of inquiry are provided (Appendices L, P). Additional data sets included videos of the coaching event, card sort data, and field note data and were collected for quality measurement purposes intended to support or refute the perceptions gathered from the interviews. Secondary data sets are used to triangulate the data in order to corroborate the truths uncovered (Creswell, 2013). These collections added quality measurements to the themes that were identified through the review, coding, and analysis of the interview transcripts. A holistic perspective of the lived experiences between Graduate RNs and Nurse Educators have been identified as themes and illustrated by exemplars.

Peer coaching in nursing evoked meaningful action-orientated learning as the coaching dyad focused on professional development in the practice setting. The two research questions were answered. The first question asked for the essence of peer coaching dialogues. The second

research question asked how the peer coaching dyads contributed to professional development during reflection on patient care experiences. These research questions have been answered with descriptive evidence.

Essence of Peer Coaching

Through a comprehensive analysis of the data, five themes emerged to describe the essence within peer coaching between nurses. Informing the coaching dyad is a nurturing engagement that accepts, anticipates needs, and creates experiences. The coaching dyad recognizes the professional RN as one who enters responsibility with a sense of confidence, alleviates fears, and uses a process to bring about relevance to clinical practice. Connections were made within the coaching dyad when reflecting on patient care scenarios and the use of probing facilitated a deeper awareness of professional self. Nursing includes an art of practice and the dyad stresses the importance of intuition. Last, the Nurse Educators provide many references in clinical practice to bolster evidence based practice to motive the Graduate RNs to advocate for safety and to think critically to prevent injury while gaining understanding and knowledge in the practice environment. These themes and their subthemes illustrate that a meaningful dialogue could activate awareness of one's professional self while dialoging with a coaching colleague and that professional development can be enriched while the dyad is engaged in reflection on patient care experiences.

Nurturing engagement. The strongest and earliest theme that emerged from the review of data was a nurturing engagement within the coaching dyad. This was a significant component or essence of the coaching experience. The partnership between the nurses was focused on successful Graduate RN development and was present within every coaching dialogue. The

exemplars of this theme focused on caring for the Graduate's feelings during review so that a meaningful dialogue could encourage professional growth.

This theme identified the coaching relationship to be one characterized as helpful, caring, and positive. As a result of this kind of relationship, one Nurse Educator, Doncha, stated she was able to incorporate discussion about clinical weaknesses and strengths into the coaching conversation. Rather than describing Professional Behavior Developmental Systems (PBDS) deficits as weaknesses, Doncha framed the conversation as opportunities to become a better nurse. Graduate RN Winnie reflected on the coaching with her Nurse Educator Doncha and said, "We talked about a real life event and [about] what I did. She encouraged some things and corrected others. She guided me along through [a discussion] and I learned." Weaknesses were brought into the conversation from the feedback assessment as opportunities for growth and patient care questioning facilitated a comfortable conversation between the dyad. Nurse Educator Nana stated she understood weaknesses were a place to grow, focus, and were not understood by either her or her coaching partner as a negative concern. She buffered the discussion about Graduate RN weaknesses from the PBDS with a need for more experience. She strove for the Graduate RN to understand the importance of learning from new patient care experiences and that would be key to success. She felt and conveyed to Graduate RNs that there were many opportunities in their professional practice that could be shared for growth and development.

All coaching dyads described their conversations as honest, caring, positive, and open. These descriptions were validated during the word selections from the card sorting exercise. The coaching dialogue, within this supportive relationship, produced discussions of their practice strengths and weaknesses. One Graduate RN spoke of the experience of the relationship:

> She sat really close to me and it was just . . . the whole body language of being attentive to what the person was saying, [she] used eye contact, (I was) leaning forward on my seat. I was not stressed out or anything.

Eight of the twelve participants identified the coaching relationship to be significant when discussing performance. Nurse Educator Sha described her coaching relationship with Candy. She said:

> You go in thinking; [you] think you are ... going [to] talk about this piece of paper and it comes out as so much more...they tell you how [they] are feeling and what experiences they need. I love working [with them]. They want to learn, they want to absorb, they want to go and do everything, and I think it's just great. I love giving them all the resources. I have this, or I have this, or use this. It is great. I love it.

Her coaching partner, Candy, felt that Sha was very helpful during PBDS review. There was an identified need during PBDS review for Candy to have different types of labor patient assignments and she needed experience caring for newborns as the admission nurse. She felt that Sha would help get these experiences for her by contacting the charge nurse. Candy described the coaching relationship was one that helped her improve by helping her to gain more pertinent experiences.

Table 7 illustrates the importance of the relationship on professional development when reflecting on patient care experiences with a colleague. Several Graduate RN and Nurse Educator verbatim are lifted from the transcripts and presented with an implied meaning to demonstrate that the impact of the coaching relationship on learning through coaching.

Table 7

Nurturing Engagement: Significant Statements of the Coaching Relationship

Significant Statement	Formulated Meaning	Name
You have to listen to be able to tailor orientation with valuable experiences to develop skill sets	The relationship is focused on their needs.	RN Sha
I need to have more experiences and help to prioritize.	Our relationship is one that is open and helping.	GN Candy
I want to be accepting and not make them feel dumb or failing. I want to come across with patience and hope they feel I have patience.	I care and support learning in this relationship.	RN Autumn
I am not as confident. Bobbi was helpful. I need to know which symptoms go with which disease, recognize adverse effects, look for possible complications, and when to call the doctor.	I feel comfortable talking when I am unsure because of our relationship.	GN Sue
Empathy is important; she needs to know I have walked in her shoes. She needs to feel positive support, caring.	Empathy within our relationship supports professional growth.	RN Nana
I need patience, open communication, and willing to think outside of the box to be changeable and adaptable.	Our relationship provides for optimal learning as we seek to understand.	RN Olga
I may not have shared or recognized my weaknesses. I realize that I need to be on my game.	There is trust within our relationship.	GN Doncha
Practicing and playing the what-if game boosted my confidence. She didn't make me feel stupid, no question was dumb.	A close feeling with another promotes confidence.	GN Winnie

GN=Graduate RN RN=Nurse Educator

All of the coaching dyads referenced the supportive nature of the relationship and the Graduate RNs felt professionally nurtured during the PBDS review. For another example, Bobbi and Sue discussed their coaching relationship as open and honest. Bobbie was first to be interviewed after the PBDS assessment and said:

> I am her peer, [but] I feel like she's one of ... my new hires, one of my newbies... that I'm going to try to look out for and watch and make sure that she's progressing...I want her to feel comfortable coming to me to help her resolve any issues.

Sue commented that Bobbie was really helpful in explaining what her weaker areas were and how she could improve her practice. She described her weakness, "My indecisiveness always comes through...and my inexperience kind of shows. I [see] her as helpful...where I can gain more knowledge, learn about disease processes, and gain a little bit knowledge." This coaching dyad had a relationship that promoted an honest appraisal and instructional feedback.

Through the use of field notes, the researcher documented evidence of engaging behaviors, active listening techniques, and general positive responsiveness between the dyads. There were many exemplars of the appearance of cadence within dyad interactions. Their body postures suggested both open and closed nonverbal interaction that was in sync. The use of gesturing promoted interaction and understanding. Their caring attitude was clear during PBDS video review of all coaching dialogues. They said words of encouragement such as: "excellent," "good," "that's perfect," "these results are only a single assessment," "not a personal reflection on your performance," and "I am here for you anytime." The field notes corroborated the theme of nurturing engagement that arose from the participants' interviews.

Of all the cards retained as significant for reflecting on patient care experiences during the card sort, over half were related to the coaching relationship. The card sort was used as a

quality measure and corroborated the nurturing engagement theme as relevant. The Nurse Educators spoke of the importance of the coaching relationship when describing successful coaching attributes. They identified "nurturing," "integrity," "openness," and "connection" as important even though none had selected the exact same words during the card sorting activity. In summary, there were many examples of support and the Nurse Educators identified that having a positive coaching relationship was important. The Graduate RNs recognized this type of relationship as being present and understood that this support was for their benefit.

Accepting attitude. The coaching dyad had an accepting attitude that arose out of the nurturing engagement theme. They accepted that there would be areas of weaknesses to explore during the coaching event and that their coaching environment was a safe place to divulge their concerns, failures, and worries. The dyad was present to learn together, and, as Winnie stated, "You have to be where they were at and not just to get the task done."

This subtheme of acceptance was present prior, during, and after the coaching event concluded. As part of the interview, questions were asked about their presence of body, mind, and spirit as they prepared, participated, and reflected on the coaching event. Presence of an accepting calmness and readiness permeated from all members of the dyads. Even when coaching a Graduate RN through termination of employment, an attitude of acceptance and respect prevailed from the Nurse Educator. In addition, Doncha described the accepting attitude as a Nurse Educator:

> I like to have [the Graduate RNs] tell me about some encounters they have had with others. Good or bad, they tell me about all [the interactions with others] and we would go through them all and talk about [professional relationships]. Through this [dialogue] I

> could help them understand [different perspectives]. I know [they] will mature as [they] work in healthcare, [they] will mature and develop.

The dyads portrayed a connection to each other, and present in their non-verbal behaviors was a spirit of acceptance and willingness to help. They maintained eye contact and faced each other during video review. They appeared to make space for each other, seemed mindful, and provided a receptive attitude. Frequently, they made reference to a commitment to the best possible outcomes of success. As Autumn commented,

> I brought a focus and presence with me for them; I always faced them, looked at them, and felt so rewarded when they grew. I pushed all the stuff on my desk to the side and I met them where they were and helped them. I mean, most of them were so happy to be here, [it was] generally a happy environment, they wanted to learn, they would absorb, they wanted to go and do everything . . . I think it has been just great. I love to give them all the resources, I have had this, I have had that [for them to use to practice], they used this [to review the disease processes] . . . it was great . . . I loved it.

The dyads were comfortable and open in discussing practice deficiencies that were identified on the PBDS assessment tool. They were able to keep the coaching conversation within a proper perspective. As Candy illustrated:

> I did not want it (PBDS) to get to me too much. I wanted to take it . . . take what [was] told me, but not take it personally... it's not criticism when somebody comes to you [in a supportive nature] with advise or a thought of something you could improve on, it is a compliment . . . it means that they want you...to be the best that you can be and that is a compliment knowing [they accept you].

Another Graduate RN, Helga, went even further describing an accepting attitude:

> Oh I adore her. Great, I feel like I can definitely go to her with anything and that she would listen. She gave great feedback and constructive responses. That has been good [because], I do not need a whole bunch of fluff. [I] want good direction and I have gotten great direction.

The coaching dyad provided for professional growth through a relationship grounded in sincerity and acceptance.

Anticipating need. Another subtheme that provided clarity to the nurturing and engaging nature was the consistent way that the Nurse Educators anticipated the learning needs of their coaching partner. All Nurse Educators prepared for the coaching event knowing that the Graduate RNs had unique needs. For example, one Nurse Educator foresaw and accommodated a language barrier because English was a second language for one of the Graduate RNs. As the Nurse Educator, Nana stated,

> I was concerned that maybe she missed something in the vignette...[she might not have] understood a portion of it. Did she not understand something? And . . . English was her second language. I [wanted] to make sure she understood. I gave some [clinical examples] for her to verbally [respond to] that represented the PBDS concepts and she was able to tell me . . . what I wanted to see. I anticipated that her assessment would need to be clarified. She has been doing fine in clinical practice. The nurse educator broke down the language barrier by allowing the Graduate RN Gertrude to verbally supplement her written assessment that was lacking within the written PBDS description.

In another interview exemplar, a Nurse Educator Olga, described bringing an alternative agenda to the PBDS coaching event because she didn't think there was a good clinical fit for this nurse. She described coaching the nurse so that she would consider transferring into a different

clinical area because the nurse's skill set had not demonstrated successful competency within the fast pace of an Intensive Care Unit. This coaching engagement for the Nurse Educator was one of the most rewarding experiences of her coaching career:

> And I brought her to [the] Progressive [Unit] and the nurses were all upset because . . . Oh, you give us [those nurses] that the intensive care unit can not handle...And I [say] . . . this one will take some time, but she will do great . . . later, . . . in the end, . . . they said that [I] was right ...it was a good idea.

Another Nurse Educator, Doncha, commented that listening was the key to provide individual attention in the coaching event. As this Nurse Educator suggested:

> It kind of depends when [working on PBDS with the Graduate RN], you make . . . an individualized [plan] . . . depend[ing] on the individual and what they were struggling on. Maybe it is an actual task oriented thing or critical thinking piece, it could even just have been an inter-personal relationship type thing. I have tried to . . . figure out, do they even like the Med-Surg. area . . . was this department for them, [they would do better as a nurse] if there had been some difficult [and different] patients.

The Nurse Educator illustrated that by listening to the themes within the story; she could clarify what was needed for practice development. Their dialogue centered on hearing the concern, acknowledging the concern, and forming a plan for new learning opportunities back in the practice environment.

All, but one of the Nurse Educators anticipated, provided, and adapted their coaching event according to the needs of their partner. In the following exemplar by Doncha, the essence of coaching was well articulated to be an event that was focused on the Graduate RN and their well-being was paramount:

> We [Nurse Educators], try really tried hard to accommodate the [the Graduate RN's] needs. It could have been knowledge, relationship, or even a maturity [deficit]. If they need to slow down in their orientation, we do. If charting is their challenge, we focus there. If text anxiety is a problem, we provide an individualized assessment plan. If they need help starting IVs, we set them up to start twelve in one day until they get it. We just need to be receptive to their needs, but they also need to help us by letting us know [what they need] and our job is to help them succeed. If they would be the one to begin the conversation [the coaching conversation] instead of us telling them [what the results of the PBDS showed], they [would] grow better as a person and would really develop professionally.

This is an interesting coaching concept that was not present elsewhere, but could be explored in other studies as an intervention.

Creating experiences. In this subtheme, many of the Graduate RNs had limited clinical experience, so the Nurse Educators created experiences to discuss. Very few recalled enough detail from the vignettes presented in the PBDS assessment. Three of the Nurse Educators, Olga, Nana, and Doncha, crafted a dialogue asking for information from current work experiences, or through the use of probing techniques, pauses, paraphrasing, and other techniques allowed for an enriched dialogue from patient care. Doncha provided a powerful testimony of this subtheme. She said:

> [We] both contribute. I listen to see if she has interest in something [clinical experience] and then I just go for it. That is when I ... provide her with the means [coaching] to grow. [We talk] about learning opportunities from these experiences, I add some additional

> scenarios as opportunities for consideration . . . I make connections happen and I help her with that and this is rewarding to me.

During Graduate RN interviews, experiences outside nursing were illustrated as contributing to their professional development. None of these life experiences were referenced during the coaching dialogue with the Nurse Educator during video review. For example, Sue illustrated her feelings with the care of a loved one who was in hospice, Lucy shared that her RN mother positively impacted her confidence, Candy talked about practicing ballet and valued structured learning. Two others discussed student nursing life experiences that compared and contrasted with their roles after graduation. All illustrated these experiences as a sense of personal accomplishment. These other life experiences remained untapped during the coaching conversations, but frequently were discussed during the interview. This suggests an avenue for a coaching connection outside of clinical experience for professional development. One Nurse Educator, Doncha, identified many examples of using experiences outside of the workplace for coaching opportunities. As illustrated:

> They [Graduate RNs] need to feel important and you have to go with their words and where they were at and respond to any situation that they discuss. They can veer into interpersonal skills and sometimes they [talk] about previous jobs . . . let us say that they worked in a day care, or a [department store]. They would talk about their encounters and we would apply that into their nursing situation.

This Nurse Educator felt at ease in bringing work experiences or patient care situations in conversation and felt at ease infusing concepts from the PBDS results throughout these discussions. She felt strongly that the Graduate RNs connected through their stories in patient care. The Graduate RNs enjoy talking about patient care experiences, and, in review of the video

transcripts, this enthusiasm was demonstrated as their body and spirit became animated when talking through patient care situations. As Gertrude replied:

> I heard it over and over and over again and then by discussing it and talking it out, . . . it becomes [something] that you know so that if a patient starts to present with something, like tachycardia, like your mind would instantly go to a list of things that [you have discussed before, you identify what it] could be, and then you start going through [it for relevance]. I liked that.

This RN discussed the importance of talking through patient care experiences with a coach to prepare for recognition of similar issues within the patient care environment.

Following a process. Most coaching dyads followed a consistent process during PBDS feedback with the Graduate RNs during interview and during review of the videos. Confirmed as following the nursing process, a couple of Graduate RNs, Candy and Lucy, reflected that the PBDS feedback process was similar to nursing school. Lucy stated, "I would . . . say in nursing school we went over, . . . your weaker areas and where you could improve on; I'd say that was [a] similar . . . process."

One Nurse Educator, Doncha, demonstrated an exemplar coaching practice that was different from others. This educator began like all others: she reviewed the PBDS results ahead of time, gathered some feedback from the unit preceptor, and planned an approach for the coaching event. The difference in this Nurse Educator's coaching style was how she opened the Graduate RN coaching conversation. She began the conversation centered on a recent patient experience of the Graduate RN and used this experience to weave a deeper discussion about critical thinking, changing patient conditions, and sense of urgency and prioritization. The coaching topic started with a general question about how the Graduate RN was feeling overall

followed by discussing specific patient cases. Before any reference to the PBDS review was made, the Nurse Educator had successfully guided the conversation through the PBDS concepts around the Graduate RN's current experiences. Some relevant questions focused on what could have gone better, what steps were taken or missed, the interactions involved in the event, and then the Graduate RN was led through a reflection exercise to identify potential complications. Doncha allowed the Graduate RN to direct the conversation. She stated, "I infuse the [Graduate RN's] discussion with resources at their fingertips . . . stroke team, online references, and my end state is that we both have an understanding of the importance of a questioning attitude within the clinical field of nursing." This approach followed a process that was personal.

Winnie, the Graduate RN within this coaching dyad, recalled the real patient experience with a lot of detail and viewed this as very helpful to clearly understand what complications could have occurred. This Graduate RN described a process that was relaxing and comfortable during the researcher interview. Winnie indicated that she learned about changing patient conditions through this type of process. As Winnie stated, "Instead of calling the doctor, I appreciate the importance of assessments to help clarify the condition and treatment plan." This conversation became real for Winnie as she kept relating to the patient she cared for in room 452 as the inquiry expanded. According to Winnie, this process led to significant learning. She said, "It is interesting that even little changes [in the condition of patients] could result in real complications." According to Winnie, she was acutely aware that any patient could be one step away from a real emergency and being responsive was important. This Graduate RN was able to connect and learn by coaching through this approach.

In addition, an emotional connection was launched when Doncha asked, "Have you had a stressful patient experience?" Winnie shared her stress about being accused by a patient of

making a medication error. Winnie was aware that for this patient she had not made a mistake since the patient's symptoms actually reflected too fast of a change in blood pressure from the dose that was ordered by the physician. The patient's questioning attitude promoted a discussion of something deeper; she could cause harm. Insight was ignited; she stated she understood how it would feel to make mistakes in practice. Awareness was reaped when emotions were tapped. No medication error had been made, the Graduate RN was able to compartmentalize her feelings, and then she got curious about caring for the patient within the coaching dialogue.

The Nurse Educator facilitated awareness through a real patient care experience. Along the way, the Graduate RN developed an understanding of being responsible for patient safety, for being a responsible investigator of patient status change, and for making knowledge and skill formation a priority. This exemplar brought into focus that coaching could result in transformational learning for the Graduate RN and suggests the coaching process is worthy of consideration.

Recognizing professional self. The second theme that emerged from the thematic analysis of the coaching dyad and underlying the coaching event was an understanding of professional self. This theme came forward serendipitously when the Graduate RNs reflected on what was their most significant learning out of the coaching event. In review, this theme was also present during the videos of the coaching events. This was a surprising theme to be present, as professional identity has been generally considered a journey over time rather than a one-time coaching event (Freshwater, 2004; Higgs, et al., 2008). Upon reflection, the Graduate RNs Helga, Doncha, Candy, and Lucy realized they had entered an awareness of responsibility, a distinction from others in the health care community, and a responsibility of continued learning

with others. They all acknowledged that they had not yet arrived. They were arriving toward their professional selves. As Candy, a Graduate RN, reflected:

> I feel like now there are just a lot more components of my job, [like] calling the resident. Since I work the night shift, you know, and [need to be] prepared...for what questions they might ask and having, yeah, I'd say calling the resident, I just had no experience with [this in] nursing school, so that has been a big change. [Knowing my role] has been a big change.

This Graduate RN illustrated the importance of the nursing role of communication with others on patient's healthcare. The medical community relied on her independent nursing actions to guide clinical patient care decisions. This Graduate RN identified with her role in communicating the patient condition accurately as she has to be the eyes of others during the night.

In another example, a Graduate RN recalled the group discussions on the nursing unit following a serious safety event. When hospital practices resulted in patient injury, a comprehensive review for causation was completed. This Graduate RN reflected and focused on the nurse's troubled feelings during this event:

> I heard that the family of this patient was still very grateful [for what the nurse] did and the nurse was [shocked when] they gave her a hug; it was really weird. [She wondered] why did they give her a hug [because their baby died on our watch]?

This example presented a contradiction. A paradox existed for the nurse who expected the family to be angry, but instead was grateful. The power of the caring role of nursing helped this family cope with a tragic outcome. Coaching provides for deeper metacognition (Freshwater, 2004; Ladyshewsky & Varey, 2005; Trivette, et al., 2009; Xun & Land 2004).

Discussion about portraying compassion, as a nurse's role during hardship, presented an opportunity for deep-dive coaching with this Graduate RN.

Recognizing confidence. The recognition of a growing confidence as a Registered Nurse presented as a subtheme during analysis of professional self. The Graduate RNs described that it was comfortable knowing what they did not know because they had a partner. It demonstrated that they knew where they needed to go. They needed to continue to apply themselves and be open to learning. When interacting with their coaching partner, there was a sense of accomplishment and respect for learning. Most shared multiple examples of what it felt like when working as a nurse. As illustrated by Graduate RN Gertrude, "I have no doubt I am exactly where I am supposed to be, doing exactly what I am supposed to be doing, [because] God open[ed] every door for me to be here." This Graduate RN recognized nursing to be a vocation with a higher purpose. Verbalized beliefs affirmed internal self-worth. An opportunity existed for a deeper conversation of confidence as a role of nursing.

A Graduate RN, Candy, revealed that being able to talk about very personal beliefs and values with another requires having a sense of confidence. Her confidence provides her an ability to accept both positive and constructive feedback as learning opportunities when being coached for professional development. Candy shared, "It [PBDS] gave me insight into things that I needed to focus on, but also gave me a little pat on the back on things that I've done good, so a little confidence was boosted." It felt good for her to work with an experienced coaching partner who was trustworthy. Receiving guidance was welcomed. This Graduate RN helped illustrate confidence as a foundation in coaching for professional identity.

Alleviating fear. Fear was another subtheme. A contrast to confidence, this subtheme was articulated as fear of mistakes, fear of being a bother to others, fear of being out of control of

the PBDS process, fear of missing accurate information about patient care, and a general concern of being able to be the eyes of those clinicians not present when adverse patient care events arose.

Most viewed the coaching review as a learning opportunity and the one who was nervous about the results still felt comfortable within the coaching event. Graduate RN Lucy stated, "[The Nurse Educator] was not a person that [was] intimidating…She was very comfortable to talk to (even though) I was kind of anxious about the test and nervous about what she was going to say." Like this testimony, most Graduate RNs recognized that their nervousness was primarily due to their unfamiliarity of the process, not the fear of failure or in talking about assessment results with the Nurse Educator. They all accepted that there was work to be done and that they were set up for success.

Generally, the Nurse Educator group persisted throughout the entire coaching event with affirmation and support to balance the discussion of the Graduate RN weaknesses with positive remarks. Any semblance of fear was not present during review of the videotapes. There is consideration that this feeling was not present because of the positive nurturing environment that was provided.

The coaching dyad agreed that clinical practice limitations were present during the coaching dialogue. They agreed that there was a lot to be learned, and although there was a knowledge deficit, the feelings toward the coaching dialogue were considered positive. Throughout the interviews, there was a sincere appreciation and value for a discussion on how to interpret clinical complications through PBDS review. The Graduate RNs shared that evaluating clinical interventions during simulated adverse patient conditions with someone they valued and

respected was helpful. Their trepidations present before the coaching event were not present during dialogue or afterwards.

Almost all of the Graduate RNs and some of the Nurse Educators viewed the coaching feedback process to be one using a questioning attitude and described their feelings as curious yet peaceful. These feelings permeated prior to, during, and after their coaching experience. The Graduate RNs contributed their feelings primarily to the caring and helpful nature of the Nurse Educator. In addition, all described a trustful nature within their relationship as a coaching dyad. This wondering attitude presented into their professional self. Sue stated, "I wasn't sure exactly how the flow would go [of the coaching event] and I wasn't sure what all this would entail, I guess you could have described my feelings as curious. I felt relaxed and comfortable."

Entering responsibility. The coaching dyads viewed themselves as responsible for continued learning and were activated to do so through review of protocols and other tools provided by the Nurse Educators. A sense of responsibility to follow established protocols and national standards was portrayed in Graduate RN interviews and validated as important when reviewing the Nurse Educators conversations during video review. There was a portrayal of confidence in successfully transitioning into practice, but all acknowledged that support and encouragement would augment their learning.

All identified with a responsibility for continued learning. There was a consensus voiced in the interviews and review of videos that using the tools provided and reviewing the internal policies and procedures would be a life-long obligation as a professional nurse. As illustrated within two exemplars, Lucy recalled, "I think as a new nurse, I just have to keep reading and have got to keep learning, I think [it is my responsibility] . . . [it] is kind of overwhelming right

now, I love this career . . .” Sue discussed, “I’m taking [my career] very seriously and I [will] keep studying [to be better].”

A sense of responsibility for patient safety came through while reflecting about patient care experiences. Two Graduate Nurses, Sue and Winnie, identified their responsibility and commitment to patient safety. They felt the obligation to impart trust with families. Sue explained that patients rely on nurses for answers. She said, “You need to provide enough information so they trust their healthcare team. The families look to you for assurance.” This individual understood her responsibility. Nurse Graduate, Winnie, realized that she had a responsibility to fully assess changing patients conditions. As she articulated her role, she said:

> It is too easy to explain away odd symptoms. Like [if patients] tell you they are hot, you [could] easily take a sheet off of their bed, but my role is to think about whether [their hotness] is something different? It could be something just that simple or it could be life or death. [It is my responsibility].

Discussing patient care situations provided the means for the Graduate RN to identify with various nursing roles and was an essential component in the coaching Dyad between nurses.

Reflecting to connect. All the Nurse Educators voiced concern about how hard it was to talk about the complications presented in the PBDS tool because the Graduate RNs had limited patient care experiences. There was limited discussion that followed from the Graduate RNs; however, there was a definite animation present when watching the coaching videos when the Graduate RNs reflected upon their personal patient care experiences. As Graduate RN Candy clearly shared during the interview with the researcher:

> I think it was more meaningful when you have . . . experience, like she was telling me about . . . a patient who had a car accident and what do you check and what do you see

> and what do you do? I think, I mainly told her about what I learned out of the book. I haven't experienced that and [the conversation was brief].

Another Graduate RN, Winnie, explained how much she liked discussing her own experience:

> I remembered the [PBDS] assessment, but [more important was talking about] ... my own patient situation. She made me think back . . . she asked me if I had a stressful event and it caused me to think . . . oh yeah there was this patient... and then she asked me if I would have done anything different, like what would I do if that patient stopped breathing . . . That was when I realized [that my responsibility is to be] on my toes...I am so glad we had this conversation.

When asked reflective questions about clinical practice, all Graduate RNs looked very engaged during review of their video coaching events. Their body posture changed, their faces lit up, and their expressions became animated. Their bodies suddenly occupied a larger space through body positioning and hand gesturing. This level of activity evoked a similar bodily response in the Nurse Educator when they gave patient care examples. It appeared that the probing or asking about an experience was important. There was definitely a bodily dance between the two when insightful questions were asked. Their movement was synchronized as if music was being played in the background. Their conversation was fluid and harmonious, swaying to some unheard symphony conductor when discussing patient care experiences.

Reflection on experiences, either from the PBDS assessment or of the patient care experiences, was not an end in itself, but rather a springboard for engagement within the coaching partnership. Whenever the Graduate RN was asked for input that was related to reflection on a detail within a vignette or from personal experience, their persona bloomed. This

awakening during the coaching event video review was so prevalent, it emerged as an essential component in the peer nurse coaching phenomenon.

Probing. The coaching dyad's primary focus was on patient care complications. This was articulated during interviews of the Nurse Educators. In addition, this focus was written into the structure of the PBDS assessment, but only half of the Nurse Educators probed for understanding. More common was the presence of a one-way conversation. Insightful questioning was minimal. In reviewing each coaching video for the presence of equal participation, there were only two dyads that had equally divided conversations and only one where the Graduate RN occupied more conversational space. Open-ended questions and probing were not commonly used. The Nurse Educator side of the conversation far outweighed the participation of the Graduate RN and generally there was not recall of the patient care scenarios. This type of conversation was not identified as effective for positive coaching during interview or word sort exercises. There was a pattern of questions from the Graduate RNs about the vignettes, but minimal space was made for pause for the Graduate RN to respond. Although minimally utilized, when the Nurse Educators used a practice of collaborative probing during the coaching event, the conversation did shift onto the Graduate RN who responded. When absent, the response of the Graduate RN reflected a pattern of closed, uninvolved body postures.

There was a presence within three of the Nurse Educators. Nana, Doncha, and Olga used paraphrasing, repeating, and recognition of nonverbal communication during the coaching event. Embedded in these three conversations was a plethora of probing questions (Appendix U). The questions were focused on the patient experience, exploring more details in the patient's symptoms, nursing actions, evaluations and physician communications. Most probing was directed based on the PBDS model.

The Graduate RNs Gertrude, Winnie, and Candy confirmed that they liked to be asked probing questions. As Gertrude stated, "I [like] probing . . . when you get this situation . . . what were you going to do, . . . [this process] was beneficial because I do not really know." Candy provided an exemplar illustrating the helpfulness of insightful questioning. She commented:

> I try to take it into [perspective when asked about things I didn't have experience]. Just because I do not know, I will not . . . take it personally . . . because it is not criticism when somebody came to you with questions or a [thinking through something with] you to improve on, it's a compliment because I learned that when I used to do ballet...When the ballet teacher corrects you [to think about your form] it means that they want you to be a good ballerina . . . so I feel like in any situation, someone who is questioning you, who comes to you to say something . . . you should take it in a compliment way... they want to make you better.

Through all the repetitions of: "I don't know," the Graduate RN cohort verbalized appreciation for the opportunity to dialogue with a Nurse Educator who had a questioning attitude and provided insight.

The Nurse Educators acknowledged that coaching someone with limited clinical practice experience made it difficult to draw him or her out. About half of the Nurse Educators described needing to be diligent in encouraging, exploring, and finding a way for the Graduate RNs to contribute to the discussion on patient care. Nurse Educator Sue shared during one example of this during interview. Sue asked what would happen when a patient has been identified with a pulmonary embolism. The Graduate RN simply stated, "They die." Sue replied, "Not always." This short conversation initially came to an abrupt stop. Afterwards, the Nurse Educator asked for clarification and a different conversation began yielding two different stories. The Graduate

RN provided clarity to his initial comment based on a recent experience of a patient dying and the Nurse Educator was able to illustrate many experiences of patient survival. The beginning was rocky, but reflection based on patient care experience continued through a concerted effort by the coaching dyad.

Accordingly, the use of probing questions resulted in insight and awareness within the Graduate RNs. An element within the coaching dialogue brought a Graduate RN's understanding of a problem into a new area of comprehension. As stated by one exemplar from Bobbi, "I can tell if they got that moment [of realization]." Many of the Nurse Educators discussed that digging deeper with the Graduate RN after the initial response resulted in a raised awareness. For example, after the Graduate RN Sue stated, "I would call the Doctor," she was prompted to think differently. Bobbi continued asking, exploring, and probing until there was deeper insight garnered by Sue. Nurse Educator Bobbie stated, "I would continue with additional questions until . . . an Aha moment was recognized (by the Graduate RN)." Bobbi commented:

> You help them figure out what they need to do by asking them: 'Ok, before you call the doctor what have you done, how do you know they had a stroke? You have done some assessments of this patient prior, so [now think through this situation differently] now what was different? What was different? What additional information do you need?'

These types of questions immersed the conversation into a deeper dialogue for exploration and discovery of how nursing professionals use critical thinking skills to continuingly assess and implement interventions to address the changing health status of hospitalized patients.

When the Graduate RNs were encouraged to reflect and provided with additional probing questions, awareness of a different perspective was discovered. They saw themselves as

different, something new was felt and expressed during interview. The data illustrates reflection on patient care experiences has relevance in coaching for professional development. Reflecting, augmented with interactive probing, potentiated the coaching experience for the Graduate RNs.

Acknowledging the art of nursing. The fourth theme that emerged from the data was the art of nursing. This theme was presented by 75% of all participants. In this theme, the Graduate RNs acknowledged those elements in their practice that could not be derived from scientific knowledge. As illustrated by Olga, one Nurse Educator, "If you [feel like] something is not right, you probably [are] right." This nursing intuition, or art of nursing, is commonly described as knowing that something is wrong or when a nurse identifies with the emotional response of knowing, but one does not intellectually identify with what is present. Doncha, a Nurse Educator, encouraged awareness of intuition during the coaching event and said, "Always go with your feelings, always, always, always. I have many times called the doctor and said something is wrong. I don't know what it is yet, but I am trying to figure it out." All, but one of the Nurse Educators and three of the Graduate RNs acknowledged a presence of the art of nursing within their clinical practice. Of interest, two Graduate RNs spontaneously initiated artful practice dialogues. Helga stated, "I have had an experience a couple times. Your guts were telling you there was something wrong." Nana replied, "Absolutely [true]." In the second dialogue, Winnie clarified, "She just looked off; I noticed something was different. I decided not to push the medication at that time." Doncha then coached her by saying, "Was this your thinking on your own, to hold the medication?" Winnie answered, "Yes." Doncha confirmed, "Perfect, good." In review of both of these videos, there appeared to be a missed opportunity, however to ask further probing questions. The dialogues could have continued to discuss how intuition could be recognized and further explored in other situations. An opportunity availed;

present within these two dialogues was the acknowledgement of the presence of nursing intuition, and that taking action was important. The Art of Nursing was present within the card sort findings. The highest selected attribute was honesty. Other mindful attributes were included, setting a good example, being fair, and modeling positivity.

Emerging a culture of safety. Only two Nurse Educators specifically discussed safety as important when interviewed; however, every Nurse Educator in review of the actual video events presented safety and prevention of human error as significant and important. This theme arose as a loud voice; safety resonated primarily within the video and it was compelling. Interjected throughout the coaching dialogues were descriptions of safety initiatives as "evidence-based care," "core measures of quality practice," and "practice guidelines." Every Nurse Educator described the relevance of calling expert teams in terms such as, "stroke teams," "rapid response teams," or "medical emergency teams," into the coaching discussion. These safety teams provided the Graduate RN with expert role models in the practice environment and were illustrated to be colleagues that could provide knowledge and assistance for professional development. This concept was so prevalent and emphasized in every video coaching event that it has been labeled an essence of the coaching dyad. As an exemplar, Nana articulated that her role as coach was to assess the Graduate RN's ability to provide safe patient care and to provide a means for success. She explained:

> "[I] am always worried about ...safety...Am I missing something? She needs to [be] safe on the floor, [so I ask] ... should we put her back on orientation?... [If Graduate RNs] are just not doing well on the floor, [I] probably should not have let [them] ... continue on without some type of further orientation. [I] am always worried about safety, outcomes, and ... of course I have always have her best interest in place too...to make sure that I am

> not putting [her] in a situation that [she is] not comfortable with. [I ask] how can I provide her feedback? What can I actually do? I've got to make sure that I build that relationship ... because I've got to help them with the support.

She further explained that the PBDS assessment results were only one piece of information that a Nurse Educator uses to assess for the nurse's ability to provide safe patient care. She said:

> "I tried to give [her] more of a case history, [adding to the history] of the patient...so she could give me those key words. I was able to actually pull those out of her, even though she didn't write it down."

This Educator used feedback from others in practice and during PBDS review would use additional patient care scenarios to assess how readily the Graduate RN understood her role in preventing error and harm in caring for patients within complex healthcare environments.

Doncha, the other Nurse Educator who identified safety during the interview, suggested journaling as a tool to help bolster Graduate RNs' ability to reflect on the critical nature of patient care. Reflecting on safety, as a writing exercise, provided for future discussions within the coaching dyad of the professional obligation to keep patients safe. The theme of patient safety was identified as a foundation to coaching for professional development. Safety had a significant place in discussion of nursing practice and was embedded in the coaching experience.

Providing advocacy. A subtheme that emerged out of the culture of safety was the Nurse Educator advocating for a safe practice environment for the Graduate RN. Advocacy was identified as important for the individual's development and for patient safety. Many Graduate RNs have problem recognition issues, personal conflicts with team members, shifting in patient assignment types, needing to change job locations, or need specific skill development. The Nurse Educators advocated for a change within the Graduate RNs' practice environments. As

illustrated by Nana, "I am going to try to look out for and watch over her and make sure that she is progressing. I have told her . . . I want her to feel comfortable coming to me, [and I will] help her resolve any issues she is experiencing in the clinical setting." In addition, there was clear indication by the Nurse Educators that they were keeping the patients safe while providing the Graduate RN with learning opportunities. These examples, brought forward during interview and within the coaching videos, demonstrated that the Nurse Educator had a dual role in providing a safe environment for the patient and for the Graduate RN.

The presence of advocacy was identified as an intrinsic attribute by one of the Nurse Educators. Sha commented, "When entering the coaching event . . . you are for them. You always have [their] her best interests in place. I make sure that I am not putting them in a situation that they were not comfortable." During the interview, all Nurse Educators identified a strong commitment to advocate for the Graduate RNs. As Nurse Educator Olga shared:

> Every time . . . [they] come out with something different, but . . . [because of] their expectations . . . I . . . work with the staff . . . [to] . . . help coach and mentor the Graduate RN on the floor . . . [they] are eager, but the [team's] expectations cannot be that high . . . they need to be patient. I need to help them understand this.

Another exemplar described how a Graduate RN was provided a safety net of support. Nana said:

> I did talk at great lengths with her preceptor on the night shift and they felt like she was doing ok. I did not see any safety [concern] . . . so she just needs time and support to learn her way...I feel I helped support her and also... made sure that we were maintaining safety . . . [the] plan of action was that she [got] a buddy.

In summary, the role of advocate was present in the Nurse Educator's mindset prior to, during, and after coaching the Graduate RN for professional development. They advocated for the Graduate RN. They provided a place within the learning environment that supported the Graduate RN's professional development while maintaining safety.

Thinking critically. The concept of critical thinking was designed into the PBDS assessment tool, was outlined to be part of the feedback conversation, but was a struggle for every coaching dyad through interview and video review. The Graduate RN had difficulty applying the principles of critical thinking and struggled with every conversation finding their ways through patient care complications. Both groups agreed that they had difficulty remembering the specifics of the PBDS vignettes. There were lengthy pauses in the conversation, the Nurse Educators had to work hard to redirect thinking, and most Graduate RNs looked disengaged, with heads tipped upward and eyes panning the ceiling searching for answers. The Graduate RNs needed significant queues to identify the underlying abnormal pathophysiology within the vignettes, but knew that calling the doctor was indicated.

Embedded within these conversations was a unique twist in thinking critically. Unique to these discussions was a call to think critically about minimizing the error potential in providing quality patient care. There were several exemplars that illustrated the theme of critical thinking for the purpose of preventing human error in the practice environment. There was recognition that the healthcare environment is complex and prone for error. The Graduate RNs were encouraged to speak up even though they had limited experience, to be curious, and to ask insightful questions of others.

The first exemplar describing the use of critical thinking to prevent patient harm came out of a conversation about treating ketoacidosis. This diabetic condition can be life threatening.

Rather than talking about the underlying disease process, the dyad (Nana and Helga) focused on thinking critically about the high-risk nature of Insulin administered as an intravenous infusion therapy. The coaching dyad readily identified being alert in high-risk situations and being able to ask good questions to seek full understanding. In review of the video, this Nurse Educator created intentional space for reflection on patient safety, used an intentional pause in the coaching conversation, followed with a change in posture, and positioned hands like a traffic cop stopping oncoming traffic. The Graduate RN was called by name for effect and encouraged to speak up in the name of patient safety. A questioning attitude was welcomed. The Graduate RN was challenged to think independently regardless of what others think and say as someone engaged in a culture of safety.

The use of a response team was presented as a safety resource for the Graduate RN in all of the coaching dialogues. The purpose of this group of nurses, doctors, and respiratory therapists is to evaluate a patient's condition when called to consult. Every Nurse Educator made reference to the response team providing support during deterioration of patient conditions. Activating the response team provides recourse for the Graduate RN who is developing critical thinking skills within real time patient care environments. In support of patient safety, the Nurse Educators reinforced the use of experienced teams and challenged the Graduate RNs to critically think for themselves on what was needed in the best interest of patient safety. The Graduate RNs were frequently praised for critical thinking of problem recognition and were challenged to activate the expertise of teams for the safest care possible.

Summary

In conclusion, the data of participant interviews augmented with video analysis, linguistic sampling from the card sort activity, and field notes brought forward an understanding of the

essence and structure of coaching for professional development between nursing peers. The sampling period of eleven months provided lived experiences of six Nurse Educators and six Graduate RNs who participated in the same coaching format for professional development. From these coaching dyads, five themes and several subthemes emerged to answer the research questions and draw attention to future considerations. These themes will be further reviewed in Chapter V following a priori assumption of the human condition of coaching. Chapter V includes a discussion of the findings and concludes with recommendations for future review, research, and action.

Chapter V: Discussion and Summary

In this final chapter, the results of peer coaching have been briefly summarized according to the research questions and are then followed by conclusions, implications, and recommendations for future research. A reiteration of the problem and purpose statements, a connection between the coaching literature and the thematic findings, and a discussion of the limitations in the study have been included so that future research recommendations can be understood and applied as appropriate.

Study Review

The purpose of this study was to discover how Graduate RNs and Nurse Educators experienced coaching as a professional development activity. A review of the coaching literature demonstrated minimal research and this study was conducted as a response to a call for nursing innovation by the Institute of Medicine in 2011. Outside of the nursing literature, peer coaching has been suggested as effective in fostering innovation (Browne, 2006; del Bueno, 2001; Robbins, 1991; Saunders et al., 2012; Xun & Land, 2004). The need to describe coaching effectiveness was inherent in the problem statement: Nurse Educators do not know how coaching affects the professional development of Graduate RNs. The Global Community of Coaches (2008) have called for additional research in the practice of coaching, key outcomes, and standardization of a coaching process.

The research participants were employed at several religious affiliated acute care hospital settings where coaching was a structured event used for professional development. Each of the Nurse Educators was a highly recommended coach and the Graduate RNs had no previous licensure experience. The dyads had established a good working relationship. Data was collected through a semi-structured interview process and supplemented by recording the

coaching event, by collecting coaching words from an activity, and by the researcher making field notes. A rich collection of data resulted.

The essence of the lived coaching experience came from 12 nurses through their reflections and perspectives, a somatic review of 6 videos, 30 pages of field notes, and 12 sets of word collections. This study was designed to inform Nurse Educators, to influence hospital decision makers, and to contribute to the body of knowledge on the subject of professional coaching, specifically peer nurse coaching for professional development.

Foundational development in the literature

Recently, practice standards for the coaching nurse have been published (Hess, Dossey, Southard, Luck, Gulino-Schaub, & Bark, 2013). The American Nurses Association (ANA) announced standards in clinical practice for the professional health coach in nursing (Hess et al., 2013). These health coaches are typically RNs who assist patients with chronic disease management. The focus of nurse coaching is to support the adoption of healthy lifestyles by those served. These new standards have provided a context to the current study, but do not specifically describe peer coaching for professional development (Hess et al., 2013). Other social science professions have documented standards that include a perspective on peer coaching (Trivette et al., 2009). This study on peer coaching for professional development could supplement the ANA coaching document.

A nurse coach has been defined by the ANA as a registered nurse who integrates coaching competencies into any setting or specialty area of practice to facilitate a process of change or development that assists individuals or groups to realize their potential (Hess et al., 2013). Nurse coaching has also been described as a skilled, purposeful, results-oriented, and structured interaction with clients for the purpose of promoting achievement of client goals (Hess

et al., 2013). There are sixteen competencies identified for nurse coaching within this publication (Appendix V). These standards suggest relevance to peer coaching. The Coaching Research Forum (Rostron, 2009) identified that coaching research needs to demonstrate a return on investment through review of the behavior, cognition, and emotion that leverages action. An opportunity exists to utilize the ANA standards to further define and develop peer coaching within nursing as a framework for future research.

The Nurse Coach Practice Competencies parallels the structure and essence within peer coaching for the Graduate RN. For example, the art of nursing was present within the context of the Professional Behavior Developmental Systems (PBDS) coaching event, emphasized by all Nurse Educators when discussing patient care situations, and was also one of the core standards in nurse coaching. Hess et al. (2013) further defined the art of nurse coaching to incorporate holistic perspective, confidence, responsibility, mindfulness, caring, creating, and self-development. Many of these attributes were identified as themes or subthemes within the Graduate RN and Nurse Educator coaching dyads. The results of this study on peer coaching in nursing have supported the expert opinions on nurse coaching recently published.

Communication skill and specifically insightful questioning is a coaching competency according to Hess et al. (2013), but no mention was made to the use of probing techniques. A question, asking for what is most significant, is a common practice used in professional coaching. Coaches purposely attempt to draw out the emotions and feelings through this technique (Robbins, 1991). Probing techniques were used to help the Graduate RNs to embrace their responsibility as professional practitioners and similar feelings might be evoked with clients if used during health coaching.

The study of the coaching dyad had one missing element that was referenced as important by Hess et al. (2013). Confidentiality, presented by Hess et al. (2013) as a tenet in coaching, was not present within the lived experience of coaching for professional development for the Graduate RNs. There was strong evidence of trust, but no direct reference was made for confidentiality within the coaching dialogues. Confidentiality was absent, but inferred. The close alignment of the stories of the coaching dyads within this current study to the ANA standards in nurse coaching validated the identified themes, conclusions, and recommendations that follow.

Research Questions and Interpretation

This phenomenological qualitative research was planned, executed, and answered two specific questions:

- How does the peer coaching dyad, within the context of a formative assessment feedback session, between Nurse Educator and Graduate RN contribute to professional development within Midwestern urban hospitals' acute care settings?
- What is the essence of the peer coaching dyad, within the context of a formative assessment feedback session, between Nurse Educator and Graduate RNs of Midwestern urban hospital acute care settings when professional practice development is the coaching topic?

A phenomenological approach using Hermeneutic techniques resulted in five themes that described the essence of the peer coaching dyad engaged in professional development when reflecting on nursing practice. The essence of peer coaching includes individuals who are nurturing, engaged, and in a relationship with established acceptance, anticipation of need, and a creation of experiences for professional development opportunities. Significant is the awareness

within the Graduate RNs of their responsibility as a professional in providing healthcare. They recognize their limitations and maintain a healthy balance between confidence and fear in receiving feedback on their clinical performance. The process of coaching connects the two clinicians together through the use of reflection and the use of probing techniques that facilitates deeper understanding. The essence of peer coaching includes an acknowledgment that there is an art to nursing. In addition, the use of safety stories and illustrations provided, to the Graduate RNs, a compelling reason to advocate and critically look for human error and to utilize their resources to promote a culture of safety within the healthcare environment. These descriptive findings provided a plethora of detail from their lived experiences for comparison with the literature on the subject of coaching borrowed primarily from other disciplines.

Nurturing engagement. The first theme, nurturing engagement, was pervasive in all of the data sets and most pertinent. The coaching dyad had a strong commitment to professional development. The dyads reported feelings of calmness, love, support, and even lightheartedness during the coaching event. One Nurse Educator described the process as fun. An analysis of the card sort revealed that the terms associated with relationship building were most frequent and determined to be important by both members. Included were examples of encouragement, emotional support, caring, helping, staying in touch, praising, and relating. In review of the literature, similar emotional connections were reported during professional coaching and determined to be important for development (Laske, 2006; Longhurst, 2006; Parker, et al., 2008). There was a presence of commitment and support for professional development within both the literature and the coaching dyads of this study.

The theme, nurturing engagement, answered the first research question related to the essence of coaching for professional development. The cultivating nature of the relationship and

the continued encouragement throughout the PBDS review provided an atmosphere for exploration without fear, criticism, or failure. Underlying the coaching dyad was a team who was engaged; professional development was nurtured.

The Nurse Educators found time and placed effort into nurturing a relationship for a meaningful coaching dialogue. The literature describes this collegiality. When both have experience in the subject, a coaching commonality brings mutual experiences together to create better patient care leadership (Coaching, 2007). Both members of the coaching dyad, for this population, would be best served as nurses. When two nurses work together, they are grounded with a caring attitude, professional helpfulness, a vested interest in goal formation, and would be motivated to take action. The need for coaching partnerships in clinical practice was substantiated in this study of Graduate RN professional development.

A previous study described peer coaching as only minimally effective, but only enrolled nursing students as coaches. The current study utilized a clinical expert with coaching skill. It wasn't surprising that Thompson et al. (2008) found only 30% of the respondents felt the relationship was effective in peer coaching. These findings by Thompson et al (2008) have limited relevance for entry into clinical practice because the coaching population studied was very different; both members within the coaching dyad of Thompson's et al. (2008) study were novice nurses.

There was some disinterest present during video review within the coaching dyads of this study that did not support a theme of engagement. During these times, the Nurse Educator occupied a dominant presence in the coaching space. Even with the presence of continued eye contact, there was a lack of signals of engaging behavior such as open body posturing and encouraging gestures. Conducting additional research to further explore this contradiction of

somatic behaviors presented by a few would be of interest to better understand the concept of engagement.

Accepting. Acceptance was a subtheme presented in the coaching relationship of the coaching dyad. Not only did the Nurse Educators understand that the Graduate RNs had limited experiences in which to reflect upon, they maintained a willing attitude to assist the Graduate RN to think through adverse patient conditions. The Graduate RNs presented a sense of calmness, knowing this exercise was for their benefit. Having a positive coaching relationship was a common indicator of successful coaching outcomes within the literature (Anderson, 2013a; Drum, 2007; Higgins & Kram, 2001; Marshall, 2011). The Nurse Educators were nonjudgmental and declared through suggesting, challenging, testing, and listening that they cared for the individuals. Being accepting is a core value to nursing and a natural fit for a nurse who practices coaching.

Anticipating need. Another attribute of the Nurse Educator participating in a nurturing coaching relationship was one of anticipation of need. All took time to prepare for the coaching event by reviewing the results and looking over the individual responses of the assessment results. They asked, "What is different with this Graduate RN's results? Was this expected? What can I offer? Will they need additional help?" In the coaching literature, this process is closely related to coaching with insight (Grealish, 2000). The coach is actively engaged in being a watchful participant, anticipating what might need to be brought forward. Coaches see themselves as formative observers and the relationship helps them bring up opinions during conversation to be acknowledged or dismissed (Coaching, 2007; Walpole & Blamey, 2008). The coach's barometer for anticipation was especially helpful in determining knowledge deficits and providing clarity and additional resources to the Graduate RNs in this study.

Creating experiences. The third attribute or subtheme present in the coaching relationship was one of creating an experience for discovery. Graduate Nurses answered questions about patient care experiences without a lot of depth in understanding during most PBDS case reviews. Their descriptions were simplistic, but the Nurse Educator filled enough detail into the stories to present alternative perspectives for the Graduate RN to consider. Guidance through experiences allows a coach to challenge the coaching recipient's beliefs as different angles are discussed (Bryant & Terborg, 2008). This subtheme of nurturing illustrates the importance of having experienced nurses in the coaching equation; alternative endings were created from the simple experiences shared by the Graduate Nurses. The use of coaching techniques allowed for the Graduate RNs to develop their professional understanding through review of patient care experiences within the coaching relationship.

Recognizing professional self. In this second theme, the Graduate RNs related to what their ideal self as a Registered Nurse could become. There were many coaching techniques that allowed for the Graduate RNs to pause and reflect on their professional identity in the patient care environment. There was an abundance of testimony that illustrated a developing understanding of professional responsibility within the Graduate RN group. Their professional responsibility descriptions included being more knowledgeable, aware, and willing to promote safety within the patient care environment.

This self-awareness was understood to be on a continuum. All of the Graduate RNs described the results of coaching to be like a journey in self-discovery and were enthusiastic. Their journeys to professional self had begun and the questioning supportive attitude of the Nurse Educators was recognized as contributing to their feelings of confidence. This attitude was an essential component for the Graduate RNs' success in learning their role as a nurse.

In addition, the theme of identifying self was a coaching outcome that was identified through the nurturing engagement of the coaching dyad. The relationship brought a connection to the participants, contributed to the Graduate RNs being able to disclose feelings of professional identity, and contributed to an awareness of self. As one Graduate RN stated, "I could come to her anytime." The atmosphere within the coaching dyad was one that felt safe enough for the Graduate RNs to discuss feelings of self-worth and to feel comfortable asking questions. Coaching is a safe place to talk about sensitive issues, to gain awareness of self and values for empowerment, and to work on boundaries (Vansickel-Peterson, 2010). The Graduate RNs embraced professional responsibility through this essential element in the lived experience of the coaching dyads.

The Graduate RNs were enthused to begin their careers. Definition of self is acknowledged in the literature as a coaching outcome (Cilliers & Terblanche, 2010). Awareness is a common outcome when a personal connection develops between coaching partners (Anseel, Lievens, & Schollaert, 2009; Horsfall, Cleary, & Hunt, 2012; McNally & Cunningham, 2010). The dialogue includes a personal connection and the coaching relationship provided an atmosphere for meaningful interaction. The presence of reflective space is called a co-created relationship; a conversation is infused with respectful silences and a pace that encourages discussion of values and beliefs (Cilliers & Terblanche, 2010). The interaction of peers engaged in a meaningful discussion brought out what was special to the Graduate RN about herself. One Graduate RN believed the presence of God directed her as a nurse. Another Graduate RN felt she needed to relay confidence when guiding patients in making decisions. The ability to portray confidence was part of self-identity as a nurse. A process that uses intentional dialogue brings personal identity forward through coaching situations (Cilliers &Terblanche, 2010). The

engaging atmosphere of a coaching dialogue provided the mechanism for self-disclosure and understanding of professional identity.

This theme of self-identity answered both research questions. The relationship of the coaching dyad contributed to feeling safe and permitted the expression and awareness of self into the conversation. There was presence of motivation and indication to further define professional self during the coaching event. The Graduate RNs stated that there remains a lot to be learned, they needed to be on top of their game and realized how important it is to accurately recognize deterioration in the patients. All of these examples were described as within their role and responsibilities as Registered Nurses. The coaching event began with a rapport between the individuals, and the coaching process connected the two individuals into exploring what it meant to be a nurse. The coaching dyad co-created an environment whereby there was a meaningful discussion of professional self. According to Cilliers and Terblanche (2010), a coaching relationship is essential to obtain understanding of professional self. Establishing rapport and using the coaching process were identified in this theme as essential components for professional development.

Entering responsibility. Although considered a subset to a larger identity of professional self, this subtheme was first to be noticed during Graduate RN interviews. When they were discussing the most significant feelings that came out of their PBDS assessment review, they all referenced a new sense of responsibility that was not fully understood prior to the coaching events. Establishing responsibility for growth and the subsequent necessary action steps is the goal for the use of coaching as a tool for development (Donner & Wheeler, 2009). Coaching provided the experience for the novice nurses to integrate their practice toward their professional selves.

Recognizing confidence. Confidence was a surprising subset theme to professional self because it was present. The researcher was amazed at the level of confidence that was presented by the Graduate RNs during interview. The coaching experience added to their confidence. Having a confidant who knew their weakness was felt to be a relief to the Graduate RNs. Having a rapport is essential to effective coaching relationships (Drum, 2007). It was easier to share with someone who was trusted and helped them feel safe.

Alleviating fear. Fear was presented by the Graduate RN group, but was placed low on a continuum rating of feelings from uncomfortable at one end to feeling panic on the high end. In fact, all the Graduate RNs related their level of anxiety to one of curiosity throughout the study. If there was a presence of fear noted, it was directed toward the coaching event, not a feeling attributed to failure. Whether this theme was about anxiety, fear, or curiosity, it signaled awareness had been garnered. The goals for the Nurse Educators were to assure that feelings did not get in the way of learning. To be facilitating, a coach needs to suggest, offer, test, and listen for what is and what is not being said (Anderson, 2013a). The Nurse Educators maintained sensitivity to the feelings presented by the Graduate RNs during coaching, using supportive techniques to facilitate learning.

Following a process. The development of one's professional self has been compared to being on a journey throughout the coaching literature (ICF, 2008; Teekman, 2000; Wojnar & Swanson, 2007). The discussion, around the Performance Based Development System (PBDS) assessment results, followed a process. According to the ANA standards of nurse coaching, the process follows the traditional nursing process (Hess et al., 2013). This process begins with an assessment, a diagnosis, identifying goals, planning for change, empowering through implementation, and an evaluation of the perceptions of the one being coached. Most of the

coaching process was followed by the Nurse Educator/Graduate RN coaching dyads during PBDS review except the evaluation of action in practice. Most Nurse Educators came prepared with practice feedback, but not all. The Nurse Educators participated in some preplanning to review the PBDS assessment, but the process was limited because it was a one-time event. During the coaching event, a diagnosis of progression in competency was articulated, and reflective inquiry with the Graduate RN provided for a plan of action. There was concurrence documented between practice and theory in review of this subtheme and this process could be easily adopted into coaching practice for professional development.

Reflecting to connect. The third theme, reflecting to connect, was identified as an important theme in understanding how to coach someone with limited experiences. The emergence of this theme clarified that reflection was important, but only as a beginning to build different ideas and concepts through inspired coaching. Learning theory supports reflection as important within the coaching process for professional development (Dewey, 1938; Hatlevik, 2012; Kolb, 1983). The Kolb (1983) model of learning conveys a humanistic view of learning to be personal and suggests that this would be pervasive in changing attitude, behavior, and values.

According to Kolb (1983) learning is more effective when self-initiated through reflection on life experiences. Reflection can provide space to consider alternative viewpoints. Future behaviors could be guided based on logical conclusions that were formed through use of the reflective process. A connection made from the past brings learning forward into the future. Kolb (1983) theorized that review of experiences perpetuates learning.

Exploring experiences with a Graduate RN could result in forward learning. Referenced in the post PBDS researcher interviews with the Graduate RNs were evidence of: precision as a ballet dancer, compassion in caring for a family member, a competing nature with other nursing

students, and feelings of confidence coming from an economics background. Following the Kolb theoretical model, future coaching studies could be done to understand how other types of experiences could be weaved through a PBDS review to engage a Graduate RN into significant learning.

In some of the coaching dyads, starting with a patient care experience led into a rich discussion of professional practice. In contrast, those dyads that focused on the PBDS demonstrated visually with less bodily animation during video review and the Graduate RNs made fewer comments. In the literature on this subject, mindful, deep learning arose out of the process of sensing, being present, and realizing the uniqueness of each experience (Ho & Ku, 2009; Senge et al., 2005). Hearing the Graduate RN's story and exploring related concepts would have merit as a coaching strategy. Getting immersed into an event allows for judgments to be suspended so that an understanding of another person's perceptions could be redirected within the living process of the whole (Ho & Ku, 2009). The expertise of the Nurse Educator helped guide and reframe thinking during the coaching experience with a Graduate RN in many dyads.

Reflection, as a connection to growth within the coaching dyad, answered both research questions. Beginning the coaching experience with a thoughtful discussion on "how has work been going?" became a springboard to professional understanding and development. Discussion on a recent patient experience connected Graduate RNs emotionally into further discussing specific concepts within the PBDS assessment. Listening for any life experiences articulated by the participants could be a marker for Nurse Educators to pause and coach for understanding.

Outside experiences that are brought into the dialogue should be viewed as a coaching opportunity rather than a distraction. The essence of the coaching dyad began with the Graduate

RN reflecting on an experience that ignited thinking and openness to learn new concepts introduced by the Nurse Educators. The Nurse Educators leveraged the emotional connection that reflection had on learning for the Graduate RNs.

Probing. The use of probing was seen as a subset of the theme of connecting between coaching partners. Presented in this study were multiple examples of probing used as a tool for inquiry. The professional development of the novice nurse has been described as happening in environments where feedback is rich and the opportunity for articulating reflection on experiential learning is planned (Benner et al., 2009). Probing was a technique that could be used to this end.

The use of questions for clarifying and moving toward mutual understanding within the coaching dyad assisted in professional formation. Professional identity is a way of formation for the novice, which begins over time from reflection on practice experience (Benner et al., 2010). Coaching with probing inquiry provided a means for guiding the Gradate RNs in professional discovery through patient care experience recall. Once a conversation ended with "exactly," the dyad could know that they had arrived together to a mutual understanding.

Acknowledging the art of nursing. This theme was captured during interview and validated within the coaching dyads' dialogues for professional development that were videotaped. From the voices of those engaged in coaching was an acknowledgement of the art of nursing. This was an unintended finding because the coaching event was designed to solicit the science of nursing. The science involves assessments of facts, synthesizing information, making decisions and taking action (Hess, et al., 2013). This theme arose without any prompting and clearly stood out. The interaction within the coaching dyad identified for the Graduate RNs that intuition was important in the clinical setting, could be trusted, and should be acted upon when

felt. The Nurse Educators explored for the presence of intuition and supplemented the conversations with their own examples. This was a significant theme and is an important contribution that nursing provides to patient care that could be incorporated into the context of PBDS.

The recent publication by the ANA validated the importance of the art of nursing in coaching practice (Hess et al., 2013). Specifically, intuition was noted by Hess et al. (2013) as one of many types of artful coaching practices. In contrast, other examples of artful nursing practice were not present in this study. Besides intuition, creativity, presence, mindfulness, imagery, relaxation, and music were all components of the art of nursing practice (Hess et al., 2013). Each one of these attributes could be further developed for Nurse Educators' use during peer coaching.

The implications for the nurse coaching dialogue could be to develop an understanding of artful nursing practices; these opportunities would promote transformational learning with the Graduate RN. Central to transformative learning would be a dialogue where members learn from each other and take action that changed beliefs, emotions, habits, facts, values, opinions, ways of doing, and ways of being (Kramer, 2007). Promoting the art of nursing would be a new way of thinking for Nursing Education.

Emerging into a culture of safety. The fifth theme, emerging into a culture of safety was a surprising phenomenon. Coaching for safety was not described in the literature as a coaching outcome, but safety had been referenced within a definition of action learning coaching (Kramer, 2007). Action learning coaches promote psychological safety which provides a theoretical base for development of action plans. There is no pretense; unconditional positive regard is provided during coaching which promotes action and new goal formation (Kramer,

2007). This type of coaching was present within the peer nurse coaching dyads. There was recognition that the Nurse Educator would not translate the New Graduate's weakness into failure; prolific during the coaching event were words like "wow," "fantastic," "good job," and "excellent."

In addition, there was evidence of discussion on the difficult subject of human error in the coaching dyad dialogues. Watching for human error was discussed in every PBDS feedback event during review of the videos. What emerged was a directing of the Graduate RNs by the Nurse Educators to have a presence of inquiry about the medical decisions, to pause for review, and to consider what else was going on in the patient care story. In addition, there were many examples of calling for the use of evidence-based standards when providing care to patients. Specific examples included using a bladder scanner for urinary retention, reference to policies and procedures, and the use of an experienced response team to affect assessment of an acute change in patient condition.

This theme of safety identified that human error was present in the patient care environment. Safety awareness was brought into the coaching conversation. Examples included using the wisdom of a response team rather than the typical chain of command to assure patient safety, words of encouragement like, "this is the gold standard," and praise for having a questioning attitude when time released capsules of medication were ordered inappropriately to be administered crushed through a tube feeding. Permission was granted and encouraged to question practice decisions or solicit opinions of others, not because of a knowledge deficit, but because patient safety must not be jeopardized.

Providing advocacy. This subset theme of the culture of safety portrayed advocacy as the innate ability of the Nurse Educators to support and coach professional growth in the

Graduate RNs with care and concern. Advocacy has been represented as a core competency in nursing practice; this coaching attribute represented what nurses do all the time. According to the ANA, the essential fabric of what fosters coaching competence includes those tenets of integrity, moral intelligence, protection of the [Graduate RNs'] vulnerabilities, preservation of humanity, dignity, and reinforcement of the oneness of unity (Hess et al., 2013). The coaching environment intended for professional development provided a shield of protection for growth and exploration for the Graduate RNs.

Thinking critically. Critical thinking is an identified important essence in the PBDS feedback review process (Appendix A) and arose as a safety subtheme. Critical thinking is a common coaching outcome described in the literature (Fero et al., 2009; Gayeski & Rowland, 2005; Giancarlo & Facione, 2001; Ladyshewsky & Ryan, 2002; Parker et al., 2008; Robbins, 1991). The context of the PBDS included discussion of the elements of critical thinking. There were discussion of patient events, complications, and probing of the Graduate RNs to respond to the scenarios. Purposeful analysis promoted self-regulatory judgment and resulted in safe, competent practice (Turner, 2005). Regardless of the structure of the coaching event or the amount of experience, coaching for critical thinking development was an essential component for coaching professional practice development based on patient care reflection.

Recommendations

The results of this study can bring transformational change to nurse peer coaching. Implications for change within the structure and content of the nurse coaching dialogue have been recommended throughout the thematic review. To further the knowledge of coaching and the use of peer coaching as a nurse specialty for professional development, several research

opportunities have been identified. The following recommendations would provide clarity and definition to peer coaching in nursing.

Bring lived experiences forward. To augment the limited patient care experiences of the Graduate RNs, alternative lived experiences can be brought forward into the coaching dialogue. There was an abundance of life stories of success and failure that were gathered during the coaching interview process with the Graduate RN cohort that was personal and relevant. Individual Graduate RNs discussed during the interviews: (a) a mother's influence, (b) previous work experiences, (c) their student life, and (d) an extracurricular activity. This testimony combined with the open and somatic nature of movement during their storytelling suggests a golden opportunity to explore any lived experiences as a means for innovative and meaningful education for professional development when present.

Reflect on any patient care experience and begin the what-if game. There were two Nurse Educators who began their coaching conversation with a question about how the Graduate RN was feeling about working with patients. Specifically, one Graduate RN was asked if she had experienced any patient problems, critical situations, or stress. This Nurse Educator steered the conversation toward a discussion of the concepts within the PBDS assessment. These concepts were incorporated into this Graduate RN's story of a patient she cared for that week. The discussion flowed from prioritization, to anticipation, into communication, into problem identification, and toward a sense of urgency. The PBDS feedback assessments were weaved into the Graduate RN's reflection of her recent experience. PBDS anchored their patient stories. The conversation could start with, "How were you getting along?" This reflective question provided a path for this Graduate RN's engagement. The nurse coaching process should be changed to begin with a personal patient care experience.

Listen for awareness. For several Nurse Educators and Graduate RNs, an awareness of something new was verbalized during the interview through the use of probing questions. When statements of opinions were made, the researcher followed up with questions like "What did you mean?" and included questions like, "When were you first aware?" These types of questions brought the underlying reasons behind the Graduate RNs' statements into focus. To move the coaching dyad into further explanation, a question like "What was significant to you about this?" would help illuminate understanding within the Graduate RNs of their persons as Registered Nurses. This type of probing and questioning attitude resulted in statements like "I didn't really understand this until we talked." A compelling desire for action going forward followed. Words and phrases like "next time" or "I learned" indicated goals and behavioral change to the researcher and could be developed within a coaching curriculum for Nurse Educators to practice listening for this presence during conversation.

Nurse Educators need to listen for the presence of words that would indicate deeper meaning. The uses of metaphors or exclamations triggered attention and focus within the coaching dyad. These powerful expressions imply a thousand words (McNally & Cunningham, 2010). Naturally occurring, the metaphor would be an avenue for coaching exploration. One recommendation from these findings would be to train Nurse Educators to incorporate metaphors into their repertoire of coaching language and to actively listen for the use of metaphors. Metaphors become a source of clarity or a bridge in understanding for Graduate RNs engaged in coaching for professional development. Participation in professional development with a competent coach Nurse Educator, trained to listen for awareness, could impact professional development in a meaningful, innovative way.

Correlate everything to safety. When coaching, safety was incorporated into every conversation. Specifically, the Graduate RNs were motivated to think on their own and to have confidence to speak up regardless of their feelings of uncertainty. Grounding this call to action, emphasis was placed on the nurses' professional obligation to protect the patient from harm. From this research, the Graduate RNs presented confidence, but that feeling needed encouragement. The Graduate RN cohort identified barriers to speaking up included having limited experiences for which to validate their opinions and being new to the team. An opportunity has been presented for the Nurse Educators to infuse safety as a coaching concept to nurture Graduate RNs' confidence and to promote speaking up for safety's sake.

For example, if the Graduate RN recognized the urgency of a situation and suggested calling the doctor, a different coaching dialogue could begin. A follow-up question could be asked, "Where would you go if your feelings of concern are not resolved by conversing with the doctor?" The Nurse Educator could say, "What if the doctor said something that you felt was not right, but didn't know exactly what was going on?" The goal of this type of coaching dialogue would be to help the Graduate RN to see a different perspective on their lack of experience and to promote questioning based on patient safety. Having confidence through persistent questioning would be viewed as a powerful way to promote patient safety. The dialogue in this example would bring development of conflict resolution skill into a safety discussion of patient care management.

The Graduate RN needed empowerment to speak up, to stop a conversation, and to seek and resolve their feelings of internal conflict when present. The development of confidence has been directly measured through developmental coaching (Browne, 2006). Building the nurses' confidence to ask questions for understanding would be a recommendation for further

development in coaching for safety. Nurse Educators need to make a conscientious effort to keep patient safety within their coaching dialogue.

The implications of harming a patient have been a significant concern in healthcare. The greatest danger to healthcare is the unanticipated effects of actions by the team; untoward effects created by those who work within complex systems are embedded in healthcare (O'Connor & Kotze, 2008). Coaching for safety would be important to be developed as a specific context for conversation with Graduate RNs. The ensuing dialogue would have potential to bring practice change during the formative years of professional nurses that could have a cultural impact on the patient care environment once hardwired into the coaching curriculum. This concept of safety inquisition is worthy of further study.

Learn to coach, coach with a coaching partner. With nurse coaching competencies established (Hess et al., 2013), a strong focused curriculum can be developed for the Nurse Educator who is responsible for coaching the Graduate RN. By exploring the art of nursing through reflection on patient care experiences and applying an artful filter, new ideas could be propagated during professional practice development. For example, the Nurse Educator could call out, "What is trying to be created here?" or "What images came to your mind in this situation?" or "How would you relax in the environment when present with the patient, family, or doctor during this situation?" These questions would provide an avenue to talk about the human experience within patient care practice that could provide an avenue for what the IOM (2010) has suggested as essential to nursing practice. According to the IOM (2010), nursing has the largest segment of the health care team and would be the *sine qua non* for facilitating transformational change in healthcare. Coaching to the art of nursing would be a novel approach to professional developmental coaching in nursing.

In addition, coach training for the Graduate RN's preceptor would have merit. With education, the preceptor from the clinical setting would add richness to the PBDS feedback assessment process for the Graduate RN. Specifically, the preceptor would add to the description of patient care experiences, ground the experiences objectively, and provide a coaching mentor within the coaching dialogue. With a coaching curriculum deployed, two peers who were closely connected to the Graduate RN's professional development would provide an enriched coaching dialogue. To develop the concept of a coaching triad, a formal education track should be considered.

Many of the Nurse Educators already include a preceptor for PBDS coaching to help facilitate development of the Graduate RN, but little is known of their coaching competencies. The inclusion of two coaching partners into the dialogue would provide a member check that the coaching process remained present in the conversation, coaching strategies were effective, process improvements developed, and coaching competency was maintained.

Continue coaching dyad research. The research possibilities are limitless because coaching has been an emerging subject within nursing. With the recent addition of the coaching standards (Hess et al., 2013), a grounded theory research approach could provide additional understanding of this topic. More qualitative studies could solidify a conceptual knowledge base from practice, supplement the nurse coaching standards, and validate the theories articulated within this coaching reference by Hess et al. (2013). There are research opportunities to inform the field of coaching in nursing.

Quantitative research measurement on the subject of coaching would further an understanding of coaching's impact on nursing and healthcare. Once a coaching curriculum has been established and validated, clinical competencies could be measured and incorporated into

quantitative research study. For example, quantitative research methods could be employed to understand the significance of coaching on Graduate RNs' professional development. Additional examples of outcome measurement could be undertaken of professional attributes such as: resilience, hope, adaptation, coping, and sense of being. There are valid tools to be used for understanding of the coaching context.

Future research on coaching the Graduate RN for professional development could be developed to understand the art and science of nursing. A mixed method comparison study of outcomes would provide evidence that both the art and science of nursing are needed for health care improvement. A research study that included coaching and non-coaching Graduate RN cohorts could be designed for this purpose. The results from this current study of the nurse coaching dyad and the new published standards provided evidence that quantitative outcome measurement of coaching in nursing could begin.

Self-report had been the source of most outcome studies on coaching; valid measurement tools are needed (Hess et al., 2013). The development of a coaching competency index would open the door for significant scientific inquiry. With this tool, researchers could begin to look at specific outcome measurements for professional development and health care improvements. Examples of professional outcome measurements could include but are not limited to: workplace wellness, resilience, depression, and stress. Practice outcomes to be considered could be: patient fall rates, serious safety events, and patient satisfaction ratings. The environment for continued research on measuring the significance of coaching through a longitudinal study on nursing practice would be promising.

The literature identified a lack of a coaching competency tool. Future research using the PBDS assessment review process could provide a forum for testing and validating a coaching

competency tool once developed. In addition, some of the coaching themes identified in this study could be considered for inclusion in a measurement tool.

Finally, additional research could be done on the concept of the coaching triad. There were many Nurse Educators who were interested in sharing their coaching stories as research participants, but were not included because their PDBS feedback process included the Graduate RN's preceptor. Preceptors assist with orientation in the clinical setting and are involved with the PBDS review. Professional development between three individuals exists naturally in many locations as a coaching trio; a duplication study could be replicated to understand this lived experience.

Limitations. The study was designed to discern the essence of the common experience of being coached and the sample size was small. Although conducted in three different locations, only six coaching dyads fulfilled the study criteria. This sample is not of sufficient size to make any generalized reference to the nursing population who coach for professional development.

Delimiting this study was the varying degree of formal Nurse Educator coach preparation; coaching competency could not be measured. In addition, the Nurse Educators varied in their coaching preparation and none had taken the Coaching in the Moment™ course by their employer. Having a cohort with documented coaching competency would have strengthened this study. Coaching research could seek to develop a coaching curriculum and measurement tool.

Another limitation to this study was the timing of the publication of the ANA coaching standards for nursing practice. Unfortunately, data collection had started before this publication

by Hess et al. (2013) was available. This foundational nursing document could have provided a valuable theoretical reference for this study in coaching between nursing peers.

Conclusion

The results of this research indicated that a single coaching event allowed for an understanding of coaching in a natural setting and the results were prolific to advance the subject of coaching for nursing practice development. A coaching dyad provided insight into both the science and the art of nursing for professional development, stimulating ideas for health care improvement. The thematic analysis of peer nurse coaching provided strategies to promote patient safety awareness, to connect nurses through reflection on patient care experiences, and to evoke an emotional response to the human condition of caring. The Nurse Educators and Graduate RNs utilized a sacred space for professional role formation. Embedded in the coaching environments were support, trust, and an openness to explore patient care experiences for meaning. Coaching has more appeal than mentoring due to the intimacy, commitment, and devotion to success within the coaching relationship (Garvey, et al., 2009). Coaching has been presented as an active learning strategy for professional development renovation. Coaching has impact as a learning strategy for the Graduate RNs' professional development and entry into practice.

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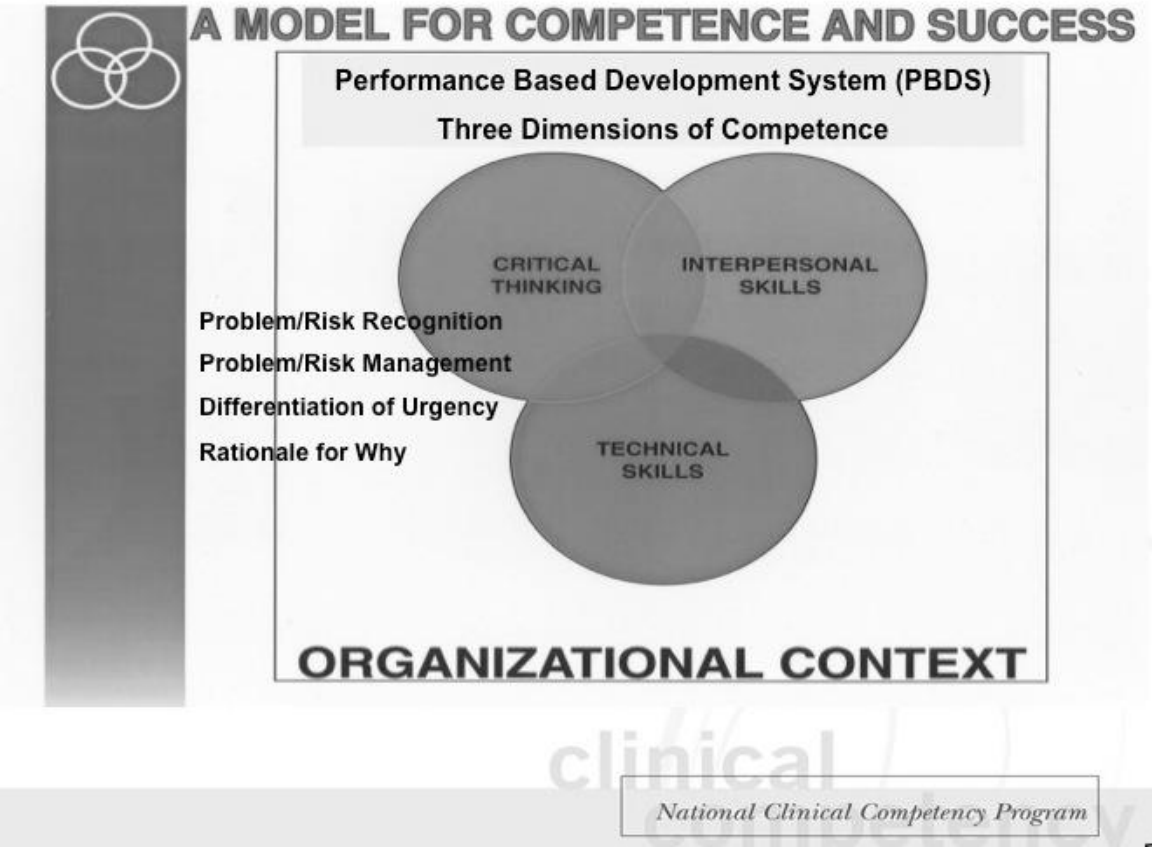
Appendix A: Professional Behavior Developmental Systems (*PBDS) Competency Model*

Model for RN Competency



Appendix B: Professional Behavior Developmental Systems (*PBDS) Feedback Summation*

PBDS Feedback Summation

Name:		Unit:		Position:		Date:	

PBDS ASSESSMENT – SUMMARY FINDINGS

CONFIDENTIAL

Does Not Meet Expectations	Inconsistent Ability Demonstrated	Does Not Meet Expectations for Problem Management	Ability Not Consistent With Stated Experience	Limited Ability – Does Not Meet Expectations	Limited Ability – But Acceptable	Meets Expectations for Experience Stated	Meets Expectations with Exceptions Noted	Exceeds Expectations

UNACCEPTABLE **ACCEPTABLE**

Figure 5. Permission granted to reproduce PBDS assessment findings by PMSI

Appendix C: Approval for PBDS from Dorothy del Bueno

PERFORMANCE MANAGEMENT SERVICES, INC.

15941 Red Hill Avenue, Suite 200
Tustin, California 92780
(714) 731-3414
(714) 731-4620 FAX

Sent via Email

To: Deb Chambers

From: Elliot Saulten, Dorothy J. del Bueno

Date: July 29, 2013

In response to your request for permission to include PMSI/PBDS materials in your Doctoral Dissertation:

- It is acceptable to use/reproduce the Competency Continuum Form as edited. (See attached).

- PMSI does not grant permission to reproduce or use the PBDS Summary Action Plan because of the confidential and proprietary nature of this document.

- Please call Dr. del Bueno at (215) 854-0619 for any questions or clarification.

Thank you.

DdB:js
Attachment

Appendix D: Coaching in the Moment ™ Training Guide

The Curriculum

- Coachable moments are present waiting to be unraveled.
- Awareness of knots in others is a leader's responsibility.
    - "Knot Seen"
        - Illuminate
    - "Knot Willing"
        - Acknowledge fears
    - "Knot Able"
        - Reflect and teach
- There is a hierarchy to unraveling knots: Illuminate and acknowledge opening one up.
    - Use insightful observations as possibilities, not as truths.
    - Don't rush; momentum is the goal. Test for engagement.
    - Appreciate worldviews
        - Describe what a successful outcome would be
        - Listen for what is not being said

Appendix E: Permission to Use Coaching in the Moment

Permission to Use Coaching in the Moment

From: Dianna Anderson <dianna@cylient.com>
Subject: Request for use response
Date: March 6, 2013 11:35:04 AM CST
To: dchambers1165@gmail.com

1 Attachment, 8 KB

Hi Deb,

My apologies but I think we may have gotten our wires crossed in terms of replying to your request to cite our material and reprint for use in your doctoral dissertation. You have our permission to use our materials as you have described with the appropriate attribution.

Good luck with your dissertation!

Dianna Anderson

Hello,
My name is Deb Chambers EdDc, MBA, BSN, RNC and I am a CHI Coach and have taken your workshop.

I am also in the process of my doctoral dissertation on the subject of coaching as a co-created lived experience between Graduate RN and Nurse Educator.

I am seeking your approval to use your coaching diagrams for print and electronic reuse and will be giving credit in the correct APA format within my dissertation.

Thank you for your consideration.

DIANNA ANDERSON, MCC
CEO | CYLIENT

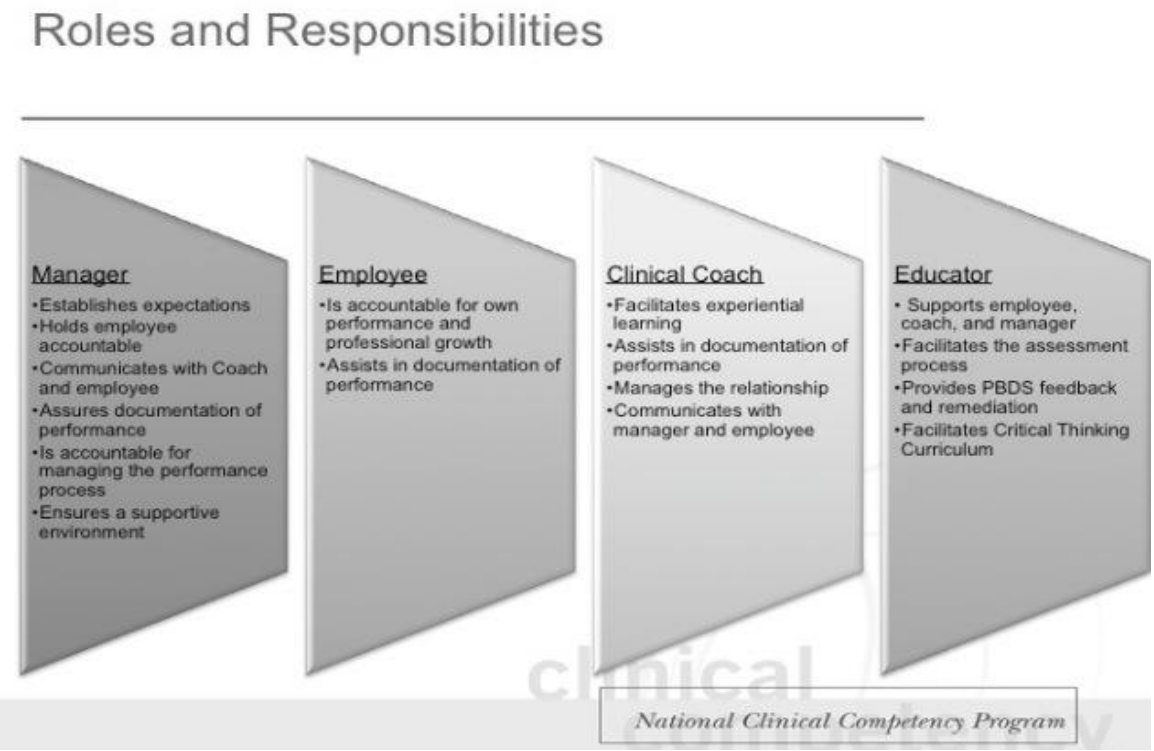
T | 515.727.4200 M | 515.537.7514 E | DIANNA@CYLIENT.COM

CHECK OUT OUR COACHING MOMENTS APP

Cylient

Appendix F: Nurse Educator Coaching Role at CHI

Coaching Roles for Nurse Educator



Appendix G: Preceptor Role of Coaching at CHI

Preceptor/ Clinical Coach

- Principles of coaching
  - Assist in developing critical thinking skills
  - Shift from "explicit" - teaching content
  - To "implicit" – coaching
    - Questioning
    - Active leaning

clinical competency

National Clinical Competency Program

Appendix H: Introductions to Leadership and Participants

Scripts for Research Introduction

Nursing administration introductions. I am conducting a doctoral research study on the topic of coaching in nursing and am seeking your permission to discuss participation with your Nursing Education department. I am going to explore coaching, as a lived experience, between Graduate RN and Nurse Educator during the formative assessment of the Performance Based Development Systems (PBDS) feedback session. I will videotape the session after written informed consent of both Graduate RN and Nurse Educator. I understand the some of your Educators may have taken the class 'Coaching in the Moment™'. This is not a requisite for participation, but highly desirable. I am seeking a Nurse Educator who uses a deductive style of learning where questioning and reflection is a common practice. I have a copy of the informed consents for your review and will leave a copy with you. I plan to enlist, at minimum, two Catholic Health Initiative hospitals into this study and to obtain a sample of three Nurse Educators and three Graduate RN pairs. The study includes videotaping the PBDS feedback session. At a convenient time following the feedback, a semi-structured interview asking more information regarding the experience of receiving PBDS feedback will be conducted. The study concludes with an activity that will involve sorting and resorting cards that have coaching descriptors written on them. The interview and card sorting activity is expected to take 30-60 minutes.

Nursing education director (Mgr.) introductions. The Vice President of Nursing has given me permission to approach your department to participate in a research study on the dynamics of a coaching dialogue for professional development between a Graduate RN and Nurse Educator. Your department and the individual participation is strictly voluntary. For the

Nurse Educators to participate, they need to have at least three years of clinical nursing experience and three years of nurse education experience. I am looking to you for your recommendations as this study is to be conducted on the subject of coaching. The ideal candidates will be solicited because they are highly recommended as an individual who uses an inquisitive style of teaching and coaches others to learn. The Nurse Educator demonstrates strong coaching (not tell/teaching) abilities and is someone who has continuing education on coaching and preferably the coaching class, Coaching in the Moment™. The Graduate RN, to be included, has to have been licensed within the past six months as a Registered Nurse (RN) and holds a BSN degree. I will leave the informed consent with you for review. Once permission is granted, I will inquire from the Director of Education on which Nurse Educators they would recommend and how best to contact them.

For the Nurse Educator introductions. Administration has given me permission to solicit your participation in a research study on coaching in Nursing Education. Specifically, you have been recommended as an expert in providing PBDS feedback to Graduate RNs. This study is designed to explore the phenomena of coaching, as a lived experience, between Graduate RN and Nursing Educator during feedback on the PBDS assessment tool. To participate, an informed consent is required. It will include videotaping a PBDS feedback session that you have with a Graduate RN. At a later time of your choosing, you would participate in a semi-structured interview about your experience and perceptions of this event and it will also include a card sorting exercise with the researcher. The interview and card sorting exercise will take approximately 30-60 minutes of your time. If the nurse educator approves to proceed, I will review the consent document and obtain informed consent. I will then proceed to discuss the next steps of how to obtain informed consent from the Graduate Nurse that you would coach.

For the Graduate RN introductions. The Nurse Educator has provided me time to share with you the opportunity to participate in a qualitative research study on coaching in nursing. This study has been designed to explore the dynamics of the coaching dialogue for Professional Development between you and the Nurse Educator as you receive feedback on your PBDS assessment. Participation is purely voluntary, and you are under no obligation to participate. It will include videotaping your PBDS feedback session and having a semi-structured interview at a convenient time of your choosing which will include a card sorting exercise with the researcher. The interview and card sorting exercise may take 30-60 minutes of your time. If you are interested, I will contact you via cell phone to arrange a time to review the consent document and assure that your participation is understood and you have consented willingly to participate unless you would like to arrange to do so now.

Appendix I: Approval to Use PBDS Tools for Dissertation Purpose

Approval to Use PBDS Tools for Dissertation Purpose

RE: Request for use of PBDS tools-clarification

Patton, Pat

Sent: Thursday, April 11, 2013 10:23 AM

To: Chambers, Deb

Thanks Deb for the further explanation. I approve for you to use the tools in your research paper for the reasons described below.

From: Chambers, Deb

Sent: Wednesday, April 10, 2013 2:08 PM

To: Patton, Pat

Subject: Request for use of PBDS tools-clarification

I am asking for permission to include the PBDS assessment feedback tools used by CHI within the appendix of my Doctoral Dissertation, specifically in Chapter III.

Chapter III is the design methodology chapter of my research. I am studying coaching through the lens of a phenomenological perspective. The context of this "lived experience" is the PBDS assessment feedback process between RN Educator and Graduate RN. I ask to include, within the appendix, the written tools, as they are part of the setting and important to include.

Thank you for your consideration.

Deb Chambers EdDc, MBA, BSN, RNC

Director of Clinical IT

Appendix J: Approval to Study PBDS and Use Tools in Catholic Health Initiative Hospitals

From: Ford, Pat

Sent: Friday, May 24, 2013 9:40 AM

To: Chambers, Deb

Subject: RE: thank you!

Deb, I found my notes from our call under other things on my desk

Attachments:

1. Competency Continuum for PBDS
2. Sample Summary Action Plan
3. Latest data we have from the parent company – Performance Management Services Inc.
4. Power point with select slides I use for overview of PBDS and Coaching

Use any of these as you feel are relevant, let me know if questions.

I hope what I have provided helps Deb, Take care

Pat

Pat Ford, MSN, RN-BC *Senior Consultant, National Clinical Competency Program*

Catholic Health Initiatives

15520 Bobby Lane | Council Bluffs, IA 51503

Phone/Fax: 712-388-8559

Email: PatFord@CatholicHealth.net

Appendix K: Informed Consent of Participation

Consent Form

ADULT Consent Form - PAGE One

ADULT

CONSENT FORM

IRB#: 1309 Approval Date: 12/09/2013 Expiration Date: 07/01/2015

Title of this Research Study:

Dynamics of a Coaching Dialogue for Professional Development between Graduate RN and Nurse Educator

You are invited to take part in this research study. The information in this form is meant to help you decide whether to participate or not. Your participation is voluntary. If you have any questions, please ask.

You are being asked to be in this study because you are either a Graduate RN or a Nurse Educator employed within a health care facility that uses coaching to provide feedback from a Professional Behavior Developmental Systems (PBDS) assessment that was recently administered.

The researcher believes that exploring coaching, for professional development, will assist in a better understanding of the workplace experience.

Participant Initials _____

ADULT Consent Form - PAGE Two

The purpose of this phenomenological study is to better understand how the dynamics of a coaching dialogue are co-created between Nurse Educator and Graduate RN during reflection of patient care experiences during feedback of a PBDS assessment tool.

Coaching for professional development is a work related phenomenon, which requires further study to assist Graduate RNs and Nurse Educators to be better prepared to work together with entry into practice education. Literature suggests that by exploring phenomenon within the context of the event, insights will arise to advance nursing education and practice development.

The researcher would like to video tape your scheduled feedback session of the PBDS assessment previously administered. In addition, the researcher is asking permission to arrange 30-60 minutes with you, when convenient, and at your place of work for an interview.

The researcher will not be present during the videotaped feedback session.

Participant Initials _____

ADULT Consent Form - PAGE Three

At a convenient time, an interview will begin followed by a card sort, where the researcher will ask you to sort verbs as they relate to the actions you utilize while coaching or being coached. A second sort of the cards will be used to better understand the verbs that specifically assist you with coaching for professional development.

The researcher would like to ask you interview questions related to your experience in coaching through the PBDS assessment event. The interview will be audiotaped to assure accuracy of information provided. Audiotapes will be destroyed following the data retrieval.

Portions of the videotape will be embedded into a Qualitative software application without names attached and will only be used for research presentation by the researcher for oral defense of dissertation and scientific presentations. The videotape will not be used for any other purpose and no identifiers, such as names, will be included. No transcriptions will include any identifiers of persons.

There are no known risks to you from being in this research study.

You are not expected to get any direct benefit from being in this research study. Possible benefit of the study is an advancement of knowledge in the subject of coaching.

Participant Initials _____

ADULT Consent Form - PAGE Four

Instead of being in this research study you can choose not to participate.

There is no cost to you to be in this research study.

You will not be paid or compensated for being in this research study.

Your wellbeing is the major focus of this research. If you have a concern, as a direct result of being in this study, you should immediately contact the researcher listed at the end of this consent form.

Reasonable steps are taken to protect your privacy and the confidentiality of your study data.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in scientific journals or presented at scientific meetings, but your identity will be kept strictly confidential.

You have rights as a research participant. These rights have been explained in this consent form and in *The Rights of Research Participants* that you have been given. If you have any questions concerning your rights, talk to the investigator or call the Institutional Review Board (IRB), telephone (402)-399-2400.

Participant Initials _____

ADULT Consent Form - PAGE Five

You can decide not to be in this research study or you can stop being in this research study and withdraw at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator or with the College of Saint Mary or the Hospital of employment and those associated staff members.

You will not lose any benefits to which you are entitled.

If the researcher gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed right away.

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

You can withdraw at any time, if you wish.

Participant Initials _____

ADULT Consent Form - PAGE Six

If you have any questions during the study, you should talk to the researcher listed below. You will be given a copy of this consent form to keep.

If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant: Date: Time:

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator: Date:

Principal Investigator: Debbie Chambers, 402-219-2292, dchambers65@csm.edu

Secondary Investigator: Dr. Jennifer Rose-Woodward, jrosewoodward@csm.edu

Appendix L: Participant Interview Questionnaires

Interview Questionnaire for Graduate RN

Instructions. Thank you for participating in the study on coaching dialogue. These demographic questions are solely requested to understand the composition of the Graduate RN group participating in this study. Your participation is purely voluntary and does not impact in any way your employment at your hospital as a Registered Nurse. I will first ask you some demographic information that will only be reported as an aggregate. Next, I will ask you some questions about your Professional Behavior Developmental Systems (PBDS) feedback assessment you recently completed, and lastly, I will have you participate in a card sorting exercise.

Ok to proceed?

Educational background as a Graduate RN.

Have you had experience as a Nursing Aide?

What other hospital experiences have you had?

What type of program have you graduated from?

How long have you been employed at this hospital?

Have you met the Nurse Educator before? In what capacity?

When did you receive your license?

Introduction to interview. Now we will begin the interview session. It may last about 30-60 minutes, but there is not a time limit. I will be audiotaping your responses and will be transcribing them, verbatim, without any personal identification. Are you willing to participate? Participation is purely voluntary.

Interview Questions for Graduate RN. Share with me the process that was used for the coaching review of PBDS? The setting, the time of day, the environment, and how the sessions progressed from beginning to end?

What were you feeling prior to starting?

Think back to the feedback session, what experiences were guiding your thinking?

How would you describe your relationship with the PBDS Nursing Educator?

How did reflection on previous patient care experiences enter into this coaching event?

What other experiences did you reflect upon during the coaching event? From your past?

What experiences guided your thinking during this session?

What experiences affected your thinking after the session?

What presence of mind did you bring to this coaching event?

What presence of body did you bring to this coaching event? Do you remember your body position, the temperature of your body?

What presence of spirit did you bring to this coaching event? Were you feeling positive or negative, and how was this felt?

Describe the your most significant learning from this event? Why? What did you do?

What was the most difficult part, for you, of this event and what suggestions do you have for change?

How did the coaching event contribute to your professional development?

In what ways did the coaching event add to your identity as a Registered Nurse?

What other ideas do you have about coaching with a Nurse Educator?

Thank you for your time. May we continue with the card sorting exercise?

Interview Questionnaire for Nurse Educator

Instructions. Thank you for participating in the study on coaching dialogue. There will be some demographic questions asked solely for the purpose of understanding the composition of the Nurse Educator group participating in this study. Your participation is purely voluntary and does not impact in any way your employment at your hospital as a Registered Nurse. I will first ask you some demographic information that will only be reported as an aggregate. Next, I will have you participate in an interview regarding a recent PBDS feedback assessment you had with _____, and lastly, I will have you participate in a card sorting exercise.

Ok to proceed?

Demographic background as a Nurse Educator.

How many years of experience do you have as a Nursing Educator?

How many years of experience do you have in clinical nursing?

Have you had formal training in coaching? What was your training?

How long was the training and approximately how long ago was this training?

Was it Coaching in the Moment ™?

Can describe your relationship with this New Graduate?

Thank you for this information, can we begin the interview?

Follow with Interview. Now, we will begin the interview session.

This may last about 30-60 minutes, but there really is not a time limit. I will be audiotaping your responses and will be transcribing them, verbatim, without any personal identification. Are you willing to participate? Participation is purely voluntary.

Interview questions for the Nursing Educator.

1. What is the most significant characteristic of someone who coaches the Graduate RN for professional development?
2. What is most significant, as coach, in providing PBDS feedback to the Graduate RN?
3. How would you describe the coaching relationship you have had with this Graduate RN? Is it similar or dissimilar to others? Would you explain more about this?
4. How did you reflect prior to entering into this coaching event? What do you typically do to prepare? What were you thinking?
5. What previous experiences guide your thinking before the coaching event?
6. How do past coaching experiences enter into the coaching event?
7. When do past experiences enter into your thinking after the coaching event is completed?
8. What presence of mind did you bring to this coaching event? Is this similar or different to other times? Can you explain?
9. What presence of body did you bring to this coaching event? Is this similar or different to other times? Can you explain?
10. What presence of spirit did you bring to this coaching event? Is this similar or different to other times? Can you explain?
11. Describe the most significant learning for you from this event?
12. What has been the most significant learning for you from your experience in coaching with this Graduate RN through a PBDS feedback assessment? Why? How would you describe the impact this has had on you as a coach of Graduate RNs?

13. What process do you employ for coaching the Graduate RN through the PBDS feedback with a Graduate RN? When have you deviated from this process? Why did this happen? Would you do this again? Why?
14. What was the most innovative plan identified by the Graduate RN for professional practice development? Why do you think this occurred?
15. Is there anything you would like to share about coaching the new graduate or this new graduate that I have not asked?

Thank you for your participation. We are now going to begin the card sorting exercise.

Follow with card sort exercise.

Appendix M: Field Note Tools

Field Notes for Card Sort

Field Notes of the Card Sorting

	Somatics				Reflection								Environment		Comments/Other
Participant	Body Forward	Body Back	Body Closed	Body Open	Pause	Experience	Interuption	Silence >3	Question	Repeats back	Clarify	Informs	Temperature	Noise	
1a															
1b															
2a															
2b															
3a															
3b															

Appendix N: Field Note Tools

Field Notes for Videotape

Field Notes of the Videotape

	Somatics				Reflection								Environment		Comments/Other
Participant	Body Forward	Body Back	Body Closed	Body Open	Pause	Experience	Interuption	Silence >3	Question	Repeats back	Clarify	Informs	Temperature	Noise	
1a															
1b															
2a															
2b															
3a															
3b															

Appendix O: Field Note Tools

Field Notes of Interview

Field Notes of the Interview

	Somatics				Reflection								Environment		
Participant	Body Forward	Body Back	Body Closed	Body Open	Pause	Experience	Interuption	Silence >3	Question	Repeats back	Clarify	Informs	Temperature	Noise	Comments/Other
1a															
1b															
2a															
2b															
3a															
3b															

Appendix P: Participant Follow Up Questions

Optional Probing Questions

Optional Probing Questions for the Researcher (Bostwick & Chambers, 2012)

Question	**Characteristic**
What does that mean to you?	Clarification
What happened then?	Description
What other ideas do you have?	Extension
If you could do it over again?	Hypothetical
What would you do next time?	Hypothetical
What was enjoyable?	Emotional
What is stopping you or the main obstacles?	Identifying
What was your desired outcome in meeting with your coach?	Outcome
How do you suppose it will work out?	Prediction
What are the chances of success?	Prediction
What action or actions have you taken?	Action
How would you summarize your work so far?	Summary
What did you make of it?	Appraisal
How did you feel about it?	Appraisal

Appendix Q: Card Sorting Exercise

Card Sort

Card sorting instructions. This exercise is designed as an exercise to inform the subject of coaching, as a learning activity, and to garner your understanding of coaching and the importance of coaching on your professional development. Card sorting is used as a data-gathering tool for researchers to help define and categorize topics (Santos, 2006). You will be asked to sort the cards two different ways. There is a coaching term written on every card with the exception of one blank card. The blank card is for you to write one of your own coaching terms. This exercise begins with you writing a term on the blank card. This will start the pile of characteristics most important for coaching for professional development. This pile will represent coaching actions or characteristics that you feel are important. Pile a second stack of those that are less important, in your opinion. The piles can be of unequal numbers. For example, if all verbs are considered helping or important, they all could be placed into one pile. I ask to you draw upon your experience of coaching when performing the sort. One pile is to contain those terms that you have experienced and felt to be very beneficial to your professional development as a nurse through a dialogue with another colleague.

After the first sort is completed, you will begin a second sort of one of the remaining piles of cards. There are no time constraints. If there any terms that are unfamiliar to you, I cannot offer you any additional definitions, but you are welcome to place it in the pile that is not important. I will be observing this activity and will be writing my observations during the exercise. Again, there is no time limit and no right or wrong way to sort these cards. I am interested in your values, beliefs, and ideas. Do you have any questions? Go ahead and begin

with the blank card. (Researcher waits before continuing and will assure cards are shuffled prior to anyone else playing the exercise.)

In this second part of the exercise, you will re-sort only the important pile. I will discard the other pile. This time, re-sort your remaining group again into two different piles. One pile is to be those terms you consider to be helpful to facilitate reflection on patient care experiences for professional growth and development. The alternative pile would be, in your opinion, not as optimal to help you learn patient care. The same rules apply.

Thank you for participating in this exercise. By participating, I will be able to compare your terms with others, looking for commonalities. This data will be added to the others to help define and describe coaching between nursing peers.

Appendix R: Card Terms

Coaching Terms Used for Card Sort

Sets a good example	Positive persuasion	Emotional supportive	Works hard
Relator	Is positive	Supports	Pays attention
Helpful	Interacts	Cares	Teaches
Uses examples	Focuses	Decides	Praises
Coaches	Considers	Shows concern	Reflects
Models success	Listens	Suggests	Tells
Voices	Informs	Honest	Fair
Participates	Knows	Stays in touch	Encourages
Finds Time	Explains	Blank #1	Challenges

(Bostwick & Chambers, 2012)

Appendix S: Card Sorting Permission from Lina Bostwick EdD

Permission for Inclusion

RE: **permission to use Card Sorting for Coaching Effectiveness**

Bostwick, Lina

Sent: Wednesday, April 10, 2013 4:54 PM

To: Chambers, Debbie

Hello Debbie,

I would be delighted for you to use these research tools as listed. You also have my permission to modify, in any way needed, in order to enhance your research study.

Lina Bostwick

From: Chambers, Debbie
Sent: Wednesday, April 10, 2013 3:21 PM
To: Bostwick, Lina
Subject: permission to use Card Sorting for Coaching Effectiveness

Good Afternoon,

As a co-researcher in the Card Sorting exercise that was conducted in HCE 866, I am asking for your permission to use the exercise that we developed for a research project that I am designing.

I am using a phenomenological lens to study coaching between Graduate RN and Nurse

Educator for the purpose of professional development.

I have modified the process to sort the cards initially to reflect effective coaching strategies and the second sort will be based on the member's perceptions of effectiveness of coaching to professional practice development.

Only the second sort will be included in my study for analysis through NVivo v10 processes. It becomes one source of data for triangulation of meaning. The goal is to reflect the structure or essence of coaching between nursing peers. I am seeking your permission to use this for data collection, to modify, to administer, and to report, within my dissertation and future publications, all findings relevant to this tool.

Thank you for your consideration and best wishes to you and your journey.

Deb Chambers

4/09/2013

Doctoral Student

Appendix T: Hermeneutic Analysis

Questions Used During Data Analysis

Is this an example of something?

What was the focus of this example?

How can this be simplified down into a few ideas?

What structure did these phenomena suggest?

What was the space felt by this individual?

What was this person's bodily and physical presence?

What appearance did coaching or to have been coached look like?

How was the relationship expressed?

How did the past, present, and future enter into these phenomena? (Creswell, 2013, pp. 194-195)

Appendix U: Probing Questions

Nurse Educator Inquiry Verbatim Examples

Well if that did happen, what would you do?

Why was their status changing?

What do those symptoms mean?

What do you expect to happen?

What do you do when this happens?

What would you do first?

You told me...but what else might be happening?

Let's walk through this together...

I am hearing your say...what does that mean?

You are their eyes...what do you see...what would you anticipate?

How do you differentiate this from other...?

So you said...what is your focus?

Let us imagine you have no laboratory values...it is just you?

How would you know this is normal?

What else might be happening?

But when there is an order that you question, how would you feel?

How do you feel it went? What does that mean? What was significant about that?

When you said... what did you mean?

Why do you say...?

When you say...what is your focus?

Appendix V: Professional Nursing Coach Practice Competencies

ANA Standard 1.	Assessment
ANA Standard 2.	Diagnosis
ANA Standard 3.	Outcomes Identification
ANA Standard 4.	Planning
ANA Standard 5.	Implementation
ANA Standard 6.	Evaluation
ANA Standard 7.	Ethics
ANA Standard 8.	Education
ANA Standard 9.	Evidence-Based Practice and Research
ANA Standard 10.	Quality of Practice
ANA Standard 11.	Communication
ANA Standard 12.	Leadership
ANA Standard 13.	Collaboration
ANA Standard 14.	Professional Practice Evaluation
ANA Standard 15.	Resource Utilization
ANA Standard 16.	Environmental Health

Hess, et al., 2013