COMMUNICATION SKILLS TRAINING WITH A COACHING APPROACH:

INFLUENCING ORGANIZATIONAL RESULTS IN A

LONG-TERM HEALTHCARE ORGANIZATION

by

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Abstract

Effective communication has been shown to play a role in the quality of patient care. The approach to providing care may differ among healthcare professionals, therefore requiring an increase in communication to create continuity between healthcare providers. If a unified way to effectively communicate cannot be established, then the quality of care in the organization may be jeopardized. Communication skills training programs can be created to remedy this issue, but limited research has explored the effectiveness of communication skills training, employing coaching methodologies, and the influence on organizational results in a healthcare system. This study explored the effectiveness of a coaching communication skills training (CCST) program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. A qualitative exploratory case study approach with a focus group design was employed and consisted of four groups of eight employees each, for total of 32 participants. The four focus groups were separated by nursing, administration, community services (homecare, adult daycare), and support services departments within the long-term healthcare facility. The purposive samples were employees who have successfully completed CCST. The data collected provided insight to understand the effectiveness of a CCST program and its influence on organizational results. The major findings of the study indicated the CCST program was able to increase employees’ retention and influence positive behavior on the job. Employees found the CCST enjoyable and that it influenced positive organizational outcomes.
Dedication

Special dedication goes to my cherished and beloved family. Everything that I have fought to achieve is motivated by bringing you happiness. I also dedicate this dissertation to my daughter, Rebecca M. Johnson, as proof that glass ceilings are illusions of the mind and obstacles are what separate the strong from the weak.

“Don’t tell me how hard and long the labor was. . . . Show me the baby.”

Look at the size of this baby!!!
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CHAPTER 1. INTRODUCTION

Introduction to the Problem

Various training programs are implemented in organizations to improve productivity and organizational outcomes (Cascio, 2000; Noe, Hollenbeck, Gerhart, & Wright, 2006). Dolezelek (2004) reported that companies in the United States spend over $50 billion annually on training programs. In the field of health care, a communication training program is deemed a necessity to improve the level of quality of care provided to clientele. The decision to implement one type of training over another is determined by the effectiveness of the training program. Therefore, if the need of effective communication is ignored or incorrect training is implemented, then a healthcare organization may jeopardize achieving organizational success (S. Gregory, 2001; Willingham & Eden, 2007).

Research has been dedicated to the exploration of the diverse nature of training and its effectiveness in organizations (Kemeny, Boettcher, DeShon, & Stevens, 2006; Kraiger, Ford, & Salas, 1993). Kraiger et al. (1993) found that to increase the effectiveness of staff training, programs should be designed to incorporate organizational goals. In addition, the objective of training should support employees’ mental and professional growth. Kemeny et al. (2006) concurred that implementing training programs that are aligned with the needs of the staff will promote effective organizational
outcomes. The techniques used during training to transfer knowledge and skills are vital to the training program’s effectiveness. A training program that utilizes combinations of training techniques (e.g., role-playing, feedback, on-the-job training, motivation) is needed to influence the effectiveness of training (Kemeny et al., 2006). Research has shown that effective communication is positively associated with successful organizational outcomes in healthcare organizations (Willingham & Eden, 2007).

Willingham and Eden (2007) recognized that organized communication is imperative in health care, but training to establish a standard has not been established. According to Rutstein et al. (1984), “a Sentinel Health Event (SHE) is a preventable disease, disability, or untimely death whose occurrence serves as a warning signal that the quality of preventive and/or therapeutic medical care may need to be improved” (p. 160). The Joint Commission on Accreditation of Healthcare Organizations (2009) reported that 70% of sentinel events occur because of lack of effective communication. The report revealed this lack of communication or poor communication occurs between all levels of occupations within health care. While this is true, implementing a training program that supports the employee and organizational outcomes has been deemed to be challenging (Willingham & Eden, 2007). Healthcare organizations have acknowledged the need to establish a unified way of communicating, but the repercussions from implementing an ineffective training program can directly affect the quality of care provided to their customers.

S. Gregory (2001) found that below-standard training with healthcare staff is related to insufficient quality of care. Recent recommendations on training were introduced to long-term healthcare professionals in order to improve care, including
strategies in leadership, mentoring, and team building (Maas, Specht, Buckwalter, Gittler, & Bechen, 2008). In addition, Leonard and Frankel (2011) declared that effective communication is an essential element to improve the quality of care provided by healthcare professionals. Piven et al. (2006) reported a strong need for training to bridge the communication between healthcare staff. Piven et al. observed a breakdown in communication between levels of occupation in health care, therefore revealing a strong need for communication skills training (CST). “Certified nurse’s assistants (CNAs) explained the lack of communication between the CNAs and minimum data set (MDS) coordinators as a lack of connection” (Piven et al., 2006, p. 301). Furthermore, an established unified way of communicating through CST is deemed beneficial for improving organizational results and diminishing the complexity of the term *quality of care*.

Quality of care in health care is jeopardized because of an unclear definition of *quality* perceived by the individuals who are employed in the facility (Piligrimienë & Bučiūnienë, 2008). A. G. Taylor and Haussmann (1988) suggested that since the 1960s, *quality of care* has been defined in a variety of ways. The term has expanded and has become complicated with its in-depth association with defining vocabulary. Hogston (1995) found that quality care in nursing has acquired the label *nebulous concept* because of its lack of true definition. Brzezinski (2009) reported that defining *quality of care* is no easy task. Over time, the definitions of the term *quality care* have become “as varied as the people and organizations offering them” (Brzezinski, 2009, p. 12). Piligrimienë and Bučiūnienë (2008) believed the term *quality care* adopts so many elements, it is not surprising that the healthcare system lacks a unified understanding of the multifarious
term. *Quality of care* is considered not only the responsibility of direct care nurses but also a standard that should be upheld by every department that comes into contact with the resident. Healthcare organizations that implement training programs to unify how healthcare professionals communicate may decrease communication breakdowns and improve the level of care provided (Willingham & Eden, 2007).

Wong, Laschinger, and Cummings (2010) argued the capacity of nurses to provide higher quality care should be a logical result of a supported work environment, which includes a trusted relationship with their leader. Wong et al. found that accountability and communication play a large role in quality of care by exploring the perceptions of long-term nurses. Therefore, because of an unclear definition of *quality care*, improved communication across all occupational levels of care providers has been one of the main focuses of training to improve care in healthcare facilities (Willingham & Eden, 2007). Gaining a deeper understanding of the effectiveness of a CST program that is designed to improve communication and accountability through methods of coaching within a long-term healthcare facility was the focus of this study.

**Background of the Study**

Effective communication has been shown to play a role in the quality of patient care. During times when the approaches to providing care differ, communication between healthcare professionals increases to create continuity between care providers (Gormley, 2011). The inability to establish a unified way to effectively communicate has been recognized as a major drawback to performance among healthcare staff (Piven et al., 2006). A coaching communication skills training (CCST) program that promotes a
unified communication technique, respect, constant observation, feedback, trust, and performance improvement has the potential to nullify differences between healthcare professionals (Graham, Wedman, & Garvin-Kester, 1994).

Gormley (2011) argued that when trying to implement new initiatives in hospitals, management and nursing staff must have a clear understanding of the objectives. Because of the complex environment, patient care pressures, lack of information, and sicker patients in health care, providing consistent efficient care has been deemed unrealistic. Consequently, high volumes of communication failures and sentinel events are reported (Leonard & Frankel, 2011). The improved effectiveness of communication among hospital staff has been recommended when trying to improve quality of care in health care. Statistics illustrate that over 24% of patients in hospitals have experienced a sentinel event, and a large percentage could have been avoided with effective communication (Classen et al., 2011). The most effective training method to unify communication and improve the quality of care has been researched but not solidified in health care.

Researchers have shown interest in CST programs to improve the performance of healthcare providers. Fukui, Ogawa, and Yamagishi (2011) investigated a CST program that taught nurses how to reveal unfortunate news to cancer patients after they have completed their screening tests. The objective was to determine how CST programs influence quality of life and patient satisfaction regarding healthcare staff. The researchers concluded that CST for healthcare professionals improved quality of life and patient satisfaction. Wilkinson, Perry, Blanchard, and Linsell (2008) reported a negative correlation between ineffective communication and quality of life. In the study, patients experienced anxiousness and dissatisfaction when the healthcare provider failed to
communicate in a clear, comprehensive, and compassionate manner. CST has shown to be beneficial among oncology nurses in Western countries (Delvaux et al., 2004). Sheldon (2005) reported the confidence scores of nurses improved after CST. The observed improvements surfaced regarding attitudes of nurses and level of confidence when interacting with patients posttraining (Sheldon, 2005). Research has revealed the purpose of CST programs is to improve communication and support the mental state of the employee. However, there are multiple opinions on how communication training should be administered in health care.

Perron et al. (2009) reported on a needs assessment of clinical supervisors in Geneva. The focus was to determine their training needs and identify factors that may hinder or promote teaching communication skills in health care. The researchers reported that clinical supervisors from both inpatient and outpatient services recognized the value in using good communication skills. In addition, nurse supervisors described three methods to train communication skills. Two of the three methods introduced coaching methodology as a valuable technique to promote learning in health care. All clinical supervisors showed interest in CST and believed in its potential to improve communication. Lack of time, competing demands, lack of interest on the part of residents, and lack of priority given by the institution to communication issues were reported as barriers to CST in healthcare organizations. Clinical supervisors reported a lack of training in communication skills, which transformed into self-incompetencies to teach effective communication skills to other healthcare providers. Clinical supervisors were unable to describe an ideal CST program, but supported coaching and the training focus toward teaching communication skills (Perron et al., 2009). The primary focus of
the current research was to understand the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization.

**Statement of the Problem**

Limited research exists exploring the effectiveness of CST, employing coaching methodologies, and the influence on organizational results in a healthcare system (Jarvis, Lane, & Fillery-Travis, 2006). The scope of this study acknowledged the gap in research for effective training programs in the healthcare industry that influence organizational results and support the needs of healthcare providers. Perron et al. (2009) suggested that coaching methodology is a valuable technique to promote learning in health care. However, they acknowledged that lack of time, competing demands, lack of interest on the part of residents, and lack of priority given by the institution to communication issues were reported as barriers to CST in healthcare organizations. Hence, understanding the effectiveness of a CCST program and its influence on organizational results should be explored further. Thus, the primary focus of this research was to understand the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization.

**Purpose of the Study**

The purpose of this qualitative exploratory case study was to contribute knowledge to the field of organizational management, human resource management (HRM), organizational communication, and training in order to understand the
effectiveness of a CCST program and its impact on organizational results. Research has revealed the implementation of training programs in health care is valuable to improve organizational results (S. Gregory, 2001; Willingham & Eden, 2007). In health care, one type of organizational result is measured by the quality of care provided. Researchers have recommended that healthcare organizations implement training on coaching (Graham et al., 1994) and communication (Wadensten, Engström, & Hággström, 2009) to improve quality of care. However, research has revealed no reports of training programs implemented in nursing homes to improve staff self-esteem through empowerment (Wadensten et al., 2009). Some studies have revealed, however, a positive correlation between supervision support, self-improvement, and quality of care (Edberg, Hallberg, & Gustafson, 1996; Hansebo & Kihlgren, 2004).

The coaching approach centers on skills that improve effective communication between employees. Communication training programs that promote a coaching approach incorporate skills that empower “a climate of communication, mutual respect, ongoing observation, feedback, trust, and a focus on performance objectives” (Graham et al., 1994, p. 82). Results from the current study add to the body of knowledge by extending the understanding of the effectiveness of CCST programs in health care. Therefore, the inclusion of CCST programs in organizational human resource development (HRD) training programs can influence the decision to utilize CCST programs to improve organizational results.
Rationale

The qualitative case study methodology allowed the researcher to gain an in-depth understanding of the CCST influence on long-term healthcare staff. Organizational coaching is defined as a “facilitative or helping relationship with the purpose of achieving some type of change, learning, or new level of individual or organizational performance” (M. L. Smith, Van Oosten, & Boyatzis, 2009, p. 150). Leonard and Frankel (2011) reported that because of the complex environment, patient care pressures, lack of information, and sicker patients in health care, providing consistent efficient care can be unrealistic. Consequently, high volumes of communication failures and sentinel events are reported (Leonard & Frankel, 2011). Training in effective communication between hospital nursing staff has been recommended when trying to improve quality of care in health care. Statistics show that over 24% of patients in hospitals have experienced a sentinel event, and a large percentage could have been avoided (Classen et al., 2011). Communication has been recognized as a valuable factor in the effectiveness of providing health care. Willingham and Eden (2007) found that organized communication is imperative in health care, but training to establish a standard has not been established. The Joint Commission on Accreditation of Healthcare Organizations (2009) reported that 70% of sentinel events occur because of lack of effective communication. Piligrimienè and Bučiūnienè (2008) believed the term quality care adopts so many elements, it is not surprising that the healthcare system lacks a unified understanding of the multifarious term. Quality of care is not only the responsibility of direct care nurses but also a standard that should be upheld by every department that comes into contact with the resident.
Thomas and Magilvy (2011) stated, “The intent of qualitative research is to provide a close-up view, a deeper and richer understanding within a specific context, which can be missed in quantitative research” (p. 152). A case study provides a comfortable and safe environment for participants to reveal personal and sensitive information that may be considered risky or ignored during surveys. According to Yin (2003), a case study method has been proven helpful when the correlation between the phenomenon and its context is not clear. Case study methodology provides researchers with narrative data that capture the complexity and contradictions of life. Allowing the participant to clarify, elaborate, and retract statements increases “openness” (Flyvbjerg, 2006, p. 238), which provides a clearer understanding of the phenomenon. Based on the rigorous nature of qualitative inquiry, this study utilized the case study qualitative methodology with a focus group approach.

Ferguson, Myrick, and Yonge (2006) suggested the use of a third-party facilitator to eliminate conflict of interest in research. Thus, the researcher used a third-party facilitator to conduct the focus groups using semistructured interview questions. The third-party facilitator has a master’s degree in social work and has been trained to conduct in-depth interviewing. The data collected from focus groups was audio recorded, and field notes were handwritten by the facilitator. All responses that could have revealed the identity of the participants were deleted before analysis. To control research bias in the study, the researcher coded all data with techniques suggested by Huberman and Miles (1994). Using semistructured focus groups, the facilitator collected data from 32 participants using open-ended questions. The purpose was to explore the effectiveness of a CCST program and its impact on organizational results in a healthcare system. The
participants were encouraged to refer to examples of real work-life experiences in answering the questions. The effectiveness of the CCST program and its impact on organizational results were explored by investigating the real-life experiences of four major occupational departments in the healthcare facility. This sampling procedure was selected to take into account the differences between cohort groups. This population was ideal to use in this study in order to better understand the effectiveness of the CCST program and its impact on organizational results.

This study is significant to the field of organizational management, HRM, organizational communication, and training because it was designed to help an organization understand the effectiveness of implementing a CST based on coaching methods and its impact on organizational results. Increased awareness of CCST is valid in improving organizational results in healthcare organizations. This research provides organizations with insight into how to best support healthcare providers. For the institution involved in this study, training on coaching communication increased efficiency and accuracy when providing care, resulting in better healthcare outcomes. Employers and payers benefited from this research by the improvement of communication skills of existing and new employees through training. As a result, decreases in misunderstandings, recurrence of sentinel events, and expenses aligned the organization with its purpose to provide top-level care. Patients were provided better care from skillful healthcare providers, and the patient–provider communication was improved. Care plans were accurately developed to capture the needs and wants of patients.
The curriculum of the CCST was based on Goleman’s (1995) model of emotional intelligence (EI). The theoretical framework for this study (see Figure 1) associated with understanding the effectiveness of the CCST was based on the conceptual four-level model developed by Kirkpatrick (1994).

*Figure 1. Theoretical framework.*
Research Question and Subquestions

This qualitative exploratory case study design answered the following primary research question: How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system?

The following subquestions guided the study:

1. What evidence illustrates that staff found the training intervention enjoyable (Level 1)?
2. What evidence illustrates that staff gained knowledge from the training intervention (Level 2)?
3. What evidence illustrates that staff changed behavior after the training intervention (Level 3)?
4. What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)?
5. How does the impact of coaching communication differ among occupational groups in health care?

The four levels indicated in the research subquestions were based on the four-level model developed by Kirkpatrick (1994): reaction level (Level 1), learning level (Level 2), behavior level (Level 3), and results level (Level 4).

Significance of the Study

In this study, the researcher explored the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare
organization. This study was significant to the field of organizational management, HRM, organizational communication, and training because it was designed to help an organization understand how implementing CST based on coaching methods influences higher levels of performance and results. Increased awareness of CST that promotes coaching was considered valuable in improving quality of care in long-term health care. This research provides organizations with insight into how to best support healthcare providers. In addition, the results of this study contribute to the limited existing research on organizational coaching and training.

**Definition of Terms**

*Active listening.* “Recognizing the emotions in others” (Goleman, 1995, p. 88) through the skills of body language, paraphrasing, and asking open-ended clarifying questions.

*Coaching communication skills training (CCST).* A relational approach that manages and supports workers in the development of problem-solving skills, critical thinking, prioritizing, and effective communication.

*Feedback (presenting the problem).* The ability to prepare, initiate communication, and state the problem in a clear and nonjudgmental fashion (Carellock & Innerarity, 2001).

*Goleman model of emotional intelligence (EI).* Allows individuals to enhance their abilities to motivate others, control frustration, control impulse, postpone gratification, adjust mood, think clearly, and empathize with others (Goleman, 1995).
**Kirkpatrick four-level model.** Theory associated with utilizing four levels of evaluation to understand the effectiveness of training. Reaction, learning, behavior, and results are the four levels of evaluation recognized by Kirkpatrick (1994):

- **Reaction level.** Level 1 reaction criteria measure how the participants react to the training. Whether training is considered to be effective is determined by the trainees’ level of favorability of that training.

- **Learning level.** Learning criteria measure how much the participants have learned during the training.

- **Behavior level.** Behavior criteria measure whether what was learned during training is being applied on the job. These criteria are determined by on-the-job performance that stemmed from the effects of training.

- **Results level.** Results criteria measure whether results are achieved after the application of training.

**Organizational results.** An organizational outcome that is influenced by interpersonal communication enriched with a coaching approach posttraining.

**Self-awareness.** One’s ability to recognize feeling while in the moment. Therefore, one’s ability to be self-aware is dependent on insight and self-understanding (Goleman, 1995).

**Self-management.** One’s ability to manage feelings. When life confronts individuals with unfortunate circumstances, self-management allows them to find calm during a negatively charged time and bounce back (Goleman, 1995).
Assumptions and Limitations

Assumptions

The following assumptions were associated with this research study. By exploring the CCST, the researcher can understand the effectiveness of a CCST program and its impact on organizational results in a healthcare system. Based on the focus of the curriculum of the training, communication is influenced by self-management, self-awareness, active listening, and presenting the problem (feedback; Goleman, 1995). The effectiveness of the CCST and its impact on organizational results was determined by utilizing Kirkpatrick’s (1994) four-level model for evaluating training. Therefore, the CCST influenced organizational results at the research organization.

The case study methodology allowed the researcher to get a deeper understanding of the effectiveness of a CCST program in long-term healthcare staff. Therefore, the researcher gained a deeper understanding of the differences between cohort groups in regard to the effectiveness of a CCST program and its impact on organizational results.

Another assumption is that participants in the study made a sincere effort to answer questions honestly. The level of comfort between the participants and the facilitator contributed to the accuracy and amount of information received during the study. Writing exactly what the participants said and asking participants to clarify what has they said increased secondary descriptive validity in the study. Secondary descriptive validity acknowledged the information that is observable, complex, and problematic (Maxwell, 1992). To analyze the assumptions associated with the research, the researcher conducted an analysis framework at the end of the study (Malterud, 2001).
Limitations

Limitations in case studies, according to Appleton (1995), include the weight of the responses depending on the facilitator’s ability to conduct interviews. If the facilitator cannot be flexible and make the participants feel at ease, the responses received during research may be misleading. The level of comfort between the participants and the facilitator contributed to the accuracy and amount of information received during this study.

Limitations involving the utilization of the micro-interlocutor analysis involved (a) the data set provided, (b) different speakers not being explicitly identified, (c) the nature of responses not being specified, and (d) nonverbal communications not being consistently noted. Thus, the data collected from the focus groups were not detailed enough to enable micro-interlocutor analysis in its strictest interpretation.

Another limitation involved the researcher depending on participants in the study to make a sincere effort to answer questions honestly. Power struggles between participants and providing public responses may also surface as a limitation during the focus group sessions. The experience and familiarity of the facilitator with conducting focus groups aimed to provide a comfortable environment for participants in the study.

The analysis framework analyzed the presentation of the research. Questions at this stage involved the purpose of the research, the structure of the research, the researchers’ style of writing, and the audience. The next phase of the framework was an analysis of the researcher’s influence on the research and whether that influence was addressed in the research; “during all steps of the research process, the effect of the researcher should be assessed, and, later on, shared” (Malterud, 2001, p. 484).
In addition to the aforementioned limitations, participants may have been influenced by previous training about communication. This study collected data from 32 long-term healthcare employees. The small sample size may jeopardize transferability to a larger population. External validity could be an issue. Participants in the study were representative of one long-term facility. Therefore, further research is needed to transfer findings to other industries. The research findings may represent only one organization and one population. The results of this study may not be applicable to long-term employees outside of the researched organization.

Finally, the number of questions asked during the focus group sessions was limited due to time constraints. In addition, utilizing a purposive sample may underrepresent or overrepresent the population.

Nature of the Study

This study utilized a qualitative exploratory case study approach with a focus group design. The effectiveness of a CCST program and its impact on organizational results in a healthcare system were studied. The curriculum of the CCST was based on Goleman’s (1995) model of EI. The evaluation of effectiveness of the CCST was based on Kirkpatrick’s (1994) four-level model. The purpose of the Goleman’s model was to create a framework that allows individuals to enhance their abilities to motivate others, control frustration, control impulse, postpone gratification, adjust mood, think clearly, and empathize with others. The CCST is a relational approach that manages and supports workers in the development of problem-solving skills, critical thinking, prioritizing, and effective communication.
Goleman (1995) acknowledged self-awareness as a key factor of EI. Self-awareness is referred to as “knowing one’s emotions” (Goleman, 1995, p. 87). The term self-awareness was defined, by EI, as one’s ability to recognize feeling while in the moment. Therefore, one’s ability to be self-aware is dependent on insight and self-understanding (Goleman, 1995). In this study, to become aware of their own judgments and assumptions that hinder communication was the goal of training individuals on the skill of self-awareness. The CCST focused on providing individuals with the tools to see the whole picture and develop positive relationships.

According to Goleman’s (1995) model, managing emotion is another key component to EI. Goleman defined self-management as one’s ability to manage feelings. When life confronts individuals with unfortunate circumstances, self-management allows them to find calm during a negatively charged time and bounce back (Goleman, 1995). In this study, to become more conscious of one’s emotional responses was the goal of training individuals on the skill of self-management. Training individuals on how to set aside emotional responses can improve communication and eliminate emotional reaction that hinders real listening.

Goleman (1995) highlighted the importance of “recognizing the emotions in others” (p. 88). When one is attuned to the emotional state of others, then the needs and wants of others become clear. Paying attention to the emotional state or subtle social signals in others allows one to relate on a deeper level. In this study, listening with full attention was endorsed when training the skill of active listening. Active listening was represented by the skills of body language, paraphrasing, and asking open-ended clarifying questions.
Carelock and Innerarity (2001) found that workers’ ability to prepare, initiate communication, and state the problem in a clear and nonjudgmental fashion were vital to effective communication that minimizes sentinel events. In this study, using objective language to identify problems and increase accountability was emphasized when training the skill of presenting the problem.

The theory associated with understanding the effectiveness of the CCST was based on the four-level model developed by Kirkpatrick (1994). Reaction, learning, behavior, and results are the four levels of evaluation (Kirkpatrick, 1994). For this study, Level 1 reaction criteria measured how the participants reacted to the training. According to Kirkpatrick, examining the reactions of trainees is equivalent to examining the trainees’ level of satisfaction. Whether training is considered to be effective was determined by the trainees’ level of favorability of that training.

For this study, Kirkpatrick’s (1994) Level 2 learning criteria measured how much the participants learned during the training. If the trainees fail to learn the skills that are being trained, then the expectation of change is hindered. Kirkpatrick emphasized that evaluating the training is a good indicator of training effectiveness. For this study, Kirkpatrick’s Level 3 behavior criteria measured whether what was learned during training was being applied on the job. These criteria were determined by on-the-job performance that stemmed from the effects of training (Kirkpatrick, 1994).

For this study, Kirkpatrick’s (1994) Level 4 results criteria measured whether results were achieved after the application of training. Research has revealed that organizations limit the collection of results data in fear that trainers may have unrealistic expectations of training outcomes. Social and economic constraints also play a role in
limiting the collection of results data (Alliger, Tannenbaum, Bennett, Traver, & Shotland, 1997). Arthur, Bennett, Edens, and Bell (2003) noted the reaction and learning levels in Kirkpatrick’s model are considered internal because what occurs within the training determines its outcome. In contrast, the behavior and results levels are considered external because of the potential influence of outside factors. The results level is considered the highest and most difficult level of evaluation in Kirkpatrick’s four-level model (Praslova, 2010). Based on Kirkpatrick’s evaluation model, the research aimed to understand the effectiveness of CCST in regard to the four levels of training evaluation.

**Organization of the Remainder of the Study**

Chapter 2 encompasses a literature review of the theories and constructs associated with this study and how the constructs were integrated. Chapter 3 provides a detailed description of the methodology of the study, including information regarding the research design, sample, setting, instruments, data collection, data analysis methods, validity and reliability, and ethical considerations. Chapter 4 provides a detailed description of the findings of the research. Finally, Chapter 5 provides a detailed description of the results, implications, and recommendations for further research.
CHAPTER 2. LITERATURE REVIEW

Introduction and Overview of the Chapter

The literature review begins with a historical perspective of the quality of care in long-term health care and brief overview of the quality of health care in the United States. The focus is to highlight the importance of communication and quality of care. Following that is an overview of various CST programs and their importance and influence on quality of care. The chapter then provides the history of EI and an overview of the theoretical constructs in the field.

The review focuses on Goleman’s mixed model of EI, a conceptual framework that allows individuals to enhance their abilities of self-awareness, self-management, feedback, and active listening. The literature review provides an in-depth examination of the concept’s history and impact on EI. The controversies in the EI field and its impact on training are then examined. The literature review continues with an examination into coaching, its history, various forms of coaching, coaching procedures, coaching in health care, and training using the coaching approach. The literature review provides a description of the CCST program implemented in the research organization and an overview of Kirkpatrick’s model for evaluating the effectiveness of training in this study. The literature review concludes with a synthesis.
**Quality of Health Care**

This section begins with a timeline of the maturation of quality care in the healthcare industry. The efforts, achievements, and failures to improve care are highlighted. The literature illustrates how communication has become a vital element to improve quality of care. Therefore, organizations that implement developmental training programs centered on bridging the gap of communication between healthcare providers can eliminate issues related to quality of health care. The focus is to highlight the importance of communication and quality of care.

The history of long-term health care can be traced back 30 years in regard to its quest to provide interventions for better care (Gruneir & Mor, 2008). In 1986, the Institute of Medicine (IOM) published a report entitled *Improving the Quality of Care in Nursing Homes*. The purpose of the report was to acknowledge existing hardships and establish guidelines to provide better care for long-term healthcare facilities. In 1987, Congress acknowledged the need to improve the quality of care in long-term health care and published the Long-Term Care Survey, which provided a platform to measure the level of care provided in nursing home facilities (Anderson, Hobbs, Weeks, & Webb, 2005). Over the years, the long-term healthcare industry has experienced many changes in efforts to improve care. For example, the journey to providing better care has witnessed the emergence of the assisted living industry and Medicare reimbursement programs, both of which are considered to provide positive outcomes. However, the quest for improving care in long-term care facilities continues to be a challenge in many facilities across the nation (Allen, 2007; B. Barker & DeBord, 2005).
In 2001, U.S. hospitals were identified as dangerous healthcare settings by the IOM (2001). *Medical News Today* (as cited in Shapiro & Loughran, 2004) estimated that medical errors contribute to almost 200,000 deaths annually in the United States. Medication errors have increased drastically, by 20%, from 1992 to 2007. It has been estimated this rapid increase costs the United States close to $3.5 billion per year (IOM, 2007). Research has revealed some of the obstacles in health care include addressing the increased cost for medical care (Catlin, Cowan, Heffler, & Washington, 2007), reducing medical errors through health information technology (McAlearney, Chisolm, Schweikhart, Medow, & Kelleher, 2007), and finding a resolution for the quality gap between insured and uninsured clientele in America (IOM, 2001).

Flood and Escarce (2007) acknowledged that healthcare organizations and researchers have inherited the challenge of developing and implementing methods to improve the quality of care. The ability to address these challenges relies on the capabilities of individuals who are unevenly disbursed between managerial, clinical, and community concerns (Hofmann & Perry, 2005; Ramanujam & Rousseau, 2004; Smedley, Stith, & Nelson, 2002). Therefore, the ability to efficiently address quality concerns in health care remains challenging for healthcare professionals. The IOM (2001) conducted a study with nine quality subject matter experts and identified six strategies to improve the quality of health care in America: safety, effectiveness, patient-centeredness, efficiency, timeliness, and equity. Safety strategies were to ensure that healthcare professionals take the necessary steps to prevent accidental injury that occurs through treatment errors. Effectiveness strategies ensured that “care that is based on the use of systematically acquired evidence to determine whether an intervention, such as a
preventive service, diagnostic test, or therapy, produces better outcomes than alternatives” (IOM, 2001, p. 46). Patient-centeredness strategies were geared to guarantee that all healthcare systems were based on the needs of the individual patient. The remaining strategies ensured that (a) care was provided with appropriate timing, (b) care was delivered efficiently, and (c) equality is the right of all patients. Gold (2007) recognized that in order to efficiently execute the strategies proposed by the IOM, the vital component to improve quality of care is communication. Gold stated, “How we change a large, complex, and often bureaucratic system into one that is designed to provide continuity across settings, with effective communication between and among providers is the challenge, especially when the financial incentives are not aligned” (p. 293). McAlearney (2008) found that healthcare organizations that implemented developmental programs were positively correlated with improving the quality of care provided in the organizations.

Developmental training programs have been linked to improving job performance, organizational culture, and organizational climate, and increasing the learning capabilities of employees (Day, Zaccaro, & Halpin, 2004; Gray & Snell, 1985; Moxnes & Eilertsen, 1991; Schein, 1985). Frankovelgia and Riddle (2010) found that developmental training programs that focus on enhancing and establishing relationships through mentoring and coaching are linked to effective performance.

Organizations that want informal developmental relationships to occur regularly for more people need to develop coaching skills in the organization and reward people for using those skills, encourage people to seek out the developmental relationship they need, and provide ample opportunities for people from across the organization to meet and develop relationships. (Frankovelgia & Riddle, 2010, p. 192)
Feltner, Mitchell, Norris, and Wolfe’s (2008) study identified communication skills of healthcare professionals as a major contributor to providing quality care. The ability to be honest, open, approachable, a good listener, and maintain confidentiality are attributes that define effective communication skills. Stapleton et al.’s (2007) meta-analysis study revealed that morale boosting and motivational characteristics of healthcare professionals optimize the quality and outcomes in the healthcare industry. Furthermore, implementing CST programs has the potential to eliminate the restraints established because of poor interpersonal relationships and the day-to-day issues in health care.

Communication Skills Training Programs

This section is an overview of various CST programs and their importance and influence on quality of care. Self-awareness, self-management, active listening, and constructive feedback are the four types of training programs discussed in this section. These four types of programs represent the major techniques taught during the CCST explored in this study. The ability to increase awareness of one’s emotion enables the worker to control that emotion by channeling a more productive reaction (Engin & Çam, 2009). Frayne and Geringer (2000) addressed the need for self-management training to increase employee performance and reduce unprofessional workplace behaviors. Duhamel and Talbot (2004) found that training active listening has increased the quality of care in healthcare organizations. Feedback has been associated with the improvement of employee skills, internal capital (Krackov, 2011), and organizational outcomes (Ericsson, 2004). The literature suggested that healthcare organizations that invest in self-
awareness, self-management, active listening, and constructive feedback training can improve the quality of care in their facilities.

**Self-Awareness Training Programs for Effective Communication**

Effective communication has been deemed a necessity in the field of health care. Sully and Nicol (2005) advised that to ensure efficient and safe practice, effective communication must be consistently practiced in a healthcare facility. When dealing with healthcare nursing employees, interaction between colleagues, residents, and family members are enhanced when both parties exhibit good communication skills (Deltsidou, 2009). When effective communication is practiced, the staff are more efficient and mistakes are minimized.

Unfortunately, death and dying are components of the healthcare industry, and communication breakdowns can occur due to stressful situations. Engin and Çam (2009) found that healthcare workers are forced to deal with emotions that are triggered by unfortunate situations on the job. The ability to increase awareness of one’s emotion enables the worker to control that emotion by channeling a more productive reaction. Özcan (2006) described the communication between nurses as an interpersonal relationship that consists of nonverbal and verbal messages. The nurses’ level of awareness toward their skills and abilities allows communication with coworkers, patients, and family members to be successful. Moreover, awareness of thoughts, feelings, and behaviors facilitates their skills and ability to improve. Jack and Miller (2008) stated the ability to be self-aware during diverse situations is vital to establishing or maintaining healthy relationships between mental health practitioners. Healthcare professionals must self-evaluate constantly to improve self-awareness, learn techniques
that allow self-evaluation, and improve effectiveness among healthcare professionals (Jack & Smith, 2007). Boud, Keogh, and Walker’s (1985) and Gibbs’s (1988) reflective models promoted the ability to self-examine negative feelings and thoughts. Thus, Jack and Miller’s model encompasses one’s ability to transform. The three stages in Jack and Miller’s framework are now, transition, and regroup; “this will include ‘unframing’ your current way of thinking, making changes and then reframing the way in which you think” (Jack & Miller, 2008, p. 32). The literature suggested that healthcare organizations that invest in self-awareness training can improve their quality of care.

Rungapadiachy (1999) posited that self-awareness training should be mandatory for healthcare professionals. Researchers have conducted studies on the value of training healthcare staff on the skill of self-awareness to improve skills and abilities (Oflaz, Meriç, Yuksel, & Özcan, 2011; Suthakaran, 2011; Ünal, 2012; Zavertnik, Huff, & Munro, 2010). Ünal (2012) argued that good communication skills and self-awareness should be taught in the early stages of nurses’ educational careers. Training objectives should focus on retention that transfers over to practice when developing curriculum that teaches self-awareness and good communication. Zavertnik et al. (2010) argued that traditional teaching of self-awareness and communication skills no longer suffices. Self-awareness and good communication training techniques that involve student interaction (role-playing, demonstrations, feedback) and real-life experiences increase retention by allowing the students to practice in a nontthreatening environment. Fleming’s (2009) feedback interventions are used to improve self-awareness in patients who suffer from traumatic brain injury. Training involves the use of real-life scenarios, meaningful exercises, goal setting, error recognition, and strategy building. In addition, the training
focuses on providing a supportive environment throughout the training process (Fleming, 2009). Schmidt, Fleming, Ownsworth, Lannin, and Khan (2012) acknowledged the impact of video, verbal, and experiential feedback on improving self-awareness in traumatic brain injury patients. Ashford, Blatt, and VandeWalle (2003) stated that leaders who are self-aware are motivated to understand the perceptions of others. As a result, leaders seek out constructive feedback to evaluate their performance. Therefore, it is vital the training program that is implemented to improve self-awareness is strategically designed to transfer learned skills to real-life practice.

The American Counseling Association’s (2005) promoted multicultural/diverse competencies should be added to training to increase sensitivity among supervisors. Research studies have shown that increased self-awareness is directly associated with increased cultural empathy (Ridley & Lingle, 1996). Suthakaran (2011) suggested experimental learning with the use of analogies to heighten self-awareness of cultural differences to improve behavior. For example, training that uses engaging and emotional stories provides a strong impact, which increases self-awareness and cultural awareness, thus influencing behavior (Brewin, 1989). Training that utilizes storytelling as a vehicle for teaching increases self-awareness and, in turn, improves intercultural competence (Andenoro, Popa, Bletscher, & Albert, 2012). M. E. McLeod (2003) believed self-awareness training in health care improves patient care by allowing healthcare providers to become aware of their own strengths and vulnerabilities. A heightened level of self-awareness requires a person to reexamine his or her beliefs; thus, he or she becomes more sensitive and appreciative of life. Empathy, listening skills, communication skills, and
self-awareness are key components to person-centered care (Epstein et al., 2005; Mead & Bower, 2000).

Oflaz et al. (2011) studied how psychodrama affected nurses’ ability to improve self-awareness. “Psychodrama is a way of looking at what did and did not happen in a given situation” (Oflaz et al., 2011, p. 570). Psychodrama training consists of group training centered on truthful responses, comfortable atmosphere, role-playing (role reversal), and sharing. The focus is to target real-life experiences that bring about emotional responses at work, normally associated with death and dying. The results showed that conducting training in a comfortable environment increased enactment and sharing of emotional feelings. As a result, the studied showed that psychodrama strategy improved self-awareness in nurses (Oflaz et al., 2011). Ünal (2012) tested the effects of training self-awareness and good communication on self-esteem and assertiveness of nursing students. The course utilized demonstrations that centered on maximizing student engagement, constructive feedback, and coaching. The research design sampled 79 nursing students, utilizing a pretest/posttest structure to collect data. The results showed that self-awareness and good communication positively influenced self-esteem and assertiveness in nurses (Ünal, 2012). Suthakaran (2011) suggested that future research use qualitative measures to investigate the effectiveness of analogies in training.

In summation, effective communication has been deemed a necessity for productivity in the field of health care (Sully & Nicol, 2005). Unfortunately, due to stressful situations, the emotions of healthcare professionals can become taxing. Self-awareness provides an opportunity to control stressful emotions and react effectively while in a work environment (Engin & Çam, 2009). Training on self-awareness is
considered vital for healthcare professionals (Rungapadiachy, 1999). Self-awareness training should be taught early in one’s career, should be focused on retention (Ünal, 2012), should be interactive, should provide feedback, should be based on real-life experiences (Zavertnik et al., 2010), and should be diverse (Ridley & Lingle, 1996).

Self-Management Training Programs for Effective Communication

Research has emphasized the need for self-management in organizational settings (Luthans & Davis, 1979), occupational settings (Frayne & Geringer, 2000; Frayne & Latham, 1987), and educational settings (Dean, Malott, & Fulton, 1983). Luthans and Davis (1979) utilized self-management training to increase employee autonomy and decrease employee supervision. Frayne and Geringer (2000) and Frayne and Latham (1987) addressed the need for self-management training to increase employee performance and reduce unprofessional workplace behaviors. Dean et al. (1983) found that self-management training increased academic productivity and achievement. Gerhardt (2007) believed that organizations are becoming aware of the importance of self-management skills and are relying on educators to prepare students and employees accordingly.

Both Frayne and Latham (1987) and Frayne and Geringer (1992) found that training self-management improved performance through self-efficacy and outcome expectancies. C. A. Snyder, Manz, and LaForge (1983) reported that a self-management approach is invaluable if the individual’s motivation to manage behavior is inconsistent. If self-management techniques are consistent, the probability of performing tactical and strategic activities successfully increases. Luthans and Kreitner (1975) measured the cost–benefit ratio of training self-management and found that self-management is less
expensive and less time consuming than hiring someone to manage. Therefore, self-management should be valued by organizations instead of being ignored. Furthermore, training self-management skills to healthcare professionals is considered a necessity for the profession (Lorig & Holman, 2003).

Lorig and Holman (2003) acknowledged that self-management has become a consistent topic in the field of health care. Researchers have reported the benefits of self-management in connection with healthcare staff productivity and patient care (Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001; Miller & Iris, 2002; Rollnick, Kinnersley, & Stott, 1993). Lorig et al. (2001) found that self-management increased self-determination, well-being, and participation among healthcare staff. Miller and Iris (2002) found that self-management maintained the quality of life for chronic patients. Kennedy, Gask, and Rogers (2005) recognized the encounters between healthcare professionals and patients were both infrequent and constant. Encounters between the two groups varied in the level of intensity, and the professionals assigned to provide care may change daily. Based on the random nature of health care, training on effective communication and self-management enables health professionals to self-manage and allows patients to self-care during uncertain times (Rollnick et al., 1993).

Self-management training programs are designed to teach skills that are linked to improving care. According to the Center for the Advancement of Health (2002), there are five core self-management skills. The first skill is problem solving, which involves defining problems, seeking out advisement for solutions, solution implementation, and result evaluation (D’Zurilla, 1986). The second skill is decision making, which requires the need for gathering vital information. How resources are utilized represents the third
self-management skill. Lorig and Holman (2003) suggested that training programs should not only inform people that resources are available, they should also train people on how to effectively use the resources. The fourth skill promotes partnership between healthcare providers. Finally, to take action and change behavior is a core self-management skill, for example, developing an action plan that is behavior-specific (Lorig & Holman, 2003). Self-management training in industrial settings utilizes these core skills to train how to focus on overcoming workplace obstacles while increasing the ability to learn new skills (Gist, Stevens, & Bavetta, 1991).

To develop self-management, Manz and Sims’s (1980) conceptual framework suggested environmental planning and behavioral programming. Environmental planning consists of changing the environment to prevent future behavior, and behavioral programming consists of self-administered consequences for future behaviors. Modeling, social reinforcement, and reinforcement flexibility are considered necessary when training self-management (Thoreson & Mahoney, 1974). Research has revealed that training programs to help healthcare professionals to facilitate behavior change and self-management should consist of individual supervision, videos, and a positive relationship between healthcare provider and patient (Coulter, 1997; Doherty, Hall, James, Roberts, & Simpson, 2000). Kennedy et al.’s (2005) training program on self-management focused on open-ended questions, picking up cues from patients, clarification, summarizing, checking out, and collaborative approach to treatment. The results of the training confirmed that training healthcare providers to self-manage promoted self-management for both the patient and the healthcare worker. Therefore, the training was deemed
beneficial for staff to provide patient-centered care and enabled patients to self-manage to cope with illness (Kennedy et al., 2005).

Manz and Sims (1989) developed the Self-Management Leadership Questionnaire that measures leadership behaviors that promote self-management. The study revealed that self-expectation, rehearsal, self-goal setting, self-criticism, self-reinforcement, and self-observation/evaluation encouraged self-management. The study findings revealed that leaders who practiced self-management were considered more effective leaders (Manz & Sims, 1989). Cohen, Chang, and Ledford (1997) found that self-management work teams are more effective than traditional managed work teams.

Karoly and Kanfer (1982) developed a self-management model that is based on negative feedback. The model posited that self-management occurs when there is a decision to be made. When decisions that deal with specific behaviors and/or reinforcement tactics, and when the desired result is no longer desirable gets interrupted, the self-management process is triggered. Frayne and Latham’s (1987) self-management model utilized techniques suggested by F. H. Kanfer (1970) and Bandura (1977). Frayne and Latham found that employees showed more attraction to self-management training when the trainings were conducted in groups. Latham and Frayne (1989) followed up their 1987 study and found that the duration of retention of self-management skills lasted up to 6–9 months after training. Baker (1986) found the combination of interpersonal skills training and self-management training maintained healthcare staff’s skills longer than those who received only interpersonal skills training. Self-management training is geared to allow an individual to succeed, but due to the complexity of establishing self-management, the skill is commonly practiced but not successfully implemented (Frayne
& Geringer, 1992; F. H. Kanfer, 1980; C. A. Snyder et al., 1983). Research studies over time have exposed the benefits of training self-management, thus generating a consistent flow of interest from theorists.

Self-management training has grown in practice because of the robust nature of the theories on which it is based and its ability to transfer training and generalize to a larger population (Frayne & Latham, 1987; Gist, Bavetta, & Stevens, 1990; Gist & Stevens, 1998; Gist et al., 1991). More recent researchers have argued the duration of a self-management intervention determines its ability to be generalized (Richman-Hirsch, 2001). Holton, Chen, and Naquin (2003) reported the ability of self-management training to transfer to practice depends on the organization. Pattni, Soutar, and Klobas (2007) tested Richman-Hirsch’s and Holton et al.’s findings among customer service providers in banking institutions. Pattni et al. reported that self-management positively influenced individual performance and self-efficacy. Frayne and Geringer (2000) found an improvement in performance 12 months after self-management training was implemented. Pattni et al. found that self-management training is effective, can generalize to different organizations when individual performance involved overcoming obstacles, and may lose influence if trained under 1 hour as suggested by Richman-Hirsch (2001).

In conclusion, the interest in training self-management in the healthcare industry has become a major topic of interest (Lorig & Holman, 2003). Research studies have linked self-management with improving healthcare productivity (Rollnick et al., 1993), quality of care (Miller & Iris, 2002), self-determination, well-being, and participation (Lorig et al., 2001). Self-management training programs should encompass the skills of problem solving, decision making, resource searching, relationship building, behavior
alteration (Center for the Advancement of Health, 2002), environmental planning, behavioral programming (Manz & Sims, 1980), and modeling (Thoreson & Mahoney, 1974). The program training tools should include individual supervision and videos (Coulter, 1997). Trainees should be able to ask open-ended questions, pick up on cues from patients, and clarify and summarize information (Kennedy et al., 2005). The concept of self-management has evolved into one of the major elements for building strategies to improve productivity in business today (Rosner, 2006).

**Active Listening Training Programs for Effective Communication**

In the milieu of the workplace, researchers have identified the benefits of active listening (T. Alessandra & Hunsaker, 1993; Mewton, Ware, & Grantham, 2005; Papa & Glenn, 1988). Papa and Glenn’s (1988) research addressed whether active listening skills influence productivity. The results showed that poor active listening skills impacted productivity when new technology changes were implemented in daily operations. Hence, Papa and Glenn’s research influenced additional research that revealed a positive correlation between active listening and job satisfaction (L. O. Cooper, 1997). T. Alessandra and Hunsaker (1993) found that active listening improved manager–employee relationships, organizational errors, and clarity of workplace dialogue. Mewton et al. (2005) found that leaders who promote and support work environments with “self-awareness, active listening, empathy, and integrity” (p. 14) are more likely to see positive change in employee performance. Nevertheless, some organizations fail to acknowledge the benefits of training active listening to influence productivity.

Bordone (2007) found that people overestimate their ability to effectively listen. Consequently, an untrained listener can process only 50% of the conversation.
Organizations have neglected active listening as a necessary training (Hayter, 2004), based on the limited measure of its impact on productivity (Saville, 1996). Cheon and Grant (2009) developed a website geared to increase effective communication skills for students by teaching them the fundamentals of active listening. Cheon and Grant noted the difficulty of teaching and learning the skills of active listening. Techniques to manage communication that is based on nonverbal cues, hidden emotions, and personal meanings are very complex and diverse. A. Rogers and Welch (2009) emphasized the difficulty with training active listening skills deals with overcoming barriers that require the understanding of “abstract constructs” (p. 154), the ability to transfer learned skills to practice, and creating a realistic environment. Therefore, very few individuals are privileged enough to undergo training focused on listening (Hagevik, 1999). Hence, organizations that disregard the benefits of active listening are promoting bad listening habits (T. Alessandra & Hunsaker, 1993), and organizations that promote active listening training are orchestrating an environment that is fully capable to be aligned with the organization’s vision (James, 2006).

Research has shown that healthcare organizations have expressed interest in improving the quality of care by training active listening to employees. When management includes active listening as a core competence, an environment that promotes sharing and trust is created (Brownell, 2008). Active listening is defined in the healthcare industry as “the skill of understanding what your patient is saying and feeling and communicating to your patient in your own words what you think he is saying and feeling” (Gerrard, Boniface, & Love, 1980, p. 133). Numerous researchers in the healthcare industry are promoting the effectiveness of training active listening skills.
(Duhamel & Talbot, 2004; Paukert, Stagner, & Hope, 2004). Duhamel and Talbot (2004) found that training active listening positively influenced nurses’ communication skills with families of patients. Paukert et al. (2004) found that 45 hours of training in active listening improved the performance of medical helpline volunteers. Healthcare organizations implement training on active listening to improve the relationship between healthcare professionals and between healthcare providers and patients.

Research in health care has consistently reported that active listening influences positive relationships (Hesselbein, 2003; Manktelow, 2005; Shatell, 2005). Manktelow (2005) reported that not only should an individual pay attention and show that he or she is listening, an active listener must give feedback, eliminate personal judgment, and respond appropriately when engaging in communication. Jonsdottir, Litchfield, and Pharris (2004) found that when active listening is practiced by nurses, it forces genuine attentiveness and sincerity. As a result, negative arousals are subdued in patients when healthcare professional interact using active listening (Shatell, 2005). Nurses in Viederman’s (2002) study stated that utilizing active listening techniques was the most effective method when dealing with difficult patients. Bryant (2009) found that active listening played a vital role when listening techniques were practiced by healthcare professionals.

To establish beneficial outcomes in health care, Bryant (2009) explored the key elements of creating a healthy rapport with patients. Bryant disclosed the steps that clinicians can follow to improve their quality of listening during a consultation encounter. The first step requires an environment that promotes relaxation for both parties involved in the discussion. Bryant suggested the parties should experience minimal to no interruption unless for unpredictable circumstances. This prerequisite allows both
participants to set aside outside distractions and concentrate on the current interaction. As a result, clinicians were more aware of exemplifying positive body language and patients found the environment very affirming. Bryant’s second step introduced the development of vital listening skills. Some people can be categorized as natural good listeners, so acquiring additional skills can only enhance one’s listening ability. The skill of focused attention is exemplified by the positioning of the listener (sitting or standing), maintaining good eye contact, and focusing on the speaker. The skill of showing understanding is demonstrated when the listener sends out gestures of empathy, sympathy, and understanding during the interaction. In addition, paraphrasing is used to allow the listener to check his or her understanding by confirming what was said. Bryant emphasized silence and how silence, when performed at the right time, promotes support for the speaker. Another skill involves one’s ability to create a sense of safety and freedom. Such an environment is necessary “so that the speaker can express thoughts and experiences without fearing a response of disapproval or rejection, correction or critical comment, or even unsolicited advice” (Bryant, 2009, p. 1). Bryant’s final skill involves one’s ability to listen to the entire story. This attribute provides support to the speaker, allowing the speaker to consider the bigger picture and make connections in areas that may have been overlooked. Active listening in health care is described as skills that build a rapport that evolves into a partnership between the clinician and patient (Bryant, 2009).

Iwasiw and Olson (1985) found that nurses presented emotion in only 32% of their healthcare-related interactions. Research has associated this level of emotional disconnect with the length of occupation in the field (Forsyth, 1978). However, in 1987, Olson and Iwasiw reported a significant increase in active listening skills when nurses
were trained over 6 hours. In 1998, Boyd recommended that nurses utilize active listening skills consistently during their interactions. The recommended skills include asking open-ended questions; paraphrasing; listening first, advising second; and committing completely. Boyd referred to a nurse’s ability to “commit completely” (Boyd, 1998, p. 55) as his or her ability to show genuine concern for the speaker by disregarding outside distractions during interactions. In more recent research, Bergeron and Laroche (2009) found that organizations that conduct listening skills assessment and provide training that encompasses coaching are more likely to positively influence organizational performance.

On the whole, research studies have revealed a positive correlation between active listening and productivity (Papa & Glenn, 1988), job satisfaction (L. O. Cooper, 1997), and employee relationship (T. Alessandra & Hunsaker, 1993; Mewton et al., 2005). However, organizations are still hesitant to implement training programs on active listening because of its intangible measures to productivity (Hayter, 2004; Saville, 1996). T. Alessandra and Hunsaker (1993) stated that organizations that fail to implement training on active listening are promoting bad listening skills. On the contrary, research studies have shown that training active listening has increased the level of quality of care in healthcare organizations (Duhamel & Talbot, 2004; Paukert et al., 2004). In addition, research has revealed that when active listening is transferred to practice, the results are beneficial for the relationship between the healthcare provider and the patient (Shatell, 2005; Viederman, 2002).

Bryant (2009) disclosed that a clinician who is trained to actively listen must be able to establish a safe environment, implement listening skills, show empathy or
sympathy, and listen to the entire story without judgment during the encounter. However, due to the rigorous nature and culture of the healthcare industry (Forsyth, 1978), implementing training engulfed in “abstract constructs” (A. Rogers & Welch, 2009, p. 154) can seem difficult.

**Constructive Feedback Training Programs for Effective Communication**

Research studies have highlighted the necessity of effective feedback by showcasing its ability to improve performance (Larson, 1989). Training employees on the skill of feedback has been connected to beneficial organizational outcomes (Ericsson, 2004). Ericsson (2004) suggested the need for deliberate practice to achieve expert performance in an outcome-based milieu. Ericsson’s deliberate practice framework endorsed feedback as a vital component to top-level performance. Krackov (2011) promoted feedback training because of its ability to positively maturate skills. Krackov recommended that feedback be associated with every training program because it develops expertise. Evidence shows that an organization that encourages feedback works toward a culture that promotes internal capital. “A culture that accepts and promotes feedback supports a feeling of positive improvement in the school or training program” (Krackov, 2011, p. 874). Ilgen, Fisher, and Taylor (1979) indicated feedback is provided in a goal-oriented setting to direct behavior or to reinforce behavior through rewards or punishments. Over time, organizations have become aware of the value of providing constructive feedback and have implemented a variety of resources designated to employee advisement.

Research literature acknowledges the strong attention to training feedback in a healthcare setting (Branch & Paranjape, 2002; Krackov, 2011; Porte, Xeroulis, Reznick,
Branch and Paranjape (2002) reported that feedback is the foundation of medical education. Porte et al. (2007) found that external feedback during training is a necessity in surgical training, especially with surgeons in the early stages of their career. Krackov (2011) referred to feedback as a “critical component” (p. 873) to learning and teaching. The technique of constructive feedback provides information that allows learners to improve or maintain good behavior. Due to a shift in medical education to an outcome-based approach, feedback has been underscored for the preparation of healthcare providers. Traditionally, the culture in health care endorsed one-way feedback instead of two-way feedback. As a result, learners felt the feedback they received was incomplete especially when dealing with difficult situations (Krackov, 2011). Feedback is most effective when it is utilized by both the listener and the teacher. Krackov found that most learners and teachers desire constructive feedback because of its potential to improve performance.

Researchers have acknowledged the importance of the feedback process and the vital role of the messenger to provide effective feedback. Ilgen et al. (1979) stated, “It is often difficult to separate the effects of the feedback from the effects of the source” (p. 350). Factors that influence how feedback is received are determined by the recipient’s relationship with the feedback source, organization, follow-up postfeedback procedures, individual perspective toward feedback, and individual goals (Atwater, Waldman, Atwater, & Cartier, 2000; Brett & Atwater, 2001; Goldsmith & Underhill, 2001). Brett and Atwater (2001) found that when feedback was considered totally opposite, recipients felt that feedback was not useful. Atwater et al. (2000) found that individuals who had a negative perspective toward their organization found feedback unnecessary because
changing within the organization was a waste of time. In addition, Atwater et al. found the recipient’s perspective of the feedback influenced his or her level of acceptance. Goldsmith and Underhill (2001) found that executives who received follow-up information after feedback improved their ability to change performance. Brett and Atwater found that recipients who wanted to learn found any form of feedback a useful development source. Research showed the approach to giving feedback needs to be tailored to the receiving audience because of the diverse perspective toward feedback.

Feedback can be delivered in multiple ways. Rondeau (1992) noted that, regardless of the technique of delivery, feedback must be consistent to be effective. Feedback must reconfirm prior knowledge from less formal feedback sources (Schwind, 1987). The style in which feedback is given can be considered equally or more important than the content of the message. When feedback is provided without an awareness of style, misinterpretation of the message becomes a possibility (Motzer & Boissoneau, 1989). Rondeau suggested the feedback provider must have a clear and direct message, be an active listener, use constructive criticism, and confirm the delivery of the feedback message.

Branch and Paranjape (2002) divided the act of feedback into three categories: brief, formal, and major. To maximize the benefits of brief feedback, one must provide brief, meaningful suggestions. The technique of brief feedback is such that the teacher announces that feedback is being given, so the student has a clear understanding of what is about to transpire. When a period of time (5–20 minutes) has been designated for feedback, the feedback is referred to as formal. Formal feedback requires an environment that complements interaction. The format empowers students to self-feedback while
receiving suggestions from the instructor. The final category is major feedback; when a period of time (15–30 minutes) has been designated for feedback, the feedback is referred to as major. Major feedback is done at the midpoint of an experience. The purpose is to reflect, make corrections, or clear up any misunderstandings. Major feedback is normally held privately and is associated with major issues. Major feedback begins with a clear description of why the feedback is being given, and concludes with an action plan to move forward (Branch & Paranjape, 2002).

Recent techniques on providing feedback have been designed to adhere to modern technology (Carr, 2006; Clay, Que, Petrusa, Sebastian, & Govert, 2007; Gukas, Miles, Heylings, & Leinster, 2008; Hughes, Toohey, & Velan, 2008; Porte et al., 2007; Spickard, Gigante, Stein, & Denny, 2008). For example, Clay et al. (2007) developed an intensive care unit assessment tool to provide feedback on exemplary practice during bedside teaching. Porte et al. (2007) utilized computer-based video training to provide feedback to accommodate a large volume of learners. Spickard et al. (2008) integrated an automated electronic clinical portfolio to improve the instructor’s ability to give consistent feedback. The tool produces more efficient patient write-ups by medical students. The Foundation Programme included multisource feedback, an assessment tool created to evaluate performance after training (Carr, 2006). “The mini peer assessment tool (Mini-PAT) is a multi-source feedback tool that collates the views from a range of clinical colleagues and compares with a trainee’s self-assessment of performance” (Davies, Archer, Heard, & Southgate, 2005, p. 195). The evolution of feedback research has adjusted to modern technology in healthcare organizations because of the recognized
value of feedback to increase learning. However, due to changes in healthcare operations, feedback skills can be difficult to train and learn for healthcare professionals.

Paice (1998) reported a change in healthcare operations from an on-call system to a shift system of working. This change decreased the amount of time employees have for training. Due to time constraints, this change also limited the amount of feedback received by employees. The change in healthcare operations forced organizations to improve the knowledge, skills, and abilities of employees with less training. Research has shown that sporadic feedback in goal-oriented settings is not enough to improve performance (Blair, 1991; Burke & Fessler, 1983). O’Sullivan, Chao, Russell, Levine, and Fabiny (2008) acknowledged that teaching medical knowledge alone is not enough to establish a therapeutic relationship with patients. In addition, communication and interpersonal skills are also considered key elements in health care. Epstein and Hundert (2002) included communication and interpersonal skills in their definition of competence: “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (p. 226). The Accreditation Council for Graduate Medical Education (n.d.) included communication and interpersonal skills in its six core competencies for medical students. O’Sullivan et al. found the six core competencies are needed even more in clinical geriatricians because of the complex relationship between clinicians, residents, and their family members. In regard to the six competencies, establishing effective communication and interpersonal skills are a challenge because of their subjective nature and the lack of time trainers have to observe that trainees are performing trained competencies effectively (Makoul & Curry, 2007).
O’Sullivan et al. found that trainers struggled to observe trainees’ performance posttraining to make a legitimate assessment of the trained competencies. The aim of their study was to develop an assessment tool to evaluate the communication and interpersonal skills in geriatric trainees. Objective Structured Clinical Examination (OSCE) stations with themes centered on the common issues in geriatric health care were developed to assess communication and interpersonal skills. Results showed that when geriatric trainees were evaluated on communication and interpersonal skills by geriatricians and standardized patients, the OSCE proved to be a valid, reliable, and good forum for feedback. Healthcare organizations are utilizing training programs that encompass feedback to teach core competencies during times when training is limited.

Modern research has suggested implementing training programs that encompass feedback and coaching to increase an employee’s ability to give difficult feedback when correcting unwanted behavior as an alternative solution to providing more training on core competencies (Hicks, 2011). Hicks (2011) indicated the act of giving feedback is the most important element of coaching. The ability to give others feedback and have the message positively received requires technique. The feedback provider must establish a climate of trust, openness, and one that is free from judgment. Hicks presented six guidelines for giving feedback: (a), address the behavior, not the intention of the behavior; (b) be specific so the individual is clear on what behavior is being addressed; (c) “avoid global labels” (Hicks, 2011, p. 85); (d) feedback should be given immediately after the behavior has occurred; (e) address only changeable behaviors; feedback providers must ask themselves if the behavior is situational or is it demonstrated in other facets of the job; and (f) never give feedback when one is upset. Feedback providers must
be self-aware to delay feedback until the message can be delivered without showing personal emotion (Hicks, 2011). Carelock and Innerarity (2001) found that workers’ ability to prepare and initiate communication and to state the problem in a clear and nonjudgmental fashion is vital to effective communication that minimizes sentinel events. In this study, using objective language to identify problems and increase accountability was emphasized when training the skill of feedback (presenting the problem).

In summation, the concept of feedback has been connected to changing behavior to improve performance (Ende, 1983). Moreover, Pendleton, Schofield, and Tate (1984) indicated the rules of feedback require high levels of engagement to maximize the benefit of the interaction. Research studies have highlighted the necessity of effective feedback by showcasing its ability to improve performance through training. Feedback has been associated with the improvement of employee skills, internal capital (Krackov, 2011), and organizational outcomes (Ericsson, 2004).

Porte et al. (2007) indicated that feedback has been determined a major element in patient care; organizational training should incorporate this skill strategically (Branch & Paranjape, 2002; Krackov, 2011). Hence, the ability to tailor how feedback is delivered is a necessity when dealing with a diverse audience. Feedback must confirm prior knowledge and be consistent, clear, and direct; the feedback provider must be an active listener and confirm delivery of the feedback (Rondeau, 1992; Schwind, 1987). The severity and amount of feedback to be delivered determines whether the message should be brief, formal, or considered a major feedback situation (Branch & Paranjape, 2002).

The techniques implemented to generate feedback coincide with modern technology. For example, Spickard et al. (2008) automated electronic clinical portfolios
to improve consistent feedback for medical students. However, in regard to the rapidly changing environment in health care, finding time for training has been deemed challenging. As a result, healthcare organizations are utilizing training programs that encompass feedback to teach core competencies during times when training is limited. Feedback research studies have revealed that communication and interpersonal skills are imperative for providing care (Epstein & Hundert, 2002; O’Sullivan et al., 2008). Modern research has suggested implementing training programs that encompass feedback and coaching to increase an employee’s ability to give difficult feedback when correcting unwanted behavior as an alternative solution to providing more training on core competencies (Hicks, 2011).

Summary of Communication Skills Training Programs

It is important to examine CST programs especially as it pertains to its level of effectiveness and influence on organizational results in a healthcare system. Distinguishing prior influence and effectiveness of the major content of the program on training allowed the researcher to identify why these various training programs were included in the CCST in this study.

Engin and Çam (2009) found that healthcare providers are required to manage emotions and be productive in a stressful environment. Özcan (2006) and Jack and Miller (2008) identified this dilemma and investigated the dynamics of interpersonal relationships in health care, and concluded the skill of self-awareness is vital to productivity and positive outcomes. Self-awareness facilitates effective communication, allowing healthcare providers to self-evaluate and reinvent (Jack & Miller, 2008), thus ensuring efficient and safe practice (Sully & Nicol, 2005). Self-awareness is a mandatory
healthcare skill (Epstein et al., 2005; Mead & Bower, 2000; Rungapadiachy, 1999) requiring creativity and strategy (Schmidt et al., 2012; Zavertnik et al., 2010) when implemented through training. The objective of training self-awareness is to focus on retention that transfers over to practice (Fleming, 2009; Ünal, 2012). When self-awareness training is effective, healthcare providers increase their emotional awareness and cultural empathy (Andenoro et al., 2012; Ridley & Lingle, 1996; Suthakaran, 2011), resulting in improved patient care (M. E. McLeod, 2003).

Researchers have reported the benefits of self-management in connection with healthcare staff productivity and patient care (Lorig et al., 2001; Manz & Sims, 1989; Miller & Iris, 2002; Rollnick et al., 1993). The random nature of health care has encouraged researchers to focus on interpersonal relationships between healthcare professionals and patients (Kennedy et al., 2005), and acknowledges the necessity of training self-management to healthcare professionals (Rollnick et al., 1993). Self-management training programs should encompass skills that enable healthcare professionals to manage themselves and their environment (Center for the Advancement of Health, 2002; Coulter, 1997; Doherty et al., 2000; Kennedy et al., 2005; Manz & Sims, 1980; Thoreson & Mahoney, 1974). When the skills of self-management are effectively implemented through training, healthcare professionals comprehend the necessary techniques to change unwanted behaviors and provide quality care (Lorig et al., 2001). Therefore, one can understand why the concept of self-management has evolved into one of the major elements for building strategies to improve productivity in business today (Rosner, 2006).
Researchers have stated the benefits of active listening include better productivity, interpersonal relationships, organizational errors, and clarity of workplace dialogue (T. Alessandra & Hunsaker, 1993; Gerrard et al., 1980; Hesselbein, 2003; Manktelow, 2005; Mewton et al., 2005; Papa & Glenn, 1988; Shatell, 2005). Research has shown that healthcare organizations have expressed interest in improving the quality of care by training active listening to employees (Brownell, 2008; Duhamel & Talbot, 2004; Paukert et al., 2004). Nurses in Viederman’s (2002) study stated that utilizing active listening techniques was the most effective method when dealing with difficult patients. Bryant (2009) found that active listening played a vital role when listening techniques were practiced by healthcare professionals. Implementing training programs on active listening in healthcare organizations is recommended to focus on the techniques to establish a safe environment, exemplify listening skills, show empathy or sympathy, and listen to the entire story without judgment during the encounter.

Research studies have highlighted the necessity of effective feedback by showcasing its ability to improve performance (Larson, 1989). Training employees on the skill of feedback has been connected to beneficial organizational outcomes (Ericsson, 2004), performance (Krackov, 2011), and increasing internal human capital. Feedback training benefits healthcare professionals because it reinforces skills and develops expertise (Krackov, 2011). Examples of feedback techniques successfully implemented through modern technology (Carr, 2006; Clay et al., 2007; Gukas et al., 2008; Hughes et al., 2008; Porte et al., 2007; Spickard et al., 2008) provide healthcare organizations with evidence of the importance of feedback in training. Branch and Paranjape (2002) reported
that feedback is the foundation of medical education and should be implemented in all training.

One can conclude that self-awareness, self-management, active listening, and constructive feedback training programs have separately contributed to organizational results when implemented in a healthcare system. In this study, the researcher examined a CCST program that encompassed all four topics through the perspective of Goleman’s (1995) model of EI.

**Emotional Intelligence**

This section provides the history of EI and an overview of the theoretical constructs in the field. The review is focused on Goleman’s (1995) mixed model of EI, a conceptual framework that allows individuals to enhance their abilities of self-awareness, self-management, feedback, and active listening. The literature review provides an in-depth examination of the concept’s history and impact on EI. The controversies in the field of EI and its impact on training are then examined.

**History of Emotional Intelligence**

The concept of EI surfaced through the theoretical models presented by Salovey and Mayer (1990), Goleman (1995), and Bar-On (1997). The seminal work of Salovey and Mayer established the foundation of EI in the 1990s. The roots of EI can be traced back to the conceptual work of Thorndike, Stein, and Gardner. Thorndike (1920) posited that success in one’s life is not solely dependent on ability but also includes social intelligence (management of relationships with others). Thorndike and Stein (1937) defined *social intelligence* as “the ability to understand and manage people” (p. 275). In
addition, Gardner’s (1983) concept of personality intelligence acknowledged the role of personality when influenced by emotions and how one’s emotions can predict future behavior. Therefore, Gardner concluded that independent multiple intelligences determined one’s level of success. Gardner’s multiple intelligence included interpersonal (others) and intrapersonal (self) intelligence, among others. Salovey and Mayer defined emotions as a feeling that occurs because of an internal or external event that causes a negative or positive reaction. As a result, Salovey and Mayer’s framework of EI subsumed both the concept of social intelligence and personality intelligence. In pursuing to document the key elements of EI, Mayer and Salovey (1997) presented a conceptual framework of emotional abilities. Salovey and Mayer’s ability model defined EI as one’s ability to screen one’s feelings and emotions and decipher the appropriate behavior for future action. EI was divided into four skills: the ability to perceive emotions, the ability to use emotions to trigger thoughts, the ability to understand emotions, and the ability to use emotions to formulate behavior that is socially accepted and promotes personal growth (Mayer, Salovey, Caruso, & Sitarenios, 2001). However, EI models that were formulated after the original framework differed in their premise of EI (Bar-On, 1997; Goleman, 1995).

Bar-On’s (1997) mixed model posited that EI is both ability and a function of personality. This intermediate model was based on the notion that emotional skills are developed and manipulated through training or reform implementation. Bar-On introduced the Emotional Quotient Inventory (EQ-I), the first instrument to test EI. The focus was to understand the causalities for success in life. He defined EI as “an array of capabilities, competencies, and skills which influence one’s ability to succeed in coping
with environmental demands and pressures” (Bar-On, 1995, p. 6). Bar-On’s theoretical model acknowledged five factors and 15 factorial components, overlapping components in Goleman’s 1995 model.

In 1995, Goleman’s mixed model brought popularity to the concept of EI (Killian, 2012). Interpersonal (others) and intrapersonal (self) intelligence expanded the research on EI and provided the framework for Goleman’s model. The purpose of the Goleman model was to conceptualize a framework that allowed individuals to enhance their abilities to motivate others, control frustration, control impulse, postpone gratification, adjust mood, think clearly, and empathize with others. Prentice and King (2011) stated that Goleman “conceptualized it [EI] as a quality possessed by every normal person, and proposed a quantitatively based spectrum of individual differences in which people are ranked along an emotional scale” (p. 50). The five domains associated with Goleman’s model are self-awareness, managing emotions, motivating oneself, empathy, and handling relationships. Goleman acknowledged self-awareness as a key factor of EI. Self-awareness is referred to as “knowing one’s emotions” (p. 87), the ability to recognize feeling while in the moment. Therefore, one’s ability to be self-aware is dependent on insight and self-understanding. Managing emotion was disclosed as another key component to EI. Goleman defined self-management as one’s ability to manage feelings. When life confronts individuals with unfortunate circumstances, self-management allows them to find calm during a negatively charged time and bounce back. Another component acknowledged the importance of “recognizing the emotions in others” (Goleman, 1995, p. 88). When one is attuned to the emotional state of others, the needs and wants of others become clear. Paying attention to the emotional state or subtle social signals of others,
allows one to relate on a deeper level. Goleman (1995) believed his model was conceptually aligned with the concepts of Salovey and Mayer, but the connections between both frameworks of emotional intelligence were never confirmed. In comparison, Goleman believed that emotions hinder intelligence, while Salovey and Mayer believed that emotion facilitates thought. For the purpose of the current study, the Goleman mixed model of EI was further examined based on its impact on the CCST program curriculum implemented at the research organization.

**History of Self-Awareness and Its Impact on Goleman Mixed Model of Emotional Intelligence**

Self-awareness takes on a vital role in the theory of EI by allowing empathy to factor into the decision-making process regarding relationships (Hurley, 2008). Perkins (2006) stated the ability to suppress judgment is a challenge in professional relationships. The U.S. Department of Health (2006) proclaimed that healthcare professionals who are able to reflect on previous behaviors, skills, attitudes, values, and beliefs improve their practice and provide better care. The research history of self-awareness provides evidence of its value and its impact on individual growth.

Early philosophies in self-awareness defined the term as an internal assessment of oneself. Moreover, the definitions collectively recognized the need for knowledge of how one is perceived by the outside world (Buss, 1980, 2001; Carver & Scheier, 1982, 1998; Gangestad & Snyder, 2000; M. Snyder, 1974; M. Snyder & Gangestad, 1986). Fenigstein, Scheier, and Buss (1975) reported that self-examination leads to self-awareness. When individuals are able to self-examine, they become aware of their unconscious mental structure. Therefore, awareness provides an explanation for the
emergence of conscious behaviors. Fenigstein et al. created a scale that measures one’s self-consciousness. The scale’s three major components involve private consciousness, public consciousness, and social anxiety. Private self-consciousness addresses inner thoughts and feelings, while public self-consciousness refers to self-perception of how a person affects others in a social environment. Social anxiety is the result of both components, which creates a reaction. The results showed that public self-consciousness exist when one is aware of another person’s perspective, allowing one to acknowledge one’s existence in a social setting (Fenigstein et al., 1975). When one realized oneself as a social object, results showed that social anxiety and public self-consciousness were not highly correlated and appeared as separate factors (Fenigstein et al., 1975). Hence, self-awareness does not suggest social anxiety, and one may feel comfortable attracting attention to oneself. Through research, it is apparent that internal and external perspectives both are considered key elements to increase one’s capacity to be self-aware.

It is well documented that awareness of one’s own perspective is a necessity to understand behavior (Avolio, 2005; Crosson et al., 1989; Dirette, 2010; Rungapadiachy, 1999; Schlund, 1999; Winson, 2007). Crosson et al. (1989) found that self-awareness can be categorized as intellectual, emergent, or anticipatory. Intellectual and emergent awareness are prerequisites of anticipatory awareness. Intellectual awareness is one’s knowledge of one’s limitations. Emergent awareness is the ability to recognize the limitation when it occurs. Anticipatory awareness is the ability to foresee the occurrence of a limitation based on experience (Toglia & Kirk, 2000). Similarly, Schlund (1999) defined self-awareness as the acknowledgment of one’s strengths, limitations, and how both impact the world. Rungapadiachy (1999) found that self-awareness has three
interrelated components: cognitive, affective, and behavioral. Self-awareness allows an individual to think, feel, and then act on a situation. Avolio (2005) found there is a connection between leadership and self-awareness. Leaders with high self-awareness are able to self-assess and identify their own strengths and weaknesses. Dirette (2010) defined self-awareness as “a conscious knowledge of one’s abilities and the impact of those abilities on daily functioning” (p. 310). One’s ability is categorized as physical, sensory, cognitive, and psychosocial. Winson (2007) succinctly stated, “Those who wish to understand and help others must first understand themselves” (p. 47). While this is true, researchers have also acknowledged the impact of external awareness and its role in a person’s total awareness.

Hall (2004) recognized both internal and external perceptions and their value to improving self-awareness. Researchers have acknowledged the need for external perception to improve self-awareness (Baumeister, 2005; Hall, 2004; Luft, 1969; M. Morgan, 2011). External perception was emphasized in the 1960s with the promotion of the Johari window. Luft (1969) promoted the use of the Johari window based on its ability to highlight the necessity to seek feedback from others to explain behavior. Baumeister (2005) addressed the need to anticipate others’ perceptions in order to evaluate oneself. M. Morgan (2011) noted that self-assessment can only start with self-awareness. Becoming self-aware of the elements that motivate personality can be divided into group and situational awareness. Group awareness involves how a person’s personality affects others, whereas situational awareness involves the modification of one’s personality based on the situation. “Becoming self-aware, understanding the composition of the landscape, and exercising situational behavior modification will
dramatically enhance your fit, impact, and satisfaction at work” (M. Morgan, 2011, p. 22). Both internal and external perceptions influence self-awareness, but research has also revealed personality traits that prohibit self-awareness (Fenigstein et al., 1975).

Fenigstein et al. (1975) addressed the individual differences that can either promote or prohibit self-awareness. For example, people who have obsessive tendencies are very critical of their own behavior; on the other hand, people who believe they have no flaws consider how others perceive them to be irrelevant. The tendency for people to engage or reflect attention is a trait of their self-consciousness. In order to make that distinction, one must have a state of self-awareness that stems from unique situations, extreme elongated tendencies, or a combination of both (Fenigstein et al., 1975).

Theorists Duval and Wicklund (1972) contended that internal and external perspectives can simultaneously influence self-awareness. Duval and Wicklund’s objective self-awareness (OSA) theory introduced self-awareness as being objective and subjective. Objective awareness is consciousness directed toward oneself. Subjective awareness is consciousness directed outward, toward aspects in the environment. Objective awareness normally contributes to passive self-evaluative behavior, whereas subjective awareness does not involve self-evaluation but is based on the perception of others. As a result, self-evaluation can only occur when an individual is aware of oneself. Duval and Wicklund’s theory indicated that objective and subjective awareness are separate entities that cannot operate simultaneously. Individuals fluctuate based on elements that trigger acknowledgment of their existence as an object. Duval and Wicklund tested the relationship of self-evaluation (self-esteem) with objective self-
awareness. S. N. Taylor (2010) built on Duval and Wicklund’s OSA theory by including the leader’s ability to anticipate his or her impact and influence on the outside world.

In summation, self-awareness is a key element of the theory of EI (Goleman, 1995). The ability to maintain strong professional relationships centers on being aware of judgments, behaviors, skills, attitudes, values, and beliefs (Perkins, 2006). Research on self-awareness revealed that an individual cannot truly be aware of one’s own behaviors until one has self-examined one’s own perspective (Fenigstein et al., 1975) and acknowledged the perspectives of the world around the individual (Baumeister, 2005). Research also provided evidence that individuals who are closed-minded to the perspectives of others, or obsessive about their own behaviors, are likely to prohibit self-awareness (Fenigstein et al., 1975). Although the OSA theory argued that internal and external perspectives cannot simultaneously influence self-awareness, it supported the need for both perspectives in order to achieve full self-awareness (Duval & Wicklund, 1972).

**History of Self-Management and Its Impact on Goleman’s Mixed Model of Emotional Intelligence**

Research studies have linked training effective communication with self-management (Whicker, Wilson, Lizzieo, & Gallois, 2003). Goleman’s (1995) EI model illustrated that managing emotion is a key component to EI. Goleman defined *self-management* as one’s ability to manage feelings. When life confronts individuals with unfortunate circumstances, self-management allows them to find calm during a negatively charged time and bounce back (Goleman, 1995). Training skills on how to set aside emotional responses can improve communication and eliminate emotional reaction
that hinders real listening. Whicker et al. (2003) researched communication and identified self-management as one of the four dimensions influencing face-to-face communication. The roots of self-management stemmed from earlier work with recovering addicts (Marlatt & Gordon, 1980), and have been molded to the industrial setting for behavior maintenance (Frayne & Latham, 1987).

Prior research has demonstrated that acquiring self-management skills can influence behavior (Brigham, 1982; Frayne & Latham, 1987; Watson & Tharp, 1993). Brigham (1982) noted the ability to terminate, modify, and reinforce others’ behaviors and the ability to change the nature of the environment are the foundation of self-modification. Frayne and Latham (1987) indicated that behavioral self-management has expanded over time into laboratory and clinical settings, and has even extended to a national level. Self-management was introduced by organizations of social ownership, instead of private ownership, in Yugoslavia in the 1950s. Self-management provided workers with autonomy to elect and terminate the individuals who represented them in management (Adizes, 1971). The concept of self-management is supported by autonomy and decentralization (Wu & Shyu, 2011). Watson and Tharp (1993) found the steps to effective self-management involved identifying the behavioral problem, observing the behavior, orchestrating a plan for change, applying behavioral principles, making adjustments if necessary, and maintaining the change behavior. Self-management has been considered a catalyst to changing behavior, especially behaviors that are linked to individual growth.

The skill of self-management is utilized to support a variety of behaviors associated with organizational growth. Goal setting, strategy selection, self-monitoring,
self-evaluation, and self-reinforcement are all behaviors that enable one to self-manage. This behavioral process is required to manage oneself to achieve a desired goal (Atkins & Rohrbeck, 1993; Ferretti, Cavalier, Murphy, & Murphy, 1993; Harchik, Sherman, & Sheldon, 1992; Kennett, 1994). Frayne and Geringer (1992) defined *self-management* as an individual’s attempt to gain control over decisions and behaviors. The techniques of self-management permit entrepreneurs to creatively focus on critical decisions that align behaviors with the goals of the business (C. A. Snyder et al., 1983). Kuo (2004) found that self-management includes recognition, attitude, personal behavior, and interpersonal communication. A person’s cognition, behaviors, and environment can be altered by the individual’s response. Thus, managing the response to external influences can change situational outcomes (Frayne & Geringer, 1992). The ability to suppress unwelcomed behaviors allows employees to manage effectively during adversity.

Thoreson and Mahoney (1974) referred to self-management as self-control. *Self-management* is defined as an individual’s ability to control oneself during times when external constraints are not available. How a behavior is managed is based on past behaviors, others’ behaviors, and socially acceptable behavior criteria (Bandura, 1977; Mischel, 1973). C. A. Snyder et al. (1983) defined *self-management* as less desirable behaviors that are necessary for effective performance in the long run. To comprehensively self-manage, one must be able to self-observe, set goals, cue strategies, rehearse, and apply consequences for oneself (Mischel, 1973; C. A. Snyder et al., 1983). Frayne (1991) concurred and added the need to monitor time and the environment for obstacles, and reinforcing or punishing behavior. Manz and Sims (1980) found self-management to be a neglected substitute for leadership. The upside of this approach...
enables individuals to become responsible and accountable for their own actions (Gerhardt, 2007). The ability to identify the problem enables an individual’s commitment to a specific goal (R. Kanfer, 1987). If the goal is not established, then the ability to self-monitor would not have an effective impact on behavior (Simon, 1979).

Rosner (2006) noted the timeline of the concept of self-management has evolved from the 19th century to its use in behavioral sciences and strategies for productivity in business today. A unified definition of self-management has not been established, but the meaning of the term has not changed. The term self-management is generally associated with unified staff decision making and the implementation of those decisions in business. When the participation in decision making is not limited due to boundaries, it is usually referred to as self-management. “A self-managed organization is a bottom-up approach in management, as opposed to the hierarchical top-down approach” (Rosner, 2006, p. 56). A self-managed organization is assumed to be productive and durable because of its self-sustaining system. The level of success of self-management is based on an organization’s ability to manage a system with limited boundaries (Rosner, 2006). Subsequently, the influence of self-management in business expanded to various fields of occupation, including health care (Lorig & Holman, 2003).

In conclusion, Goleman’s model endorsed self-management as a key element of EI. Self-management has been defined as one’s ability to manage emotion (Goleman, 1995). Research on self-management has grown over time and has extended into behavior management in business (Frayne & Latham, 1987). Therefore, self-management has been considered the catalyst for individual growth. In 2003, Whicker et al.’s research on communication revealed a correlation that determined self-management to be a major
influence. Organizations embraced the skill of self-management and endorsed autonomy and decentralization (Wu & Shyu, 2011). The steps of effective self-management are identifying the behavioral problem, observing the behavior, orchestrating a plan for change, applying behavioral principles, making adjustments if necessary, and maintaining the change behavior (Watson & Tharp, 1993). In addition, research has revealed that applying consequences to oneself for unwelcome behavior is a necessity in the self-management process (Frayne, 1991; Mischel, 1973; C. A. Snyder et al., 1983). Goal setting, strategy selection, self-monitoring, self-evaluation, and self-reinforcement are behaviors that allow individuals to self-manage (Atkins & Rohrbeck, 1993; Ferretti et al., 1993; Harchik et al., 1992; Kennett, 1994). The ability to self-manage not only enhances individual growth but also aligns one’s behavior with the goals of the organization (Rosner, 2006; C. A. Snyder et al., 1983). Thoreson and Mahoney (1974) referred to self-management as self-control, the ability to suppress unwelcome behavior based on past behaviors, others’ behaviors, and socially acceptable behavior criteria (Bandura, 1977).

**History of Active Listening and Its Impact on Goleman’s Mixed Model of Emotional Intelligence**

Goleman (1995) acknowledged the importance of “recognizing the emotions in others” (p. 88). When one is attuned to the emotional state of others, the needs and wants of others become clear. Paying attention to the emotional state or subtle social signals in others, allows one to relate on a deeper level.

Research on the skill of listening can be traced back to the 1940s. Early research studies showed a heightened interest in improving listening skills of students, clients, and organizations. Nichols (1947) formulated listening-emphasis groups at the University of
Minnesota to improve communication skills for students. Bird (1953) found a majority of college students’ time was spent listening as opposed to speaking, reading, and writing and determined that listening played a significant role in the success of college courses.

C. R. Rogers (1957, 1959, 1975) developed a person-centered approach focused on nondirective counseling. This form of counseling promoted the awareness of the client’s verbal and nonverbal cues. Nondirective counseling increased the level of understanding between counselor and client by expressing empathy and practicing active listening skills designed to probe for more in-depth information (C. R. Rogers, 1957, 1959, 1975). Nichols and Stevens (1957) explored effective listening in organizations and the difficulty in learning how to listen effectively. Nichols and Stevens attributed this difficulty to a lack of training and the false perceptions of employees. In 1962, Nichols brought awareness to sympathetic listening, through efficiency listening training, and found the amount of organizational funds disbursed to training on writing skills outweighed training on listening skills. This dilemma created research interest because it was determined that writing skills were the least used communication skills.

Researchers have defined the term active listening to emphasize its enormous impact on communication. Earlier researchers acknowledged the multistep process of active listening involved an empathetic mindset, exploratory questions, paraphrasing, and summarizing for clarity (Cramer, 1998; Gordon, 2003; Turnbull & Turnbull, 1990). More recent researchers have concurred that active listening is a process of reflection, paraphrasing, asking open-ended questions, and summarizing dialogue (Dennis, 2004; Paukert et al., 2004). Dennis (2004) referred to the ability to actively listen as a “skill” (p. 23). The skill of active listening allows the communicator to reiterate spoken words,
interpret spoken words, and determine meaning through focused attention (Dennis, 2004). McNaughton, Hamlin, McCarthy, Head-Reeves, and Schreiner (2007) acknowledged the goal of active listening is “to develop a clear understanding of the speaker’s concern and also to clearly communicate the listener’s interest in the speaker’s message” (p. 224). The art of listening requires active interaction between parties to generate meaningful messages (L. Barker & Watson, 2000; Grover, 2005; Lewis & Graham, 2003). Effective communication is established when all parties involved express genuine concern to generate mutual comprehension.

Active listening has even been referred to as constructive communication, expressing genuine interest (Billings & Kowalski, 2007). Manktelow (2005) defined active listening as listening with full attention to understand a message in its totality. Active listening requires the listener to show interest through genuine sympathy or empathy with what the speaker is saying (Fowler, 2005; Salem, 2003). Therefore, allowing the inner thoughts and feelings of the speaker to surface using probing questions is a required element for listening effectively (Obenchain & Abernathy, 2003). Genuine interest can be expressed through the active listening skill of asking open-ended questions (Brunner, 2008; Friedman, 2007; Read, 2007; D. Smith, 2008). Salem (2003) found that utilizing the components of active listening are needed to provide appropriate feedback to the speaker.

Knippen and Green’s (1994) views on active listening were aligned with Carl Rogers’s nondirective approach. Knippen and Green reported that in order for a manager to become a good listener, one must be able to exemplify the techniques of restatement, summary, responding to nonverbal cues, and responding to feelings. The objective of
active listening is to “demonstrate to the communicator that the message was important and that the manager is conscientious” (Knippen & Green, 1994, p. 358). In addition, knowing when to use active listening techniques, selecting the right technique at the right moment, implementing the technique, evaluating the communicator response, and then taking action are the steps required when one decides to engage in active listening (Knippen & Green, 1994).

In regard to the sales industry, active listening was considered the highest level of listening until the conceptual framework of Comer and Drollinger (1999) came about. Comer and Drollinger concurred that empathy was a vital element for listening and added an additional level called active empathetic listening (AEL). AEL is defined as “a process whereby the listener: receives verbal and nonverbal messages, processes them cognitively, responds to them verbally and nonverbally, and attempts to assess their underlying meaning intuitively by putting themselves in the customers’ place throughout” (Comer & Drollinger, 1999, p. 18). Comer and Drollinger’s conceptual framework followed Castleberry and Shepherd’s (1993) framework by incorporating empathy and active listening. Gerrard et al. (1980) reported that active listening is a component of empathy.

Listening theorists believed the process of listening consists of multiple dimensions (Brownell, 1985; Stiel, Barker, & Watson, 1983). Ramsey and Sohi (1997) found that listening consists of three elements: sensing, processing, and responding. A. J. Alessandra, Wexler, and Barrara (1987) reported the hierarchy of listening ranges from marginal, evaluative, and active listening. They defined marginal listening as the act of hearing words but not necessarily processing those words due to distractions. Evaluative
listening consists of a higher concentration level of the receiver. Active listening encompasses the attributes of evaluative listening and includes a conscious effort to recognize nonverbal cues to stimulus as a deeper level of communication (A. J. Alessandra et al., 1987; Brownell, 1990; Castleberry & Shepherd, 1993). Salem (2003) reported that active listening builds trust and understanding between the people in the interaction. Moreover, active listening promotes joint problem solving, encourages information sharing, and manages tension. The process of learning active listening effectively requires practice and patience. The process of changing how one listens can be very difficult (C. R. Rogers, 1970). Resistance to active listening questions the effectiveness of the technique. Stewart and Thomas (1995) argued that active listening cannot truly identify inner thoughts, paraphrasing can come across condescension, and active listening can be distracting, thus preventing individuals from focusing on the actual conversation. As a result, the ability to genuinely engage with the speaker manipulates the effectiveness of communication (Salem, 2003).

On the whole, a major construct of Goleman’s (1995) model of EI involves the ability to actively listen. Goleman’s model showcased listening as a vital ingredient to effective communication. Seminal researchers on the art of listening were inspired to improve the listening skills for students, clients, and organizations (Bird, 1953; Nichols & Stevens, 1957; C. R. Rogers, 1957). Research has shown positive correlations between the act of listening and communication (Dennis, 2004). Active listening has been defined as a multistep process influenced by conveying genuine interest through the act of probing verbal expressions and an empathetic mindset (Cramer, 1998; Gordon, 2003; Turnbull & Turnbull, 1990). The purpose of utilizing the skill of active listening is to
comprehend the speaker’s message in its totality (Manktelow, 2005). Only at this point can the receiver provide effective feedback to the speaker (Salem, 2003).

The speaker’s nonverbal cues and feelings are factors to which the listener must be aware when practicing active listening (Knippen & Green, 1994; C. R. Rogers, 1957, 1959, 1975). Knippen and Green (1994) found the listener’s level of conscientious, knowing when to use active listening techniques, selecting the right technique at the right moment, implementing the technique, evaluating the communicator response, and then taking action are the steps required when one decides to engage in active listening.

Castleberry and Shepherd’s (1993) framework and Comer and Drollinger’s (1999) AEL framework exemplified how the addition of empathy enhances one’s ability to connect with the speaker on a more in-depth level. Ramsey and Sohi (1997) found that listening consisted of three elements: sensing, processing, and responding. Therefore, when one engages in all three phases while communicating, one is considered to be practicing active listening (A. J. Alessandra et al., 1987).

**History of Constructive Feedback**

Scholars have defined and identified the importance of feedback in regard to influencing behavior. Ilgen et al. (1979) defined *constructive feedback* as information that is provided in order to improve employee performance. Ende (1983) defined *feedback* as a means to guide future performance in the same or similar activity. DeGregorio and Fisher (1988) concurred that performance feedback promotes positive job performance. Pendleton et al. (1984) identified the rules of providing feedback and the rules of receiving feedback. Their rules of feedback are (a) observer adheres strictly to facts, (b) trainee identifies success, (c) observer identifies observational success, (d) trainee
discusses areas for improvement, (e) observer identifies observed weaknesses, and (f) observer and trainee formulate action plan for improvement. Pendleton et al. recommended that in giving feedback, the observer be clear, be specific, stay positive, be constructive, focus on behavior, be descriptive, provide a comfortable environment if possible, and provide advice (with caution). Sargeant, Mann, and van der Vleuten (2008) found that reflection should be a component of feedback to allow the learner to revisit, analyze, make adjustments, or acknowledge positive attributes to maintain expert performance. The feedback interaction requires all parties associated to be actively involved, while remaining considerate of the perspective of each other. When an individual complies with a strategic plan while providing feedback, it ensures the feedback is effectively provided and welcomed in a situation that may force someone to question ability. The concept of feedback has been utilized for individual growth and professional growth as a resource for improvement.

Atwater, Waldman, and Brett (2002) noted that superior-only feedback, upward feedback, and multisource feedback are the different types of feedback explored through research. Through upward feedback, subordinates are provided an opportunity to give feedback to their supervisors. Multisource feedback allows the employee to anonymously receive feedback from subordinates, peers, management, and/or customers. Lockyer (2003) stated, “The look from all perspectives helps to frame a more complete picture of performance” (p. 5). Multisource feedback is used to provide constructive feedback to improve performance (Atwater et al., 2002; Waldman & Atwater, 1998). Waldman and Atwater (1998) reported that multisource feedback allows an employee to be evaluated anonymously by people who witness the employee’s work performance. Atwater et al.
(2002) stated that 360-degree evaluations are considered a competitive advantage for companies that practice this technique. Atwater, Roush, and Fischthal (1995) found positive correlations between multisource feedback evaluation and performance. Multisource feedback is assumed to cause an increase in employee motivation to change poor behavior when applied efficiently (Atwater et al., 2002).

Prior to the 1990s, performance appraisal was determined the most popular employee feedback technique. The performance appraisal technique is administered by supervisors to their employees and conducted face-to-face to determine employee eligibility for reward. All forms of feedback have their similarities and differences. Performance appraisals are generally done to evaluate past task-related performance, while multisource feedback/upward feedback is done to provide insight on behavior/performance. All forms of feedback provide an employee with insight on how others perceive the employee’s behavior (Atwater et al., 2002). Lockyer (2003) reported that industries use multisource feedback to effectively influence decisions made about employees and to improve the quality of work. In the healthcare industry, effective feedback has been determined as one of the most vital skills needed to provide top-level care (Porte et al., 2007). The literature on feedback supports its use in organizational settings, but has also brought critical views on the subject.

Research has referred to feedback in health care as passive feedback (Mugford, Banfield, & O’Hanlon, 1991). Reilly, McIntosh, and Currie (2002) defined passive feedback as an unwelcomed delivery of information with minimal to no plan of action. Mugford et al. (1991) found that active feedback is more effective than passive feedback,
but unfortunately this form of feedback is not frequently practiced. Active feedback occurs

Where the interest of clinicians has been engaged in a particular aspect or aspects of practice: standards may have been agreed, the clinicians may be involved in continuing education, or the information may itself be the basis for a discussion about appropriate care. (Reilly et al., 2002, p. 398)

Kluger and DeNisi (1996) argued that feedback interventions occasionally fail to improve performance. Statistics show that a small percentage of feedback intervention cases have led to a decrease in performance (Kluger & DeNisi, 1996). In regard to upward feedback, research has revealed that only half of the managers who receive feedback exemplify a change in performance (Atwater et al., 2000). Critics note that the combination of anonymity and an individual tendency to rate oneself positively can result in nonmotivating negative feedback (Harris & Schaubroeck, 1988; Kluger & DeNisi, 1996).

Although the concept of feedback has drawn its share of critics, research has shown that one’s level of self-awareness increases when feedback is received (Atwater et al., 1995).

Research has identified a correlation between self-awareness and feedback (Atwater, Ostroff, Yammarino, & Fleenor, 1998; Atwater et al., 1995; Hazucha, Hezlett, & Schneider, 1993; Hegarty, 1974). Hegarty (1974) found that individuals’ self-awareness morphs to mirror the feedback received by others. Atwater et al. (1995) reported that the effects of feedback on self-awareness were also found in subordinate ratings for leaders and managerial skills in managers. The research showed an improvement in self-awareness when the recipient was in agreement with the positive or negative feedback (Atwater et al., 1998; Hazucha et al., 1993). The success of feedback is dependent on the relationship between the feedback recipient and the source.
In summation, research studies have showcased the necessity of exercising the skill of feedback in the workplace to improve performance. Pendleton et al. (1984) emphasized caution by recommending rules when providing and receiving feedback. The rules require both participants to interact on a level that is engaging, supportive, and emotionally connected. Superior-only feedback, upward feedback, and multisource feedback are three ways organizations attempt to maximize performance through the benefits of feedback. All three forms require the employee to receive feedback from individuals or groups that have directly witnessed the employee’s performance (Atwater et al., 2002).

Due to operational changes, feedback in health care has drawn criticism. Critics have referred to feedback in health care as passive rather than active, which is less beneficial to improving performance (Mugford et al., 1991; Reilly et al., 2002). On the other hand, researchers have connected feedback with improving employee self-awareness (Atwater et al., 1998; Atwater et al., 1995; Hazucha et al., 1993; Hegarty, 1974). The effectiveness of feedback is determined by the strength of the relationship between the recipient and the source, organization, follow-up procedures, individual perspective toward feedback, and individual goals (Atwater et al., 2000; Brett & Atwater, 2001; Goldsmith & Underhill, 2001).

**Controversies Surrounding Emotional Intelligence**

The concept of EI and its influence on performance has attracted attention at an enormously fast rate and has become one of the more popular theories in the domain of organizational psychology. However, the recent emergence of the concept of EI has created much controversy, causing the concept to be heavily contested (Langley, 2000).
Cherniss, Extein, Goleman, and Weissberg (2006) believed the overwhelming number of conflicting constructs of EI have made research in the field challenging. Woodruffe (2001) noted that critics have dismissed the more recent concepts of EI based on the collective unproven concepts that fail to add to the level of understanding. Van Rooy and Viswesvaran (2004) noted that attempts to unify the constructs of EI have been unsuccessful because of the magnitude of diversity of the term. Murphy (2006) reported that current constructs of EI are inconsistent, unclear, and immeasurable. Therefore, researchers have also claimed the predictive validity of EI is limited and that, despite its popularity, researchers should use caution when the concept is applied to research.

Lopes, Salovey, and Straus (2003) questioned whether EI measures skill or the result of adapting to social norms. “The claims that EI can be a more important predictor than cognitive ability (e.g., Goleman, 1995) are apparently more rhetoric than fact” (Van Rooy & Viswesvaran, 2004, p. 87). Van Rooy and Viswesvaran (2004) reported that EI had low predictability for academic and job performance. Clarke (2006) found limited research studies supporting the concepts of EI in the field of HRD:

> It is important to note that it is argued that training programs aimed to developing EI based on mixed and/or personality models offer little more than a repackaging of previous soft-skills training and as a result offer us little in way of better understanding the true potential of EI in the workplace. (p. 423)

Research has even shown that implementing training on EI might be considered premature due to immeasurable conflicting constructs (Kristjannson, 2006). Kristjannson (2006) suggested not utilizing social emotional learning due to limited evidence of its success.
Impact of Training on Emotional Intelligence

The need for EI training in the human service sector has increased (Cadman & Brewer, 2001; Carrothers, Gregory, & Gallagher, 2000). At the same time, there are limited studies illuminating the effectiveness of training programs based on EI (Clarke, 2006). Therefore, organizations, employees, executives, and career professionals are trying to comprehend what EI is, how to develop EI in individuals, what tools are needed, what methods need to be implemented, and what techniques are needed to incorporate EI into their operational systems. “Despite EI becoming a multimillion-dollar training industry in itself, research outputs from EI academics are yet to reach the wider populations” (Kunnanatt, 2008, p. 615). Law, Wong, and Song (2004) and McEnrue and Groves (2006) acknowledged this deficiency and suggested more robust research to understand the requirements to develop employees through training programs that are influenced by EI.

EI development programs should be designed to encompass six stages: “emotional mapping, emotional diagnosis, emotional authentication, emotional navigation, empathy building, and building social influence” (Kunnanatt, 2008, p. 622). Feldman, Philippot, and Custrini (1991) defined emotional mapping as the emergence, disappearance, and fusing of emotions based on social events. Emotional mapping training exercises train individuals to have a deeper understanding on how emotions impact the mind (Saarni, 1999). Goleman (1995) defined emotional diagnosis as the ability of the mind to develop neural pathways to guide one’s behavior during social interactions. These pathways are formed through continuous repetition and reinforcement that eventually determine behavior. The stage of emotional diagnosis trains individuals to
explore these pathways to determine effective strategies to increase their ability to make productive decisions (Kusche & Greenberg, 2001). The emotional authentication stage trains individual to self-monitor emotions and actions based on past experiences and to become aware of how those emotion or actions impact others (Halberstadt, Denham, & Dunsmore, 2001). The stage of emotional navigation trains individuals to embrace their emotions in order to slow down emotional reactions and make productive decisions (Sayegh, Anthony, & Perrewé, 2004). The final stage of building social influence exercises is focused on building interpersonal influence to effectively manage social relationships (Kunnanatt, 2008). Training programs that can incorporate all six stages are designed to influence the productivity and behavior of workers.

Brooks and Nafukho (2006) found that EI development programs in human resources enhanced employee effectiveness. Researchers have also recognized that organizations that support EI change efforts are influencing work environments that create stronger performance and career establishment (Carmeli & Josman, 2006; Park, 2005). Prentice and King (2011) found that training on EI improved the psychological functions of human resources through more effective recruitment and staffing. However, Zeidner, Roberts, and Matthews (2004) recognized that changes need to be made to validate the constructs of EI to make training more appealing to organizations.

Zeidner et al. (2004) suggested seven changes, including a more rigorous conceptual and definitional system of constructs, more refined tools and techniques of measurements, the ability to determine suitable behavioral criteria, and “the investigation of whether it is practically useful in applied settings to train higher EI or to measure EI for selection purposes” (p. 240). Equally important, some research studies have provided
evidence that EI training programs based on the personality/mixed models have
developed vital interpersonal and intrapersonal measurements associated with emotional
found a positive correlation of a developmental EI training program intervention when
examining 60 retail managers. The results showed an improvement following training on
organizational performance. Cherniss (2000) posited that EI has become acknowledged
as an appropriate theory for the measurement of emotions. Research evidence has shown
that EI is more prevalent in organizational settings as opposed to the traditional
intelligence in organizations that are driven by emotion (Van der Zee & Wabeke, 2004).
For example, research studies have shown that employee commitment (Carmel, 2003),
and teamwork (Ruderman, Hannum, Leslie, & Steed, 2001) have improved with EI.
Ashkanasy and Daus (2005) concurred that EI is more successful in organizations that are
driven by emotional labor. EI is valued in diverse career and life settings (Goleman,
1995), so training to strengthen these skills remains an organizational goal.

**Summary of Emotional Intelligence**

In summary, this section viewed EI from the perspective of Goleman (1995).

Researchers have criticized the utilization of EI in training programs to determine
organizational outcomes because of its immeasurable and conflicting concepts (Clarke,
2006; Kristjannson, 2006; Murphy, 2006; Woodruffe, 2001). However, Law et al. (2004)
and McEnrue and Groves (2006) acknowledged this deficiency and suggested more
robust research to understand the requirements to develop employees through training
programs that are influenced by EI. This analysis indicated that various subcomponents
of EI are critical in understanding coaching as an approach that allows communication to
be delivered and received in a uniform, effective manner. This is important to consider as the purpose of this study was to determine if the CCST was effective and influenced organizational results in a healthcare system.

**Coaching**

This section provides an examination of coaching, its history, various forms of coaching, coaching procedures, coaching in health care, and training using the coaching approach. The section also provides a description of the CCST program implemented in the research organization and an overview of Kirkpatrick’s model for evaluating the effectiveness of training in this study.

**The Coaching Approach**

The coaching approach in business to improve employee performance and development was originally inspired by coaches in sports (Čiutienė, Neverauskas, & Meilienė, 2010). Coaching increased in popularity in the 1980s because of its use in organizational management (Ellinger, Ellinger, & Keller, 2003). Stober (2006) found coaching to be influenced by multiple disciplines, for example, Rogers’s person-centered perspective, cognitive psychology, behavioral psychology, social science, positive psychology, and organizational development. The scope of coaching has expanded due to its vast beneficial factors associated with influencing behavior.

The intentional factors of coaching have been documented in scholarly literature. “Coach refers to a particular kind of carriage. Hence, the root meaning of the verb to coach is to convey a valued person from where one was to where one wants to be” (Witherspoon & White, 1996, p. 124). Cox (2006) acknowledged the intention of
coaching is to use successful experiences and future visions as a catapult to motivate change in others. Grant and Stober (2006) described the intention of coaching to be the ability to unveil potential by teaching others to learn in order to improve performance. In addition, coaching inspires creativity and accountability, and increases problem-solving skills through goal setting (Driscoll & Cooper, 2005). Biswas-Diener (2009) found the commonalities between all forms of coaching methods encompass a belief in self-improvement of the coachee, a focus on a mutually set goal, and a status-free relationship. Therefore, there are various forms of coaching that are based on personal goals, professional status, or organizational outcomes.

Business coaching is a form of coaching that addresses business issues and may not involve personal or career concerns (Kumata, 2002). The International Coach Federation (2003) incorporates all employees in its definition of business coaching by referring to the process as “professional coaching” (para. 1). The common denominators among the various definitions of the purpose of business coaching are self-awareness, the ability to acquire new knowledge, and professional growth. The employee–coach relationship has been deemed a vital element in the success of employee development and the overall business coaching process (De Haan, 2008; Gyllensten & Palmer, 2007). The coaching approach is designed to cater to the needs of individuals and groups by establishing effective business coaching relationships. Kets de Vries (2005) found that regardless of whether business coaching is implemented for individuals or groups, the results establish beneficial behavioral changes.

The coaching relationship must consist of a coach, “the one who provides one-on-one coaching” (Joo, 2005, p. 465), and coachee, “the one who gets the professional
“Organizations are anxiously trying to adapt to the changing environment of the workplace to improve overall performance. During this time of change, many organizations have supported business coaching relationships to obtain organizational goals (Brocato, 2003)—hence, the need for various coaching approaches to address organizational demands.

Brocato (2003) found that organizations are now shifting and expecting their leaders and managers to be coaches and help improve performance to reach organizational goals. “Organizations need to understand what coaching is and how to help their team leaders and managers develop this vital role” (Brocato, 2003, p. 18). Researchers have theorized employee coaching as the coaching relationship between a manager and his or her subordinate. This relationship has been recognized as an essential element to the success of coaching employees (J. B. Gregory & Levy, 2011; Hunt & Weintraub, 2002; London, 2002; Yukl, 2002). J. B. Gregory and Levy (2011) investigated coaching relationships and determined that transformational leadership, feedback environment, trust, and interactive empathy strongly supported a successful interaction. De Haan (2008) acknowledged that an effective coaching relationship is positively correlated with the success rate of the coaching process. The professional coaches who facilitate coaching relationships can be executives or line staff employees (Joo, 2005). Hamlin, Ellinger, and Beattie (2008) acknowledged that organizations utilize both internal and external coaches. HRD professionals, supervisors, and managers are occupying internal coaching positions. At the same time, HRD and management development are brought into organizations to occupy the role of external consultants.
Performance coaching, executive coaching, and life coaching are the three variants of coaching utilized by organizations today (Lazar & Bergquist, 2004).

Lazar and Bergquist (2004) categorized organizational coaching into three categories: performance coaching (Goldsmith, 2000; Whitmore, 1996), executive coaching (Ludeman & Erlandson, 2004), and alignment coaching. Goldsmith (2000) referred to performance coaching as a strategy designed to address behavior. Ludeman and Erlandson (2004) noted that executive coaching involves organizational members in high levels within the organization. This form of coaching is geared to address decision-making issues created by the alpha personality that cause blocks in communication.

“Executive coaching involves a series of one-on-one interactions between a manager or executive and an external coach in order to further the professional development of the manager” (McCauley & Hezlett, 2001, p. 321). Some researchers define executive coaching differently due to alternative perspectives. Bacon and Spear (2003) defined executive coaching as “an informed dialogue whose purpose is the facilitation of new skills, possibilities, and insights in the interest of individual learning and organizational advancement” (p. xvi). Lazar and Bergquist acknowledged that both performance coaching and executive coaching are used as interventions to alter performance. When both forms of coaching appear ineffective, an alternative approach may be required.

Thus, alignment coaching is designed to focus on the “values, beliefs, expectations, and attitudes” (Lazar & Bergquist, 2004, p. 17) of the coachee. The four types of alignment coaching are spiritual, philosophical, ethic, and career life coaching. These forms of coaching are normally combined with performance and executive coaching to get a
broader perspective of “the whole person” (Lazar & Bergquist, 2004, p. 17), not just the behavior.

Besson Levine (2012) reported the process of coaching has similar phases but the executed methodology varies among coaches. Lachman (2000) found the steps needed to execute a successful coaching session start with opening the meeting by stating the specific reason for the coaching session. Second, the coach needs to get an understanding that the coaching topic is the issue of concern. Third, the coach and coachee must explore the benefits and drawbacks to alternative suggestions. Fourth, the coach must get a commitment for action. The final steps involve a summation of the conversation and establishing a follow-up procedure. In addition, as excuses surface during the coaching interaction, the coach must be able to redirect the conversation back to the original point, while remaining empathetic to the coachee’s concerns (Lachman, 2000).

The phases of coaching are contracting, assessment, action plan, and evaluation. In the contracting phase, the coach begins by establishing confidentiality, a plan of action, and set goals, and discloses the terms and conditions of the agreement. In the assessment phase, the coach utilizes an assessment tool (e.g., 360-degree survey, Myers–Briggs) to assess the strengths, weaknesses, and future opportunities for the coachee. The next phase requires the coach and coachee to establish an action plan based on the results of the assessment. Lastly, the evaluation phase is continuous throughout the coaching process in order to adjust to changes or obstacles that may surface during the coaching process (Besson Levine, 2012). The benefits of coaching are determined by the efficiency, skill, and persistence of the coach. However, failing to implement the coaching approach successfully can create unsatisfactory results (Brocato, 2003).
Brocato (2003) found that coaching is more likely to fail when the coach does not equally interact with the coachee, fails to give specific feedback, addresses the attitude instead of the behavior, fails to establish a plan of action, fails to follow up, or fails to acknowledge improvement. When coaching has come to a standstill in a coaching relationship, Oberstein (2010) suggested the coach maintain the energy of coaching, use this time to realign objectives, inspire positive “self-talk” (p. 56), and disclose any negative personal feelings toward the coachee. When coaching becomes challenging, coaches should become catalysts and practice catalytic conversational skills. It has been documented that a coach can become a better catalyst by being more curious, proactive, observant, and courageous (Haneberg, 2011). Due to the increased popularity of coaching, practitioners must be aware of the drawbacks and benefits of the coaching approach.

Joo (2005) found that the membership of the International Coach Federation tripled from 1999 to 2003 and has been rising ever since. The popularity of coaching has increased rapidly, but the research to determine its effectiveness has trailed behind (Jarvis et al., 2006). “While practice on coaching is increasing, more attention needs to be paid to coaching by researchers” (Joo, Sushko, & McLean, 2012, p. 21). Research shows the coaching approach to learning experience is responsible for fewer turnovers, an increase in customer loyalty, and an increase in profit when implemented effectively in organizations (Berard, 2005). Carol (2006) reported that training alone increases employee productivity by 23%; however, when training is combined with coaching, the organization’s productivity increases by 88% (Carol, 2006). Research has revealed that training employees outside of their work environment creates the risk of trained
knowledge being lost by the time the participant returns to work (Stevens & Frazer, 2005). Statistics show that 20–90% of retention is loss within the first 90 days posttraining (Stevens & Frazer, 2005). “Many organizations effectively rise to this challenge by supplementing classroom training with effective follow-on coaching” (Stevens & Frazer, 2005, p. 8). When coaching is provided to support training, it reinforces retention over time. Stevens and Frazer (2005) recommended that coaching be used in addition to training as a corporate blended learning strategy. A survey conducted by ClearRock (2014), a coaching firm in Boston, revealed that coaching is one of the five most effective elements for retaining top-performing employees. Numerous organizations have explored the benefits of training using a coaching approach especially in the organizational setting of the healthcare industry.

Research studies have acknowledged the need for a coaching approach in the healthcare industry. Parker, Wall, and Jackson (1997) found the healthcare field is changing strategically. Due to economic barriers, the healthcare field is using programs that promote innovation and employee development. Oberstein (2010) stated, “Coaching skills are becoming critical management competencies as organizations attempt to develop their employees using fewer financial, human, and training resources” (p. 54). Locke (2008) argued that corporate leaders in health care are forced to find a competitive advantage in a struggle to survive in the industry. Locke found that healthcare organizations are turning to developmental coaching to resuscitate the bottom line by tapping into intangible talent. Developmental coaching is aligned with Herzberg’s (1987) theory. Both concepts acknowledge that individuals are motivated by challenges, self-growth, level of contribution, recognition, and level of responsibility at work. Therefore,
challenging employees, employee growth, autonomy, employee recognition, and responsibility are the key elements to developing and motivating employees (Herzberg, 1987). Locke found that developmental coaching is commonly used with novice nurses to develop technical competencies. In addition, high-potential employees are known to benefit from developmental coaching in order to increase their scope of influence within the organization. New managers are exposed to developmental coaching because it allows them to develop new skills to motivate and improve the knowledge, skills, and abilities of employees. Lastly, developmental coaching is known to be used with organizational teams. “Team coaching is concerned with developing the capabilities of integrated, interdependent human systems” (Locke, 2008, p. 109).

The benefits of implementing training programs, merged with the coaching approach, have produced positive results in the healthcare industry. Therefore, recent studies have shown an increased interest in coaching in regard to the nursing industry (Ammentorp, Jensen, & Uhrenfeldt, 2013; Ammentorp & Kofoed, 2010; Fielden, Davidson, & Sutherland, 2009; Johnson, Hong, Groth, & Parker, 2011; Yu, Collins, Cavanagh, White, & Fairbrother, 2008). Johnson et al. (2011) found that coaching improved job satisfaction and organizational commitment in nurses. In 2009, Fielden et al. found a positive correlation with coaching and career development, leadership skills, and capabilities in nurses. Yu et al.’s (2008) pre-/posttest analysis revealed that coaching can be beneficial for nurses in group or individual settings because the methodology promotes an increase in participation and learning. Ammentorp et al. (2013) analyzed the experience of health professionals with coaching. They stated that little is known of the coaching procedures during the sessions and why it contributes to positive organizational
outcomes. However, their research revealed that healthcare providers found a new positive job perspective and new insight, and established an action plan to achieve personal goals. Regardless of the increased popularity of coaching programs in the healthcare industry, researchers have also expressed a demand for more research studies based on theory to investigate the effectiveness of training programs with a coaching approach.

Researchers have requested that future research in coaching be linked to theory (Bennett, 2006; Sherman & Freas, 2004). For example, effective coaching has been linked to control theory to illustrate how self-regulation is essential for upper management in the modern workplace (J. B. Gregory, Beck, & Carr, 2011). Ellinger and Bostrom (1999) referred to feedback as a vital element to coaching. Hall, Otazo, and Hollenbeck (1999) recognized the role of a coach is to provide challenging feedback. In addition, coaches should only provide feedback toward changeable behaviors (Gegner, 1997). Hunt and Weintraub (2002) linked control theory to coaching and noted that feedback allows coaches to bridge the gap between actual performance and anticipated performance. J. B. Gregory, Levy, and Jeffers (2008) suggested that feedback be given early in the coaching process. Kluger and DeNisi (1996) recommended that coaches remain cognizant of the type of feedback provided to coached clients. Negative feedback should always be accompanied by an explanation of how the negative feedback can be beneficial to the client. In addition, negative feedback should be focused on process-oriented feedback instead of outcome-oriented feedback, to prevent a decrease in motivation (Medvedeff, Gregory, & Levy, 2008). Levy, Albright, Cawley, and Williams (1995) noted that coaches should teach and encourage their clients to seek feedback.
The values of coaching are considered necessary in a business setting. Coaching allows organizations to orchestrate a beneficial future, instead of focusing on past mistakes (Whitmore, 2011). Carol (2006) noted that “coaching can improve employee and manager skills on communication, career/personal growth, job satisfaction, relationship with coworkers/supervisors, leadership development, supervision, organizational/personal values, negotiation, strategies, decision-making skills, and work/life balance” (p. 28). Besson Levine (2012) found that statistics in coaching are extremely scarce, but evidence shows that coaching improves the financial status, productivity, employee satisfaction, and working relationships within organizations.

Coaching should be used in an organization when there is a need for employees to exceed expectation. Coaching allows organizations the resources to maximize its employees’ potential. “A coach can be called in for many reasons, and in a variety of scenarios where an organization can see value in developing, retaining and motivating their employees” (Besson Levine, 2012, p. 52).

This section provided a deeper understanding of the definition, purpose, and benefits of the coaching methodology. Now it is paramount to gain a deeper understanding of the CCST curriculum implemented in this research study.

**Coaching Communication Curriculum**

The CCST utilized in this study was designed to help employers and their staff build the skills necessary to deliver highly personalized, relationship-centered care. The curriculum introduces coaching skills to healthcare workers in home and residential care settings. With a focus on communication and problem solving, the curriculum is designed
to teach skills to build positive relationships and provide a foundation that allows employees to grow personally and professionally.

The curriculum introduces coaching skills to healthcare professionals in the context of the realities of work settings. The curriculum is focused on communication with a coaching approach that builds positive relationships between healthcare professionals and coworkers, healthcare professionals and residents, and healthcare professionals and residents’ family members or guests. The program begins with a thorough introduction of coaching communication while simultaneously establishing a private, respectable, and open environment. Once this environment has been established, the trainers introduce the four skills of the CCST program: active listening, self-management, self-awareness, and constructive feedback.

The first skill introduced in the program is active listening. The CCST program describes active listening as one’s ability to listen with one’s full attention. No matter the duration of the interaction, the listener must practice genuine concern for the speaker. The CCST program is designed to train various active listening skills, including attentive body language, paraphrasing, and asking open-ended questions. An additional goal is to reinforce the difficulty and importance of clear verbal communication and to identify strategies to improve communication. The training methods utilized in the active listening section are demonstrations, paired role-plays, discussions, large-group exercises, and interactive presentation.

The second skill introduced in the CCST program is self-management. Self-management training helps participants to become more conscious of their emotional reactions to particular situations or people. The curriculum showcases how emotional
reactions can block real listening and explores strategies to set aside reactions to listen openly, improve communication, and solve problems. The curriculum describes and demonstrates how active listening and self-management are applied to the coaching communication approach. The curriculum reinforces self-management and active listening skills using the training methods of demonstrations, paired role-plays, practiced role-plays, discussions, small-group preparation work, small-group work, brainstorming, and interactive presentations.

The third skill taught in the CCST program is self-awareness. This section of the program raises participants’ awareness of the judgments and assumptions they make about coworkers, residents, and residents’ family members. These judgments and assumptions may prevent them from seeing the whole picture when a problem arises and may negatively impact their relationships in the workplace. The curriculum explores personal styles, particularly as they relate to how individuals communicate and understand and react to situations. The exercises are designed to have participants identify their personal styles and recognize how differences in styles may affect workplace relationships. The training methods utilized in this section are role-plays, discussions, interactive presentations, and large-group exercises.

The fourth skill taught in the CCST program is feedback (presenting the problem). The curriculum reinforces the importance of balancing empathy and support with holding workers accountable for performing their jobs to specific standards. For example, one aspect of processing and holding the worker accountable is the act of presenting the problem without blame or judgment. The exercises in this section are designed to have participants practice using the three rules for presenting the problem: be
clear and direct, use objective language, and indicate belief in the worker. The training methods utilized in this section are large-group discussions, demonstration role-plays, pairs work, discussions, interactive presentations with pairs work, pairs practice, and large-group debrief.

The final section of the CCST program calls for participants to review and consolidate the skills that were learned through real work-life scenarios. The participants are reminded of how using a coaching support in the workplace can benefit productivity and the culture of the organization. By the end of the program, participants are expected to demonstrate these concrete, measurable behaviors.

Leonard and Frankel (2011) declared that effective communication is an essential element to improve the quality of care provided by healthcare professionals. Piven et al. (2006) reported a strong need for training to bridge the communication among healthcare staff. Willingham and Eden (2007) concurred that organized communication is imperative in health care, but training to establish a standard has not been established. Details of the CCST curriculum were included in this section to illustrate a CST program that exemplifies the recommended attributes acknowledged by Graham et al. (1994). Graham et al. stated that a CCST program should promote a unified communication technique, respect, constant observation, feedback, trust, and performance improvement to nullify differences between healthcare professionals. In addition, the CCST program in this research study is aligned with Kraiger et al. (1993) because the curriculum was designed to incorporate organizational goals and support employees’ mental and professional growth. Utilizing combinations of training techniques recommended by Kemeny et al. (2006), this curriculum aims to bridge the gap in communication among
healthcare staff. The effectiveness of the CCST was evaluated using Kirkpatrick’s (1994) model for training effectiveness.

Kirkpatrick’s Model for Training Effectiveness

The theory associated with evaluating the effectiveness of the CCST is based on the four-level model developed by Kirkpatrick (1994). Reaction, learning, behavior, and results are the four levels of evaluation recognized by Kirkpatrick (1959). Level 1 reaction criteria measure how the participants react to the training. Kirkpatrick (1994) believed that examining the reactions of trainees is equivalent to examining the trainees’ level of satisfaction. Whether training is considered to be effective is determined by the trainees’ level of favorability of that training. Alliger et al. (1997) found the reaction level consists of positive reaction and educational gain. Their research also revealed no relationship between the need for the reaction level in conjunction with the other three levels of the model. However, it is recommended that all four levels of Kirkpatrick’s model be used to evaluate training outcomes. Level 1 is based on the participant’s level of enjoyment with the training; collecting this information is much easier than evaluating the training based on all four levels (Arthur et al., 2003).

Kirkpatrick’s (1994) Level 2 learning criteria measure how much the trainees have learned during the training. If the trainees fail to learn the skills that are being trained, then the expectation of change is hindered. Kirkpatrick emphasized that evaluating the training is a good indicator of training effectiveness. Immediate posttraining measures are needed in the form of pre-/posttest or other forms of assessment (Praslova, 2010).
Kirkpatrick’s (1994) Level 3 behavior criteria measure whether what was learned during training is being applied on the job. These criteria are determined by on-the-job performance that stemmed from the effects of training (Kirkpatrick, 1994). Alliger et al. (1997) referred to this level as the transfer criteria and found there was a modest relationship between the learning criteria and the behavior criteria. Arthur et al. (2003) associated the lack of relationship with the posttraining environment that hinders the trainees’ ability to practice the skills learned during training.

Kirkpatrick’s (1994) Level 4 results criteria measure whether results are achieved after the application of training. Based on an organizational perspective, the results level of evaluation is determined by the achievement of the expected outcome of the training. Because of the difficulty of assessment, these criteria are utilized the least (Arthur et al., 2003). Research revealed that organizations limit the collection of results data in fear that trainers may have unrealistic expectations of training outcomes. Social and economic constraints also play a role in limiting the collection of results data (Alliger et al., 1997). Arthur et al. (2003) noted the reaction and learning levels in Kirkpatrick’s model are considered internal because what occurs within the training determines its outcome. In contrast, the behavior and results levels are considered external because of the potential influence of outside factors. The results level is the highest and most difficult level of evaluation in Kirkpatrick’s four-level model (Praslova, 2010).

Recent studies have utilized the four-level model developed by Kirkpatrick. Slater, Lawton, Armitage, Bibby, and Wright (2012) adopted Kirkpatrick’s model to evaluate the effectiveness of a training program on patient safety within quality improvement methods. The results showed a positive correlation between Kirkpatrick’s
model and its ability to evaluate the implemented training program. In addition, the method of interviews to evaluate Levels 3 and 4 generated additional themes that were not originally acknowledged in the research question. Hill, Tzu-Chieh, Barrow, and Hattie (2009) investigated the effectiveness of a training program on resident teaching abilities. Utilizing Kirkpatrick’s model, the results presented the elements that were considered training features that ensured success. Based on Kirkpatrick’s (1994) evaluation model, the current research study was conducted to understand the effectiveness of a CCST program in regard to the four levels of training evaluation.

**Summary of Coaching**

In summary, this section provided analysis of the coaching approach. The popularity of coaching has expanded due to its influence on changing employee behavior (Biswas-Diener, 2009; Cox, 2006; Grant & Stober, 2006; Witherspoon & White, 1996). Training programs that incorporate coaching have reported more success in terms of productivity and retention (Carol, 2006). This analysis addressed the need for coaching to be combined with other training programs in health care (Locke, 2008; Parker et al., 1997). The CCST utilized in this study was designed to focus on a coaching communication approach. The objective of the curriculum is to teach skills to build positive relationships and provide a foundation that allows employees to grow personally and professionally. The curriculum introduces coaching skills to healthcare professionals in the context of the realities of work settings. In addition, this section acknowledged the recommendation to conduct future research that combines coaching with theory in research (Bennett, 2006; Sherman & Freas, 2004). The CCST program in this study
incorporates four core concepts of the theory of EI: active listening, self-management, self-awareness, and constructive feedback (Goleman, 1995).

To determine whether the CCST was effective and influenced organizational results in a healthcare system, the four-level model—reaction, learning, behavior, and results—developed by Kirkpatrick (1994) was implemented in this study. Therefore, the examples of the benefits of coaching revealed in this analysis (Ammentorp et al., 2013; Ammentorp & Kofoed, 2010; Fielden et al., 2009; Johnson et al., 2011; Yu et al., 2008) provided motivation as to why the CCST implemented in this study was evaluated using Kirkpatrick’s model (Hill et al., 2009; Slater et al., 2012). Organizations have supported the coaching relationship to obtain organizational goals (Brocato, 2003; Goldsmith, 2000; Lazar & Bergquist, 2004; Ludeman & Erlandson, 2004; Whitmore, 1996); therefore, this was important to consider as the purpose of this study was to determine if the CCST was effective and influenced organizational results in a healthcare system.

**Synthesis**

This literature review began with a historical perspective of the quality of care in long-term health care and a brief overview of the quality of health care in the United States. The review highlighted the importance of communication and quality of care. Therefore, developmental programs are a necessity, and through the recommendation of the IOM (2001) and the research of Frankovelgia and Riddle (2010), McAlearney (2008), Feltner et al. (2008), and Stapleton et al. (2007), it is apparent that CST programs are needed in health care. This analysis was important because the organization utilized in
the study is a long-term healthcare facility whose mission is to provide top-notch care to its clientele.

Next, the chapter provided an overview of various CST programs and their importance and influence on quality of care. It was important to examine CST programs especially in the context of the primary research question: How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system? Distinguishing prior influence and effectiveness of the major content of the program on training allowed the researcher to identify the reasons these various training programs were included in the CCST in this study. Engin and Çam (2009) pinpointed the emotional frustrations associated with healthcare providers. Özcan (2006) and Jack and Miller (2008) identified this dilemma and investigated the dynamics of interpersonal relationships in health care, and concluded the skill of self-awareness is vital to productivity and positive outcomes. Articles by Rungapadiachy (1999), Mead and Bower (2000), and Epstein et al. (2005) were selected to provide evidence that self-awareness is a mandatory healthcare skill. The research of Fleming (2009), Zaertnik et al. (2010), Schmidt et al. (2012), and Ünal (2012) revealed the skill of self-awareness is needed to be strategically trained in health care to increase retention that transfers to practice.

Articles by Manz and Sims (1989), Rollnick et al. (1993), Lorig et al. (2001), Miller and Iris (2002), and Kennedy et al. (2005) were selected to showcase how researchers have determined that self-management programs improve productivity and patient care. Articles by Thoreson and Mahoney (1974), Manz and Sims (1980), Coulter (1997), Doherty et al. (2000), Center for the Advancement of Health (2002), and
Kennedy et al. (2005) were selected to illustrate the content needed in self-management training to be effective. Therefore, one can understand why the concept of self-management has evolved into one of the major elements for building strategies to improve productivity in business today (Rosner, 2006).

Articles by Gerrard et al. (1980), Papa and Glenn (1988), T. Alessandra and Hunsaker (1993), Hesselbein (2003), Manktelow (2005), Shatell (2005), and Newton et al. (2005) were selected to distinguish the benefits of active listening to improve productivity, interpersonal relationships, organizational errors, and clarity of workplace dialogue. The research findings of Viederman (2002), Bryant (2009), Duhamel and Talbot (2004), Paukert et al. (2004), and Brownell (2008) showed that healthcare organizations have expressed interest in improving the quality of care by training active listening to employees.

Larson (1989) highlighted the necessity of effective feedback by showcasing its ability to improve performance. The research of Ericsson (2004) and Krackov (2011) illustrated that training employees on the skill of feedback has been connected to beneficial organizational outcomes, performance, and increased internal human capital. Clay et al. (2007), Porte et al. (2007), Spickard et al. (2008), Carr (2006), Gukas et al. (2008), and Hughes et al. (2008) conducted research that revealed feedback techniques successfully implemented through modern technology. Branch and Paranjape (2002) reported that feedback is the foundation of medical education and should be implemented in all training. One can conclude that self-awareness, self-management, active listening, and constructive feedback training programs have separately contributed to organizational results when implemented in a healthcare system. In this study, the
researcher examined a CCST program that encompasses all four topics through the perspective of Goleman’s (1995) model of EI.

Also included in this chapter was a brief history of EI and an overview of the theoretical constructs in the field. The review focused on Goleman’s (1995) mixed model of EI and provided an in-depth examination of the concepts of self-awareness, self-management, feedback, and active listening. The history and impact of EI were examined. The controversies in the EI field and its impact on training also were analyzed. The CCST associated with the primary research question is based on Goleman’s theory of EI. Articles by Kristjannson (2006), Woodruffe (2001), Murphy (2006), and Clarke (2006) represented critics of EI who stated the utilization of EI in training programs to determine organizational outcomes lacked reliability due to immeasurable and conflicting concepts. However, the researcher provided evidence from Law et al. (2004) and McEnrue and Groves (2006) to acknowledge researchers who have recognized this deficiency and recommended more robust research to understand the requirements to develop employees through training programs that are influenced by EI. This analysis indicated that various subcomponents of EI are critical in understanding coaching as an approach that allows communication to be delivered and received in a uniform, effective manner; this was important to consider as the purpose of this study was to determine if the CCST was effective and influenced organizational results in a healthcare system.

The literature review continued with an examination into coaching, its history, various forms of coaching, organizational coaching, coaching procedures, coaching in health care, and training using the coaching approach. The literature review concluded with a description of the CCST program implemented in the research organization and an
overview of Kirkpatrick’s model for evaluating the effectiveness of training. This section provided analyses of the coaching approach. Articles by Witherspoon and White (1996), Cox (2006), Grant and Stober (2006), and Biswas-Diener (2009) were selected to showcase the enormous growth in popularity due to its influence on changing employee behavior. Carol’s (2006) findings illustrated how training programs that incorporate coaching have reported more success toward productivity and retention. Parker et al.’s (1997) and Locke’s (2008) studies were selected because they clearly addressed the need for coaching to be combined with other training programs in health care.

The CCST utilized in this study was designed to focus on a coaching communication approach. The objective of the curriculum is to teach skills to build positive relationships and provide a foundation that allows employees to grow personally and professionally. Bennett’s (2006) and Sherman and Freas’s (2004) articles were selected to show that recommendations have been made to conduct future research that combines coaching with theory in research.

The CCST program in this study incorporates four core concepts of the theory of EI: active listening, self-management, self-awareness, and constructive feedback (Goleman, 1995). To determine whether the CCST was effective and influenced organizational results in a healthcare system, the four-level model—reaction, learning, behavior, and results—developed by Kirkpatrick (1994) was implemented in the study. Therefore, the reaction level was addressed in Research Subquestion 1, What evidence illustrates that staff found the training intervention enjoyable (Level 1)? The learning level was addressed in Research Subquestion 2, What evidence illustrates that staff gained knowledge from the training intervention (Level 2)? The behavior level was
addressed in Research Subquestion 3, What evidence illustrates that staff changed behavior after the training intervention (Level 3)? The results level was addressed in Research Subquestion 4, What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)?

The examples of the benefits of coaching revealed in this analysis were exemplified through articles by Yu et al. (2008), Fielden et al. (2009), Ammentorp and Kofoed (2010), Johnson et al. (2011), and Ammentorp et al. (2013). The research of Slater et al. (2012) and Hill et al. (2009) provided evidence that confirmed the selection of Kirkpatrick’s model to evaluate the CCST implemented in this study. Brocato (2003), Whitmore (1996), Goldsmith (2000), Ludeman and Erlandson (2004), and Lazar and Bergquist (2004) confirmed that organizations support coaching relationships to obtain organizational goals. Therefore, this was important to consider as the purpose of this study was to determine if the CCST was effective and influenced organizational results in a healthcare system.

Articles by Paice (1998) and Ericsson (2004) were selected because they reported a change in healthcare operations. This change decreased the amount of time employees have for training. Due to time constraints, healthcare operations force organizations to improve the knowledge, skills, and ability of employees with less training. Articles by Hicks (2011), Bergeron and Laroche (2009), and Mewton et al. (2005) demonstrated previous research that combined various skills associated in this CCST and reported positive results. Combinations involve feedback and coaching, active listening and coaching, self-awareness, active listening, empathy, and integrity. The popularity of coaching has rapidly increased, but research to determine its effectiveness has trailed
behind (Jarvis et al., 2006). Suthakaran (2011) found evidence to suggest that future research use qualitative measures to investigate the effectiveness of analogies in training. The literature review addressed these major topics using these particular articles because the literature directly relates to the primary research question in this study.

Chapter 3 provides a detailed description of the methodology of this study. Details include information regarding the research design, sample, setting, instruments, data collection, data analysis methods, validity and reliability, and ethical considerations.
CHAPTER 3. METHODOLOGY

Introduction

The purpose of this qualitative exploratory case study was to explore the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. This study contributed empirical knowledge to the field of organizational management, HRM, organizational communication, and training because it was designed to help an organization understand how implementing CST based on coaching methods influences higher levels of performance and results. To improve the quality of care in long-term health care, results from this study can add to the body of knowledge by increasing awareness of the value of CST programs that promote coaching. This research provides organizations with insight into how to best support healthcare providers.

This study used a qualitative design as opposed to a quantitative design to enable the researcher to examine an individual/group and gain a deeper understanding of a phenomenon/experience (Creswell, 2009). Qualitative research is designed to gain access to data that may not be revealed through quantitative data collection methods (Sweet & Norman, 1995). In qualitative research, the researcher is required to gain as much information as possible until saturation of data is achieved. The purpose of qualitative research is not to generalize but to investigate a topic of interest thoroughly. As a result,
qualitative research adds to previous knowledge or builds a more person-centered practice (Thomas & Magilvy, 2011). This qualitative study followed an exploratory case study design. A case study design was considered the most beneficial approach because of its ability to take into account multiple perspectives (Huberman & Miles, 2002). A focus group methodology was selected as the primary method of data collection because of the exploratory nature of the study. Researchers have frequently used focus groups to explore or evaluate to gain a deeper understanding of the phenomenon in question (Barbour, 2007; Crabtree & Miller, 1992; Patton, 1990). The benefits for using focus groups in exploratory research are that it is a method that provides flexibility, richness of data, is low cost, and enables more in-depth responses (Fontana & Frey, 1994).

According to Freebody (2003), focus group data analysis must compare and contrast interpretations, expand by developing themes, and explore findings that are inconsistent to or disconfirming of the research question. In this study, the technique used to analyze focus group data was based on constant comparison analysis of the framework by Glaser and Strauss (1967) and micro-interlocutor analysis, a new method of analysis developed by Onwuegbuzie, Dickinson, Leech, and Zoran (2009).

The researcher employed Computer Assisted Qualitative Data Analysis Software (CAQDAS) to manage all of the data for this qualitative case study. Using CAQDAS allowed the researcher to monitor the data, minimize mistakes, and compare and contrast data. A code-and-retrieve program was used to compare and understand data (Miles & Huberman, 1994). NVivo 9.0 was selected as the CAQDAS used in the research process. All themes were presented and defined in the text. Reliability in the study was obtained.
by reviewing transcribing errors, coding, triangulation of data, member checking, and peer examination.

**Research Question and Subquestions**

**Research Question**

How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system?

**Research Subquestions**

1. What evidence illustrates that staff found the training intervention enjoyable (Level 1)?
2. What evidence illustrates that staff gained knowledge from the training intervention (Level 2)?
3. What evidence illustrates that staff changed behavior after the training intervention (Level 3)?
4. What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)?
5. How does the impact of coaching communication differ among occupational groups in health care?

The four levels indicated in the research questions are based on the four-level model developed by Kirkpatrick (1994): reaction (Level 1), learning (Level 2), behavior (Level 3), and results (Level 4).
Research Design

This study utilized a qualitative case study methodology. The sample was drawn from a long-term healthcare facility in New York. The participants were asked questions to explore the effectiveness of a CCST program and its impact on organizational results in a healthcare system. Flyvbjerg (2006) referred to case studies as beneficial to the success of a researcher. Case study methodology allows researchers to get a closer look at the phenomenon in question (Yin, 2009). When conducting this form of methodology, researchers develop the skill of investigating real-life situations to discover nuances in reality (Flyvbjerg, 2006; Yin, 2009). In his seminal work, Whitley (as cited in Yin, 2006) defined the case study research method as an in-depth descriptive approach that strives to make a connection between the total person and how that person is influenced by the total world that exists around him or her. Yin (1984) defined the case study method as an experimental analysis that investigates an existing phenomenon in its natural setting, where the correlation between the phenomenon and its environment is blurred, and various sources of evidence are utilized (Yin, 2006). Stake (1995, 2005) confirmed a case study is the study of a complex single case with the intention to gain a deeper understanding of a significant situation (Yin, 2009).

Yin (2003) found that case study methodology has been proven helpful when the correlation between the phenomenon and its context is not clear. Whitley (1932) concurred the case study method allows the researcher to probe the participants for personal accounts. Based on Sweet and Norman (1995), resident care is the top priority and the core focus of the mission and vision of healthcare organizations. The case study method provides a comfortable and safe environment for the participants to reveal
personal and sensitive information that may be considered risky or ignored during surveys. When the behavior revealed goes against the goal of the organization, fear of termination is an issue (Sweet & Norman, 1995).

The qualitative case study methodology allowed the researcher to thoroughly investigate the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. Semistructured focus groups, audio recordings, archival records, and field notes were used to generate data from participants. Previous research has promoted the combination of case studies and focus groups in social sciences. For example, Owens, Crone, Kilgour, and El Ansari (2010) utilized a qualitative case study methodology that encompassed focus groups; they stated the combination of methods chosen promotes “spontaneous interaction” (p. 3) and in-depth responses.

The process of how data are collected is a vital element in the case study methodology. Yin (2009) stated the six sources of evidence most commonly used are documentation, archival records, interviews, direct observation, participant observation, and physical artifacts. In addition, the list of sources of evidence extends far beyond the previous six sources mentioned. When data collection is performed using a variety of sources, valuable data can be harvested that may not have been revealed through less ambitious data collection techniques. Stake (1995) emphasized the importance of making a conscious effort to manage time during research to investigate different sources of evidence thoroughly (Yin, 2006). Combining different sources of evidence can only benefit the results in a case study method. Each source of evidence has its own strengths
and weaknesses, but one is not considered more valuable than another. Investigators need to select their sources of evidence with specific intentions to achieve significant results.

A focus group methodology was selected as the primary method of data collection because of the exploratory nature of the study. The popularity of focus groups has increased in health science research (Sims, 1998; Webb & Kevern, 2001). Researchers have frequently used focus groups to explore or evaluate to gain a deeper understanding of the phenomenon in question (Barbour, 2007; Crabtree & Miller, 1992; Patton, 1990). In this study, the researcher explored the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. The benefits for using focus groups in exploratory research are that it is a method that provides flexibility, richness of data, is low cost, and enables more in-depth responses (Fontana & Frey, 1994). Asbury (1995) endorsed the use of focus groups over one-on-one interviews because of the quantity and richness of responses generated through group interactions. Krueger and Casey (2009) acknowledged the limitations of focus groups are the possibility of receiving false information, exaggerated information, emotionless information, unclear responses, and dominant personalities that may negatively affect the responses of the group. In order to remedy the drawbacks of focus groups, researchers are urged to make sure the moderator is experienced in conducting focus groups, the research is well designed, and the interview protocol is designed to generate useful information (Krueger & Casey, 2009).

The individuals who volunteered to participate in this study were asked a series of open-ended questions regarding their work-life experiences post-CCST. The influence of the CCST on communication was understood based on the participants’ responses to the
questions. The researcher used CAQDAS to manage all of the data for this qualitative case study, which allowed the researcher to monitor the data, minimize mistakes, and compare and contrast data. A code-and-retrieve program was utilized to compare and understand data (Miles & Huberman, 1994). Reliability in the study was obtained by reviewing transcribing errors, coding, triangulation of data, member checking, and peer examination.

Prior to the focus group taking place, participants responded to the request to participate in the study. Most of the employees in the organization were eligible to participate in the study; employees who were excluded were part-timers, per diem employees, interns, volunteers, and probationary employees. The following departments were required to complete the CCST program: nursing, adult health care, admissions, childcare, clinical compliance, dining services, environmental, facility management, support services, finance, human resource, homecare, information technology, marketing, finance, security, and recreation. D. L. Morgan (1997) stated the number of participants in each focus group normally ranges between 6 and 12. Therefore, four focus group sessions with eight participants each were conducted in this study. Data were collected from 32 participants in total.

Sample

Target Population

While communication and quality of care have been widely studied (Hogston, 1995; Willingham & Eden, 2007), CCST has yet to be entirely explored to improve communication and provide quality care in long-term health care. All staff employed in
long-term health care can benefit from this study as the outcome established a successful way to communicate and contribute as another component used to influence quality of care. Therefore, it is expected that employees of all levels and disciplines will benefit from this study. The target population is multigenerational and has a wide range of experience and education.

In this study, the homogeneous focus groups were separated into four groups: nursing, support services, community-based (homecare, adult daycare), and administration departments from within the long-term healthcare facility. The groups were separated in order to bring together individuals who share similar experience and background (Patton, 1990). The similar background in this study is department (e.g., nursing, administration), and the similar experience is the CCST program.

**Demographic Data and Inclusion Criteria**

The sample frame was generated from a population of employees at a long-term healthcare organization located in the northeastern region of the United States. All participants resided in the same area as the research organization. In this qualitative case study, eligible participants (excluding part-timers, per diem employees, interns, volunteers, and probationary employees) were represented by any employee in the organization who had successfully completed the CCST. The departments involved in the study were nursing, support services, community services, and administration. This study was conducted with both female and male participants ranging in age from 18 to 65.

**Recruitment and Participant Selection**

Recruiting for participants was achieved through flyers posted throughout the organization, face-to-face by the researcher, via e-mail, and through monthly in-service
calendars. All volunteer participants were presented with an inform consent form that
detailed the purpose and procedure of the study, thus building mutual trust between
participants and researcher.

The sampling procedure technique utilized in this qualitative case study design
was a purposive homogeneous sampling. According to Patton (1990), “the purpose of
purposeful sampling is to select information-rich cases whose study will illuminate the
questions under study” (p. 169). Thirty-two employees who had successfully completed
the CCST in-service at the research organization were used in the study. All employees
who are employed by the research organization are mandated to complete the CCST in-
service. The CCST is attended by employees from different departments. The participants
were selected (based on availability) and informed at least 2 weeks prior to attending the
CCST. To bring a sense of specialty to the training, participants were notified in person
of the date, time, and day of training by the staff development department.

The qualitative data collection, in the form of semistructured focus groups, was
completed at least 3 months after participants had completed the CCST. The focus groups
were comprised of four cohort groups—nursing, administration, support services, and
community services—of eight participants each. A variety of procedures can be used to
select participants in case study research. Coughlan, Cronin, and Ryan (2009) indicated
that probability, nonprobability, stratified, random, cluster, and systematic sampling are
some examples of how samples are drawn from a population. Therefore, program
evaluation that utilizes focus groups is normally conducted using purposive samples
(Patton, 1990). In case studies, empirical data are collected in a rigorous and accurate
fashion and attention is dedicated to only one or a few cases. The overall intention of the
researcher is to select participants who have a high probability of providing valuable data. This study utilized the purposive sampling approach.

**Sample Size**

According to Yin (2003), the case study methodology can be represented by a single or multiple cases. The agenda of a case study researcher is to gain a deeper understanding of the phenomenon in question. Conducting interviews in the participants’ natural setting or increasing the number of participants are techniques used to gain a deeper understanding of a significant situation (Stake, 1995). In this research study, focus groups were conducted to generate data to gain a clear understanding of the effectiveness of a CCST program and its impact on organizational results. The focus groups were comprised of four groups with eight participants each. The four focus groups were represented by the four occupational departments within the facility. Separating focus groups by occupational department allowed the researcher to identify differences in life experience between groups. Thirty-two participants were selected out of a total population of 1,156 employees. Researchers have reported that focus groups are normally 1–2 hours in duration (Vaughn, Schumm, & Sinagub, 1996) and the number of participants normally ranges between 6 and 12 (D. L. Morgan, 1997). In this study, there were eight participants in each cohort group. Strauss and Corbin (1990) believed that focus groups should consist of enough participants to produce information that is diverse, but be small enough that the environment promotes sharing from all participants. The use of multiple focus groups allows the researcher to saturate data until responses become repetitive (Strauss & Corbin, 1990).
**Instrumentation**

According to Xu and Storr (2012), evidence is not a fixed reality; therefore, researchers who practice qualitative methods must have the ability to take on a whole new way of thinking. The researcher is the primary instrument who orchestrates the effectiveness of the collected data. Qualitative researchers who have the necessary skill set to conduct research realize the importance of using observation and interviewing to generate and interpret data. According to Rubin and Rubin (2005), the researcher must have the ability to hear data to produce results that are nuanced and thorough. For example, during interviews for qualitative research, fluidity of conversation is required. The ability to utilize probing, silence, and follow-up questions can determine the effectiveness of data received (Xu & Storr, 2012).

Yin (1981) referred to a human instrument as an advantage that allows the researcher to exercise his or her full interviewing potential. A case study method has been proven helpful when the correlation between the phenomenon and its context is not clear (Yin, 2003). Whitley (1932) concurred the case study method allows the researcher to probe the participants for personal accounts. According to Sweet and Norman (1995), resident care is recognized as top priority and is the core focus of the mission and vision of healthcare organizations. A case study provides a comfortable and safe environment for the participants to reveal personal and sensitive information that may be considered risky or ignored during surveys. A human instrument can be described as one with the ability to acknowledge verbal and nonverbal communication, validate responses, and address any real-time issues (Merriam 2009).
Appleton (1995) reported the disadvantage of being a human instrument is when the weight of the responses depends on the researcher’s ability to conduct interviews. If the researcher cannot be flexible and make the participants feel at ease, the responses received may be misleading. The level of comfort between the participants and the researcher contributes to the accuracy and amount of information received during the study. Human instruments must avoid or embrace biases associated with conducting research and approach the research with an open mind (Merriam, 2009; Patton, 2002).

In this qualitative case study, the facilitator as instrument and the micro-interlocutor analysis were the key instruments used to collect data during the focus groups. Onwuegbuzie et al.’s (2009) micro-interlocutor analysis allowed the researcher to measure the level of consensus/dissension within each focus group. In regard to the role of the researcher as instrument, the researcher implemented a strategic plan to eliminate or control ethical concerns associated with dual-role researchers. The areas of concern are informed consent, researcher-participant relationship, risk-benefit ratio, confidentiality, and dual-role researcher effect.

An informed consent form was administered to all potential participants in the study. The information included detailed descriptions of the procedures and intentions of the researcher as well as the research study. A written guarantee was provided to declare that all information contained in the informed consent form is accurate and honest. Also, participants were notified that participation is voluntary and that no potential harm was associated with participating in the study. The researcher upheld confidentiality by not revealing the names of the participants who took part in the focus groups. All participants
were represented by pseudonyms to ensure the participants’ privacy during and after the study.

Sussman, Lichtman, and Dent (2001) reported that focus group methodology normally requires a well-trained facilitator who is skilled in asking open-ended questions. Fulfillment of this requirement ensures more in-depth responses, a requisite of qualitative case study methodology (Stake, 1995). Ferguson et al. (2006) suggested the use of a third-party facilitator to eliminate conflict of interest in research. In this study, the facilitator was selected after interviewing three potential applicants. All applicants were required to conduct a field test focus group session. The facilitator selected has a master’s degree in social work and has been trained to conduct in-depth interviewing. The third-party facilitator was given a semistructured script of questions pertaining to the research questions. The interviews were structured in a way to allow the facilitator to explore the influence of the CCST in depth. The facilitator was provided the freedom to ask probing questions and allow the participants flexibility to clarify or explain their responses. Reactions, body language, and concerns were documented by the facilitator through field notes during each focus group session. The facilitator was experienced in interviewing and counseling employees, based on educational background and professional work. In addition, the facilitator signed a confidentiality agreement and was informed of the purpose of her involvement. Based on the qualifications of the facilitator and on the strategic plan to eliminate conflict of interest and bias, the effects of a dual-role researcher were managed in the study.

All responses that revealed the identity of the participants were deleted before analysis. To control research bias in the study, the researcher coded all data with
techniques suggested by Huberman and Miles (1994). Collected data underwent a secondary analysis through member checks and peer reviews to increase the validity of the data. Member checking was utilized to allow all participants to review their responses for accuracy and address any concerns. All data were collected in their original state to allow peer review analysis. Utilizing others to analyze data allows others who are unbiased to check the interpretation of the data and the impact of the researcher on the study (J. McLeod, 1999). All details of the strategy to ensure confidentiality were disclosed to all participants before the data collection process began.

While the researcher works for the same company, the participants are located in a different facility. To overcome conflict of interest in the study, all participants were informed the purpose of the study was to understand the effectiveness of the CCST program. In addition, this study had no impact on employment status.

All potential participants were invited to participate face-to-face by the researcher. During this face-to-face encounter, the researcher informed potential participants that participation is voluntary, anonymous, and not connected to their annual training requirements. Throughout the data collection process, the facilitator reminded participants that they can withdraw at any point. Information for the Institutional Review Board (IRB) was presented to all participants, along with the names and phone numbers of the coaching support team assembled to address any grievances. The ethical protocol (Casey, 2004) of the instructor was disclosed to eliminate any potential confusion during research.

The facilitator disclosed that approval had been granted by the IRB and the organization’s ethics board. In addition, members of the organization’s ethics board were
able to address all ethical concerns via e-mail or through a conference format. The participants were advised that organizational coaches have been established and represented a support system to address any concerns regarding the study or their participation in the study. All participants were notified that the only people who would view their responses were members of the research team.

In conclusion, the researcher explored and adopted the strategic plan of Houghton, Casey, Shaw, and Murphy (2010) to address informed consent, researcher-participant relationships, risk–benefit ratio, confidentiality, and dual-role researcher effect in qualitative research. In addition, the researcher explored previous dissertations conducted by dual-role researchers that were capable of providing significant results (Bross, 2008; Bumgardner, 2005). The instructor was experienced in interviewing and counseling employees, based on educational background and professional work. Based on the qualification of the instructor and on the strategic plan to eliminate conflict of interest and bias, the effects of a dual-role researcher were managed in the study.

Field Testing

The researcher conducted a field test to determine inappropriate or too-complicated questions, establish the proper focus group procedures, and control different elements that may hinder the success of the research (Van Teijlingen & Hundley, 2001). In addition, the researcher focused on establishing the most effective probing, follow-up, direct, indirect, structured, and interpreting questions to maximize complete informative responses provided during the study (Liampittong, 2011). The duration of the field test (a focus group) was 50 minutes and the attendees were subject matter experts with the following occupational titles: director of staff development (training instructor), trainer
(content specialist), psychologist (PhD; experienced qualitative researcher), community director (trained in focus group/survey design), and teacher (specializing in comprehension/reading level of content).

The results of the field test were as follows. Archer (2007) recommended that the researcher should be prepared with questions that can be asked early in the focus group. These questions tend to address the participants’ eligibility (demographics), availability (time), and comfort with speaking in the group. The original Focus Group Question 1 asked, “How did you first learn about coaching communication?” The field test participants stated that all participants will be notified of the program by the organization. Therefore, the revised interview and probing questions asked, “When were you trained in coaching communication? Did anything occur that prevented you from finishing the entire course?”

Archer (2007) noted that during the focus group process, the researcher should avoid all questions that alienate or categorize a participant. The original Focus Group Question 2 asked, “When were you trained in coaching communication? Who provided the training?” The field test participants stated that Focus Group Question 1 would be redundant and the final study participants may feel reluctant to provide the name of the instructor. Therefore, the revised interview and probing questions asked, “Did you have a positive experience or a negative experience with the training? Please describe your experience. What happened? (Level 1)”

Norton (1983) stated, “Communicator style, or the way one communicates, signals to help the receiver process, interpret, filter, or understand literal meaning” (p. 47). The original Focus Group Question 3 asked, “Describe your experience with the
training. What was helpful overall about the training? What could have been improved?
In what way did the trainers contribute to your sense of the success of the seminar? Did the trainers model coaching during training? Were they able to engage their audience? Did they ask questions and listen?” The field test participants stated there were too many layers to the question and the complexity of the question may cause confusion, resulting in incomplete responses. Therefore, the revised interview and probing questions asked, “What was the most important skill you took away from the intervention? Please provide a story regarding how the skill has affected your work life. (Level 2)”

Krueger (1994) stated that focus group discussions should be strategically planned, focused on the perception of the phenomenon, and conducted in a nontthreatening environment. The original Focus Group Question 4 asked, “How has the coaching communication training affected you personally?” The field test participants stated the question should be focused on participants’ behaviors at work. Therefore, the revised interview and probing questions asked, “Was there any component of the training you found wasteful and did not apply to your work situation? Please explain why. (Level 2)”

Calder (1977) indicated the exploratory focus group approach allows a researcher to explore unfamiliar areas that are based on the perception of the participants. Leonard and Frankel (2011) emphasized the importance of effective teamwork to improve quality of care. Therefore, the researcher explored the perception of the influence of effective teamwork on quality of care. The original Focus Group Question 5 asked, “Where have you had the opportunity to practice the skills?” The field test participants stated the question should reflect on the impact the skills had on coworkers directly, as the
situations should allow participants to reflect on work-life experiences. Therefore, the revised interview and probing questions asked, “How has the use of coaching and communication influenced your relationships with coworkers at work? Please provide examples. (Level 3)”

Leonard and Frankel (2011) emphasized the importance of reliable processes of care. The original Focus Group Question 6 asked, “How has coaching communication impacted your satisfaction with your job?” The field test participants stated that satisfaction is not a variable being measured and thus, the question should focus on the CCST. Therefore, the revised interview and probing questions asked, “How has the use of coaching and communication influenced your relationships with residents at work? Please provide examples. (Level 3)”

Leonard and Frankel (2011) found that because of the complex environment, patient care pressures, lack of information, and sicker patients in health care, providing consistent, efficient care is unrealistic. Consequently, high volumes of communication failures and sentinel events are reported. The original Focus Group Question 7 asked, “How has coaching communication helped you manage problems? Does problem solving happen at different levels of the organization as a result of coaching communication? Please explain.” The field test participants stated there were too many layers to the question; the complexity of the question may cause confusion, resulting in incomplete responses; broad terms (e.g., problem solving) should be defined to avoid confusion; and participants may not be familiar with all levels within the organization. Therefore, the revised interview and probing questions asked, “How has the training helped you manage problems at work? Please explain. (Level 4)”
Douglas (2006) connected effective communication in implementing change strategies, managing teamwork, increasing employee understanding, and decreasing dissatisfaction with employee development. The original Focus Group Question 8 asked, “Does practicing coaching have an impact on your allocation of time? Please explain.” The field test participants stated that allocation is a term that may cause confusion based on the diverse reading levels of the participants. Therefore, the revised interview and probing questions asked, “What are the benefits of having effective communication regarding your ability to complete your work? Please provide examples. Please provide work-life experiences. (Levels 3 & 4)”

Leonard and Frankel (2011) focused on components of effective teamwork and communication that can be structured into consistent language to improve care. The original Focus Group Question 9 asked, “Has coaching communication affected your relationship with coworkers? Have you seen any changes in coworkers’ behavior?” The field test participants stated the question should be directly linked to the methods of training. Therefore, the revised interview and probing questions asked, “Since you have completed the training, do you notice other employees communicating using the methods of coaching? Please provide examples. (Levels 3 & 4)”

Fukui et al. (2011) found that CST programs are linked to improving quality of life. The original Focus Group Question 10 asked, “Do you have any stories involving improvements in the relationship between staff and clients based on exposure to coaching communication? Finally, we are interested in hearing your opinions about the future of coaching here at the research organization.” The field test participants stated the question was not linked to the impact of the training. Therefore, the revised interview and probing
questions asked, “Since you have completed the training, have you noticed situations at work where coaching communication has improved the quality of care? (Level 4)“

Willingham and Eden (2007) reported that, based on an unclear definition of quality care, improving communication across all occupational levels of care providers has been one of the main focuses to improve care in healthcare facilities. The original Focus Group Question 11 asked, “Where do you see coaching communication being used successfully in the organization? What would you like to see more of on the part of coworkers, supervisors, and leaders?” The field test participants stated the question was too broad and should be departmentalized. Therefore, the revised interview and probing questions asked, “What results have you witnessed from the training? (Level 4)“

Finally, Focus Group Question 12 asked, “Would you take the training again?” The field test participants stated the yes/no answer to this question would not provide deep understanding, which was the intention of the study. Therefore, the question was omitted.

Coaching Communication Skills Training Program

The CCST program is a relational approach to support healthcare workers that helps develop problem-solving skills, critical thinking, prioritizing, and the ability to communicate effectively.

Data Collection

Before collecting any data, the researcher requested and was granted permission to use the micro-interlocutor analysis instrument from Onwuegbuzie et al. (2009). The micro-interlocutor analysis instrument (see Figure 2) was provided at no cost to the
researcher. The researcher agreed to utilize the instrument strictly for research purposes, while ensuring proper citation throughout the research text. Prior to any data collection for this study, approval was obtained from the IRB of Capella University.

![Figure 1. MICRO-INTERLOCUTOR ANALYSIS (Onwuegbuzie, Dickinson, Leech, & Zoran, 2009). Matrix for assessing level of consensus in focus group](image)


The focus groups were conducted by the facilitator using semistructured interview questions. The focus groups were audio recorded, and field notes were handwritten by the facilitator. In addition, micro-interlocutor analysis data were collected during the focus
groups. Onwuegbuzie et al.’s (2009) micro-interlocutor analysis allows the researcher to measure the level of consensus/dissension within the focus group. This technique permits data collection of participants who fail to contribute due to time constraints, shyness, response patterns, intimidation, difference in opinion, or level of intelligence. In addition, this technique permits the researcher to provide richer data by acknowledging counts in the narrative analysis (Sandelowski, 2001). All focus groups were conducted at an agreed-upon location inside the facility.

All volunteer participants were recruited face-to-face by the researcher, flyers posted throughout the organization, via e-mail, and through monthly in-service calendars. All forms of recruiting were designed to inform all potential participants that participation is voluntary, anonymous, and not connected to their annual training requirements. Throughout the data collection process, the participants were continually reminded by the facilitator that they can withdraw at any point. All participants were also aware that all transcripts can be viewed for accuracy.

**Data Analysis**

This research study utilized a case study methodology employing focus groups as the medium. The analysis involved all data gathered from notes taken by the facilitator and recorded focus group sessions. The audio tapes were transcribed by recognizing connections between responses and the research question. This form of data collection allowed the researcher to focus on the research question and transcribe only the information that expanded knowledge about the phenomenon in question. Moreover, the researcher analyzed all field notes collected during the focus group sessions. The
technique used to analyze focus group data was based on constant comparison analysis, the framework by Glaser and Strauss (1967), and micro-interlocutor analysis, a new method of analysis by Onwuegbuzie et al. (2009).

Glaser and Strauss’s constant comparison analysis consists of three stages (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987). The first stage, open coding, allows the researcher to separate the data into small coded units. The second stage, axial coding, requires the researcher to separate the codes into categories. In the third stage, the researcher develops themes based on the content. This stage is referred to as *selective coding* (Strauss & Corbin, 1998). Constant comparison analysis allows the researcher to assess the saturation of data and compare data between multiple focus groups (Charmaz, 2000). Onwuegbuzie et al.’s (2009) micro-interlocutor analysis allows the researcher to measure the level of consensus/dissension within the focus group. This technique permits data collection of participants who fail to contribute due to time constraints, shyness, response patterns, intimidation, difference in opinion, or level of intelligence. In addition, this technique permits the researcher to provide richer data by acknowledging counts in the narrative analysis (Sandelowski, 2001).

All themes were presented and interpreted in the text. Reliability in the study was established through checking for transcribing errors, coding, triangulation of data, member checking, and peer examination. Krueger and Casey (2000) recommended utilizing an assistant during the focus group to maintain audio-video equipment and help create a comfortable environment for the participants. In this study, a volunteer assistant provided by the organization’s volunteer department was used to assist the facilitator and participants during the focus groups.
Credibility, Transferability, Validity, and Reliability

According to Trochim (2006), credibility is defined as the researcher’s ability to “establish that the results of qualitative research are credible or believable from the perspective of the participants” (p. 1). The researcher conducted focus groups to gather credible data that were based on the responses of currently employed long-term healthcare professionals’ lived experiences. The responses were interpreted and documented with accuracy to avoid any miscommunication.

Transcribing exactly what the participants say and asking participants to clarify what has been said increases secondary descriptive validity in the study. Secondary descriptive validity acknowledges the information that is observable, complex, and problematic (Maxwell, 1992). The verbiage that is used by the participants can influence how the responses are interpreted. The organization’s population is diverse. The researcher anticipated that participants’ accents and jargons would be very different. For this study, diverse responses were controlled by asking for clarification during the focus group process. The term interpretive is appropriate primarily because this aspect of understanding is most central to interpretive research, which seeks to comprehend phenomena not on the basis of the researchers’ perspectives and categories, but from those of participants in the situations studied (Maxwell, 1992).

In this research, theoretical validity was expected to play a large role in interpreting data. The researcher attempted to make connections between the stories told and the skills learned during the CCST. Theoretical validity was reinforced when participants exemplified transferring theory into practice.
Transferability was expected to be a major concern in the study as well. Trochim stated, “Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings” (p. 2). Internal generalizability was expected to be an issue because the researcher conducted focus groups using only the individuals involved in the CCST. To increase internal validity, members of each department had an equal opportunity to participate in the study. Conducting the research in this manner increased the possibility that the results can be generalized facility-wide.

According to Maxwell (1992), “internal generalizability in this sense is far more important for most qualitative researchers than is external generalizability because qualitative researchers rarely make explicit claims about the external generalizability of their accounts” (p. 294). The researcher increased the chances of transferability/external generalizability by thoroughly defining the assumptions connected to the study.

According to Trochim (2006), describing the research context and assumptions allows the research to be transferred to a different setting.

Dependability of the study was addressed in the text. The researcher acknowledged the changes in the facility that could have influenced the responses from participants (e.g., employee layoffs, budget cuts, lateral movements, downsizing). The researcher communicated the purpose of the study, which was to improve training communication in the organization, so that situations of this magnitude can be handled differently.

In this study, member checking, peer review, and saturation of data were conducted to ensure validity and reliability. Member checking was utilized to allow all participants to review their responses for accuracy and to address any concerns. All data
were collected in their original state to allow peer review analysis. Utilizing others to analyze data allows others who are unbiased to check the interpretation of the data and the impact of the researcher on the study (J. McLeod, 1999).

**Expected Findings**

By exploring a CCST, the researcher can understand the effectiveness of a CCST program and its impact on organizational results in a healthcare system. Based on the focus of the curriculum of the training, communication was influenced by self-management, self-awareness, active listening, and presenting the problem (feedback; Goleman, 1995). Whicker et al. (2003) found that self-management is a major factor influencing face-to-face communication. Zavertnik et al. (2010) recognized the need to train staff on self-awareness to improve communication. Cheon and Grant (2009) found the communication skill of active listening is difficult to teach, but the ability to recognize nonverbal cues, emotions, and personal meaning were considered vital to active listening and good communication. Carelock and Innerarity (2001) found that workers’ ability to state the problem in a clear and nonjudgmental fashion is vital to effective communication that minimizes sentinel performance events. The effectiveness of the CCST and its impact on organizational results was determined by utilizing Kirkpatrick’s (1994) four-level model for evaluating training.

The researcher expected this case study would show the CCST influenced organizational results. Because of the selection to utilize a case study methodology, the researcher expected the method of research would allow him to get a deeper understanding of the effectiveness of a CCST program in long-term healthcare staff. In
addition, the researcher expected the case study methodology would allow him to get a deeper understanding of the differences between cohort groups in regard to the effectiveness of a CCST program and its impact on organizational results.

Krueger and Casey (2009) acknowledged one of the limitations of focus groups is the possibility of receiving false information. The researcher expected that participants in the study would make a sincere effort to answer questions honestly. Finally, the researcher expected he would have no influence on the responses given by the participants.

To analyze the assumptions associated with the research, the researcher conducted an analysis framework at the end of the study. The framework involves first analyzing the presentation of the research. Questions at this stage pertained to the purpose of the research, the structure of the research, the researcher's style of writing, and the audience. The next phase of the framework was an analysis of the researcher’s influence on the study and whether that influence was addressed accordingly; “during all steps of the research process, the effect of the researcher should be assessed, and, later on, shared” (Malterud, 2001, p. 484).

The next phase of the framework was an analysis of the methods of the research. The questions in this section pertained to the participants to be used in the study: Where was the research conducted? Was the method used correctly? How were the data collected? Was the method of data collection done correctly and articulated in the study? Did the findings in the research answer the questions they intended to answer?

"Internal validity asks whether the study investigates what it is meant to; whereas external validity asks in what context the findings can be applied” (Malterud, 2001, p.
Finally, the researcher analyzed the validity of the study. “The effect of an investigator on a study, the principles and interpretation during analysis, all affect research, and are closely related to different aspects of validity” (Malterud, 2001, p. 483).

**Methodological Limitations**

There were some methodological limitations in this study. According to Appleton (1995), limitations in case studies include that the weight of the responses depends on the facilitator’s ability to conduct interviews. If the facilitator cannot be flexible and make the participants feel at ease, then the responses received during research may be misleading. The level of comfort between the participants and the facilitator contributed to the accuracy and amount of information received during the study. Another limitation of this study was that the participants may have been influenced by previous training about communication. Another limitation involved the collection of data from only 32 long-term healthcare employees. The small sample size may jeopardize transferability to a larger population (Creswell, 2007). Therefore, external validity could be an issue.

The research organization brought limitations because the participants in the study are representative of only one long-term facility in the Northeast. The research findings may represent only one organization and one population. Therefore, further research is needed to transfer findings to other industries. The results of this study may not be applicable to long-term employees outside of the researched organization. A researcher depends on participants in the study to make a sincere effort to answer questions honestly.
Power struggles between participants and providing public responses were possible focus group limitations in this study (Krueger & Casey, 2009). The number of questions asked during the focus group sessions was limited due to time constraints. Utilizing a purposive sample may underrepresent or overrepresent a population.

**Ethical Considerations**

According to the National Institutes of Health (NIH) Office of Extramural Research (2008), it is unethical to use participants solely as a means to an end. D. R. Cooper and Schindler (2008) believed that protecting the rights of participants, protecting the safety of participants, respecting the boundaries of the study, and conducting ethical research are vital to research. The NIH reported that research conducted on human subjects is based on honesty, trust, and respect. Respect for persons, beneficence, and justice are the three principles established in the *Belmont Report* for conducting research with humans (NIH, 2008). Research must not be conducted if the possibility of harming the participants materializes. It is the researcher’s responsibility to ensure that any potential risk during the study is minimized and disclosed (Denzin & Lincoln, 2011).

Data collected in this study might disclose information that influences the organization to make decisions about CST programs. The data collection concerns in qualitative research involve the privacy of the participants, personal feelings about questions, and research bias (Merriam, 2009). The researcher ensured the study was conducted to a moral and ethical standard. The researcher’s primary focus was to make sure all participants involved in the study were protected from physical and emotional harm. At no point in time was deception used in this study. If unethical circumstances
surfaced during the study, the risks versus benefits ratio was investigated by the researcher.

In the early stages of the study, the procedures, intentions, and objectives of the study were described in detail by the researcher. This ensured that all parties associated with the study are fully aware of all factors pertaining to the study. According to D. R. Cooper and Schindler (2011), “it is the researcher’s responsibility to design a project so that the safety of all interviewers, surveyors, experimenters, or observers is protected” (p. 43). Anonymity of all participants was upheld throughout and after the study.

All participants signed a consent form to establish legal documentation that all parties were aware of all elements in the study. The researcher was the only one to have access to signed documentation. All signed documentation and data material were stored in a locked combination safe. The researcher was the only person who had access to this material. The material will be stored for 8 years after the study is completed. The researcher submitted a proposal to the IRB and received approval and permission to begin collecting data. All participants were informed of the IRB response.

**Chapter Summary**

This chapter focused on describing the methodology that was utilized for this study. This qualitative study followed an exploratory case study design to explore the effectiveness of a CCST program and its impact on organizational results in a healthcare system. The strategy allowed the researcher to explore and gain a deeper understanding of the phenomenon through semistructured focus groups. The benefits of this method
were that it provided flexibility, richness of data, was low cost, and enabled more in-depth responses (Fontana & Frey, 1994).

The purposive homogeneous focus groups were separated into four cohorts (nursing, administration, community services, support services departments) of eight participants each. Recruiting of participants was achieved through recruitment flyers posted throughout the organization, face-to-face by the researcher, via e-mail, and through monthly in-service calendars. The purposive samples were asked a series of open-ended questions regarding their work-life experience post-CCST. Data collected from focus groups were audio recorded, and field notes were handwritten by the facilitator. The data collected were analyzed using constant comparison analysis (Glaser & Strauss, 1967) and micro-interlocutor analysis (Onwuegbuzie et al., 2009).

Reliability in the study was obtained by checking for transcribing errors, coding, triangulation of data, member checking, and peer examination. Instrumentation, credibility, transferability, validity, reliability, expected findings, and limitations were presented in this chapter. Finally, this chapter emphasized that ethical considerations were considered throughout the study to ensure the protection of the participants and institution.

Chapter 4 presents the results of the study. The chapter begins with a description of the sample and proceeds with an overall summary of the results. The researcher then presents a detailed analysis of the data, organized by focus group from which the results were garnered.
CHAPTER 4. RESULTS

Introduction

The purpose of this qualitative exploratory case study was to explore the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. A focus group methodology was selected as the primary method of data collection because of the exploratory nature of the study. The chapter begins with a description of the sample and proceeds with an overall summary of the results. The researcher then presents a detailed analysis of the data, organized by focus group from which the results were garnered. The chapter concludes with a summary.

The Researcher

The researcher became interested in the topic selected for this study because of his educational and professional background in the field of human resources. The researcher believes in the organizational benefit of human capital through motivation and training. The ability to maximize existing and new employee potential motivated the researcher to investigate the capabilities of training. The researcher is a motivated and experienced practitioner with a breadth of experience in cross-functional human capital management, including human resource administration, training and development, regulatory compliance, and performance management. The completion of this study
strengthened the researcher’s vision to improve organizations’ bottom lines through human capital during economic hardships.

This study was the first research study conducted by the researcher. The researcher utilized Yin (2003) to guide the qualitative case study approach that encompassed a focus group format. The researcher maintained consistent interactions and advisement from an established qualitative researcher throughout the study. The mentor provided guidance and feedback when necessary. The researcher has limited experience with NVivo software. Therefore, he attended online training to get better acquainted with operating NVivo successfully.

**Primary Research Question**

How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system?

**Research Subquestions**

1. What evidence illustrates that staff found the training intervention enjoyable (Level 1)?

2. What evidence illustrates that staff gained knowledge from the training intervention (Level 2)?

3. What evidence illustrates that staff changed behavior after the training intervention (Level 3)?

4. What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)?

5. How does the impact of coaching communication differ among occupational groups in health care?
Description of the Sample

In this qualitative case study, eligible participants (excluding part-timers, per diem employees, interns, volunteers, and probationary employees) included any employee in the chosen long-term healthcare organization who had successfully completed the CCST. The departments involved in the study consisted of nursing, administration, support services, and community services. The focus groups were each comprised of four groups with eight participants each.

Focus Group Questions

A total of 11 questions were asked of participants in each focus group:

1. When were you trained in coaching communication? Did anything occur that prevented you from finishing the entire course?

2. Did you have a positive experience or a negative experience with the training? Please describe your experience. What happened? (Level 1)

3. What was the most important skill you took away from the intervention? Please provide a story regarding how the skill has affected your work life. (Level 2)

4. Was there any component of the training you found wasteful and did not apply to your work situation? Please explain why. (Level 2)

5. How has the use of coaching and communication influenced your relationships with coworkers at work? Please provide examples. (Level 3)

6. How has the use of coaching and communication influenced your relationships with residents at work? Please provide examples. (Level 3)
7. How has the training helped you manage problems at work? Please explain.  
(Level 4)

8. What are the benefits of having effective communication regarding your ability to complete your work? Please provide examples. Please provide work-life experiences. (Levels 3 & 4)

9. Since you have completed the training, do you notice other employees communicating using the methods of coaching? Please provide examples.  
(Levels 3 & 4)

10. Since you have completed the training, have you noticed situations at work where coaching communication has improved the quality of care? (Level 4)

11. What results have you witnessed from the training? (Level 4)

**Summary of the Results**

Participants in the four focus groups had many similarities. Overall, the participants’ responses included positive results regarding implementing pullback, overall improved communication skills and self-awareness, improved social interaction and workplace environment, and negative perceptions of the training (redundancy and resistance to implementation and practice). The themes extracted from the focus group data were assessed by Kirkpatrick’s four levels: reaction (Level 1), learning (Level 2), behavior (Level 3), and results (Level 4). The reaction level entails how one feels about the training, the learning level entails whether one believes that he or she knows more after the training than before, the behavior level entails how behavior has changed since the training, and the results level entails how the training has improved communication.
Reaction

Participants illustrated an overall sense of satisfaction with the training. The identified themes for each focus group were compared to get a general sense of the overall opinion of the participants. Similarities identified among the themes for all four focus groups included a general sense of improvement posttraining and the perception that the work environment was a more positive setting. One participant in the Support Services Focus Group stated, “It was a positive experience, anytime you get a chance to talk to a person in a more civilized way.” Commenting on the discourse of the panel, Community-Based 6 stated, “I’m really impressed sitting with everybody here to see how much people took away from the training and remember using because as a trainer you don’t really know the feedback from people, so that’s pretty exciting for me.” Focus group participants noted that although the learned communication skills were different, they proved to have excellent results. Most of the participants indicated that nothing prevented the impact of training or implementing what was taught. However, a few participants stated there were other individuals who did not buy-in to the training and did not want to implement any new changes.

Learning

All participants indicated the training helped them improve their communication and social interactions. The identified themes for each focus group were compared to get an overall sense of the consensus of the participants. Similarities identified among the themes for all four focus groups included the perception that new and different communication techniques were implemented effectively, such as pulling back, paraphrasing, and other similarly related methods. One participant in the Administration
Focus Group stated, “But I do think that being able to offer this kind of communication and communication skills to my staff was the best thing that I took away from this, that I could share it with them.” One member of the Nursing Focus Group stated, “I learned how to paraphrase a lot of the stuff that was said.” Participants also indicated they learned the concept of self-awareness and that it helped them with addressing situations. A participant in the Nursing Focus Group said, “It made my eyes open, made me more aware on how to handle the situation.” Conflicts were outlined as resolvable via coaching sessions, pulling back, team work, and better communication.

**Behavior**

Many focus group participants stated they felt they were now able to address and handle situations better due to the training. The researcher identified themes for each focus group and compared them to get a basic sense of the collective opinion of the participants. Identified similarities among the themes for all four focus groups included a feeling of family and cohesion among employees due to the respect and appropriate communication engendered. Overall, participants demonstrated their improved skills regarding communication and social relationships when given the opportunity to utilize what was taught in the training. A member of the Nursing Focus Group stated, “[The training] helped me out a lot, because the way I behaved before and the way that I behave now is totally different.” A general sense of amicability was felt among those participants who actively applied the new communication techniques. One participant in the Support Services Focus Group stated, “For me it was more positive, learning how to be less judgmental and more communication; sticking with the facts pretty much led me to be more of a better person when communicating with my supervisors.” Many participants
indicated they noted changes in the dynamics of the relationships with coworkers and family members due to their improved communication style.

**Results**

The results of the training were demonstrated as being widely utilized, positive, and effective among participants. The researcher identified themes among the responses for each focus group and compared them to get an overall idea of the consensus of the participants. Identified similarities among the themes for all four focus groups included the perception that the training helped with communication at the workplace (with employees and management) and even in participants’ personal lives (with family members). One member of the Support Services Focus Group stated, “It did, I thought, create a closer relationship between the staff and more of an open communication line.” Participants also indicated that previous situations that were once difficult and burdensome are now handled with a better approach and result in more positive outcomes. Similarly, participants noted the environment and atmosphere at the workplace is more manageable due to the ability to calm a situation down with the appropriate communication. The practice of what was taught in the training has allowed for better communication and has become intrinsic for the participants. One participant in the Community-Based Focus Group stated, “A key part of the program was to establish relationships, was for people to really get to know each other, and so by doing that, the communication kind of naturally comes easier and is more effective.” Participants noted happier clients and better camaraderie among coworkers and an overall improved quality of care.
Detailed Analysis

The constant comparison method of data analysis was used to analyze the collected data (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss, 1987). In the first stage, the researcher used open coding to separate the data into small coded units. The second stage, axial coding, required the researcher to organize the codes into broader thematic categories. Finally, in the third stage, the researcher coded the data based on the identified axial themes and selected specific statements from participants that best illustrated the interthematic relationships that emerged based on the content (Strauss & Corbin, 1998). The results of the open, axial, and selective coding processes are presented in the subsections to follow.

The CCST utilized in this study was designed to focus on communication and problem solving. The objective of the curriculum was to teach skills to build positive relationships and provide a foundation that allows employees to grow personally and professionally. The curriculum introduced coaching skills to healthcare professionals in the context of the realities of work settings. The program introduced four primary skills: active listening, self-management, self-awareness, and constructive feedback.

The CCST program described active listening as one’s ability to listen with one’s full attention. The CCST program was designed to train various active listening skills, including attentive body language, paraphrasing, and asking open-ended questions. An additional goal reinforced the importance of clear verbal communication and identified strategies to improve communication. Self-management training helped participants to become more conscious of their emotional reactions to particular situations or people. The curriculum showcased how emotional reactions can block real listening and explored
strategies to pull back and set aside reactions to listen openly, improve communication, and solve problems.

The self-awareness training raised participants’ awareness of the judgments and assumptions they make about coworkers, residents, and residents’ family members. These judgments and assumptions may have prevented them from seeing the whole picture when a problem arose and may have negatively impacted their relationships in the workplace. Constructive feedback reinforced the importance of balancing empathy and support with holding workers accountable for performing their jobs to specific standards.

The final section of the CCST program calls for participants to review and consolidate the skills that were learned through real work-life scenarios. The participants were reminded how using a coaching support in the workplace can benefit productivity and the culture of the organization. By the end of the program, participants are expected to demonstrate these concrete, measurable behaviors.

Excerpts from participants’ responses are included for support and are identified by focus group and number (e.g., Nursing 1, Support Services 3, etc.) or as a collective group response.

**Nursing Focus Group**

**Axial themes.** Open, axial, and selective coding of Nursing Focus Group responses revealed four themes: (a) conflict with coworkers, (b) pullback, (c) improved communication, and (d) improved work environment. Several members of the nursing staff indicated they have experienced conflict with their coworkers. Several of the nurses noted improved communication since the training and cited use of the pullback technique. Many of the nurses referred to a general improvement in the work
environment since the training. Open and axial coding of Nursing Focus Group responses are presented in Table 1.

<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defensiveness, power struggles, poor attitudes, loss of temper</td>
<td>Conflict with coworkers</td>
<td>People are automatically defensive. People were blowing up. Arguing and yelling. Argued like Chihuahuas. People come with an attitude. Too many chiefs, not enough Indians.</td>
</tr>
<tr>
<td>Walking away from negative situations, being cognizant of need to walk away, creating distance to de-escalate</td>
<td>Pullback</td>
<td>Step back, take a breather. Have to pull back in some situations. Aware of when to pull back. Take a breather. Stepping back. Pulling back. Pull back and look at the situation. Step aside and walk away. Pull back and try not to argue.</td>
</tr>
</tbody>
</table>
### Table 1. Open and Axial Coding of Nursing Focus Group Responses (continued)

<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increases in frequency and quality of communication, new techniques being used</td>
<td>Improved communication</td>
<td>Communication with patients is . . . better.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>They communicate really good.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We’re heard more, listening more.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We talk more.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff communicates more.</td>
</tr>
<tr>
<td>Workplace that is fun, conflict-free, relaxing, enjoyable to work in</td>
<td>Positive work environment</td>
<td>Keep environment peaceful.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Try to make it fun.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Just have fun for 8 hours.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nice, calm environment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workplace is now a relaxed environment.</td>
</tr>
</tbody>
</table>

Axial coding of Nursing Focus Group responses revealed the following thematic relationships from strongest to weakest:

Eight participants referred to application of the pullback strategy as a means for conflict resolution and diffusion of tense situations in the workplace. For example, Nursing 3 stated,

It’s okay to step back, take a breather, walk away if you have to, and handle the situation later. Pull back and look at the situation. Step aside and walk away. And so the training helped me learn to just listen to them, just pull back, try not to argue with them, agree to disagree, and to move on.

140
Seven participants described an improvement in the quality and frequency of communication among staff members following the completion of the training. Examples of their statements are as follows:

**Nursing 4.** “My communication with my patients is so much better, so much better; I feel like now we’re heard more than before. Now we’re listening more, where before we were defensive.”

**Nursing 3.** “Since a lot of people had the coaching workshop, they learned that there is a way to speak.”

**Nursing 5.** “I have seen the staff actually communicate with each other more as to what’s best for the resident.”

Six participants described experiences in dealing with conflict in the workplace prior to the training they received due to defensive attitudes and impulsive reactions. Examples of their statements are as follows:

**Nursing 3.** “Before, you would be automatically defensive and you would say something that’s only going to make the situation worse.”

**Nursing 3.** “Before the workshop, we used to have situations where people were just blowing up at each other.”

**Nursing 4.** “Too many chiefs and not enough Indians.”

Five participants reported an improvement in the overall tranquility and harmony of the workplace since the training and made referred to active efforts to maintain a peaceful work environment. Examples of their statements are as follows:

**Nursing 3.** “You kind of come in with that in your mind, you know? ‘Oh, guys, we are going to have a calm day’ and ‘This is going to be a good day.’ You know, at report time in the morning: ‘Oh, please, guys, let it be a good day, a calm day, we get out of here easy.’”

**Nursing 4.** “If the environment you work in is a nice calm environment, your day goes great.”

**Nursing 4.** “[When] your work is great, I’m happy, everybody’s happy.”
Selective coding. Axial coding of the Nursing Focus Group responses generated four themes: (a) conflict with coworkers, (b) pullback, (c) improved communication, and (d) positive work environment. For selective coding of the data, the researcher selected one nurse’s statement that reflected the themes with the greatest degree of clarity and congruence. Nursing 3 stated,

I also have a coworker that feels the need to voice every opinion, and sometimes you have to pull back, you have to look at the situation and you don’t want to, where before, you would be automatically defensive and you would say something that’s only going to make the situation worse. Instead of doing that, you kind of let them speak, stay quiet, walk away if you have to, you know, just let it go, because if you do say anything, it only gets worse. And so you want to keep your job and you want to make sure that the environment that you work in is a peaceful one, and if you don’t use these techniques to your advantage, then you’re going to turn your workplace into a war zone. And we’re not here for that.

Micro-interlocutor analysis.

- All eight participants in the Nursing Focus Group gave statements indicating agreement in response to Focus Group Question 1.
- The majority of participants \((n = 5)\) gave statements indicating agreement in response to Questions 2 and 3.
- The majority of participants \((n = 7)\) gave statements indicating agreement in response to Question 4.
- Half of the participants \((n = 4)\) completely agreed in response to Question 5 and the other half \((n = 4)\) gave statements indicating agreement.
- The majority of participants \((n = 5)\) indicated complete agreement in response to Question 6.
- The majority of participants \((n = 6)\) gave statements indicating agreement in response to Question 7.
• The majority of participants ($n = 5$) gave statements indicating agreement in response to Question 8.

• Half of the participants ($n = 4$) completely agreed in response to Question 9 and the other half ($n = 4$) gave statements indicating agreement.

• Half of the participants ($n = 4$) completely agreed in response to Question 10 and the other half ($n = 4$) gave statements indicating agreement.

• The majority of participants ($n = 5$) indicating complete agreement in response to Question 11.

Frequencies and percentages for answers to Nursing Focus Group questions are presented in Table 2.

Table 2. Frequencies and Percentages for Levels of Consensus in Nursing Focus Group

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Agreement</th>
<th>Dissent</th>
<th>Statement indicating agreement</th>
<th>Statement indicating dissent</th>
<th>No agreement or dissent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
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<tr>
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<td>8</td>
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<td>6</td>
<td>75</td>
<td>-</td>
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</tr>
</tbody>
</table>
Table 2. *Frequencies and Percentages for Levels of Consensus in Nursing Focus Group (continued)*

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Agreement</th>
<th></th>
<th>Dissent</th>
<th></th>
<th>Statement indicating agreement</th>
<th></th>
<th>Statement indicating dissent</th>
<th></th>
<th>No agreement or dissent</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4</td>
<td>50</td>
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<td>2</td>
<td>29</td>
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</tr>
</tbody>
</table>

*Note.* Due to rounding, percentages may not total to 100.

**Support Services Focus Group**

**Axial themes.** Open, axial, and selective coding of the Support Services Focus Group responses revealed three themes: (a) improved communication and social interaction, (b) workplace tension and attitudes, and (c) positive impact on employee cohesion. Most members of the Support Services group indicated they have had positive interactions with other individuals due to improved communication skills since the training. Many participants referred to negative attitudes and tensions from working with other individuals. Participants also noted improved cohesion among employees. Open and axial coding of Support Services Focus Group responses are presented in Table 3.
<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning different communication strategies, maintaining regular communication, not listening passively</td>
<td>Improved communication and social interaction</td>
<td>Learned how to deal with different situations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Listen actively.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learned how to communicate a lot better.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate all the way.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line of communication stays open.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Be able to talk and listen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Instead of me attacking her, I actually explained.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Be big enough to apologize.</td>
</tr>
<tr>
<td>Chaotic environment, resistance to change, lack of respect, lack of understanding</td>
<td>Workplace tension and attitudes</td>
<td>We are in charge of a lot of people and it can get chaotic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bosses or employees that are not going to change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Talk more rather than fight.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Turned supervisor, so it’s a little harder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It depends on how respectful you were before.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managers don’t understand.</td>
</tr>
<tr>
<td>Open code</td>
<td>Axial code</td>
<td>Verbatim phrases/descriptive words</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Teamwork, joint problem solving, collaborative effort, strengthening relationships</td>
<td>Positive impact on employee communication and cohesion</td>
<td>More effective when communicating.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Defuse and come to an agreement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work together to find a solution.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coaching session created a closer relationship.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tell employees they are good workers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employees working together.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Become more family-like.</td>
</tr>
</tbody>
</table>

Axial coding of the Support Services Focus Group responses revealed the following thematic relationships from strongest to weakest:

All participants indicated an overall positive impact on employee communication and a sense of cohesion among employees. Examples of their statements are as follows:

**Support Services 5.** “[The training] was very positive because there were specific exercises utilized to be more effective. [I] learned to deal with anger management or resentment without it escalating so that we can defuse and come to an agreement.”

**Support Services 1.** “I was able to make suggestions that we can accept, and we are still friends. [The training] has really given me the opportunity to really concentrate in telling my staff the good that they do and we appreciate what they do.”

Almost all participants indicated an improvement in social interactions and communication with other individuals. Examples of their statements are as follows:
Support Services 1. “[The] coaching approach is different and I appreciate that because you need to treat people accordingly.”

Support Services 54 “The most important skill taken away was paraphrasing, like when people come with a problem and you actually get it back.”

Support Services 1. “Rather than going to write a person up, we sit down and have a communication and try to work together to find a solution.”

Support Services 7. “Just me sitting back and listening to them . . . it’s a positive.”

Six participants described situations that revealed workplace tension and attitudes. Examples of their statements are as follows:

Support Services 7. “We are in charge of a lot of people and at times it gets to you.”

Support Services 1. “No matter what you do, you have bosses or employees that are not going to change and family members that are always complaining.”

Support Services 1. “Managers don’t understand that a happy employee is a more productive employee.”

Selective coding. Axial coding of the Support Services Focus Group responses generated three themes: (a) improved communication and social interaction, (b) workplace tension and attitudes, and (c) positive impact on employee cohesion. For selective coding of the data, the researcher selected one participant’s statement that reflected the themes with the greatest degree of clarity and congruence. Support Services 7 stated,

I think we had a lot of problems going on [and] I get very defensive and then I get loud, and I know that I learned to stop doing that. I learned to sit down and listen [and] pull back . . . listen to what other people have to say before jumping the gun. You got to get the solution for it first, because most of the time we’re just there listening and ready to pick up a fight, but after you listen, you say, “Oh, this is the way it should be done next time.” You have to find a solution first. I think we communicate a lot better. I like working with a team, I really do, and I think with our communication that we all learn how to communicate better. You can
actually sit down and have a conversation without yelling and screaming, as it should be between coworkers, instead of jumping the gun. I’m actually sitting back and asking myself, “Well, why did this happen?” instead of saying, “You did this.” So there is a big difference and I’m a lot happier. I got to be honest with you, I come to work [and] I don’t come to work anymore saying, “Five days. Just only five days’; I come in and I’m like, “Hey, how is everybody?” It’s a difference, it really is.

Micro-interlocutor analysis.

- The majority of participants ($n = 7$) in the Support Services Focus Group completely agreed in response to Focus Group Question 1.
- Half of the participants ($n = 4$) completely agreed in response to Question 2 and the other half ($n = 4$) gave statements indicating agreement.
- The majority of participants either completely agreed in response to Questions 3 and 4 ($n = 3$) or gave statements indicating agreement ($n = 3$).
- Half of the participants ($n = 4$) gave statements indicating agreement in response to Question 5.
- Half of the participants ($n = 4$) indicated complete agreement in response to Question 6.
- Half of the participants ($n = 4$) gave statements indicating agreement in response to Question 7.
- The majority of participants ($n = 5$) gave statements indicating agreement in response to Question 8.
- The majority of participants ($n = 5$) indicated complete agreement in response to Question 9.
- The majority of participants ($n = 6$) indicated complete agreement in response to Question 10.
The majority of participants \((n = 5)\) indicating complete agreement in response to Question 11.

Frequencies and percentages for answers to the Support Services Focus Group questions are presented in Table 4.

Table 4. *Frequencies and Percentages for Levels of Consensus in Support Services Focus Group*

| Focus group question | Agreement | | | Statement indicating agreement | | | Statement indicating dissent | | | No agreement or dissent |
|----------------------|-----------|------------------|-------------------|------------------------|------------------|------------------------|
|                      | \(n\) | \(\%\) | \(n\) | \(\%\) | \(n\) | \(\%\) | \(n\) | \(\%\) | \(n\) | \(\%\) |
| 1                    | 7   | 88   | -   | -   | 1   | 13  | -   | -   | -   | -   |
| 2                    | 4   | 50   | -   | -   | 4   | 50  | -   | -   | -   | -   |
| 3                    | 3   | 38   | -   | -   | 3   | 38  | -   | -   | 2   | 25  |
| 4                    | 3   | 38   | -   | -   | 3   | 38  | -   | -   | 2   | 25  |
| 5                    | 3   | 38   | -   | -   | 4   | 50  | -   | -   | 1   | 13  |
| 6                    | 4   | 50   | -   | -   | 3   | 38  | -   | -   | 1   | 13  |
| 7                    | 3   | 38   | -   | -   | 4   | 50  | -   | -   | 1   | 13  |
| 8                    | 3   | 38   | -   | -   | 5   | 63  | -   | -   | -   | -   |
| 9                    | 5   | 63   | -   | -   | 3   | 38  | -   | -   | -   | -   |
| 10                   | 6   | 75   | -   | -   | 2   | 25  | -   | -   | -   | -   |
| 11                   | 5   | 63   | -   | -   | 3   | 38  | -   | -   | -   | -   |

*Note.* Due to rounding, percentages may not total to 100.
Community-Based Focus Group

Axial themes. Open, axial, and selective coding of the Community-Based Focus Group responses revealed five themes: (a) redundancy, (b) pullback, (c) self-awareness, (d) improved communication, and (e) improved working relationships. Several of the community-based workers reported they felt the training was redundant. Many of the community-based workers identified pullback as a strategy used in the workplace. A number of community-based staff reported that communication had improved within the office. Several of the community-based workers also noted that working relationships among their staff members had improved since the training. Open and axial coding of the Community-Based Focus Group responses are presented in Table 5.

Table 5. Open and Axial Coding of Community-Based Focus Group Responses

<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning different communication strategies, maintaining regular communication, not listening passively</td>
<td>Improved communication and social interaction</td>
<td>Learned how to deal with different situations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Listen actively.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learned how to communicate a lot better.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate all the way.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Line of communication stays open.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Be able to talk and listen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Instead of me attacking her, I actually explained.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Be big enough to apologize.</td>
</tr>
</tbody>
</table>
Table 5. *Open and Axial Coding of Community-Based Focus Group Responses*

<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaotic environment, resistance to change, lack of respect, lack of</td>
<td>Workplace tension and attitudes</td>
<td>We are in charge of a lot of people and it can get</td>
</tr>
<tr>
<td>understanding</td>
<td></td>
<td>chaotic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bosses or employees that are not going to change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Talk more rather than fight.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Turned supervisor, so it’s a little harder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It depends on how respectful you were before.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managers don’t understand.</td>
</tr>
<tr>
<td>Teamwork, joint problem solving, collaborative effort, strengthening</td>
<td>Positive impact on employee communication and</td>
<td>More effective when communicating.</td>
</tr>
<tr>
<td>relationships</td>
<td>cohesion</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Defuse and come to an agreement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work together to find a solution.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coaching session created a closer relationship.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tell employees they are good workers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employees working together.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Become more family-like.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employees can walk up to a coach and ask him to help.</td>
</tr>
</tbody>
</table>

Axial coding of the Community-Based Focus Group responses revealed the following thematic relationships from strongest to weakest:
Six participants referred to a feeling of redundancy concerning the strategies and skills presented in the training due to the belief these were skills in which community-based workers had already been trained. Examples of their statements are as follows:

**Community-Based 2.** “I found several parts to be redundant [for] some us that have been involved in this kind of stuff before.”

**Community-Based 4.** “I know the technique training, so when someone is trying to do it with me, it’s like, ‘Wait a minute, been there done that.’”

**Community-Based 2.** “Most of the things in the training are things you know I’ve heard dozens of dozens of time or things . . . you don’t do what I do for 40 years without accomplishing a few things along the way.”

**Community-Based 4.** “Some of these skills that are part of the training that you already bring to the table.”

Eight participants referred to use of the pullback strategy for dealing with coworkers and resolving problems in the workplace, which is aimed at increasing clarity through careful reflection on the problem before deciding on an action. Examples of their statements are as follows:

**Community-Based 3.** “Pulling back and then revisiting the problem and the situation and coming back to it and address it with a deferent tone.”

**Community-Based 7.** “It’s great, it’s done a lot for me within my department.”

**Community-Based 6.** “It’s easy to just jump to a conclusion about something, so I know that pulling back and always reminding myself that there’s a back story . . . really seems to clarify things.”

Five participants mentioned the importance of self-awareness in recognizing one’s triggers and being mindful of the implications of one’s actions and behaviors, to reduce and resolve problems in the workplace. Examples of their statements are as follows:
Community-Based 5. “Knowing yourself and identifying triggers so you’re able to pull back, and awareness; I think it really helped me in terms of awareness. And because I’m aware, I can help other people be more aware of themselves.”

Community-Based 3. “I was able to apply self-awareness and be aware of what is my thinking process, what am I thinking at the moment when this is happening, and how should I react to it.”

Community-Based 5. “Self-awareness made me assess myself and say, ‘You know what? I checked in with myself; these are my options,’ and then I said, ‘You know what? This is what I need to do.’”

Community-Based 7. “Self-awareness. You know that there [are] certain people at certain times [who] would push your buttons, so you have to know your triggers.”

Six participants cited the improvement of communication in the workplace as a result of the skills learned, or refreshed, in the training exercises. Examples of their statements are as follows:

Community-Based 5. “There was actual different vignettes and ways to get better communication between you and your peers.”

Community-Based 2. “Around here, communication often went awry, so you can see the changes, and there are very positive changes.”

Community-Based 3. “I used to tend to drift away and not even be there. They would be going on and on. And I didn’t do [it] because I was being rude, just that my mind would keep flowing away. The active listening and what I have learned here in the training, it was like, self-awareness. You have to train your mind to be here in the moment and listening to what they’re saying because it’s important.”

Eight participants noted the improvement of working relationships in the office, including a greater sense of camaraderie and teamwork, as a positive outcome of the training experience. Examples of their statements are as follows:

Community-Based 7. “It help[ed] me here in my relationship with my coworkers and the people I supervised.”

Community-Based 2. “I think it contributed to an overall tone of openness and that would have benefits beyond its original intent.”
Community-Based 4. “The relationship has taken a 180-degree turn and it really helped me to begin to lay the groundwork for other things.”

Community-Based 6. “I feel that that was very helpful in understanding people better with your coworker, really, everybody.”

Community-Based 7. “It’s really an overwhelming feeling of positiveness and just team.”

Community-Based 2. “There has been a greater sense of team among the management team and I think that also extended to line staff.”

Selective coding. Axial coding of the Community-Based Focus Group responses generated five themes: (a) redundancy, (b) pullback, (c) self-awareness, (d) improvement in communication, and (e) improvement in working relationships. For selective coding, the researcher selected a statement from one participant that most fully reflected the themes presented by this group. Community-Based 4 stated,

The opportunity to participate in this [training] was an opportunity to refresh my skills and my knowledge ‘cause we often go through the curriculum and [then] we go out into the world, and if we are not practicing what we learned, sometimes that language is lost—not that the skills is lost, ‘cause we apply them, but we don’t always have the label and not labeling it as such, so this is an opportunity to refresh that and have language that that was common amongst colleagues. And for me personally, it was a side opportunity to meet new colleagues and interact with them because I’m offsite. But one of the things that I think [about] the self-awareness piece and the pullback piece, because when you’re a new manager you’re still learning the ropes and still learning what the culture of the organization is, and if you’re offsite in a different program, you got to learn that culture as well, so it’s like a double learning. . . . Interestingly, in the beginning, I had a situation where I saw an opportunity, something was happening and I saw an opportunity to say something, and I was challenged and I had to think about what my reaction was going to be to that because it was an open challenge, and I tend to brood about things, I tend to take it home, there are times when I may react and there are times when I pull back, and in that particular instant I think I just completed the training and it was an opportunity to pull back, and I’m really glad I did ‘cause I went home and really thought it through, and I found a way to approach the situation in such a way that I think it really helped to eliminate any further question about perhaps my ability to manage situations, and as result, the relationship has taken a 180-degree turn and it really helped me to begin to lay the groundwork for other things. It was really helpful.
Micro-interlocutor analysis.

- All eight participants in the Community-Based Focus Group gave statements indicating agreement in response to Focus Group Question 1.
- The majority of participants \((n = 6)\) gave statements indicating agreement in response to Question 2.
- The majority of participants either completely agreed in response to Question 3 \((n = 3)\) or gave statements indicating agreement \((n = 3)\).
- The majority of participants \((n = 5)\) gave statements indicating agreement in response to Question 4.
- Participants were most likely to give statements indicating agreement in response to Question 5 \((n = 3)\).
- Participants were most likely to indicate complete agreement in response to Question 6 \((n = 6)\).
- The majority of participants \((n = 7)\) gave statements indicating agreement in response to Question 7.
- Two of the participants gave statements indicating agreement in response to Question 8.
- Half of the participants \((n = 4)\) gave statements indicating agreement in response to Question 9.
- The majority of participants \((n = 6)\) indicated complete agreement in response to Question 10.
- Half of the participants \((n = 4)\) indicated complete agreement in response to Question 11.
Frequencies and percentages for answers to the Community-Based Focus Group questions are presented in Table 6.

Table 6. *Frequencies and Percentages for Levels of Consensus in Community-Based Services Focus Group*

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Agreement</th>
<th></th>
<th></th>
<th>Statement indicating agreement</th>
<th></th>
<th></th>
<th>Statement indicating dissent</th>
<th></th>
<th></th>
<th>No agreement or dissent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
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<td>25</td>
<td>-</td>
<td>-</td>
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<td>50</td>
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<td>25</td>
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<td>-</td>
<td>4</td>
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<td>10</td>
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<td>-</td>
<td>3</td>
<td>38</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>

*Note.* Due to rounding, percentages may not total to 100.

**Administration Focus Group**

**Axial themes.** Open, axial, and selective coding of the Administration Focus Group responses revealed five themes: (a) pullback, (b) resistance to training, (c) positive
attributes from training, (d) improved social interaction, and (e) improved communication. Several members of the Administration Focus Group indicated they have benefited from the pullback technique. Many participants indicated there were other individuals who were resistant to change but were implementing what was taught in the training. Administrators also commented on overall positive changes since the training in both their personal and professional lives. Several administrators noted improved social interaction and communication since the training. Open and axial coding of the Administration Focus Group responses are presented in Table 7.

Table 7. Open and Axial Coding of Administration Focus Group Responses

<table>
<thead>
<tr>
<th>Open code</th>
<th>Axial code</th>
<th>Verbatim phrases/descriptive words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pullback used often, pullback at intrinsic level</td>
<td>Pullback</td>
<td>Pullback has been the most important.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Now I find myself pulling back.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learned to tell them using pullback methods.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It’s become intrinsic.</td>
</tr>
<tr>
<td>Training seen as a burden, some people are not using training, lack of buy-in</td>
<td>Resistance to training</td>
<td>The 9 days [of training] was a bit much.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training was more difficult to some than others.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This person’s characteristics are never going to change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>They are still unapproachable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some folks are not buying in.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People tell you, “It’s not for me. I don’t have time.”</td>
</tr>
<tr>
<td>Open code</td>
<td>Axial code</td>
<td>Verbatim phrases/descriptive words</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Takeaways, learned skills, new perspective, new tools</td>
<td>Positive attributes from training</td>
<td>Biggest takeaway has been self-awareness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>They took away the tools that would help me.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More self-aware.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adopted a new attitude.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allows you to see the full picture.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better understand my staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helps us deal with situations.</td>
</tr>
<tr>
<td>Conflict resolution, better relationships, using learned strategies</td>
<td>Improved social interaction</td>
<td>Taught me how to deal with conflict.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It has improved relationships and developed some.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I just listen and smile and do all that nice stuff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Getting their permission to let me help them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Using counseling with a coach between myself and another, and it was rewarding.</td>
</tr>
<tr>
<td>Learning different style of communicating, greater willingness to talk</td>
<td>Improved communication</td>
<td>Bounce off [writing] with coworkers: “How can we soften it up…?”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>They can come and talk about it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gave us a lot more to think of in terms of communicating.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Now with better communication.</td>
</tr>
</tbody>
</table>
Axial coding of the Administration Focus Group responses revealed the following thematic relationships from strongest to weakest:

Seven participants indicated an overall positive impact in the workplace due to the training. Examples of their statements are as follows:

**Administration 5.** “I’m self-aware of everything, from phone skills to listening skills, and to the way I approach people.”

**Administration 8.** “I’ve found situations that you should be able to apply what you’ve learned to help them [staff] and help me as well. You learn not to take somebody strictly by what you see.”

**Administration 2.** “It allows you to see the full picture and put everything in place before you respond and give a complete answer.”

**Administration 4.** “It has helped me better understand my staff and get to know everybody else a lot better because I’m taking the time to hear them.”

**Administration 5.** “It helps us deal with situations in a better light.”

Five participants indicated improvement in social interactions and relationships with other individuals after the training. Examples of their statements are as follows:

**Administration 5.** “I had to confront a coworker, and I practiced, and I approached the situation with my full toolbox and had excellent results.”

**Administration 2.** “It’s opened up the opportunity to know who you feel comfortable with and to explore those who maybe you don’t feel comfortable with.”

**Administration 5.** “I think residents just need somebody to talk to, so I just listen and smile and just really focus on them.”

**Administration 2.** “It was mediation, you know: I aired what I thought, they aired what they thought, and then we all came together.”

Five participants noted resistance to training and implementing what was taught. Examples of their statements are as follows:
Administration 2. “Even after the training, they’re still unapproachable.”

Administration 6. “There’s no question from an organizational standpoint that there are still some folks who are not buying in and people who are just not there.”

Administration 7. “You see the people that go up and tell you that ‘No [CCST]. No coaching communication [because] it’s not for me [and] I don’t have time.’”

Four participants cited the use of pulling back and its implementation in appropriate situations. Examples of their statements are as follows:

Administration 6. “I think the pullback has been most important.”

Administration 8. “I used to be somewhat accusatory [and] now I find myself pulling back. And if it’s a major issue, I would hand it to my boss and [have] him review it.”

Administration 1. “I’ve learned to tell the residents [by] using pullback methods and trying to paraphrase to them so they can understand or have a better understanding.”

Administration 2. “Although I don’t hear it as much anymore, people are pulling back and they don’t have to say that they pull back [because] it’s become intrinsic.”

Four participants described situations that revealed improved communication in the workplace as a result of the training. Examples of their statements are as follows:

Administration 2. “I would always write something down before, but now I even bounce it off my coworkers: ‘Help me rephrase this because I know it might sound a little too assertive and how can we soften it up a bit?’”

Administration 4. “I think the training has enabled me to look at a person and think of the skills that I use to speak with them to address an issue, so I think you [trainers] gave us a lot more to think of in terms of communicating.”

Administration 1. “What I learned is that instead of going directly at the person, I will speak to the person and with better communication; it’s trying to work.”

Administration 6. “People had a common language to discuss how to get a sense of themselves and then they can come and talk about it.”
Selective coding. Axial coding of the Administration Focus Group responses generated five themes: (a) pullback, (b) resistance to training, (c) positive attributes from training, (d) improved social interaction, and (e) improved communication. For selective coding of the data, the researcher selected one administrator’s statement that reflected the relationship between the identified themes with the greatest degree of clarity and congruence. Administration 5 stated,

I think it’s taught me how to deal with conflict in a better way. So I had to confront a coworker about an issue that was very dear to me, and I practiced and practiced and practiced, and I got it right in my head the way I wanted to, what needed to be said, and what was the best way to say it, and I approached the situation with my full toolbox and I had excellent results. And I always look at that to kind of guide me. Because when it’s the typical day-to-day problems, you kind of always react very robotic, but this was something very touching, so I was either going to lose it or I had to think about things, and it allowed me to take it in, and I spent like a day and a half just thinking about it and thinking about it until I was ready.

Micro-interlocutor analysis.

- The majority of participants \((n = 5)\) in the Administration Focus Group indicated agreement in response to Focus Group Question 1.

- One participant gave a statement indicating agreement in response to Question 2.

- The majority of participants \((n = 6)\) gave statements indicating agreement in response to Question 3.

- The majority of participants \((n = 5)\) gave statements indicating dissent in response to Question 4.

- Participants were most likely to give statements indicating agreement in response to Question 5 \((n = 5)\).
- Half of the participants \((n = 4)\) gave statements indicating agreement in response to Question 6.

- Participants either completely agreed in response to Question 7 \((n = 4)\) or gave statements indicating agreement \((n = 4)\).

- Half of the participants \((n = 4)\) did not indicate agreement or dissent in response to Question 8.

- The majority of the participants \((n = 5)\) completely agreed in response to Question 9.

- The majority of participants \((n = 6)\) did not indicate agreement or dissent in response to Question 10.

- The majority of participants \((n = 6)\) completely agreed in response to Question 11.

Frequencies and percentages for answers to the Administration Focus Group questions are presented in Table 8.

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Agreement</th>
<th>Dissent</th>
<th>Statement indicating agreement</th>
<th>Statement indicating dissent</th>
<th>No agreement or dissent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>%</td>
<td>(n)</td>
<td>%</td>
<td>(n)</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>63</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 8. *Frequencies and Percentages for Levels of Consensus in Administration Focus Group* (continued)

| Focus group question | Agreement | | | Dissent | | | Statement indicating agreement | | | Statement indicating dissent | | | No agreement or dissent |
|----------------------|-----------|---|---|---|---|---|-----------------------------|---|-----------------------------|---|---|---|
|                      | n | %  | n | %  | n | %  | n | %  | n | %  |
| 3                    | 2 | 25 | - | -  | 6 | 75 | - | -  | - | -  |
| 4                    | 3 | 38 | - | -  | - | -  | 5 | 63 | - | -  |
| 5                    | 2 | 29 | - | -  | 5 | 71 | - | -  | - | -  |
| 6                    | 3 | 38 | - | -  | 4 | 50 | - | -  | 1 | 13 |
| 7                    | 4 | 50 | - | -  | 4 | 50 | - | -  | - | -  |
| 8                    | 1 | 13 | - | -  | 3 | 38 | - | -  | 4 | 50 |
| 9                    | 5 | 63 | - | -  | 3 | 38 | - | -  | - | -  |
| 10                   | 2 | 25 | - | -  | - | -  | - | -  | 6 | 75 |
| 11                   | 6 | 75 | - | -  | 2 | 25 | - | -  | - | -  |

*Note.* Due to round, percentages may not total to 100.

**Group Comparison of Micro-Interlocutor Analysis**

The results of the micro-interlocutor analysis show similarities and differences between the levels of dissension among the four focus groups. In the Nursing, Support Services, and Community-Based Focus Groups, no members expressed outright dissension in response to any of the focus group questions. These three groups, however, contained members who offered no apparent dissension or agreement in response to one or several of the questions. Members of the Administration Focus Group were the only
participants whose suggested disagreement in response to a question. The Administration Focus Group also displayed the most cases of neutrality, with members expressing neither assent nor dissent in response to several of the questions. Table 9 presents a detailed comparison of the frequencies by group.

Table 9. Frequency of Response Type by Group

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Agreement</th>
<th>Suggested agreement</th>
<th>Suggested dissent</th>
<th>Dissent</th>
<th>No agreement or dissent</th>
</tr>
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<tbody>
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<td>Nursing</td>
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<tr>
<td>Support Services</td>
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<td>35</td>
<td>-</td>
<td>-</td>
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<td>Community-Based</td>
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<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Administration</td>
<td>33</td>
<td>31</td>
<td>5</td>
<td>-</td>
<td>11</td>
</tr>
</tbody>
</table>

**Chapter Summary**

The purpose of this qualitative exploratory case study was to explore the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. The researcher utilized focus groups as the method of data collection in this study. The researcher employed open, axial, and selective coding to analyze the focus group response data. Coding of the Nursing Focus Group responses revealed four themes: (a) conflict with coworkers, (b) pullback, (c) improved communication, and (d) improved work environment. Coding of the Support
Services Focus Group responses revealed three themes: (a) improved communication and social interaction, (b) workplace tension and attitudes, and (c) positive impact on employee cohesion. Coding of the Community-Based Focus Group responses revealed five themes: (a) redundancy, (b) pullback, (c) self-awareness, (d) improved communication, and (e) improved working relationships. Finally, coding of the Administration Focus Group responses revealed five themes: (a) pullback, (b) resistance to training, (c) positive attributes from training, (d) improved social interaction, and (e) improved communication. Table 10 presents the identified themes by focus group.

Table 10. Identified Themes by Focus Group

<table>
<thead>
<tr>
<th>Nursing</th>
<th>Administration</th>
<th>Community-Based</th>
<th>Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improved communication</td>
<td>1. Improved communication</td>
<td>1. Improved communication</td>
<td>1. Improved communication</td>
</tr>
<tr>
<td>2. Improved work environment</td>
<td>2. Improved social interaction</td>
<td>2. Improved working relationships</td>
<td>2. Improved social interaction</td>
</tr>
<tr>
<td>5. Resistance to training</td>
<td>5. Redundancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The researcher identified a large degree of similarity among the responses provided by the four focus groups. Overall responses indicated positive results from implementing pullback, overall improved communication skills and self-awareness,
improved social interaction and workplace environment, and negative perceptions of the training (redundancy and resistance to implementation and practice).

In Chapter 5, the researcher discusses the implications of the findings within the context of the literature and provides suggestions for further research.
CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

Introduction

Research studies have been dedicated to finding the most effective training to improve organizational outcomes in organizations. Willingham and Eden (2007) acknowledged the need for training effective communication in health care, but establishing a unified standard has been unsuccessful. S. Gregory (2001) linked poor organizational outcomes in health care to below-standard training. Therefore, the body of knowledge dedicated to understanding the effectiveness of healthcare training has focused on the components of training needed to improve quality of care. Kraiger et al. (1993) suggested the objective of training should aim to accomplish organizational goals and influence employee growth. Maas et al. (2008) recommended training programs that influence leadership, mentoring, and team building. Kemeny et al. (2006) stated the level of effectiveness of training is determined by the forms of techniques utilized during the training program. Role-playing, feedback, on-the-job training, and motivation are a few techniques recommended by Kemeny et al. to increase the effectiveness of training.

There are various perspectives regarding how to capitalize on training vital skills and knowledge to employees. In the field of health care, the focus is on utilizing CST programs to improve quality and bridge the gap established because of an unclear definition of the term (Piligrimienė & Bučiūnienė, 2008). A CCST program that
promotes a unified communication technique, respect, constant observation, feedback, trust, and performance improvement has the potential to nullify differences between healthcare professionals (Graham et al., 1994). Limited research has explored the effectiveness of CST, employing coaching methodologies and the influence on organizational results in a healthcare system (Jarvis et al., 2006). The scope of this study acknowledges the gap in research for effective training programs in the healthcare industry that influence organizational results and support the needs of healthcare providers. This chapter iterates the purpose of the study and includes a general discussion of the research methodology, a summary of the results, a discussion of the results, a discussion of the results in relation to the literature, the limitations, implications, and recommendations for further research.

**General Discussion of the Research Methodology**

The research methodology was qualitative and exploratory. The main focus was to explore the effectiveness of a CCST program and its impact on organizational results in a healthcare system. The study used a qualitative design rather than a quantitative design to enable the researcher to examine an individual/group and gain a deeper understanding of a phenomenon/experience (Creswell, 2009). The study began with research questions to gain a deeper understanding of the effectiveness of a CCST program implemented in a long-term healthcare organization. This qualitative exploratory case study was designed to answer the following primary research question: How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system?
The study was guided by the following research subquestions:

1. What evidence illustrates that staff found the training intervention enjoyable (Level 1)?
2. What evidence illustrates that staff gained knowledge from the training intervention (Level 2)?
3. What evidence illustrates that staff changed behavior after the training intervention (Level 3)?
4. What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)?
5. How does the impact of coaching communication differ among occupational groups in health care?

This qualitative study followed an exploratory case study design. A case study design was considered the most beneficial approach because of its ability to take into account multiple perspectives (Huberman & Miles, 2002). Employees in the organization who had successfully completed the CCST represented the purposive sample in the study (excluding part-timers, per diem employees, interns, volunteers, and probationary employees). For the study, the data collected were generated from semistructured focus groups, audio recordings, archival records, and field notes.

The qualitative data consisted of four focus groups with eight participants each. The qualitative data were examined using NVivo 9.0. The groups were separated into the following cohorts: administration, community-based, nursing, and support services. No demographic information or other identifiable information from any of the participants was outlined in the results. For the focus group analysis, themes were assessed overall
and not per focus group question. Themes were assessed using open coding, axial coding, and selective coding. The themes were assessed by group and not for all four groups together. Excerpts from participants’ responses were included for support and were identified by focus group and number (e.g., Nursing 1, Support Services 3, etc.) or as a collective group response. After the presentation of the themes, similarities and differences among the themes per focus group were outlined. Lastly, the themes per focus group were categorized into the four Kirkpatrick (1994) levels: reaction, learning, behavior, and results.

Summary of the Results

A number of strategic data management procedures were used to ensure efficient recording and easy retrieval of the focus group data. The Onwuegbuzie et al. (2009) micro-interlocutor analysis allowed the researcher to measure the level of consensus/dissension within the focus group. This technique permitted data collection from participants who failed to contribute due to time constraints, shyness, response patterns, intimidation, difference in opinion, or level of intelligence. Semistructured focus groups were used to apply the four levels of Kirkpatrick’s (1994) model for training effectiveness in answering the research subquestions.

The results of the primary research question and subquestions are as follows. In regard to the first subquestion, Level 1 (reaction), participants indicated an overall sense of satisfaction with the training. Examples of their statements are as follows:

**Administration 4.** “It was positive, it was interesting and very new in terms of a program that the facility was moving forward, and I was encouraged about it, so I thought it was very positive.”
Community-Based 5. “It was a very enlightening experience.”
Nursing 5. “I had a positive experience. . . . The materials were pretty good and the presenters were good and they tried to, you know, make sure . . . it was positive for me.”

Support Services 1. “The coaching approach seemingly is a different approach, and I appreciate that.”

In reference to the second subquestion, Level 2 (learning), all participants indicated the training helped them improve their communication and social interaction. Examples of their statements are as follows:

Administration 8. “I had my staff come back to me and say, ‘This is what you’ve got to do,’ so I know that they took away the tools that would help them and help me as well.”

Administration 6. “The coaching boosters did become a place for folks to talk.”

The communication techniques were implemented throughout the training and participants’ reactions were positive. Community-Based 5 stated, “Self-awareness made me assess myself and say, ‘You know what? I checked in with myself; these are my options,’ and then I said, ‘You know what? This is what I need to do.’”

The techniques the employees implemented from the training were pulling back, paraphrasing, and other similarly related methods. Examples of their statements are as follows:

Support Services 4. “Paraphrasing . . . like scenarios when people come with a problem and actually get it back to the person in a different way using different words but the same fact.”

Nursing 5. “Constantly. I have to pull back a lot.”

Community-Based 1. “When it came to paraphrasing, I thought it was a little silly, but then I used it and it helps.”
Participants also indicated they learned the concept of self-awareness and that it helped them with addressing situations. Conflicts became as resolvable via coaching sessions, pulling back, teamwork, and better communication. Examples of their statements are as follows:

**Administration 4.** “I’d have to say [I’m] a little more self-aware about some of the things that I do regularly, without even thinking, in terms of my body language and communication.”

**Nursing 3.** “That’s how the coaching techniques work . . . it gives you a tool, something you can use.”

Participants in all four cohorts were able to give examples or use vocabulary to exemplify learned knowledge.

In reference to the third subquestion, Level 3 (behavior), the results showed the participants’ responses demonstrated their improved skills regarding communication and social relationships when given the opportunity to utilize what was taught in the training. Administration 6 stated, “I think the fact that people had a common language . . . they can come and talk about it.” One participant referred to his behavior and stated, “I’ve done the paraphrasing. . . . It helps because you think you understand what someone is saying, but sometimes you have missed a step or a little detail” (Community-Based 1). Another participant referred to an altercation with a coworker and stated, “I was doing everything nice and cool ‘cause I remember what our coach said: ‘Just take a step back and breathe easy.’ . . . She wasn’t letting me breathe easy” (Nursing 7). One participant learned to self-manage and stated, “I get very defensive . . . and I know that I learned to stop doing that. . . . Listen to what other people have to say before jumping the gun” (Support Services 7).
Another participant referred to her behavior and stated, “I think what residents expect is more listening. . . . I just listen and I smile, and I do all that nice stuff—I just really focus on them” (Administration 5). Another participant stated, “Body language speaks volumes, and unfortunately I have one of those self-expressive faces that can go a long way in either direction” (Community-Based 5). Another participant confessed, “On my own floor, that’s where I needed it [CCST] most . . . dealing with alert residents telling me what to do . . . when the resident is talking to you in a demeaning manner” (Nursing 8). The theme of improved behavior was exemplified when one participant stated, “In the beginning, I would just call my supervisor . . . but after coaching, I just explain to her that ‘You wouldn’t want your mother living in these conditions’” (Support Services 6). All four cohorts were able to provide examples of behavior modifications through training.

In reference to the fourth subquestion, Level 4 (results), the findings showed the results of the training were demonstrated as being widely utilized, positive, and effective among participants. Responses indicated positive workplace communication and communication in employees’ personal lives, improvement of difficult and burdensome situations, and a unified way to communicate. Therefore, participants described happier clients and better camaraderie among coworkers and an overall improved quality of care. Examples of their statements are as follows:

**Administration 2.** “The interaction [improved] between the supervisors and the nurses, ultimately impacting on the resident.”

**Community-Based 5.** “I would say the line staff has really stepped up with working with difficult people in the very emotional situations.”
Support Services 1. “CNAs on the floor [are] talking to each other and getting together to work, and when you do that, what do you get? Better resident care.”

Nursing 6. “Definitely, definitely, the residents have benefited from this.”

In reference to the fifth subquestion, the results showed that among the four focus groups, the major differences involved the Support Services Focus Group solely outlining tension in the workplace and the Nursing Focus Group solely outlining conflict among coworkers.

The primary research question was answered by the collective results of the four levels of Kirkpatrick’s model. Therefore, regarding the primary research question, How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system? the results showed the participants found the CCST favorable, participants’ communication and social interaction improved, participants recalled techniques and concepts implemented in the training, participants experienced fewer conflicts after the training, participants experienced positive social relationship changes, and previous situations that were once difficult and burdensome are now handled with a better approach and result in more positive outcomes. A summary of the results of the micro-interlocutor analysis data are presented in Table 11.
Table 11. *Summary of the Results: Focus Group Questions/Micro-interlocutor Analysis*

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When were you trained in coaching communication? Did anything occur that prevented you from finishing the entire course?</td>
<td>4 out 4 cohorts’ statements suggested agreement</td>
</tr>
<tr>
<td>2. Did you have a positive experience or a negative experience with the training? Please describe your experience. What happened? (Level 1)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Support Services, and Community-Based</td>
</tr>
<tr>
<td>3. What was the most important skill you took away from the intervention? Please provide a story regarding how the skill has affected your work life. (Level 2)</td>
<td>4 out 4 cohorts’ statements suggested agreement</td>
</tr>
<tr>
<td>4. Was there any component of the training you found wasteful and did not apply to your work situation? Please explain why. (Level 2)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Support Services, and Community-Based</td>
</tr>
<tr>
<td>5. How has the use of coaching and communication influenced your relationships with co-workers at work? Please provide examples. (Level 3)</td>
<td>Administration Focus Group’s statements suggested dissent</td>
</tr>
<tr>
<td>6. How has the use of coaching and communication influenced your relationships with residents at work? Please provide examples. (Level 3)</td>
<td>2 out 4 cohorts’ statements suggested agreement: Nursing and Administration</td>
</tr>
<tr>
<td>7. How has the training helped you manage problems at work? Please explain. (Level 4)</td>
<td>2 out 4 cohorts’ statements suggested agreement: Nursing and Community-Based</td>
</tr>
<tr>
<td>8. What are the benefits of having effective communication regarding your ability to complete your work? Please provide examples. Please provide work-life experiences. (Levels 3 &amp; 4)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Community-Based, and Administration</td>
</tr>
</tbody>
</table>
Table 11. Summary of the Results: Focus Group Questions/Micro-interlocutor Analysis (continued)

<table>
<thead>
<tr>
<th>Focus group question</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Since you have completed the training, do you notice other employees communicating using the methods of coaching? Please provide examples. (Levels 3 &amp; 4)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Support Services, and Administration</td>
</tr>
<tr>
<td>10. Since you have completed the training have you noticed situations at work were coaching communication has improved the quality of care? (Level 4)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Support Services, and Community-Based Administration Focus Group’s statements suggested neither agreement nor dissent</td>
</tr>
<tr>
<td>11. What results have you witnessed from the training? (Level 4)</td>
<td>3 out 4 cohorts’ statements suggested agreement: Nursing, Support Services, and Administration</td>
</tr>
</tbody>
</table>

Discussion of the Results

Limited research has explored the effectiveness of CST employing coaching methodologies and the influence on organizational results in a healthcare system (Jarvis et al., 2006). This qualitative exploratory case study contributed knowledge to the field of organizational management, HRM, organizational communication, and training. The results of the study provided a unique perspective in order to understand the effectiveness and impact of a CCST program (see Table 12).
Table 12. *Summary of the Results by Research Question*

<table>
<thead>
<tr>
<th>Research question</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subquestion 1. Level 1 (reaction): What evidence illustrates that staff found the training intervention enjoyable?</td>
<td>• Overall sense of satisfaction with the training</td>
</tr>
<tr>
<td>Subquestion 2. Level 2 (learning): What evidence illustrates that staff gained knowledge from the training intervention?</td>
<td>• Techniques were learned</td>
</tr>
<tr>
<td></td>
<td>• Improved communication</td>
</tr>
<tr>
<td></td>
<td>• Improved social interaction</td>
</tr>
<tr>
<td>Subquestion 3. Level 3 (behavior): What evidence illustrates that staff changed behavior after the training intervention?</td>
<td>• Improved skills regarding communication</td>
</tr>
<tr>
<td></td>
<td>• Improved social relationships</td>
</tr>
<tr>
<td>Subquestion 4. Level 4 (results): What critical factors were experienced illustrating improved organizational results after the training intervention?</td>
<td>• Positive workplace communication</td>
</tr>
<tr>
<td></td>
<td>• Improved communication in personal lives</td>
</tr>
<tr>
<td></td>
<td>• Improved difficult and burdensome situations</td>
</tr>
<tr>
<td></td>
<td>• Created a unified way to communicate</td>
</tr>
<tr>
<td></td>
<td>• Happier clients</td>
</tr>
<tr>
<td></td>
<td>• Improved camaraderie among coworkers overall</td>
</tr>
<tr>
<td></td>
<td>• Improved quality of care</td>
</tr>
<tr>
<td>Subquestion 5: How does the impact of coaching communication differ among occupational groups in health care?</td>
<td>• Support Services Focus Group solely outlined tension in the workplace.</td>
</tr>
<tr>
<td></td>
<td>• Nursing Focus Group solely outlined conflict among coworkers.</td>
</tr>
<tr>
<td>Primary research question: How do participants experience coaching communication skills training (CCST) and did the training influence organizational results in a healthcare system?</td>
<td>• Participants found CCST to be favorable.</td>
</tr>
<tr>
<td></td>
<td>• Participants’ communication and social interaction improved.</td>
</tr>
<tr>
<td></td>
<td>• Participants recalled techniques and concepts implemented in the training.</td>
</tr>
<tr>
<td></td>
<td>• Participants experienced fewer conflicts after the training.</td>
</tr>
<tr>
<td></td>
<td>• Participants experienced positive social relationship changes.</td>
</tr>
<tr>
<td></td>
<td>• Previous situations that were once difficult and burdensome are now handled with a better approach.</td>
</tr>
<tr>
<td></td>
<td>• More positive outcomes</td>
</tr>
</tbody>
</table>
The results of the micro-interlocutor analysis suggested that, overall, participants felt comfortable participating in the focus groups. However, when participants were asked Focus Group Question 2 regarding their overall feelings about the training (Level 1), only one participant, in the Administration Focus Group, gave a statement indicating agreement.

When participants were asked Focus Group Question 4 concerning their feelings of whether the training was wasteful (Level 2), the majority of participants in the Administration Focus Group gave statements indicating dissent.

When participants were asked Focus Group Question 5 concerning improvements in relationships with their coworkers (Level 3), less than half of the participants in the Community-Based Focus Group gave statements indicating agreement.

When participants were asked Focus Group Question 8 concerning the benefits of effective communication (Levels 3 & 4), half of the participants in the Administration Focus Group did not indicate agreement or dissent.

When participants were Focus Group Question 10 concerning improvement in the quality of care as a result of training, the majority of participants in the Administration Focus Group did not indicate agreement or dissent.

Questions that had a negative tone, for example, Focus Group Question 4 concerning participants feeling the training was wasteful, the majority of the Administration Focus Group were reluctant to respond. Questions that referred to quality of participants’ own work and the quality of care in the organization, for example, “What are the benefits of having effective communication regarding your ability to complete your work?” again, the majority of the Administration Focus Group were reluctant to
participate. In response to questions that referred to participants’ relationships with coworkers, the majority of the Community-Based Focus Group were reluctant to participate. It is possible the participants failed to contribute due to time constraints, shyness, response patterns, intimidation, difference in opinion, or level of intelligence.

In reference to the participants’ experiences regarding the CCST program (Level 1), the majority of their responses indicated a positive experience. Some participants found it necessary to mention their perceptions of other individuals who they suggested were closed-minded, distant, and found the CCST to be unnecessary. However, participants in all four cohorts were open-minded and willing to engage in and learn from the CCST program.

The Level 2 themes that surfaced regarding participants’ level of retention were apparent in three of the four cohorts. The Nursing Focus Group themes that verified retention of skills and concepts learned during the CCST were evident in participants’ consistent reference to the pullback technique. Eight participants referred to application of the pullback strategy as a means for conflict resolution and diffusion of tense situations in the workplace. The Community-Based Focus Group themes that verified retention of skills and concepts learned during the CCST were evident in participants’ consistent reference to pullback and self-awareness. Eight participants described use of the pullback strategy for dealing with coworkers and resolving problems in the workplace, which is aimed at increasing clarity through careful reflection on the problem before deciding on an action. Five of the participants mentioned the importance of self-awareness in recognizing one’s triggers and being mindful of the implications of one’s actions and behaviors, to reduce and resolve problems in the workplace. The Administration Focus
Group theme that verified retention of skills and concepts learned during the CCST was evident in the consistent reference to the pullback technique. Four participants described the use of pulling back and its implementation in appropriate situations. The results provided data that verified the majority of participants were able to retain key terms and skills that were taught during training.

The Level 3 themes that surfaced regarding participant’s ability to apply what was learned on the job were apparent in all four cohorts. The Nursing Focus Group themes that verified behavior posttraining were conflict with coworkers, pullback, improved communication, and improved work environment. Eight participants referred to application of the pullback strategy as a means of conflict resolution and diffusion of tense situations in the workplace. Seven participants described improvement in the quality and frequency of communication among staff members following completion of the training. Six participants referred to experiences in dealing with conflict in the workplace prior to the training they received due to defensive attitudes and impulsive reactions. Five participants reported improvement in the overall tranquility and harmony of the workplace since the training and referred to active efforts to maintain a peaceful work environment. The Support Services Focus Group themes that verified behavior posttraining were improved communication and social interaction, workplace tension and attitudes, and positive impact on employee cohesion. Almost all participants indicated improvement in social interactions and communication with other individuals. Six participants described situations that revealed an improvement in workplace tension and attitudes. The Community-Based Focus Group themes that verified behavior posttraining were pullback, self-awareness, improved communication, and improved working
relationships. Eight participants described use of the pullback strategy for dealing with coworkers and resolving problems in the workplace. Five of the participants mentioned the importance of self-awareness in recognizing one’s triggers and being mindful of the implications of one’s actions and behaviors, to reduce and resolve problems in the workplace. Six participants referred to the improvement of communication in the workplace as a result of the skills learned, or refreshed, in the training exercises. Eight participants noted the improvement of working relationships in the office, including a greater sense of camaraderie and teamwork, as a positive outcome of the training experience. The Administration Focus Group themes that verified behavior posttraining were pullback, improved social interaction, and improved communication. Five participants reported improvement in social interactions and relationships with others. Four participants referred to the use of pulling back and its implementation in appropriate situations. Four participants described situations that revealed improved communication at the workplace.

The Level 4 themes that surfaced regarding whether results were achieved after the application of training were apparent in three of the four cohorts. The Nursing Focus Group theme that verified whether results were achieved after application of training was improved communication. Seven participants described improvement in the quality and frequency of communication among staff members following the completion of the training. The Community-Based Focus Group theme that verified whether results were achieved after application of training was improvement in working relationships. Eight participants noted improvement in working relationships in the office, including a greater sense of camaraderie and teamwork, as a positive outcome of the training experience.
The Administration Focus Group theme that verified whether results were achieved after application of training was improved social interaction and pullback. Five participants reported improvement in social interactions and relationships with other individuals. Four participants referred to the use of pulling back and its implementation in appropriate situations.

**Discussion of the Results in Relation to the Literature**

This research study provides evidence that showcases the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. The research contributes to the body of knowledge by creating awareness that a CCST program that utilizes coaching to improve communication by focusing on self-awareness, self-management, constructive feedback, and active listening can influence higher levels of performance and results. Therefore, the results of this study may be considered valuable in improving quality of care in long-term health care. The analysis of the training program shadowed Kirkpatrick’s (1994) four-level model for training effectiveness, which proposes that reaction, learning, behavior, and results are needed to evaluate the effectiveness of a training program.

The reaction level was addressed in Research Subquestion 1 that asked, What evidence illustrates that staff found the training intervention enjoyable (Level 1)? Alliger et al. (1997) found the reaction level consists of positive reaction and educational gain. In the current study, the participants indicated their overall sense of satisfaction with the training. Participants were able to recall terms and techniques taught during the CCST program. The themes that exemplified the reaction criteria were improved
communication and social interaction, collective agreement, and positive attributes from training. For example, Community-Based 4 stated,

The opportunity to participate in this [CCST] was an opportunity to refresh my skills and my knowledge ‘cause we often go through the curriculum and [then] we go out into the world, and if we are not practicing what we learned, sometimes that language is lost.

This response is aligned with Kraiger et al.’s (1993) suggestion that the objective of training should be to accomplish organizational goals and influence employee growth. The response provided verifies that the CCST accomplished organizational goals and influenced employee growth.

The learning level was addressed in Research Subquestion 2 that asked, What evidence illustrates that staff gained knowledge from the training intervention (Level 2)? Kirkpatrick (1994) noted that evaluating the training is a good indicator of training effectiveness. Immediate posttraining measures are needed in the form of pre-/posttest or other forms of assessments (Praslova, 2010). In the current study, the participants indicated the training helped them improve their communication and social interaction. A variety of techniques learned during the training were implemented posttraining, for example, pullback, paraphrasing, and active listening. The themes that exemplified the learning criteria were improved communication and social interaction, positive impact on employee communication and cohesion, pullback, self-awareness, and positive attributes from training. For example, Administration 1 stated, “I’ve learned to tell the residents [by] using pullback methods and trying to paraphrase to them so they can understand or have a better understanding.” Özcan (2006) described the communication between nurses as an interpersonal relationship that consists of nonverbal
and verbal messages. The nurses’ level of awareness toward their skills and abilities allows communication with coworkers, patients, and family members to be successful. Moreover, awareness of thoughts, feelings, and behaviors facilitates their skills and ability to improve.

The behavior level was addressed in Research Subquestion 3 that asked, What evidence illustrates that staff changed behavior after the training intervention (Level 3)? Kirkpatrick’s Level 3 behavior criteria measure whether what was learned during training is being applied on the job. This criteria are determined by on-the-job performance that stemmed from the effects of training (Kirkpatrick, 1994). Alliger et al. (1997) referred to this level as the transfer criteria and found there was a modest relationship between the learning criteria and the behavior criteria. In the current study, the results also showed a relationship between the learning and behavior criteria. Many participants stated they felt they were now able to address and handle situations better due to what was taught in the training. Many participants indicated they noted changes in the dynamics of their relationships with coworkers and family members due to their improved communication style. The themes that provided evidence that what was learned during training is being applied on the job were improved communication, positive work environment, positive impact on employee communication and cohesion, pullback, and self-awareness. For example, regarding self-awareness, Community-Based 3 stated,

I used to tend to drift away and not even be there . . . my mind would keep flowing away. The active listening and what I have learned here in the training was like, self-awareness. You have to train your mind to be here in the moment and listening to what they’re saying because it’s important.
T. Alessandra and Hunsaker (1993) found that active listening improves manager–employee relationships, organizational errors, and clarity of workplace dialogue. Mewton et al. (2005) found that leaders who promote and support work environments with “self-awareness, active listening, empathy, and integrity” (p. 14) are more likely to see positive change in employee performance. Duhamel and Talbot (2004) found that training active listening positively influences nurses’ communication skills with families of patients. Manktelow (2005) reported that not only should individuals pay attention and show that they are listening, but an active listener must also give feedback, eliminate personal judgment, and respond appropriately when engaging in communication. Jonsdottir et al. (2004) found that when active listening is practiced by nurses, it forces genuine attentiveness and sincerity. Negative arousals are subdued in patients when healthcare professionals interact using active listening (Shatell, 2005). Nurses in Viederman’s (2002) study stated that utilizing active listening techniques was the most effective method when dealing with difficult patients. In the current study, the participants stated their behavior has changed due to the CCST.

The results level was addressed in Research Subquestion 4 that asked, What critical factors were experienced illustrating improved organizational results after the training intervention (Level 4)? Flood and Escarce (2007) acknowledged that healthcare organizations and researchers have inherited the challenge of developing and implementing methods to improve the quality of care in healthcare organizations. The ability to address these challenges relies on the capabilities of individuals who are unevenly disbursed between managerial, clinical, and community concerns (Hofmann & Perry, 2005; Ramanujam & Rousseau, 2004; Smedley et al., 2002). Therefore, the ability
to efficiently address quality concerns in health care remains a challenge for healthcare professionals. McAlearney (2008) found that healthcare organizations that implemented developmental programs were positively correlated with improving the quality of care provided within the organizations. Frankovelgia and Riddle (2010) found that developmental training programs that focus on enhancing and establishing relationships through mentoring and coaching are linked to effective performance. Kirkpatrick’s (1994) Level 4 results criteria measure whether results are achieved after the application of training. Based on an organizational perspective, the results level of evaluation is determined by the achievement of the expected outcome of the training. Because of the difficulty of assessment, these criteria are utilized the least (Arthur et al., 2003). In the current study, the results of the training were demonstrated as being widely utilized, positive, and effective among participants. Participants indicated the training helped with communication at the workplace (with employees and management) and in their personal lives (with family members). Participants also stated that previous situations that were once difficult and burdensome are now handled with a better approach and result in more positive outcomes. Similarly, participants noted the environment and atmosphere at the workplace is more manageable due to their ability to calm a situation down with the appropriate communication. The practice of what was taught in the training has allowed for better communication and has become intrinsic for the participants. Participants described happier clients and better camaraderie among coworkers and an overall improved quality of care.

The CCST focused on self-awareness, self-management, constructive feedback, and active listening. Research has shown that all four concepts, when trained in a
healthcare setting, contribute to organizational outcomes and productivity (Ericsson, 2004; Frayne & Latham, 1987; Jack & Smith, 2007; Mewton et al., 2005). Jack and Miller (2008) suggested that healthcare organizations that invest in self-awareness training can improve their quality of care within their facilities. Researchers have reported the benefits of self-management in connection with healthcare staff productivity and patient care (Lorig et al., 2001; Miller & Iris, 2002; Rollnick et al., 1993). Krackov (2011) promoted feedback training because of its ability to positively maturate skills. Krackov recommended that feedback be associated with every training program because it develops expertise. Evidence shows that an organization that encourages feedback works toward a culture that promotes internal capital. A CCST program that promotes a unified communication technique, respect, constant observation, feedback, trust, and performance improvement has the potential to nullify differences between healthcare professionals (Graham et al., 1994). Based on the results of this study, the CCST was effective because the program influenced a unified way to communicate, a positive reaction, increased learning, and improved behavior, and had an impact on organizational outcomes. Therefore, the results of this study provide evidence in regard to the primary research question and subquestions.

**Effectiveness of Communication Skills Training and Employing Coaching Methodologies**

Based on Kirkpatrick’s (1994) four-level model of evaluation, the implemented CCST program influenced participants on all four levels of evaluation. The CCST program was positively reviewed by all 32 participants involved in the study. The
reaction (Level 1) of the participants indicated an overall sense of satisfaction, self-improvement, and a more positive work environment. Participants stated that after participating in the training, their ability to communicate and interact socially improved. In their responses regarding work-life experience, the participants articulated the various coaching techniques and showed the ability to relate what was learned (Level 2). The participants provided evidence of the influence of the CCST on their behavior (Level 3) by expressing confidence in the ability to address and handle situations more effectively due to what was taught in the training. In addition, participants recognized the behavior of their coworkers and family members and noticed a feeling of cohesion through improved communication posttraining. The results (Level 4) of the training were demonstrated as being widely utilized, positive, and effective among participants. Participants were aware the CCST improved communication in the workplace and in their personal lives. Therefore, situations that were deemed difficult are now considered manageable due to the improved communication, resulting in better outcomes. The effectiveness of CST employing coaching methodologies created happier clients and better camaraderie among coworkers and an overall improved quality of care.

Figure 3 illustrates a summary model of the research describing the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. First, the model showcases the CCST and the four core coaching techniques (active listening, constructive feedback, self-awareness, and self-management) implemented during the training. Second, the model illustrates that the researcher explored the effectiveness and influence of the CCST on four cohort focus groups (Nursing, Community-Based, Administration, and Support Services). Finally, the
model illustrates the research findings of the effectiveness of a CCST program and its influence on organizational results based on Kirkpatrick’s (1994) four-level training evaluation model.

Figure 3. CCST research results as measured by the Kirkpatrick (1994) model.

**Limitations**

The limitations of this research study were noted throughout the course of the study. The first limitations involved the weight of the responses provided by the participants. Appleton (1995) reported the weight of the responses depends on the
facilitator’s ability to conduct interviews. The researcher depended on participants to make a sincere effort to answer questions honestly.

Utilizing a focus group methodology may have created limitations due to power struggles between participants and the impact of providing public responses. The participant’s personality, level of occupation, and education were not prerequisites for participation.

The researcher recognizes the limitation involving the utilization of the micro-interlocutor analysis. When utilizing the micro-interlocutor analysis, the researcher incorporates and analyzes information from the focus group by delineating which participants respond to each question, the order of responses, and the nature of the responses (e.g., non sequitur, rambling, focused) as well as the nonverbal communication used by each of the focus group participants. (Onwuegbuzie et al., 2009, p. 3)

In the data set provided, different speakers are not explicitly identified, the nature of responses is not specified, nor are nonverbal communications consistently noted. Thus, the data collected from the focus groups were not detailed enough to enable micro-interlocutor analysis in its strictest interpretation.

The number of questions asked during the focus group sessions may have provided a limitation due to time constraints. The ability of the facilitator to be flexible and establish a comfortable environment may have contributed to the accuracy and amount of information received during the study.

The organization selected for this study has conducted previous communication trainings, which may have influenced participants’ responses. The small sample size of 32 long-term healthcare participants may have jeopardized transferability to a larger population, which may have influenced the external validity of the study. Utilizing a
purposive sample may have underrepresented or overrepresented the population. Participants in the study represented one long-term healthcare facility. Therefore, the research findings may represent only one organization and one population. The results of this study may not be applicable to long-term healthcare employees outside of the researched organization.

**Implications**

In this study, the researcher explored the effectiveness of a CCST program and its influence on organizational results when trained facility-wide in a long-term healthcare organization. The results showed the participants found the CCST favorable and referred to the training as an enjoyable experience. Participants improved their communication and social interaction after the training. Participants recalled techniques and concepts implemented in the training and experienced fewer conflicts in the work environment. Participants experienced positive social relationship changes, and previous situations that were once difficult and burdensome are now handled with a better approach and result in more positive outcomes.

Long-term healthcare organizations should be made aware of the results of this study. Paice (1998) reported a change in healthcare operations from an on-call system to a shift system of working, which has decreased the amount of time employees have for training. Due to time constraints, this change also limits the amount of feedback received by employees. The change in healthcare operations has forced organizations to improve the knowledge, skills, and ability of employees with less training. Willingham and Eden (2007) acknowledged the need for training effective communication in health care, but
establishing a unified standard has been unsuccessful. S. Gregory (2001) linked poor organizational outcomes in health care to below-standard training. The themes generated in the current study provide a compelling reason for management in long-term organizations to implement CCST programs. Increasing awareness of CST that promotes coaching would be considered valuable in improving quality of care in long-term health care. This research provides organizations with insight into how to best support healthcare providers.

Self-awareness, self-management, constructive feedback, and active listening are considered valuable skills for healthcare professionals to improve communication and performance. The coaching method for communication in this study was considered a valuable way to unify how healthcare professionals communicate. The results of this study verified the need for organizations to invest in human capital by implementing CCST programs. If implemented efficiently, the results would positively influence organizational outcomes.

The effectiveness of the CCST and its impact on organizational results was determined by utilizing Kirkpatrick’s (1994) four-level model for evaluating training. Therefore, the CCST influenced organizational results at the research organization. As recommended by Arthur et al. (2003), this study illustrates the need of all four levels of Kirkpatrick’s model in order to evaluate training outcomes.

The case study methodology allowed the researcher to get a deeper understanding of the effectiveness of a CCST program in long-term healthcare staff. Therefore, the researcher gained a deeper understanding of the differences between cohort groups in regard to the effectiveness of a CCST program and its impact on organizational results.
Krueger and Casey (2009) argued the limitations of focus groups are the possibility of receiving false information, exaggerated information, emotionless information, unclear responses, and dominant personalities that may negatively affect the responses of the group. In the current study, the participants made a sincere effort to answer questions honestly. The level of comfort between the participants and the facilitator contributed to the accuracy and amount of data received. The methodology allowed the facilitator to ask clarifying questions, and the recording of data ensured precise transcription of participants’ responses. Therefore, the benefits acknowledged by Fontana and Frey (1994)—flexibility, richness of data, low cost, and in-depth responses—were exemplified throughout the data process.

Appleton (1995) argued that weight of the responses depends on the facilitator’s ability to conduct interviews. In the current study, the third-party facilitator was trained to conduct in-depth interviews. Based on the experience and skills of the facilitator, the level of comfort between the participants and the facilitator contributed to the accuracy and amount of information received during the study. In addition, as Malterud (2001) recommended, an analysis framework was utilized at all steps of the research process to analyze the presentation of the research and the researcher.

**Recommendations for Further Research**

The researcher strongly recommends that future researchers attempt to widen the scope of this study. The case study methodology allowed the researcher to get a deeper understanding of the effectiveness of a CCST program in long-term healthcare staff. Therefore, the researcher gained a deeper understanding of the differences between
cohort groups in regard to the effectiveness of a CCST program and its impact on organizational results. Alternative qualitative methods of research are needed on this topic to gain a deeper understanding of the effectiveness of a CCST program and its impact on organizational results in a healthcare system. Limitations due to weight of the responses can be eliminated with alternative methods of data collection. Researchers may discover more in-depth data using one-on-one interviews instead of focus groups. Interviews can be conducted over the phone instead of in person to increase the participant’s level of comfort. Participants may be more inclined to answer questions honestly due to the elimination of potential power struggles between participants and the effect of public responses. In this study, the researcher utilized a semistructured focus group format. Therefore, formal or informal structures may generate more informative data. In addition, future researchers can observe participants through observational techniques (e.g., video) to study the dynamics of real work-life situations. Such a format could generate quantitative statistical data.

Researchers should consider changing the research methodology to uncover more quantifiable results and determine their correlation with organizational outcomes. The utilization of surveys, questionnaires, and testing both before and after training can provide numerical statistical value. The quantitative methodology would provide a more formal, objective process that can be tested to uncover correlations and cause-and-effect. As noted previously, external validity was a limitation of this study. The quantitative methodology process would permit a larger sample and allow the results to be generalized to a larger population.
This research study focused on four separate cohorts: Nursing, Support Services, Community-Based, and Administration. The researcher recommends that future researchers focus on each cohort separately or examine the correlation between groups. In addition, researchers should examine the effectiveness of a CCST for management versus front-line staff. The archival data collected from the previous surveys (Staff Satisfaction Survey, Management Team Coaching Experience Survey) conducted at the research organization indicated the need for future research exploring the commitment of management to the coaching approach.

Researchers should increase the generalizability of the results by examining other populations, utilizing different sample procedures and different long-term care facilities across different regions. Future researchers should focus on how communication using a coaching approach influences tangible organizational results. The researcher recommends future researchers conduct a longitudinal study to gain a deeper understanding of the time frame of communication training retention.

**Conclusion**

The study explored the effectiveness of a CCST program and its impact on organizational results in a healthcare system using Kirkpatrick’s (1994) training evaluation model. An exploratory case study design was considered the most beneficial approach because of its ability to take into account multiple perspectives of the experience and influence of the CCST program. The participants were placed in semistructured focus groups to gain an in-depth perspective of their experience with the CCST program. The data collected were generated from audio recordings, archival
records, and field notes. A previous organizational survey indicated that only half of the organization management team supports the use of coaching communication when dealing with workplace issues.

The results of this study suggested the CCST and approach were effective overall. The consistency of the participants’ responses, noted throughout the micro-interlocutor analysis, suggested that, overall, participants felt comfortable taking part in the focus groups. In reference to their experience in the CCST program (Level 1), participants in all four cohorts were open-minded and willing to engage in and learn from the CCST program. The Level 2 themes that surfaced revealed participants’ level of retention was apparent in three of the four cohorts. The Nursing and Administration Focus Groups verified retention by acknowledging the pullback technique. In addition, the Community-Based Focus Group themes that verified retention were pullback and self-awareness. The Level 3 themes that gave a glimpse into the participants’ ability to apply what was learned on the job were apparent in all four cohorts. The Level 4 themes that indicated whether results were achieved after the application of training were apparent in three of the four cohorts. The Nursing Focus Group acknowledged improved communication. The Community-Based Focus Group acknowledged improvement in working relationships. The Administration Focus Group acknowledged improved social interaction and pullback.

Overall, the CCST program was able to increase employees’ retention and influence positive behavior on the job. Employees found the CCST enjoyable and influenced positive organizational outcomes. This research study provides evidence of the effectiveness of a CCST program and its influence on organizational results when
trained facility-wide in a long-term healthcare organization. The research contributed to the body of knowledge by creating awareness that a CCST program that utilizes coaching to improve communication by focusing on self-awareness, self-management, constructive feedback, and active listening can influence higher levels of performance and results. Therefore, the results of this study are considered valuable in improving quality of care in long-term health care.

Future research is recommended to change the research methodology to uncover more quantifying results and determine their correlation with organizational outcomes. More qualitative research on this topic is needed to gain a deeper understanding of the effectiveness of a CCST program and its impact on organizational results in a healthcare system. In addition, future research with in-depth focus on each cohort separately, research that examines the effectiveness of a CCST for management versus front-line staff, research in other populations and different long-term facilities across different regions are recommended. Lastly, future researchers should conduct a longitudinal study and focus on how communication using a coaching approach influences tangible organizational results.
REFERENCES


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APPENDIX. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University’s Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person’s ideas or works.

The following standards for original work and definition of plagiarism are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others’ work through proper citation and reference. Use of another person’s ideas, including another learner’s, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else’s ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University’s Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.
Statement of Original Work and Signature

I have read, understood, and abided by Capella University’s Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA Publication Manual.

Learner name and date

Mentor name and school John Herr, School of Business and Technology