

# Certified Nursing Assistant and Care Assistant Views on Incontinence Care: Insights for the Creation of Quality Improvement Programs

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## Abstract

**Background:** Incontinence is a prevalent condition affecting the health and quality of life of many elderly, particularly those living in institutional settings. Incontinence can lead to skin breakdown and infection and rates of occurrence of both are increasingly being used to assess facility quality. Certified nursing assistants (CNAs) and care assistants (CAs) provide most of the hands-on care in long-term care facilities, yet little is known about their views on managing incontinence.

**Aims:** This study examined the knowledge and attitudes of CNAs and CAs regarding incontinence care to inform quality improvement (QI) programs related to this condition.

**Sample:** The population consisted of 69 CNAs and 22 CAs, comprising 15 focus groups, from 32 facilities in Georgia in the southeastern United States (US).

**Methods:** Experts in elder care, including social workers and physicians, consulted on the script and trained facilitators guided sessions. Data were subject to extensive content analysis to identify themes related to incontinence care.

**Results:** The majority of CNAs and CAs cared for incontinent residents. Both groups were aware of risk factors for the condition, particularly the role of dementia and stroke. They were familiar with the standard clinical consequences, but emphasized the negative effect of incontinence on resident pride and well-being. Bladder and bowel training programs were viewed as highly effective treatments, but all groups stressed that learning resident toileting patterns was most important and could often prevent episodes. Areas for care improvement were: communication between shifts about resident toileting patterns; teamwork when the facility was short-staffed to maintain toileting schedules; securing clothing that did not impede toileting; and notifications about changes in medications which affect toileting patterns. All

staff agreed that some residents could avoid episodes, but did not want to.

**Conclusion:** The findings here underscore that including CNAs and CAs in designing incontinence QI efforts is critical and one promising path may be to increase staff autonomy in managing the condition. Themes identified here also indicate the need to improve communication between staff, particularly across shifts, and with families. Such adaptations are likely to help reduce episodes and hence minimize negative sequelae from the condition.

**Keywords:** Certified nursing assistants; Care assistants; Quality improvement; Incontinence; Nursing homes; Assisted living facilities

## Introduction

Incontinence is a prevalent condition affecting the health and quality of life of many elderly, particularly those living in long-term care settings. Over 40% of institutionalized elderly in the US suffer from bowel or bladder incontinence, while a Canadian study found the urinary incontinence rate to be 62% and that for fecal incontinence to be 46% among this group [1,2]. The World Health Organization has recognized incontinence as a major, worldwide, geriatric syndrome for which treatment is often lacking [3].

In most instances, incontinence is manageable and treatable, but without proper care it can lead to skin breakdown and infection [4,5]. Preventing sequelae related to incontinence can be a useful measure of quality of care. In the US, the Government sponsored health insurance program for the elderly, Medicare, uses the percent of nursing home residents with individualized incontinence care plans and rates of skin breakdown as measures to evaluate nursing home quality [6].

Of note is the US, CNAs and CAs provide most of the hands-on assistance to long-term care residents, particularly in relation to toileting. Thus, they largely determine how daily incontinence care is delivered and to what degree it follows any specified plan. Thus, their care practices play a large part

in the likelihood of complications arising from this condition and efforts to improve incontinence care hinge on CNA and CA involvement [7,8].

In spite of their critical role, the majority of quality improvement (QI) initiatives around nursing home care generally have not included direct care workers in their design, including those for incontinence [9,10]. Further, quality improvement interventions are often developed through research projects. As such, they have often failed to use facility staff during the development and testing phases, putting their sustainability at risk [11].

Increasingly, researchers have begun to recognize the importance of including direct care staff in the creation of QI programs [12]. Examples include efforts related to dementia care and pain management [13,14].

The Emory Center for Health in Aging (ECHA) is a university affiliated center which focused on quality improvement in nursing homes. In order to inform the design of a QI initiative around incontinence care, the ECHA, in collaboration with local long-term care facilities, undertook a series of focuses with certified nursing assistants (CNAs) and care assistant (CAs) to discuss issues related to incontinence management.

The majority of long-term care in the US is provided in two settings: nursing homes and assisted living facilities, with the former offering more intensive care. CNAs tend to work in nursing homes with residents of who require on-going skilled nursing services and substantial assistance with activities of daily living (ADLs). They are required to have a high school education and some form of post-secondary nursing instruction. They must complete 85 hours of course work and 24 hours of supervised on-the-job instruction and then pass an exam to be certified [15].

CAs, on the other hand, tend to work in assisted living facilities (ALFs) whereby residents require limited assistance with activities of daily living (ADLs) and general monitoring. They are required to have 24 hours of on-the-job training and 18 hours of continuing education every year. The staff-to-resident, at one to fifteen, is far higher than in nursing homes [16].

## Methods

The study was conducted using established qualitative research methods. This approach constitutes a systematic investigation of a problem in order to generate new knowledge related to a group involved with the concern and is commonly used in nursing research [17]. The descriptive subtype, pursued here, focused on assessing existing attitudes and knowledge, determining the frequency with which they occur, and categorizing general themes through content analysis [18].

### Script development

The institutional review board at Emory University in Atlanta, Georgia reviewed the project in terms of ethical and

regulatory consideration, along with the soundness of the research approach. It approved the project with no modifications.

Clinical experts in the area of incontinence, including physicians, nurses, and social workers, developed the script. Questions focused on: prevalence, knowledge of condition risk factors, facility care practices and ways to improve care. Local social workers reviewed the script for reading level, language and content. A copy of the script is available from the corresponding author (V.P.).

The script was piloted with a group of CNAs and CAs at a single facility affiliated with the Emory Healthcare, the medical arm of the university. Questions were modified based on feedback from this group.

Two to three trained facilitators guided each group; one facilitator initiated discussion, while the other(s) took notes and monitored the recording equipment. Extensive content analysis was conducted by two of the authors (D.Y.R., V.L.P.). Both transcripts of session tapes and notes from each session were used to identify the range of responses to each question. Responses were then grouped according to common themes, using established qualitative research guidelines [19,20].

### Sample

The sample of CAs and CNAs was drawn from 22 nursing homes and 10 ALFs, all of which were facilities collaborating on QI projects with the ECHA. Participants (n=91) volunteered or were nominated by their facility. Fifteen focus groups were held: five in a metropolitan area (the state capitol) and two in semi-urban/rural areas. Focus group size ranged from 3 to 10 participants with multiple groups held at three of the sites. Forty-two participants were from facilities outside the capitol and 25% worked in ALFs.

### Data collection tools

Each participant answered a short questionnaire about him/herself at the beginning of the session. Facilitators began with an open-ended question about resident health status, and then moved on to questions about incontinence relating to: prevalence, risk factors for the condition, facility practices regarding incontinence management, ways in which it affected job performance and how care could be improved. The results presented below follow the flow of the questionnaire described above.

### Results

Ninety-five percent of respondents were female and the mean age of the group was 39 (SD 11.4). CNAs had worked significantly longer in their current place of employment than CAs, 6.8 (0.06-36) years compared to 2.8 years (0.08-11) ( $p<0.01$ ), while both groups had worked in the field an average of 9.5 (0.08-36) years.

## Scope of the incontinence in nursing homes and assisted living facilities

All groups reported that incontinence, both bowel and bladder, was a major issue in their facilities. Regarding prevalence, twelve out of fifteen groups responded that most or all, were incontinent, with two CNA and one CA group putting the figure at 50% or less. They also included constipation under the incontinence rubric.

Respondents viewed bladder and bowel as equally problematic, although in different ways.

### Bladder incontinence was noted as difficult based on the constancy of the problem:

"We have one that wants to go to the bathroom, use the bathroom and all that, they can't do that then...so you have to constantly, constantly check on them, then I just tell them when you have to go let us know, don't let us know when you've already gone. Sometimes they just don't know when they're going to go (Focus Group 11, CNA).

In relation to bowel incontinence, the odor, time taken to clean up, and nature of the problem, particularly in relation to dementia patients, were graphically noted:

"Bowels (are more difficult). Because they have large bowel movements and some of them will smell. Then you have some that will play in it and put it everywhere. Throw it. We had one yesterday from head to toe. Even on the bottom of his feet. I haven't figured out how. I don't know how he got it on the bottom of his feet (Focus Group 2, CNA)."

## CA and CNA Knowledge of Risk Factors for and the Consequences of Incontinence

### Risk factors

CNA and CA groups were aware of many risk factors for incontinence. The two factors emphasized were cognitive and neurological impairment and physical dependence. Fourteen out of 15 of the focus groups identified dementia or Alzheimer's disease as a risk factor for incontinence. Four out of nine CNA groups mentioned physical dependence as a result of stroke as the second most common risk factor.

**One group commented on both:** "The ones that aren't as mobile as the others. Or some of them are so, they forget how to use the bathroom, and it happens around where they can't use it all and need help getting it out or it hurts (Focus Group 11, CNA)."

**One group noted depression as a risk factor:** "The depressed have the most problems. They could go on their own but they won't (Focus group 1, CNA)."

**Another group mentioned diet:** "It all depends on what they eat. It has a lot to do with what they eat for different

meals; if we have greens that day, after lunch we're taking everybody to the toilet (Focus Group 12, CNA)."

**Half of the groups pointed out that the residents' medication caused incontinence:** "You also find that sometimes their changes in medication can also...causes accidents. Because I have a lot of complaints that you know, a doctor will come in and change a patient's medication, and all of a sudden, they're just can't control their bladder function. I've heard that complaint (Focus Group 5, CA)."

**Another group commented:** "One of ours (residents) has CHF (congestive heart failure) so they're on Lasix and that makes a difference; ... (They provide) stool softeners or laxative so sometimes they overmedicate themselves with the laxatives (Focus Group 12, CNA)."

**A CA group commented on a number of reasons for residents' lack of self-control ranging from difficulty taking off clothes or lack of familiarity with the environment:** "Because a lot of times they just can't undo their belt, or figure out how to get their pants down, or they don't know where the bathroom is so they just wander around. So, I have to ask them a lot. You know you see them wandering a lot of times, if you ask them if they're looking for the bathroom a lot of times they are. Point them in the right direction... So, if some of them are in a familiar environment, they know where the bathroom is, they have the right kind of clothing, they would not be incontinent. They'll be able to go by themselves, pull down their pants (Focus Group 5, CA)."

### Consequences

**All groups were aware of the negative clinical consequences of incontinence. One CNA group stated:** "(They) Get skin breakdown and infections. Maybe it's like you get a lot of it. Like if they're incontinent, bladder, you know, by that urine stain on them they get a lot of breakdown, they get yeast infections, and all these little urinary infections (Focus Group 10, CNA)."

All groups recognized how difficult being incontinent can be for many residents.

**All CA groups and one-third of CNA emphasized the issue of resident pride:** "They are very old. We take them into the bathroom and leave the room. They want privacy...I know they have their pride and what they used to do 25 years ago, or even two years ago, they are not capable of anymore....a lot of it is just pride (Focus Group 1, CNA)."

**Another CA group discussed the approach they take with some of their residents to minimize embarrassment:** "I've never said put on a diaper. I say let's change your panties... Alzheimer's patients, residents, it's amazing how much their memory they're losing but they're always embarrassed about that, having to wear those products. That's the one thing they do remember. Some of them just hate to put them on... Other people are wearing them that helps there too. Accept the idea. But some of them are so embarrassed (Focus Group 4, CA)."

## Facility Practices in Relation to Incontinence: Identification of the Problem among Residents and Care Practices

### Identification of residents

Groups were asked how they were informed which residents were incontinent. Two-thirds of the CNA groups learned of the problem through written documentation or staff meetings, compared to five out of six for CAs. One group described their facilities documentation: "We have like an ISP (individualized service plan) form, a nurse goes out when they move in. And it has the information, like if you're incontinent; if they're able to walk; it has all that information (Focus Group 5, CA)."

Another added that they observe the resident on arrival: "We have certain hours that what the family has told us that they pretty much go. And what we do, we do that for three days seeing if they are going at those particular times. If they are, if they are in sequence as to what the family members said, then we as staff know when to take them so that we can catch the incontinence most of the time before it happens. (Focus Group 15, CNA).

Notification does not always go smoothly as one CNA group explained: "Really the nurse is supposed to give you a report on each patient. When I first started there I had to learn on my own. Learn the different ways of trying to deal with each patient on your own (Focus Group 10, CNA).

They also mentioned a range of other factors, including smells or finding wet clothes that signaled an incontinence problem: "Then they are dressed so nice and you smell them. They will be dressed with lipstick and makeup and they be wet underneath and you smell it (Focus Group 6, CA)."

### Incontinence care practices

All groups reported that the main method for dealing with incontinence, bowel and bladder, is training programs. One third of CNA groups discussed the practice of turning physically impaired residents every couple of hours and half mentioned the use of medication. Most mentioned the importance of knowing the residents schedule.

The groups described similar toileting schedules: "If they have a problem with their urine they are going to put them on a bowel and urine training program where we have to toilet them every two hours and record it (Focus Group 14, CNA)."

Others described the two-hour regime as a guideline and that they could use their own experience to let them know whether checking and consequent action is necessary: "After you work with them for so long, you know when they have to have a bowel movement, because they're going to have it just about the same time every day; Most CNA (or CA) come up

with their own schedule for each resident. That gets back to knowing the resident... (Focus Group 13, CA)."

Half the CA groups mentioned consulting with the resident's doctor if a problem arose, compared to no CNA groups. Many described similar issues, such as the importance of continual cleaning and keeping residents dry.

One group noted a disturbing facility practice, blanket distribution of a laxative, in relation to bowel incontinence and dealing with constipation: "They have it all over everything. It takes a long time to get it up...especially when you have to change a whole bed after someone. They get it all over the bed...especially on laxative day. It's Tuesdays and Thursday's where I'm at, and on those days the halls be dripping (Focus Group 11)."

In terms of treating incontinence, all groups believed that bladder programs work and could eliminate the problem for some residents: "Some of the residents, if you program them they'll not be incontinent. For example, if you have specific times you ask them to go to the bathroom, if it becomes a routine, so at that time they use the bathroom. So, if you follow the routine they'll not be wet. The bladder kind of gets trained to that particular time (Focus Group 5, CA)."

They were also familiar with medications and supported their use, in spite of their occasional side-effects. Groups also noted motivating the residents, encouraging them to eat properly and keeping them moving were effective: "Because mainly if you're, like, there are a lot of patients that if you....get them motivated, go take them to the toilet, they're not going to use it on themselves (Focus Group 10, CNA)."

"...Although some do try to keep up their diets for bowel and bladder. They make sure they get their fruit, fiber, prune juice. Like going to the bathroom on the way to the dining room and eating a good diet (Focus Group 1, CNA)."

"Helping them walk is also helpful with bladder and bowel program. As soon as they can't move, they get more and more dependent (Focus Group 1, CNA)."

## Incontinence Issues Affecting Job Performance

### Staffing shortages

All groups identified staffing shortages as the primary factor making their jobs more difficult and potentially affecting the quality of care.

One of the CA groups commented that: "I notice we have most of our problems when we're short staffed. It may not always be 2 hours (when they are toileted). Sometimes you're up changing the bed and everything else...mostly when we have our problems, if we've been short staffed the night before because it's hard when you've got a floor of 30 people and you've only got 2 people on that floor (Focus Group 3, CA)."



**A CNA group discussed the need to accommodate for staffing shortages, and one emphasized the challenges when others do not prioritize basic care tasks, including toileting:** "I just go in with the idea that I'm going to do my best with what I have and that's going to consume the basic ADL's, the grooming, the toileting, the meals, the hydration, the fluid intakes. If I had to prioritize that I guess those four things would be the most important for me (Focus Group 15, CNA)."

**Most groups also mentioned the importance of teamwork, particularly when facilities are short-staffed. One CNA group noted:** "You have some employees that won't change the person...or change them at all. (I would) Report her. That's why in our field, you have to care. Its teamwork, we pick up the slack for one another (Focus Group 12, CNA)."

### Supplies from the facility and families

**A CA group discussed the difficulty with clothing of residents:** "Sometimes they don't provide the clothes. Sometimes, a lot of times with the men, they've got the belts, and a lot of them have a hard time getting their belts undone. The probably the clothing is the biggest (Focus Group 5, CA)."

**The same CA group discussed the difficulty with family members who are supposed to purchase incontinent supplies:** "Having supplies available. Sometimes the facility provides the products depending on the relatives, the family members. Some family members will say no, you're charging too high, I'll bring my own incontinent products. So we have to wait for them to bring the incontinent products, so if they're late, or the products get finished before they come and supply, so we don't have things to use.... I mean if I'm in a position like that, I would go ahead and use what we have. A lot of time they'll get upset anyway....We really need cooperation from the family members to comply with the caregivers (Focus Group 5, CA)."

**A CNA group concurred:** "Linens. Not enough towels, pads, diapers. Bed pads, needs to change patients bed pad and bed. We have to go and get them ourselves; Out stuff goes out now and it isn't back when you need it. Linens are a big problem (Focus Group 1, CNA)."

### Resident behavior

The majority of groups believed that some residents can control their bladders, but chose not to. **They cited residents need of attention as a primary reason.**

"We have one patient who is blind, but he could use the urinal. He wants a diaper at night cuz he doesn't like to get up. He can do for himself. I think some just want the attention... Some just want you to do everything for them, if they do get used to you doing everything, they want you to continue (Focus Group 1, CAN)."

**They also mentioned and the input of family members:** "Some of them are just lazy. Sometimes the daughter will call and say 'Take my mother to the bathroom' and she can go by herself...The family makes it worse.... We have good family members who help. A lot of people do it because they pay for

it...it's a service (Focus Group 12, CNA)." The majority of groups believed that some residents can control their bladders, but chose not to. They cited residents need of attention as a primary reason.

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### Discussion

Based on analysis of extensive qualitative interviews, this article described CNA and CA knowledge of incontinence and their care practices related to it. It also identified themes on how to improve incontinence management within long-term care facilities. Of note is addressing many of these issues is unlikely to be costly as they involve improvements in process.

All groups cared for residents with incontinence with the majority reporting that nearly all of their residents in their facilities suffered from incontinence. Both CNAs and CAs were well versed in risk factors for incontinence, including dementia, stroke, depression, poor diet, medication side-effects, and clothing that is difficult to remove.

All groups were very familiar with the clinical sequelae that could arise from poorly managed incontinence. Showing significant empathy, they stressed the deleterious effects of incontinence on resident dignity and discussed how to alter care practices to minimize this occurrence.

Both CNAs and CAs described the use of bladder and bowel training programs as the most common approaches to managing incontinence. Across the board groups stressed that learning the resident's natural toileting pattern was most important and could often prevent episodes. They also cited motivating residents and walking them as extremely helpful.

Data from the focus groups underscored several areas for quality improvement. Allowing staff more autonomy and flexibility in managing the condition was viewed as a key area for improving care. Improving communication was also viewed as critical.

The primary challenge they identified was communication among staff. Breakdowns tended to occur between shifts and during periods when the facility was short-handed. Providing consistent care and working to resident schedules was difficult during these periods.

Communication between staff and management could also be improved to ensure prompt identification of incontinent residents and to clarify which ones do and do not need help.

Informing staff of changes in medication, which can lead to incontinence, would also facilitate better care. Further, consistent messaging from management about sharing responsibility and the appropriate way to respond to an episode were viewed as important and lacking in some cases.

They also noted that increased communication with families would also be helpful. Topics included clarifying how much toileting assistance their family member needs and maintaining an adequate supply of appropriate clothing and incontinence products.

## Limitations

This study has a number of limitations. The responses reported here are from a convenience sample of self-selected or facility-selected worker. Random selection of participants was not possible as providers had to release staff for half a day or staff had to agree to come on his/her day off. Participants worked at facilities with a strong interest in QI, thus they may not be representative of other nursing homes and ALFs in the area and may be providers on the higher end of the care quality scale.

The sample was predominantly composed of African American women from the south with extensive experience in the field. Further, CNAs in the groups had been with their facilities, on average 7 years. Workers with less experience may be less knowledgeable about incontinence care.

Additionally, although facilitators varied greatly in age (24 to 60 years) and race, their characteristics may have affected participants' responses in ways unknown. Focus groups were held off-site and all responses were guaranteed to be held in confidence. How responses were affected by a concern about reports back to their employer is unknown.

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