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Not Just How Many but Who Is on Shift: The Impact of Workplace Incivility and Bullying on Care Delivery in Nursing Homes

Heather A. Cooke, PhD*, and Jennifer Baumbusch, PhD, RN

School of Nursing, University of British Columbia, Vancouver, Canada.

*Address correspondence to: Heather A. Cooke, PhD, School of Nursing, University of British Columbia, T201-2211 Wesbrook Mall, Vancouver, British Columbia V6T 2B5, Canada. E-mail: heather.smithcooke@ubc.ca

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Abstract

Background and Objectives: Much of the literature examining the staffing–care quality link in long-term care (LTC) homes focuses on staffing ratios; that is, how many staff are on shift. Far less attention is devoted to exploring the impact of staff members' workplace relationships, or who is on shift. As part of our work exploring workplace incivility and bullying among residential care aides (RCAs), we examined how RCAs' workplace relationships are shaped by peer incivility and bullying and the impact on care delivery.

Research Design and Methods: Using critical ethnography, we conducted 100 hr of participant observation and 33 semistructured interviews with RCAs, licensed practical nurses, support staff, and management in 2 nonprofit LTC homes in British Columbia, Canada.

Results: Three key themes illustrate the power relations underpinning RCAs' encounters with incivility and bullying that, in turn, shaped care delivery. Requesting Help highlights how exposure to incivility and bullying made RCAs reluctant to seek help from their coworkers. Receiving Help focuses on how power relations and notions of worthiness and reciprocity impacted RCAs' receipt of help from coworkers. Resisting Help/ing outlines how workplace relationships imbued with power relations led some RCAs to refuse assistance from their coworkers, led longer-tenured RCAs to resist helping newer RCAs, and dictated the extent to which RCAs provided care to residents for whom another RCA was responsible.

Discussion and Implications: Findings highlight "who" is on shift warrants as much attention as "how many" are on shift, offering additional insight into the staffing-care quality link.

Keywords: Critical ethnography, Horizontal hostility, Nursing aides, Power relations, Workplace relationships

Background

In providing 80% of the direct care for residents in long-term care (LTC) homes, residential care aides (RCAs; unregulated workers also known as personal support workers and nursing assistants) play a pivotal role in shaping residents' daily life experiences and well-being (Berta et al., 2013). Predominantly women, many of whom are foreign-born (Chamberlain et al., 2019), RCAs find themselves on the lower end of the workplace hierarchy, accorded little formal power, respect, or recognition (Armstrong et al., 2009). Despite comprising the largest workforce within the LTC sector, RCAs remain an

understudied and underrepresented occupational group (Ginsburg et al., 2016).

In the continued quest for quality care, much attention has focused on the link between staffing levels and staffing mix of unregulated (e.g., RCAs) and regulated (e.g., registered nurses [RNs] and licensed practical nurses [LPNs]) staff and care quality (Armijo-Olivo et al., 2020; Backhaus et al., 2014; Spilsbury et al., 2011). Staffing levels and mix are typically measured via direct care hours per resident per day or number of full-time equivalents per 100 residents for each category of (and total) nursing staff, while quality indicators commonly include resident outcomes (e.g., infections, weight loss), safety (e.g., prevalence of pressure ulcers, falls), and quality of life (e.g., opportunity for choice, autonomy) measures (Armijo-Olivo et al., 2020; Spilsbury et al., 2011). However, systematic reviews examining the association between direct care staffing and care quality (Armijo-Olivo et al., 2020; Backhaus et al., 2014; Castle, 2008; Dellefield et al., 2015; Spilsbury et al., 2011) repeatedly yield mixed and inconclusive results. Similar findings are reported regardless of whether the review focuses on cross-sectional (e.g., Spilsbury et al., 2011) or longitudinal studies (e.g., Backhaus et al., 2014). The most recent review (Armijo-Olivo et al., 2020) found mixed (e.g., positive, negative, and neutral) effects for the association between RCA staff time and overall quality of care, nursing home deficiencies, and physical restraint use; positive or neutral effects for RCA time and development of pressure ulcers, psychotropic drug use, and quality of life; and no association between RCA time and fall occurrence. While the mixed results reported in the multiple reviews are likely due in part to methodological heterogeneity (e.g., disparate methods for defining and measuring staffing and care quality) and quality (e.g., accuracy and sensitivity of reporting sources, high risk of bias) (Armijo-Olivo et al., 2020; Backhaus et al., 2014; Castle, 2008; Spilsbury et al., 2011), they also underscore the complexity of the staffing–care quality link. Such findings only provide an indication of the relationship, as opposed to insight into the causal mechanism between staffing and care quality (Spilsbury et al., 2011), or what Konetzka (2020) refers to as the "black box" of predictors of quality and quality outcomes.

The absence of a consistent relationship between direct care staffing and care quality suggests other elements of the work environment (e.g., organizational/workplace culture, staff morale, teamwork and safety climate, unit-specific practices) warrant consideration (Backhaus et al., 2017; Zúñiga et al., 2015); that is, it is not just the quantity of staff that matters but the quality of the team (Backhaus et al., 2018). Zúñiga and colleagues (2015) examined the relationship between staffing (level, mix, and turnover), work environment characteristics (leadership, support, teamwork, and safety climate), work stressors (conflict, workload), implicit rationing of nursing care, and care worker-reported quality of care in Swiss nursing homes. Perception of staffing and resource adequacy, lower workload stress, and less implicit care rationing were all significantly related to care quality, while staffing level, staff mix, and turnover were not. Notably, the strongest association was between teamwork and safety climate and care quality. In a similar Dutch study, team climate, communication, and collaboration were significantly associated with staff-reported quality of care, while total direct care staffing was not (Backhaus et al., 2017). Such findings are consistent with earlier research underscoring the importance of teamwork, good communication, and respectful and collaborative workplace relationships in quality care provision (Caspar et al., 2013; Scott-Cawiezell et al., 2004; Xyrichis & Ream, 2008).

Of increasing concern is the potential for workplace incivility and bullying to disrupt workplace relationships (Roberts, 2015). However, the majority of research in this area focuses on acute care and professional (e.g., RN) staff; little is known about the impact on RCAs' relationships and care delivery. We recently reported the common uncivil behaviors encountered by RCAs including social exclusion (e.g., refusal to acknowledge or speak to one's coworker), gossip, and rumor-mongering (e.g., purposefully spreading information to portray a coworker in a particular light; talking about job performance or work ethic behind a coworker's back), blame and criticism, and sabotage (e.g., not passing along key information or not teaching a new/casual staff member the correct way to perform a care task) (Cooke & Baumbusch, 2020); all of which potentially impact RCAs' collaboration, communication, and team/safety culture. Indeed, Pickering and colleagues (2017) highlight how RCAs exposed to incivility and bullying invoked various adaptive strategies including keeping quiet about safety issues (e.g., work-related injuries, witnessing resident abuse/neglect) as reporting put them at risk for retaliation or blame and implementing workarounds, for example, learning to transfer residents without coworker's assistance. Seeking to add to the small body of literature on RCAs' workplace relationships, we draw on findings from a critical ethnography examining workplace incivility and bullying in two LTC homes in British Columbia, Canada to explore: (a) how are RCAs' working relationships impacted by workplace incivility and bullying and (b) what is the impact on care delivery?

Method

Critical ethnography, the method of inquiry for the study, seeks to question the status quo by uncovering taken-for-granted assumptions underlying operations of power and control and sources of inequities that contribute to marginalization (Madison, 2011). Adopting this approach facilitates insight into the domination and exploitation that have become a "naturalized" part of RCAs' work life. Questioning

taken-for-granted beliefs, discourses, and practices of LTC while analyzing RCAs' workplace interactions helped illuminate the institutional processes and ideologies that reify accepted norms within the LTC workplace (Thomas, 1993). A critical lens thereby underscores the salience of power relations in the tacit patterns and subtleties of RCAs' workplace relationships, in which certain individuals are privileged over others.

Study Setting and Participants

Two care units in two suburban LTC homes in British Columbia, Canada were selected as study sites. Operated by the same not-for-profit organization, the homes relied on government funding to operate and provided 24-hr nursing care to approximately 100 residents. Both sites were purpose-built within the last 15 years and featured supportive environmental characteristics associated with quality care (e.g., single-occupancy rooms with ensuite bathrooms and ceiling track lifts; Eijkelenboom et al., 2017) and teamwork (e.g., spacious circulation environments, proximity to supplies; Gharaveis et al., 2018). Each unit housed 25–30 residents on several wings, many of whom were nonambulatory, and was primarily staffed with three RCAs and one LPN during the day and two RCAs and one LPN in the evening/overnight. Although permanently assigned to their unit, RCAs rotated through their care assignments according to a predetermined schedule. RCAs at both sites were directly employed by the organization and, as unionized employees, received CDN$20–21/hr and medical and employment benefits.

Following University and Health Authority's ethics approval, the study was introduced via information mail-outs to all full-time, part-time, and casual staff, presentations at shift change, and flyers posted throughout the sites. Thirty-eight staff provided informed consent (21 RCAs, six LPNs, seven administrative staff, and four support staff), all of whom were female, primarily Caucasian, and Canadian-born (see Table 1). RCAs' average age was 43.9 years. All RCAs had their RCA certificate, obtained following a 4- to 6-month community college course, and had worked in the field an average of 10.4 years and at their current site for 5.4 years. The demographics reflect those reported by Chamberlain and colleagues (2019) for RCAs within the British Columbian health authority in which the study sites were situated.

Data Gathering

Of the 38 consenting staff, 31 participated in semistructured interviews (total interviews = 33) over a 13-month period between October 2018 and September 2019. Six RCAs and one LPN declined to do a semistructured interview and instead shared their experiences solely during participant observations. Interviews occurred in locations chosen by the participants, for example, a coffee shop, or on-site in a private office. An interview guide (see Supplementary Material), which drew in part from existing research (Roberts, 2015; Tong et al., 2017) and measures of incivility and bullying (Einarsen et al., 2009; Matthews & Ritter, 2016), explored RCAs' teamwork and their relationships with other RCAs. Given the study focus on workplace incivility, questions were more heavily weighted to the negative aspects of workplace relationships and RCAs' experiences of workplace mistreatment. Interviews lasted between 43 and 130 min, were audio-recorded, and transcribed verbatim, with all names and identifiable information removed or disguised to protect anonymity.

Approximately 100 hr of participant observations were conducted between October to January and May to July. Spread over different times and days, observations focused on RCAs' routines and interactions with coworkers and supervisors (see Supplementary Material for guide). In the role of observer-as-participant, author 1 shadowed RCAs during their daily care routines and engaged them in multiple informal conversations. Probing participants regarding observed behaviors and interactions provided a more nuanced understanding of RCAs' relationships and a means of clarifying/validating observations. As observations and interviews were conducted concurrently,

Table 1. Demographic Data—All Participants

Demographic characteristic	Site 1 (n = 23)	Site 2 (n = 15)
Gender		
Women	23	15
Men	0	0
Age: mean (years)	43.4	46.2
Age: range (years)	24–57	27–69
Position		
RCA	12	9
LPN	3	3
Administrative	3	2
Support	5	1
Ethnicity		
Caucasian	23	12
Filipino	0	3
Employment status		
Full-time	16	9
Part-time	4	6
Casual	3	0
Mean length of time working in LTC (years)	10.6	10.6
Mean length of time at current site (years)	3.6	5.8

Notes: LPN = licensed practical nurse; LTC = long-term care; RCA = residential care aide.

observations provided an opportunity to capture behaviors and interactions noted during the interviews and vice versa. Information was captured via handwritten field jottings and expanded into detailed field notes shortly thereafter.

Data Analysis

Thematic analysis occurred concurrently with data collection and employed an iterative, multistep process (Braun & Clarke, 2006). Transcripts and field notes were entered into NVivo 11. Guided by the research questions and theoretically informed by a critical perspective (i.e., focused on RCAs' social locations such as age, site tenure, and issues of power and control), we conducted multiple readings of the data. We paid particular attention to the manifestation of power and authority that appeared to shape RCAs' relationships and team dynamics, for example, instances where participants explicitly displayed power and power-like behaviors and power-infused interpersonal exchanges. We drew on both observational and interview data to identify how RCAs were positioned by and among their coworkers, and examine who helped (or did not help) whom and how RCAs discussed and rationalized these behaviors. This resulted in a series of initial, inductively derived codes drawn from key words/common ideas recurrent within participants' narratives and behaviors (e.g., power dynamics, power imbalance, power relations, strategic helping, worthiness, judgment, waiting for help). These codes were then categorized, compared, and contrasted across data sources to form provisional themes (e.g., strategic helping, worthiness, and waiting for help were collapsed into receiving help).

Rigor

Rigor was addressed through prolonged engagement in the field, triangulation of multiple data collection methods and sources, creation of an audit trail (through the documentation of key decisions, activities, and process memos), and analysis of reflexive memos written following each participant observation and interview (Creswell, 2013). Emergent findings were discussed with key informants and members of our community advisory committee, providing opportunities for questions, critique, and feedback.

Results

Three themes—Requesting Help, Receiving Help, and Resisting Help/ing—illustrate the power relations underpinning peer incivility and bullying. Situated within an understaffed, underresourced, and task-oriented care context, RCAs' individual behaviors compounded over time, perpetuating and entrenching a culture of workplace incivility and bullying that shaped care delivery.

Requesting Help

For some, exposure to peer incivility and bullying created a reluctance to seek assistance from coworkers with whom they had a previous altercation, had made it obvious they did not want to assist the RCA, or implied the RCA was incompetent because of their need for help. Reflecting on an egregious incident in which a yelling match had broken out between herself and a coworker, Audrey noted:

> It's broken … the trust is broken … to stand two feet from you on the other side of the bed and work with you pulling tabs off pads, rolling people, that's a really intimate workspace. How can I possibly feel comfortable asking her for help at this point?

For Audrey, the ability to implicitly trust her coworker was integral to delivering safe and dignified care. Indeed, we observed how RCAs constantly communicated with one another as they worked in concert to change incontinence pads or to reposition/lift a resident. However, being on the receiving end of an onslaught of verbal insults left Audrey feeling anxious and apprehensive about inviting her coworker into that space and how her comments/questions during the care task would be met. The risk of a hostile look or another verbal attack led Audrey to discount requesting assistance from her coworker.

Social exclusion impacted Emily's reluctance to request assistance:

> … you start your day off at report and seriously … the other person will not even say a bloody word to you and you know, you go about your day, there's still no contact, no eye contact, nothing. They just keep to themselves completely. So, then you know not to ask them for help.

By not making eye contact or speaking to her, Emily's coworker conveyed the power-imbued message that Emily was not worthy of the effort to communicate. Nonverbal cues repeatedly displayed by other coworkers following requests for help, such as "huffing and puffing," eye rolling, and "storming" down a hallway conveyed a sense of being inconvenienced such that, relatively early on in her position, Emily stopped asking particular coworkers for help. In successfully getting Emily to halt her requests for assistance, power relations were reinforced. Power continued to be accorded to her coworkers, while Emily, reminded of her lower stature in the RCA hierarchy, was made to understand that her requests for help were an imposition and that coworkers were not there to do her work as well as their own.

Not wanting to be viewed as incompetent, because incompetence—whether real or fabricated by unhelpful coworkers—was equated with powerlessness, was a potent motivator among RCAs. Alluding to expectations around workload and capacity, as well as a fear of being judged, Miranda explained she requested help less often when

working with unfamiliar coworkers: "I don't know what their expectations are and if they look at me sideways because I asked for help with something, right? ... But I don't want someone else looking at me sideways or thinking that I'm incompetent."

Receiving Help

RCAs were cognizant of the behaviors that were valued by and would ensure help from coworkers; notions of worthiness and reciprocity featured prominently in their narratives. To be considered worthy of receiving help, an RCA had to work independently and efficiently. Exposed to structural factors that commonly contribute to increased workloads (e.g., staffing shortages, underresourcing, increased resident complexity), RCAs were sensitized to potential sources of power inequities and the need to maintain balance. As Stacey expressed, "I'm there working hard, I expect you to work hard." Commenting on her team, Melinda noted:

> Certain people they find lazier than others. So, then they get bitter about helping and then you kind of feel, well, I didn't help you today so I shouldn't ask for help ... If someone hasn't helped their coworker all day and then they go for their break and all their call bells are ringing and all their people need their pads changed, their coworker's going to be really bitter later if she gets asked for help or if she doesn't get help, because she did all the work.

Her comments underlie the constant sense of evaluation and judgment around work ethic, which resulted in resentment towards RCAs perceived as not doing their share of work or not doing it in an acceptable manner. Faced with increasingly complex resident needs and heavy workloads, RCAs did not want to work with someone they perceived as not contributing enough. Over time, this sense of inequity accumulated and undermined collegiality.

This resentment and lack of collegiality fostered a sense of who was or was not worthy of receiving help. RCAs expressed continued annoyance at having to respond to what they deemed frivolous requests by newer staff, such as the location of a resident's compression stockings, or assistance to transfer/lift a resident they could lift/transfer by themselves. They believed these requests impinged on the limited time they had to complete their own tasks, putting their reputations for working independently and efficiently at risk.

For some, decision-making around receiving help was strategic and guided by notions of reciprocity. As Courtney shared: "you've got to play the game, you need to make sure if you do something for somebody nice, they're always going to do something back to you nice." Her reference to "playing the game" is suggestive of how individuals navigated power relations. During participant observations, Courtney routinely expressed exasperation with coworkers whom she helped but who did not reciprocate. She explained such lack of reciprocity made her feel as if she was caring for far more residents than the 10 she was assigned.

It did not take newer RCAs long to appreciate the power relations and potential consequences for not conforming to implicit helping practices. Sheena, having worked at her site for 4 months, acknowledged the extra effort she made to help those who helped her; "it's got to be reciprocated … if I have time, especially because I'm new, I'm on it. People are quick to say 'so and so never helps' … I don't want them thinking I'm lazy." Her reference to "because I'm new" speaks to the importance of proving one's worth; by reciprocating and offering assistance, Sheena avoided being labeled lazy and conveyed to her longer-tenured coworkers her worthiness of receiving help.

Longer-tenured RCAs ensured that power relations favored them by promoting the notion that newer or casual staff had to wait for their assistance. Brooke noted:

> In all the places I've worked, when you first start or you're coming in as a casual, they'll just be like, "Sorry … you're just going to have to wait." Well, how long am I going to wait with somebody set up in a sling to be moved or taken off the toilet or put on the toilet?

Over time, however, as Brooke learned the power relations and the importance of working independently and efficiently, the power imbalance between Brooke and her longer-tenured coworkers shifted.

> Where now if I say, "Hey, I need you for a second" "Okay, I'll be right there" … And so now they've maybe seen that I am helpful and useful and I do my job well. And so now they're like, okay, you can do it, you really do need help. It's not just that you're new and don't know what you're doing.

By extending help to her coworkers and making herself useful, Brooke proved herself a valued and competent member of the team who contributed to the unit workload, that is, someone worthy of assistance. As such, power was conferred to her by her longer-tenured coworkers and her position in the hierarchy changed.

As the above exemplars illustrate, longer-tenured RCAs used their positions to maintain the status quo and, therefore, hold power over newer coworkers. This system ensures the workplace culture of power relations remains ingrained in practice and those who do not learn how to "play the game" do not stay employed at that site.

Resisting Help/ing

The power relations underpinning RCAs' workplace relationships impelled some RCAs to decline coworkers' offers of assistance, led longer-tenured RCAs to resist

helping newer RCAs, and dictated the extent to which RCAs provided care to a resident for whom another RCA was responsible. Olivia, an LPN who supervised a team of RCAs, relayed witnessing several RCAs socially exclude a coworker, which included resisting her help when offered.

> I felt there was a bit of bullying going on there, that she was being left out on purpose. You know, there'd be conversations at the desk and they wouldn't bother, wouldn't look at her, right, just talk to other people. Like who does that when you're an adult? And she would do nothing but try to be nice and try to help them. She would go and ask if they wanted help. And normally they would always say yes, obviously, but those two people go "no, I don't need your help."

The targeted RCA appeared aware of the power relations around reciprocity, yet her efforts to offer help were rebuffed. In refusing her offers of assistance, her coworkers conveyed and reinforced the power differential, sabotaging the RCA's attempt to gain power by proving worthiness. Courtney, who was perpetually blamed by her coworkers for something amiss with a resident/resident's room for whom she was not actually responsible, simply refused assistance telling her coworkers, "… this is my wing. Stay away from me."

Brooke called out her longer-tenured coworkers whose attitude towards newer RCAs, who complained about a lack of assistance when requested, was "I've broken my back. You need to just deal with it," a message which in essence conveyed, "I've earned my power, now it's your turn." She explained:

> … I hate that attitude because it makes all these new girls that are coming in first of all, feel really shitty for even asking for help and second of all … it doesn't end the cycle not stopping.

In resisting helping their newer coworkers, longer-tenured RCAs socialized newcomers to the power relations around reciprocity and helping. In referring to the "cycle not stopping," Brooke illustrates how power relations were "taught" to newcomers, thereby perpetuating and entrenching incivility in the workplace culture. Brooke believed exposure to incivility and refusals of assistance early in one RCA (Leah's) tenure created a situation whereby Leah subsequently resisted all help, even when caring for residents who, for safety reasons, required two workers to complete their care.

> Like all of the new people that are coming in are still doing everything alone. Like Leah's 20. And I go over to her side, "Can I help you do anyone?" "Oh no, I'm fine." Okay, like every single one of your people on this wing are two-person assists and you're saying you're fine? You don't even want me when I have time to come in and help you. Because she's been shown when she came in, "You don't need to need anyone" … They picked her apart … I'm sure of it. And now she's learned to just tough it out and suck it up.

During repeated participant observations on a wing where many residents were designated as two-person transfers and/or lifts, we observed RCAs' different patterns of helping behavior. Leah, the youngest (and newest) RCA on that wing proceeded as Brooke described, completing the care for all 10 residents by herself. Katherine, a slightly older and more experienced RCA, sought help with lifts and/or transfers for at least two of the 10 residents, while Emily, an older, more experienced RCA, expected help with at least four of the 10 residents. Assistance was rarely offered to Emily and Katherine and when they did request it, they commonly had to wait, an observation illustrative of their place within the power hierarchy. When given the opportunity to have an RCA, who was orientating to the unit, work with her for the duration of her shift, Leah resisted the help. When first author, H. A. Cooke, asked why, she simply shrugged her shoulders and stated, "I don't need the help, I can do everyone by myself"; this despite the fact that all other staff we observed were adamant they receive help with one particularly tall and heavy, wheelchair-using younger resident. Leah's reluctance to request or accept help suggested she was aware of the power relations on the unit and was seeking to gain acceptance and, therefore, power by demonstrating self-sufficiency and independence. Her experience illustrates how, over time, power relations are implicitly sanctioned and reinforced within the LTC workplace.

When staff at the study sites would leave the unit for their coffee/meal break, they were supposed to leave their phone with a coworker, whose job it was to then answer incoming calls. We observed how, at times, RCAs' coworkers would simply ignore such calls, or answer them, only to tell the resident they would be there shortly and then continue their conversation with their coworker at the nursing station. Emily explained how several of her coworkers went one step further:

> … what I find is when I come back from my break, they've ignored the calls, they've cleared the phones so I can't tell who's called and by the time I get down to so and so's room, they're [the resident] pissed because they've been ringing for twenty minutes, half an hour and nobody's come down.

A coworker of Emily's relayed how she and another coworker were frustrated with Emily's (a new addition to the team) insistence she receive assistance caring for residents whose care they were able to provide without assistance. Emily's experience reflects yet another means by which RCAs attempt to reinforce power relations. Resentful at having to interrupt their own care tasks to complete Emily's tasks during her break, Emily's coworkers appeared to covertly take matters into their own hands and deleted the

incoming calls. Unfortunately, such behavior not only impacted Emily, but also the resident waiting to be toileted.

Sabrina, an LPN, highlighted a similar issue surrounding RCAs' resistance in providing care to residents for whom another RCA was primarily responsible. Feeling bitter at having to answer calls while a coworker was on her break, or because they perceived the RCA as not pulling their weight (and thus unworthy of assistance), the RCA left on the unit provided only minimal care, in turn compromising resident safety and skin integrity.

> Safety becomes an issue because care aides are cutting corners … especially if it's not their resident. They'll just do the bare minimum. If they're pissed at you because they have to answer the call, they'll just do what's necessary rather than what really needs to be done … for example, if one of the residents had a bowel accident and someone complained, they might just move the resident and not do the care. Because they don't want to do it for that person they perceive as not doing their job that day … or they'll just go and turn the call bell off and not help the resident because they don't want to do that person's work.

While we did not observe such practices occurring, several RCAs described similar experiences, highlighting the far-reaching impact of power relations on helping behaviors, peer incivility and bullying, and resident care.

Discussion

Our study is one of the first to explore how power relations underpinning RCAs' encounters with workplace incivility and bullying shape care delivery. Study findings reflect and extend the small body of literature on RCAs' workplace environments, revealing the ways in which power relations shaped RCAs' requests for, and receipt of, help from coworkers and their efforts to resist help/ing, thus offering a glimpse into how RCAs' workplace relationships impact care delivery.

Researchers suggest the relationship between staffing levels and care quality is likely nonlinear (Backhaus et al., 2018; Spilsbury et al., 2011), such that adding more staff may be a necessary but not sufficient means of improving care quality (Castle & Engberg, 2008). Consequently, it is important that we expand the discussion around staffing and quality beyond numbers to include a focus on the work environment and care processes (Backhaus et al., 2018; Castle & Engberg, 2008; Spilsbury et al., 2011).

Our qualitative findings support those of Zúñiga and colleagues (2015) and Backhaus and colleagues (2017) who, respectively, found teamwork and safety climate and team climate, communication, and collaboration to be significantly associated with staff-reported quality of care. Exposure to verbal outbursts, ongoing social exclusion, constant judgment around work ethic, power relations underpinning reciprocity and helping behaviors, and refusals of assistance early in one's tenure on a unit all appear to negatively impact the development of a psychologically safe and trusting team environment that fosters cohesion, communication, and collaboration.

The interpersonal interactions displayed by RCAs in our study reflect the default "common pattern" of local interactions observed by Anderson and colleagues (2014), in which direct care workers blamed, ignored, and criticized others, avoided collaboration, or invoked "it's not my job" and which were linked to mediocre or poor care outcomes. Indeed, the power relations underpinning RCAs' reluctance to request help, not receiving help, and resisting help/ing meant that when they needed to keep residents safe (by following the two-person lift policy or providing timely continence care), there was no unified team to provide support, which not only placed the resident and RCA at risk of harm, but also left the RCA feeling unrecognized and unsupported.

Although less frequent, Anderson and colleagues (2014) also observed "positive patterns" of local interaction that promoted staff interconnections, including being approachable, pitching-in, seeking assistance, and reciprocating, all of which fostered effective collegial relationships and laid the foundation for information exchange and problem-solving around resident care. While several RCAs in our study initially sought to engage in such positive patterns, refusals of assistance and a lack of reciprocity meant they gradually abandoned such behavior. Reciprocity is about giving and receiving in a manner that generates goodwill; however, working within a care context of staffing shortages, underresourcing, and increased resident complexity placed limits upon RCAs' reciprocity. RCAs did not want to work with coworkers who willingly took but did not offer help or continue to extend help themselves when they did not receive help in return.

RCAs' experiences with requesting and receiving help and resisting help/ing illustrate the role of power relations in organizational socialization and culture. Organizational culture refers to long-standing rules of thumb that outline shared standards of relevance as to the critical aspects of the work to be accomplished, certain customs and rituals of how members are to relate to coworkers, and models for social etiquette and demeanor (Van Maanen & Schein, 1977); that is, all that is and is not appropriate with an organization. Such rules become so entrenched that they are seen by insiders as perfectly natural responses to the workplace they inhabit. At our study sites, power relations underpinning worthiness, reciprocity, and helping behaviors promoted a culture of self-sufficiency. Nonverbal cues (e.g., eye rolling), being forced to wait for help, rebuffing offers of help, and not responding to "frivolous" requests for assistance all served as means of organizational socialization, of schooling new RCAs to the units' power hierarchy, and the social knowledge and skills needed to succeed.

To the outsider, such acts are clearly uncivil and detrimental to cohesive and collaborative teamwork, yet for insiders (i.e., long-tenured RCAs), the behaviors were a natural response to the structural care context in which they found themselves. Unfortunately, the normalization of such behaviors perpetuates a climate of incivility resulting in a workplace in which anxiety and mistrust flourish (Andersson & Pearson, 1999).

RCAs' experiences illustrate that a positive work environment and cohesive, collaborative workplace relationships cannot be left to simply organically emerge; rather, staff relationships require cultivation and support to ensure sustainability over the long term (Anderson et al., 2014). This is especially salient when one considers the high turnover rates and human resource shortages within the industry and the part-time/casual status of much of the LTC workforce (Dahlke et al., 2018). Supervisors (e.g., LPNs) and unit managers appear integral in fostering an environment of civility, mutual support, trust and reciprocity, and, in turn, the achievement of better care outcomes (Anderson et al., 2014). Tyler and Parker (2011) examined the relationship between teamwork and LTC organizational culture and found unit managers in high-teamwork facilities modeled the positive collegial attitudes they in turn expected from staff; they also had a regular presence on the unit where they were seen to be reinforcing collaboration and respect for coworkers. Being out on the floor also enables managers and supervisors to identify, support, and expand interactions and relationships that promote better performance (Anderson et al., 2014).

In addition, high-teamwork facilities had formalized orientation programs, in which new employees were socialized into the facility by working with a mentor (Tyler & Parker, 2011). New staff not only learned facility systems and routines but more positive ways in which to talk to and about each other, thus perpetuating positive cultural attributes and facilitating new employees' integration into the care team. In contrast, low-teamwork sites had no such mentoring opportunity. Indeed, at our study sites, RCAs' orientation shifts were frequently abbreviated due to staffing shortages and the need to have them working their own wing as soon as possible, their training partner chosen by virtue of who was on shift that day, rather than preselected for their collaborative workplace relationships. In this manner, new RCAs were left to figure out the power relations of relationship-building on their own with little support and direction.

It is important to acknowledge that unit supervisors (i.e., LPNs) do not typically receive management training as part of their schooling (Tyler & Parker, 2011), yet from their first day on the unit, they are responsible for managing a team of diverse workers. Similarly, they are rarely offered professional development opportunities or mentorship themselves as to how to cultivate positive work environments and relationships. Consequently, increased training and ongoing support are also needed for supervisors and managers.

Study Limitations and Future Research

This research was conducted in two suburban homes in one geographic region in British Columbia, Canada. While we utilized rich description of context, participants and methods to offer readers the opportunity to determine the transferability of findings to other LTC settings (Lincoln & Guba, 1985), it is unclear whether staff in LTC homes in larger urban settings would report similar experiences with strained workplace relationships. Similarly, RCAs in our study were primarily Caucasian, Canadian-born and had relatively stable tenure at their workplace. Although reflective of the regional demography of English-speaking Caucasians and RCAs within the area (Chamberlain et al., 2019), their experiences may not reflect those of ethnic minority women more commonly involved in care work in larger urban centers. Participating RCAs were also unionized and employed at not-for-profit sites; the experiences of those working in private for-profit or health-authority-operated sites may differ. The interview guide was specifically framed around the experience of peer incivility and bullying. While appropriate for our research question, the absence of interview questions that might have solicited more positive aspects of teamwork contributes to a particular narrative. Given the knowledge gap around RCAs' workplace relationships in LTC, future research will want to include questions that provide a more holistic perspective.

While the data presented implicitly suggest the impact of workplace incivility and bullying and strained relationships on care quality, this is an area warranting further study. Today's LTC workforce is increasingly diverse; many RCAs are born outside Canada and, as aging workers remain in the labor force for longer, multiple generations work alongside one another. As such, future research will want to examine the role of workplace diversity in workplace incivility and bullying and team processes. Lastly, team building has been shown to improve both the psychological climate in which teams operate and overall team functioning (Beauchamp et al., 2017). As few, if any, resources are directed towards team building activities in LTC homes, this offers a potential area for future intervention research.

Conclusion

While staffing levels and staff mix are important contributors to care quality, it is difficult to achieve if staff members do not routinely engage with one another in a positive manner. Ongoing exposure to peer incivility can create an environment that inhibits collaboration and cooperation, thereby impacting care delivery and potentially, care quality. Our findings reveal the complexity of workplace relationships and team functioning, suggesting that "who" is on shift warrants as much attention as "how many" are on shift.

Supplementary Material

Supplementary data are available at *The Gerontologist* online.

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Conflict of Interest

None declared.

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