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Nursing Aides' Perceptions of Co-worker Support

By

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Abstract

Previous research on social support in the workplace has focused on effects of support on health, burnout and staff turnover. Limited information is available on specific behaviours that provide social support at work. An ethnographic approach was used to examine behaviours of co-workers which nursing aides perceived as being supportive. Analysis of data from observations in the work environment, individual audio-taped interviews with nine nursing aides employed in continuing care centers, and shadowing of nursing aides in their work setting revealed co-worker behaviours perceived to be supportive. Participants' behaviours which were intended to provide support and non-supportive behaviours of co-workers were also identified. Positive and negative consequences that the nursing aides experienced in response to behaviours perceived as supportive or non-supportive and contextual factors in the work environment which influenced the nursing aides' perceptions of co-workers' behaviours were also examined.

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Chapter 1

INTRODUCTION

Associated with an increase in the aging population (Statistics Canada, 2001) is a rising need for continuing care facilities and nursing staff. To reduce the costs of nursing care, the least expensive and least prepared caregiver is often employed to provide the necessary care. Currently, nursing aides provide 80% to 90% of the direct care to residents in nursing homes and continuing care centres (Chappell & Novak, 1992). Half of all nursing aides leave their jobs within the first six months and many leave within days or weeks of being hired (Atchison, 1998). This has resulted in numerous openings for staff in long term care facilities.

Factors contributing to a high vacancy rate in nursing aide positions include staff turnover, low work satisfaction, and burnout. Turnover among nursing aides is high as they hold entry-level positions with little formal training. Less skilled workers are known to have higher turnover rates than more skilled workers (Price, 1977). Turnover among individuals in entry-level positions is especially susceptible to influence from the organizational structure, or the conditions in which they work and receive rewards (Halbur, 1983). Work assignments of nursing aides in continuing care centres and nursing homes include performance of both routine and unpleasant tasks. Limited involvement in the decision-making process at work also contributes to low work satisfaction for nursing aides (Waxman et al, 1984).

Studies among geriatric care providers show that their work environment is stressful (Cohen-Mansfield, 1989). Specific stressors include fatigue due to heavy lifting, caring for patients suffering from debilitating diseases, dealing with behavioural

disturbances, speech deficits, cognitive deficits, and encountering death and dying on a daily basis (Carter & Phillips, 1987; Astrom et al, 1991). In examining the relationship between patient characteristics and physical health among nursing aides in long-term care facilities, Chappell & Novak (1994) found an association between mental impairments, uncooperativeness, restlessness, and constant crying of residents and stress for care providers. The constant daily demands placed on nursing staff working with confused, dependent elderly residents can lead to job stress and burnout that is characterized by physical, emotional and spiritual exhaustion and involves the loss of concern about those with whom one is working (Heine, 1986). Nursing aides experienced more emotional burnout than nurses in a study comparing burnout of nursing aides and nurses working in long term care facilities (Hare & Pratt, 1988).

While numerous factors have been linked with nurse turnover, job satisfaction is the most often mentioned. A review of 48 research articles on job satisfaction among nurses found stress to be negatively related and commitment to be positively related to being content with one's job (Blegen, 1993). Stress among nurses has been associated with undesirable work outcomes, such as loss of compassion for patients, increased incidence of mistakes, on-the-job injury, inability to provide patient care, absenteeism, and tardiness (Motowidlo et al, 1986). Other common variables having a positive correlation with job satisfaction included the importance of interpersonal aspects of nursing: communication with both supervisors and co-workers, and receiving recognition and feedback for work. Satisfied employees tend to provide better quality patient care and work more efficiently (Douglas et al, 1996). Moreover, higher job satisfaction among employees is positively associated with a lower intent to quit (Newman, 1974).

This in turn may decrease turnover and attrition, sparing the remaining staff the additional work and stress of continuously training and developing new co-workers. Due to the nationwide nursing shortage it is difficult to find staff to fill vacant or new positions. Thus, it is vital that factors which retain nursing staff in their positions be identified and acted upon.

Researchers have begun to examine various resources to enhance nurses' ability to deal with stress in the workplace, including social support (Mowinski-Jennings, 1987). Kahn & Antonucci (1980) define social support as interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid. Affective transactions include expressions of liking, admiration, respect or love. Transactions of affirmation include expressions of agreement or acknowledgement of the appropriateness or rightness of some act or statement of another person. Lastly, those transactions bearing assistance, or direct aid, including things, money, information, time, and entitlements are also included as social support. McAbee (1991) identified organizational social support and personal coping strategies as potential buffers to decrease occupational stress in nursing, and thus decrease burnout. "There is now a substantial body of evidence that indicates that the extent to which social relationships are strong and supportive is related to the health of individuals who live within such social contexts" (Berkman, 1995, p. 245).

In the work situation, social support may be tangible, practical, informational, or socio-emotional (Henderson & Argyle, 1985). For example, friends at work may provide social support by being confidants, giving advice about stressful work situations, providing information and help with work tasks, and providing moral support or being

allies in difficult interpersonal situations at work. This support can reinforce nurses' coping mechanisms, preserve their dignity, and thereby promote quality patient care (Brooks et al, 1993). Creating work environments that enhance nursing staff's health is essential, as it benefits not only organizations and employees, but also patients.

The work environment and scope of practice of nursing aides and registered nurses are not identical: there are some similarities and some differences. Characteristics of personnel within both groups vary, such as level of formal preparation and opportunity for career mobility. Much of the research on social support has been done exclusively with registered nurses. Some studies have included nursing aides, but few looked solely at this group. The need exists to explore social support among nursing aides exclusively to better understand their unique workplace issues and needs better.

Purpose

The purpose of this study was to identify behaviours of co-workers which nursing aides perceived as being supportive in their work. There is limited research on behaviours perceived to provide social support for nursing aides in continuing care centres. Work-site norms and role expectations constrain behaviour and may deem particular help-giving behaviours as inappropriate (Heaney, 1991). Exploring an emic perspective was necessary to understand what makes nursing aides feel supported in their care-giving work environment.

Research Questions

The following research questions were examined in this study:

1. What behaviours of co-workers do nursing aides working in a continuing care centre perceive as providing them with social support?

2. What are the contextual influencing factors that lead to perceiving these behaviours as supportive?
3. What are the personal outcomes for nursing aides who perceive support from co-workers in the workplace?

Definition of Terms

Perceived social support refers to "the cognitive appraisal of being reliably connected to others" (Barrera, 1986, p. 416). It incorporates two dimensions: perceived availability and perceived adequacy of supportive ties. Perceived availability refers to the individual's confidence that support is or would be available if needed, whereas perceived adequacy refers to the individual's certainty that the support coming from their social network will be sufficient.

A **social network** is comprised of "the web of social ties that surround an individual" (Berkman, 1984, p. 414). It is the infrastructure of support which concentrates on the social linkages with people rather than the attributes of the people. Members within the support network may or may not be supportive.

Informal support originates from lay sources such as partners/spouses, family members, friends, neighbours, co-workers, or volunteers (Stewart & Langille, 2000). It includes self-help mutual aid groups

Formal support originates from professional sources such as health professionals. It includes employers' formal benefits and policies (Stewart & Langille, 2000; Greenberger et al, 1989).

Nursing aide refers to an employee in a continuing care centre who performs basic nursing care tasks to meet residents' personal care needs. Nursing aides work

within the scope of the job classification "nursing attendant or nursing assistant or nursing aide".

Co-workers are the peers with whom the nursing aide interacts with during her/his daily work. In this study colleagues will specifically include other nursing aides, licensed practical nurses, registered nurses, and the unit manager.

Chapter 2

LITERATURE REVIEW

Nursing aides provide most of the direct nursing care for residents living in long term care facilities. Their work has been found to be very stressful (Cohen-Mansfield, 1995; Hare & Skinner, 1990; Heine, 1986; Riggs & Rantz, 2001). In comparison to other hospital health care workers, they have heightened job stress due to lack of formal training (Estryn-Behar et al, 1990). A relationship between stressors and physical health has been acknowledged for some time (Cobb, 1976; Morris & Snyder, 1979). Earlier research emphasized the role of social relationships in moderating or buffering the health effects of psychosocial stress or other health hazards and the link between positive social support and health (Cassel, 1976; Cobb, 1976; Cohen, 1990). Social support helps in one of three ways: by directly reducing the stress, by weakening the effects of stress, or buffering it, and lastly, by an indirect effect where the stress itself is prevented (Beehr & McGrath, 1992).

The role of the psychosocial work environment has become increasingly important to health as many people spend a great deal of time at their work. The workplace can have a significant effect on an individual's morale, physical and mental health, and personal identity (Mor-Barak, 1988). The value of social support for both men and women in dealing with stress in the workplace has been well documented (House, 1981; Stansfeld et al, 1998). The effects of stress on physical health are recognized in one group of health care workers, nurses (Estryn-Behar et al, 1990). Findings from research on social support in the workplace for nurses and ancillary nursing staff were reviewed and are presented here to set the foundation for this study.

A computer literature search of peer- reviewed journals was conducted for the key terms of social support, nurses, nursing assistants, workplace, and nursing homes for the years 1982 to 2002. Much of the research focused on registered nurses and licensed practical nurses with only limited studies using nursing aides as the sole participants. Although differences exist between registered nurses, licensed practical nurses and nursing aides, the commonalities of shift work, working in highly structured environments and providing care to patients leads to the findings being somewhat applicable to all three groups. Thus, findings from relevant qualitative and quantitative studies for registered nurses, licensed practical nurses and nursing aides will be discussed. Literature related to social support will be addressed first, followed by research on social support in the workplace and health, social support and burnout, and social support and job turnover. Lastly, studies that examined behaviours that provided social support will be addressed.

Social Support

The concept of social support has been studied from two different perspectives: as a structural model and as a functional model (Cohen & Smye, 1985). The structural model portrays an individual's social network of relationships and the functional model focuses on the individual's types and qualities of support available within relationships. Structural measures describe the existence of and interconnections between social ties, and includes marital status and the size of the social network; whereas functional measures assess whether interpersonal relations serve particular functions, such as providing affection or providing material aid. Structural measures are generally considered to document objective characteristics of social networks, while functional

measures generally assess perceptions of the availability or adequacy of resources provided by other persons.

Social Networks

Social networks represent the broader framework within which social support occurs. While social support is one function of a person's network, only certain qualities of network relationships are supportive (Mowinski-Jennings, 1987). Members of the social network influence one's reaction to a stressful situation in two ways: they can be a source of support or a source of stress, or both, depending upon the nature of the relationship (Mor-Barak, 1988). Supportive networks are considered to provide a health benefit and their absence is detrimental to health. One basis for relationships in the social network is proximity. Farris (1981) identifies five types of proximity in which individuals are more apt to interact together informally due to sharing a similarity: physical, professional, task, social, and formal, organization-created proximity.

Functional measures

Research on social support as a multidimensional construct has led to several descriptions of its functional role. A common classic view differentiates four types of social support to which all acts of support can be assigned: emotional, instrumental, informational and affirmational support (House, 1981). Emotional support is defined as involving the provision of caring, empathy, love and trust. This dimension is identified as the most important category through which the perception of support is conveyed to others. Instrumental support is described as the provision of tangible goods and services or tangible aid. Tangible aid is explained as concrete assistance, such as giving financial aid or performing assigned work for others. Informational support is that information

provided to another during times of stress. Affirmational support involves the communication of information which is relevant to self-evaluation.

Outcomes of social support

Succinctly, two main outcomes are correlated with social support: direct or indirect effects. A direct generalized beneficial effect of social support occurs because social networks provide persons with regular positive experiences and a set of stable, socially rewarded roles in the community resulting in a sense of predictability and stability in one's life and a recognition of self-worth (Cohen & Wills, 1985). The relationship of social network support to physical health outcomes occurs through emotionally induced effects on neuroendocrine or immune system functioning or through influence on health-related behaviours. The main effects model proposes that social support is beneficial to the health outcome regardless of the level of stressors.

Indirectly, a buffering effect occurs when social support intervenes between stressful events and a stress reaction by either altering the appraisal of the threatening events and/or bolstering one's own perceived ability to cope with imposed demands (Cohen & Wills, 1985). This buffering hypothesis proposes that social support protects individuals from potentially harmful influences of acute stressful events and enhances coping abilities (Stewart, 1993). The terms mediating or moderating are often found in the results of studies in the literature. For the purposes of this study, a mediating effect describes how effects occurred and implies a causal sequence, and a moderating effect represents an interaction with the independent variable, specifying the condition under which the variable exerts its effect. Although noted to be conceptually different (Quittner et al, 1990), the terms mediating and moderating are used interchangeably in the research

literature and refer to indirect effects rather than direct or main effects.

Perceived support

Perceived social support is the cognitive appraisal of being reliably connected to others through available and adequate supportive ties (Barrera, 1986). It influences how supportive transactions are interpreted, and are remembered, and is associated with high self-esteem, low dysfunctional attitudes, and low psychological distress (Stewart, 1993). Perceived support is deemed to be more important than received support in predicting adjustment to stressful life events (Wethington & Kessler, 1986). The perception that one's network is ready to provide aid and assistance if needed has been demonstrated to have a buffering effect on stress.

Social Support in the Workplace and Health

Research indicates that social support has positive direct effects on physical and mental health (Barrera, 1986; Berkman, 1995; House et al, 1988; Hupcey, 1998; Stansfeld et al, 1998; Stewart, 1993;). House et al (1988) state that insufficient social support should be considered an important risk factor for poor health and mortality. Social support has been associated with longer life, psychological well-being, compliance with health regimes, decreased mortality, and recovery from serious physical illness and injury (Israel & Rounds, 1987).

Social Support and Stress

The job strain hypothesis proposes that health problems, both physical and psychological, are associated with job strain that results from the combination of high psychological demands and low decision latitude at work (Karasek et al, 1988). Low decision latitude refers to a low degree of decision-making freedom with respect to task

organization and skill usage. A two-part study by Viswesvaran et al (1999) first reviewed literature comprised of 68 studies that examined social support, work stressors and job strain, and then tested the direct effects model, the moderator effects model and the mediator effects model for the role of social support in the process of workplace stress and strains. Results showed a threefold effect: first, social support had a direct effect on strain, reducing the strains experienced independent of stressors; second, social support buffered perceived stressors, and third, social support moderated the relationship between stressors and strains.

Nurses. Main and buffering effects of social support on stress among nurses have been found. Boumans & Landeweerd (1992) examined both the direct and indirect effects of received social support in the workplace of American intensive care and surgical nurses to determine whether a main effect or a buffering effect occurred in response to stressful situations. Received social support, distinct from perceived social support, indicates what people get from others that was helpful or intended to be helpful (Stewart, 1993). Five hundred and sixty-one nurses from sixteen randomly chosen hospitals completed a series of questionnaires in a correlation study. The results offered more support for the main effect than for the buffering effect. Nurses receiving more support in the workplace obtained significantly higher scores on job satisfaction and experienced fewer health complaints demonstrating a direct or main effect. Social support was also found to provide some protection against work pressure, illustrating a buffering effect. Schmieder & Smith (1996) explored the association of social support with job stress for shiftworking and non-shiftworking nurses (n=191) in two American hospitals, one rural and one urban. Mainly buffering effects of social support were found

in the survey results. For shiftworkers, supervisor and co-worker support buffered the effect of stress in predicting job satisfaction, implying that higher levels of social support from colleagues resulted in greater satisfaction in their jobs even though stress levels were high. Supervisor support also buffered the effects of stress in predicting intent-to-quit. However, none of these relationships held for non-shiftworkers.

Physical Health

Nurses. Perceived and received social support at work have been related to nurses' physical health status. Walters et al (1996) examined the effects of social support in the workplace and away from the workplace upon the physical health of 2,285 male and female registered nurses. Questionnaires were mailed to a random sampling of nurses registered in Ontario. Results showed interpersonal aspects of nurses' lives to be important in predicting health problems. Lack of supervisor support increased the frequency of health problems and having a friend or someone to confide in decreased the likelihood of such problems. Gender differences were not significant. McIntosh (1991) assessed the main and moderating effects of social support on emotional exhaustion and physical symptoms in a study of 186 registered and licensed practical nurses working in an American urban hospital. Perceptions of workload and coping with patient deaths were also examined. Perceived adequacy of support had a main effect on stressors, reducing the perception of workload. When the number of patient deaths was high, higher levels of social support, measured by the number of confidante-type relationships, reduced the experience of emotional exhaustion and physical symptoms. When the number of patient deaths was either high or low, greater adequacy of perceived support reduced emotional exhaustion. She concluded that further research was needed to

examine the types and sources of social support experienced by nurses in their workplace.

Nursing aides. Comparative studies of the effects of social support on physical health of registered nurses and nursing aides depicted inconsistent findings. Josephson, Vingard, & MUSIC Norrtälje Study Group (1998) compared social support at work, physical workload, and care seeking for lower back pain among Swedish female nursing personnel which included three registered nurses, 30 nursing aides, and 48 home care workers. Auxiliary nursing personnel with insufficient social support in combination with forward-bending work positions were at higher risk than nurses for seeking care for lower back pain. The second study (Ahlberg-Hulten et al, 1995) compared the relationship between the perceptions of social support from co-workers and supervisors with neck, back and shoulder pain among Swedish nurses (n=39) and nurses' aides (n=51). Symptoms from the neck and shoulder areas were significantly associated with the level of social support at work - the lower the support score, the more severe the symptoms. Nursing aides did not differ significantly from nurses.

Studies that examined social support and physical health among nursing aides only had contradictory results. Trainor's (1994) research with 150 nursing assistants working in American long-term care facilities found lack of social support to be positively associated with health concerns, absenteeism, and emotional exhaustion. The findings also suggested that work-related interpersonal stress may be associated with internalized symptoms of job strain, such as psychological or physical symptoms. A Canadian study of 245 nursing aides working in long term care facilities revealed different results (Chappell & Novak, 1994). Neither functional or structural measures of social support were significantly related to physical health outcomes which included sick

days in bed, missed work shifts, use of medications, and existence of health problems. However, they did find that patient characteristics emerged as a significant predictor of physical health stress for the nursing aides. The researchers suggested the younger age of the participants who had a mean age of 38.3 years may have contributed to their findings.

Mental Health

An early review by Cohen & Willis (1985) looked at several studies to examine the process through which social support had a beneficial effect on well-being. Their review concluded that individuals with high levels of perceived support appeared to be more resistant to adverse psychological effects of environmental stressors than were individuals with relatively low levels of perceived support.

Nurses. Two comparative studies of registered nurses demonstrated positive associations of social support and mental health. Pisarski et al (1998) examined the direct and mediating effects of 172 shift-working Australian metropolitan hospital nurses' coping strategies and social support in the workplace on their psychological health. Results showed that the effect of social support from supervisors on psychological symptoms was mediated by co-worker support, a finding indicating that a supportive co-worker milieu is dependent to some extent on the support given by supervisory staff. However, the researcher concluded that the exact nature of the support is yet to be established. Bourbonnais et al (1999) studied the association of job strain with psychological problems and the modifying role of social support at work in a sample of 1,378 female acute care nurses working in Quebec using self-reported questionnaires. They found that social support had a direct effect on psychological symptoms: emotional exhaustion was associated with low social support at work. In a correlational study,

Morano (1993) investigated the relationship between social support and work-related stress among staff nurses working in a large American city hospital (n=51). The study found that emotional support from unit managers and aid in the form of assistance and information from co-workers was associated with lower levels of perceived stress.

Nursing aides. In a correlational study of nurses (n=74), nurse managers (n=19) and nurses' aides (n=13) working in one of two city hospitals in Wales, both anxiety and depression were significantly associated with the level of managerial support available (Bennett et al, 2001). Findings were not differentiated for the different categories of nursing staff.

Social Support and Burnout

Social support from persons both inside and outside the work environment is recommended as the major means of moderating the effects of job-related stress, and thereby decreasing burnout (Constable & Russell, 1986; Freudenberger, 1974). Professional burnout is defined as a syndrome of physical and emotional depletion characterized by negative work attitudes, a poor self-concept, and loss of concern for patients (Jones, 1980). Maslach (1982) identified burnout as having three dimensions: emotional exhaustion, reduced personal accomplishment, and depersonalization. Emotional exhaustion refers to a loss of energy and greater fatigue, and to feelings of being overextended and drained by others. Reduced personal accomplishment involves a negative image of oneself, feelings of low competence and low achievement in one's work with people. Depersonalization refers to negativity in responses to patients, and having a callous or impersonal attitude towards one's clients. Staff turnover, low productivity, job dissatisfaction, a loss of creativity, withdrawal from work or

absenteeism, and frequent irritation and anger with patients are manifestations of burnout.

Research indicates that burnout of employees in helping professions results from job-related stress and lack of positive conditions within the work environment (Constable & Russell, 1986). Maslach (1976) suggested that the occurrence of burnout is rooted, not in the individual's permanent traits, but in the specific social and situational factors that can be changed.

Several studies were found in the literature that examined social support and burnout among registered nurses, licensed practical nurses, and nursing aides. All of the studies used a tool with acceptable psychometric properties to measure the three dimensions of burnout. Twenty-three of the twenty-seven studies found utilized the Maslach Burnout Inventory (MBI) which is a 22-item scale widely used in the assessment of burnout. The MBI consists of three subscales: a 9-item emotional subscale, a 5-item depersonalization subscale, and an 8-item personal accomplishment subscale (Constable & Russell, 1986). Three of the remaining four studies used the Staff Burnout Scale for Health Professionals, an instrument measuring four dimensions of burnout: cognitive, affective, psycho-physiologic, and behavioural (Cronin-Stubbs & Rooks, 1985; Duquette et al, 1995; Stewart & Arklie, 1994). The other study used the Tedium Scale, containing 21 items measuring a person's feelings at work (Duxbury et al, 1984). The MBI has been widely used in the assessment of burnout and has good measures of reliability (Eastburg et al, 1994). Cronbach's alpha reliabilities of .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment have been reported (Maslach & Jackson, 1981). Although used less frequently, both the Staff Burnout Scale and the Tedium Scale also have good reliability: Cronbach's alpha of

0.83 and 0.92 respectively (Duquette et al, 1995; Duxbury et al, 1984;). One main limitation in the use of these tools is that they are all self-report assessments with fixed parameters.

Nurses. Several quantitative studies found a significant negative relationship between social support in the workplace and burnout in nurses working in a variety of hospital or community settings (Beehr et al, 1990; Bourbonnais et al, 1999; Constable & Russell, 1986; Cronin-Stubbs & Rooks, 1985; Duxbury et al, 1984; Eastburg et al, 1994; Ellis & Miller, 1994; Garrett & McDaniel, 2001; Janssen et al, 1999; Leiter, 1988; Mallet, 1988; Oehler et al, 1991; Ogus, 1990; Robinson et al, 1991; Smith & Tziner, 1998; Stewart & Arklie, 1994). Only one study showed no relationship between social support and burnout among nurses (Koniarek & Dudek ,1996).

The effects of supervisor support on nurse burnout are well documented. In a cross-sectional exploratory study of acute care nurses working fulltime in an American hospital (n=287), using a self-administered survey, a perceived lack of supervisor support predicted both emotional exhaustion and depersonalization (Garrett & McDaniel, 2001). A study on the effects of social support and the relationship between the negative aspects of the work environment and burnout among 310 American military hospital nurses found that an increase in supervisor support and job enhancement predicted a decrease in emotional exhaustion (Constable & Russell, 1986). The major determinants of burnout in this study were identified as low job enhancement (autonomy, task orientation, clarity, innovation and physical discomfort), work pressure, and lack of supervisor support. The study concluded that high supervisor support aids nurses in coping with negative aspects of the job. Leiter (1988) used questionnaires to measure organizational commitment,

burnout and social support in a study of nurses belonging to a provincial nursing union (n=850). Results showed burnout to be negatively associated with organizational support. Supervisor support was more closely related to both emotional exhaustion and organizational commitment than was co-worker support. A study examining the relationship of head nurse leadership with self-reported burnout and job satisfaction among nurses (n=283) working in 14 American neonatal intensive care units (NICU), found that head nurse consideration was correlated to staff satisfaction and to a lesser extent to burnout (Duxbury et al, 1984). Consideration was defined as the emphasis on concern for group members' needs. The behaviours associated with consideration included mutual trust, respect and two-way communication. A correlational study of 225 nurses randomly selected from seven Michigan hospitals, showed social support received in the form of positive job-related communications from the supervisors was negatively associated with feelings of emotional exhaustion and depersonalization (Beehr et al, 1990).

Some studies demonstrated that perceiving support in the workplace had a negative effect on burnout. Stewart & Arklie (1994) utilized self-administered questionnaires in a study of 101 Canadian community health nurses to research the effect of perceived social support on burnout and found as perceived support increased at work, job satisfaction increased and burnout decreased. A study by Oehler et al (1991) of 49 NICU nurses employed in an American hospital showed that higher job stress, higher anxiety, less experience as a nurse and the perception of less supervisor support, were associated with higher burnout. In a sample of 314 nurses from a large American metropolitan hospital, Robinson et al (1991) examined whether nurses' varying

perceptions of support across the three shifts would account for and predict burnout. Perceived supervisor support was most important in predicting emotional exhaustion for the nurses on day shifts. Nurses on both the day and evening shift valued peer cohesion and efficiency in getting work done. In contrast, perceived support from supervisors and peer cohesion was not significant for predicting burnout for nurses on the night shift.

Some studies considered specialty nursing units as a variable when examining social support and burnout. The research revealed differences in burnout exist between the specialty areas nurses work in. Research on 296 nurses working in psychiatry, medicine, the operating room or intensive care in one of three urban American hospitals explored the relationship of occupational stress, social support and burnout (Cronin-Stubbs & Rooks, 1985). No significant differences in burnout were found between the four work settings. However, it is worth noting that when the hospital specialty unit was included, the three hospitals differed significantly on frequency and intensity of occupational stress and burnout. Results also showed that on-the-job and off-the-job social support was negatively associated with and predictive of burnout. In another study, Mallet (1988) compared occupational stress, levels of burnout, and social support between a sample of American hospice and critical care nurses (n=376). The two nursing groups did not differ in social support when both quantity and quality of support were examined. Critical care nurses reported significantly more occupational stress and higher burnout scores; however, hospice nurses reported feeling less emotional exhaustion, utilized depersonalization less frequently and experienced a greater sense of personal accomplishment. The study also found a positive association between occupational stress and burnout and a negative association between burnout and social support for both

groups. Ogus (1990) compared the relationship between stress and social support in dealing with burnout among medical (n=62) and surgical nurses (n=66) employed in one of three community hospitals in a large Canadian city. Nurses with high sources of social support at their work and high levels of satisfaction with that support reported significantly less burnout than nurses with few supports and less satisfaction with those supports, regardless of level of work stress. In addition, surgical nurses reported significantly higher satisfaction with social support than did medical nurses. Eastburg et al (1994) examined the relationship between work-related social support, personality variables, and burnout among 76 staff nurses in a small American hospital. Findings showed a strong negative correlation between work-related social support and burnout, as well as revealing that extroverted nurses required more work-related peer support than did introverts to avoid emotional exhaustion.

The remaining four studies showed noteworthy relationships between social support and burnout. A correlational study by Ellis & Miller (1994) examined the impact of supportive communication on burnout, organizational commitment and retention for 490 medical-surgical nurses working in an acute care hospital in a large American city. They found a significant negative association between emotional support and burnout. Emotional support was also the only support variable directly related to organizational commitment and retention. In another study, social support was significantly negatively correlated with emotional exhaustion among nurses working in a large Canadian hospital (n=241) (Smith & Tziner, 1998). Results from a study of 1378 nurses employed in one of six selected acute care hospitals in Quebec indicated low social support at work was associated with emotional exhaustion (Bourbonnais et al, 1999). A study of 156 nurses

working in a general hospital in the Netherlands (Janssen et al, 1999) revealed that there were higher levels of emotional exhaustion when work overload was high and when they received little social support.

One study showed notably different results, finding variation in the role of social support in relation to burnout for hospital nurses. Koniarek & Dudek (1996) found that burnout levels among nurses (n=1,023) working in a Polish hospital correlated highly with organizational and global stress. However, the role of social support varied according to type and scope of support in determining the particular dimension of burnout. No reliable correlation was found between emotional exhaustion and social support of any type. Neither social support in the workplace nor general social support impacted emotional exhaustion; however the nurses' feelings of personal accomplishment were most sensitive to the impact of social support. A sense of personal accomplishment was higher, but not significantly, when accompanied by high social support at work and in general. The researchers did not speculate as to why differences were found.

Nursing Aides. Findings reported in some of the studies that explored burnout in both registered nurses and nursing aides did not differentiate the results among the nursing groups (Barber & Iwai, 1996; de Jonge et al, 1996; Duquette et al, 1995; Leiter & Meechan, 1986; Ray & Miller, 1994). Two studies included licensed pratical nurses (Hare et al, 1988; & Landsbergis, 1988), and only three examined social support and burnout in nursing aides exclusively (Chappell & Novak, 1992; Northrop, 1996; Trainor, 1994).

Many of the studies conducted with nursing aides had findings consistent with

research on nurse burnout. Research by Duquette et al (1995) utilized self-report questionnaires to identify determinants of burnout in geriatric nurses and nursing aides (n=1545) working in either Quebec hospitals or nursing homes. Both support from superiors and peer cohesion were equal determinants of burnout, suggesting that if these nurses perceived social support in their work settings, either from their superiors or their peers, they would be less likely to experience burnout. A study of 245 Dutch nurses and nursing aides employed in either home health, a hospital or nursing homes, showed emotional exhaustion to be associated with high job demands and low social support (de Jonge et al, 1996). Their results suggested that increasing the autonomy in nurses' work combined with high work-related social support would have beneficial effects. Hare et al (1988) conducted a study exploring interpersonal, intrapersonal, and situational factors expected to contribute to burnout among American professional and paraprofessional nurses working in acute care hospitals (n=156) or long term care centres (n=156). Results demonstrated that a lack of support at work significantly predicts staff's vulnerability to burnout. The absence of tension-releasing coping and instrumental/ problem-focused coping were the most frequent predictors of burnout. Personal demographics (age, level of education, marital status, and family status) had considerably less power as predictors of burnout than did interpersonal and intrapersonal factors. Landsbergis (1988) studied a sample of 289 nursing personnel working in an American nursing home or in one of two selected hospitals. He found self-reported low social support from supervisors and co-workers to be significantly associated with burnout.

Where work setting for nursing aides were long term care facilities or nursing homes, the effects of social support on burnout varied. Northrop (1996) studied relations

between stress, support and burnout among 216 American nursing home staff. Findings revealed higher levels of burnout were associated with higher levels of stress and lower levels of support. Chappell & Novak (1992) interviewed 245 nursing aides employed in long term care centres in a large Canadian city to examine burnout, social support, and stressors in the workplace. They found social support was related to burnout irrespective of the level of stressor experienced, and therefore indicated a main effects view of social support existed. Specifically, training for dealing with residents with cognitive impairments and support from family and friends were found to assist nursing aides in dealing with burnout.

Not all studies showed social support having a positive effect on burnout. In a study mentioned earlier, social support was positively associated with emotional exhaustion among 150 nursing assistants working in American long-term care facilities (Trainor, 1994). It was speculated that the helpfulness of social support was outweighed by the conflict experienced in interpersonal relationships on the job. Results of another study of nursing aides and charge nurses in a large American nursing home (n=119) revealed that different sources of social support worked in various ways to relieve the strain of work stress (Ray & Miller, 1994). Increased levels of family support were associated with increased levels of emotional exhaustion, and at high levels of stress, co-worker support was positively related to burnout. A possible explanation given by the researchers was that receipt of support is stressful and increases burnout because developing and maintaining of a social network is inherently stressful in itself. Another possible explanation is that although support may be increased to assist the persons dealing with stress, the support may be insufficient for the levels of stress experienced.

Leiter & Meehcan (1986) found emotional exhaustion occurred less often when the social support network at work was not concentrated solely within the formal work subgroup in a study of nurses and nursing assistants (n=35) working in Canadian residential mental health and rehabilitation centres. Findings in Barber & Iwai's research (1996) did not reveal a relationship between social support and emotional exhaustion for 75 nursing personnel employed in American long-term care facilities. Instead they attributed two work environment characteristics, role conflict and role ambiguity, to predicting burnout. The researchers noted that the restriction of support only to the workplace could have impacted the findings.

Social Support and Staff Turnover

Turnover represents a major problem for nursing and health care in terms of cost, ability to care for patients and the quality of care given (Cavanagh, 1989). The loss and disruption of organizational performance is a major consequence of turnover. Price (1977) indicated turnover reduces consensus, increases conflicts and reduces satisfaction among those staying. In comparison with professionally trained nursing positions, research shows that higher turnover is experienced in low rank direct care job categories, such as nursing aides (George, 1979; Halbur, 1983; Tai, 1996).

Nurses. A review of literature on nursing turnover research by Tai et al (1998) concluded that "an increased perceived personal and work-group support climate reduced the likelihood of turnover" (p. 1919). Health care employees who have personal support from other staff and supervisors were more likely to have higher job satisfaction than others, which in turn was associated with lower turnover rates.

Although many studies demonstrate the relationship between social support, job

satisfaction and turnover, very little research has been conducted on examining the operational aspects of social support and work satisfaction. Carter & Phillips (1987) reported on the comments of nurses who were participating in a study on staff turnover in urban Australian nursing homes (n=158). Good working relations among staff was identified as an important factor contributing to their work satisfaction. The link between satisfaction and staff retention was not documented in the article due to the third stage of the study still being in progress. A recent literature search did not identify subsequent articles on this study.

Nursing aides. The effect of supportive working relationships on job satisfaction was consistently found in the research on nursing aide turnover. A study of nursing aides (n=31) from three American urban or rural nursing homes, using forced choice questionnaires, found that supervision, achievement, and responsibility ranked high for influencing the retention of nursing staff, but the leading factor identified was interpersonal relationships in which staff got along well with each other (Holtz, 1982). An extension of their findings were revealed in a study by Grau et al (1991) of 219 nursing aides working in two American large urban nursing homes. The caring, friendliness and support of co-workers and supervisors were more influential for staff loyalty to the institution than was personal satisfaction with job tasks and resources. Douglas et al (1996) studied retention of Mexican nursing aides working in two acute care urban hospitals in two different cities (n=59). Although social support specifically was not studied, a frequently reported stressor was interpersonal relationships at work. In another study of 84 nursing aides working in 25 American nursing homes, Sheridan (1985) found group cohesion was significantly related to staff turnover among newly

hired nursing aides, but was not significantly related to turnover for those who had worked there for more than six months. Hence, a supportive working climate can be regarded as a significant factor in staff retention, particularly for new employees. Three of these studies reported acceptable levels for validity and reliability tests for the scales they used (Grau et al, 1991; Holz, 1982; Sheridan, 1985), but one study did not address the topic (Douglas et al, 1996).

Weaknesses in the research presented in this section include that unless otherwise stated, studies of more than one group of nursing personnel (ie. nurses, nursing aides) or that were conducted with nursing staff employed in more than one specialty area, had findings that were not differentiated for the classification of nurses or for the specialty. Some of the limitations of self-report surveys and questionnaires which were frequently used in many of these studies are that the respondents may not be representative of the sample, particularly in smaller sample sizes; participants may provide socially acceptable responses; and, there is no opportunity to clarify misunderstanding of questions. Forced choice questionnaires do not allow participants to answer in their own words, instead they must choose from provided alternatives, which limits collection of their own perspective.

Early research on social support demonstrated that it has positive effects on physical and mental health. Over the past two decades, a great deal of research has been conducted on social support in the workplace and its influence on burnout and turnover of nursing staff. The findings presented so far are from quantitative research. Although studies of this nature confirm associations, provide predictions and give comparative results for selected variables of social support and the other phenomena, they are unable to give the individual's perspective of the experience or feeling. The focus of the current

study required a deeper exploration of the literature to determine what the specific behaviours of social support were. Social support is a dynamic construct but few studies have described the precise behaviours involved.

Behaviours Providing Social Support

Limited research has been done to examine the sorts of actions that yield support in the workplace. Much of the research focusing on characteristics of support was conducted with registered nurses. Only one study, which was quantitative, included nursing aides (Cohen-Mansfeld, 1989). No studies were found that examined supportive behaviours for nursing aides exclusively. For ease of interpretation, studies will be presented by their design: quantitative or qualitative.

Quantitative Studies

Elements of supportive work relationships were identified and found to be related to job stress among nurses. Brooks et al (1993) administered questionnaires to nurses in two large urban American acute care hospitals (n=538) to examine job stress and situational support. Five variables of support were confirmed to be inversely associated with job stress: autonomy, control over practice, group cohesion, substantive exchange, and manager consideration. Group cohesion described the degree to which a nursing staff member felt integrated as part of the team, and manager consideration was the degree to which the manager regarded the comfort, well-being and contribution of workers.

Nurses' perceptions of supportive behaviours were influenced by the communications they had with their supervisors. In an article mentioned earlier, Beehr et al (1990) studied contents of communication with supervisors and perceptions of support

among 225 nurses randomly selected from seven Michigan hospitals. Results revealed that subordinates' perceptions of available support from their supervisors were primarily related to positive job-related or non-job-related communications and only slightly related to negative job-related communications. A buffering effect was especially found for non-job-related communications as a form of social support.

Interpersonal relationships with co-workers have been identified as sources of enjoyment at work. An exploratory study by Cohen-Mansfield (1989) of nursing staff (n=30) from two units of a large long term care facility in the States, examined the reasons the nurses, licensed practical nurses, and nursing aides enjoyed and disliked their jobs. Interpersonal relations with patients was the most reinforcing aspect of the job, followed closely by interpersonal relations with co-workers. However, interpersonal relations with co-workers and supervisors were also among the most frequently mentioned areas of difficulties.

Qualitative Studies

The complexity of social support is reinforced in the qualitative literature that focuses on the descriptions of support behaviours. Three studies were found that further developed the understanding of workplace support for registered nurses. What support meant to nurses, when and what support was needed, and how support was solicited, were all examined in a phenomenological study by Smith & Vargolu (1985). Nurses' perceptions of stressors and when they needed support were identified in grounded theory research by Hartick & Hills, 1993. The third study used critical incident technique to examine support needs of nurses, and identify both personal outcomes of support and providers of workplace support (Lindsey & Attridge, 1989). Findings from these studies

provide a foundation to conduct qualitative research focusing on nursing aides.

A phenomenological approach was used to determine the meaning of support for 18 hospice and 49 extended care nurses working in a Canadian city (Smith, 1986; Smith & Varoglu, 1985). An open-ended interview was developed to collect the data. Content analysis was used to uncover and categorize the meanings of the nurses' responses. Categories included encouragement and listening for both groups; guidance, team cooperation, and back-up for extended care nurses; and assistance for hospice nurses. Their study also identified times when these nurses felt they needed support. Such times for extended care nurses included when there is a significant change in the condition of the patient, when making decisions about residents' care, when feeling run down, when there is conflict or friction among staff, and when the workload is frantic. For hospice nurses, support was needed when there was: emotional involvement with a dying patient, family crisis or conflict, and the patient's death was emotionally distressing. Their research also explored what help was needed by hospice nurses, and how they sought help. The most frequent category of support needed was physical help with workload, followed by a need for someone to listen to them and to talk to. A direct verbal approach was the most frequently used method to seek support. The study's participants were less specific about the kind of support they provided to colleagues therefore a category of undifferentiated responses was included in the results.

Hartrick & Hills (1993) used grounded theory to explore the stresses and support needs of 28 acute care nurses employed in two large urban hospitals in Canada. Three categories of stressors were identified - organizational/environmental, job components, and intrapersonal stressors. Eleven support needs were described: help with physical

tasks, listening/understanding, consult/problem solving, support services, clinical coordinating, communication, input into changes, clear roles/policies, support group, and physical changes.

Lindsey & Attridge (1989) used the critical incident technique to identify what acute care staff nurses' perceptions of support and lack of support in the workplace were. Personal outcomes resulting from perceived support were also identified in the sample of thirty acute care registered nurses working in Canadian hospitals. Participants were interviewed and categories were developed from the data. The eight categories when nurses felt they needed support were situations involving: 1) value/respect for nursing expertise and quality patient care, 2) control over work, 3) work-related emotional stress, 4) vulnerable/humiliating work circumstances, 5) collegial work relationships, 6) resource availability, 7) work/career advancement, and 8) work and personal life. Control over work was the category where the most unsupported incidences occurred, followed by resource availability. The nurses reported that the unsupportive incidences had the greatest impact on their work performance. Eighteen of the thirty nurses interviewed changed their place of employment as a result of a specific unsupported incident. Head nurses and staff nurses were most frequently involved in supportive interactions, whereas physicians' actions were predominantly unsupportive. Personal outcomes when nursing staff considered themselves supported included heightened self-esteem, greater self-confidence, and a motivation to work to the best of their ability. Whereas, if they felt themselves to be unsupported, they felt anger, frustration, disinterest and lack of motivation to give optimal patient care.

Conclusion

There is an increasing level of burnout in nurses, causing a high rate of staff turnover and poor job performance (Lobb & Reid, 1987). Support in the workplace moderates adverse health consequences of job stressors, decreases burnout, and enhances job satisfaction (Cronin-Stubbs & Rooks, 1985; Revicki & May, 1989; Cohen-Mansfield, 1989). The literature supports the relationship between perceived low levels of social support, burnout and turnover of nursing staff. However, many of the studies examined the relationships between social support and other workplace variables, such as stress and job satisfaction, rather than defining the concrete behaviours of support. Structured questionnaires were frequently used to collect data. This method does not contribute to the understanding of workers' perceptions of supportive actions and behaviours in the context of the workplace. Due to a need for thick and rich data, a qualitative ethnographic approach was used in the current study to provide access to nursing aides' perceptions.

Many of the studies reviewed focused on registered nurses. Where nursing aides were included, the results were generally not specified separately for each staff category. Auxiliary healthcare workers are faced with different challenges than are registered nurses and licensed practical nurses: they are at a lower rank and always supervised by professional nurses, thereby lacking autonomy; they provide most of the direct care to residents in continuing care facilities, being in a position of continuous exposure to mental and physical stressors; and they receive a much lower salary, which may be perceived as lower recognition. Due to these differences in their positions, it is difficult to assume transferability of research findings from studies on nurses to nursing aides. It

is important therefore to specifically examine work relationships of nursing aides. Little is known about the supportive behaviours exchanged between nursing aides and their co-workers or the contextual factors influencing the occurrence of these behaviours. Thus, qualitative methods of examining behaviours nursing aides perceive to be supportive will provide a better understanding of such actions and knowledge of the contextual factors that may influence perception of the behaviours as being supportive.

Chapter 3

METHOD

When the purpose of research is to gain insight into a phenomenon from the participant's perspective, qualitative research is appropriate (Morse & Field, 1995). Ethnography was selected as the research method because it provides a means of gaining access to practices of a culture allowing the researcher the opportunity to view the phenomena in the context in which they occur (Morse & Field, 1995). Spradley (1980) defined cultural knowledge as the understanding of people, what they do, what they say, how they relate to one another, what their customs and beliefs are, and how they derive meaning from their experiences.

The fundamental principles of ethnographic research are: 1) the researcher is the instrument; 2) research occurs in the field - the location of the culture of interest; 3) the nature of data collection and analysis is cyclic; 4) there is a focus on culture; 5) there is a cultural immersion; and 6) there is a tension between the researcher as researcher and the researcher as cultural member (Streubert & Carpenter, 1999). A critical dimension of an ethnographic study is a description of the context in which examined behaviours occur because this method moves beyond describing behaviours to revealing aspects of the social patterns (Morse & Field, 1995).

An ethnographic approach including participants who were most knowledgeable about their culture was used in this study. To grasp an emic view of co-workers' behaviours that nursing aides perceived to provide social support, nursing aides knowledgeable about the culture of their work environment were included. Because the topic was selected before the data collection commenced, focused ethnography methods

were used which limit participant observation to particular times and events and interviews to specific topics (Morse & Field, 1995).

Sample

Inclusion Criteria

Purposive sampling was used to recruit participants who knew the culture of the work environment in continuing care centers. Inclusion criteria for nursing aides to be in the sample were: currently working at a continuing care centre for longer than six months, able to speak and read English fluently, and willing to participate in an interview. Both male and female nursing aides were included in the recruitment process.

Recruitment

One of the major operators of continuing care centers in the local area was selected to use as the setting for this study. The agency suggested the facility and specific unit from which to recruit nursing aides, identifying the unit as having a majority of staff members who had worked there for more than five years, and who were quite open to discussing working conditions.

A letter explaining the study and inviting voluntary participation was delivered with the bi-monthly pay slips to all nursing aides working on the unit selected for recruiting participants (Appendix A). Participants willing to volunteer were asked to leave their name and phone number on an answering machine accessible to only the researcher. Because no volunteers responded to the letter, a poster offering an honorarium to each participant was posted on all units in the selected facility (Appendix B). Six participants were recruited by this method. Two months later the same notice was posted in a second facility operated by the same agency to recruit

additional participants. Two participants came forward through this recruitment process. One other participant who worked in a facility operated by a different continuing care agency in Edmonton was recruited by the snowball method (ie. referral from another participant).

In order to recruit participants from ethnic groups that were not represented in the sample, an attempt to conduct a focus group with nursing aides at a continuing care center operated by another agency was made. A poster (Appendix C) was placed in the staff lounge and the staff change rooms in the facility. Missing telephone number tear-off tabs on the poster indicated the posters were noticed by the nursing aides but no potential participants came forward from this recruitment method despite the offer of an honorarium for each volunteer. A factor preventing nursing aides from volunteering for the focus group may have been not having anonymity from colleagues knowing that one had participated in the study. This was a concern expressed by most participants prior to the individual interviews.

Data Collection

Data generation in this study included both observation and interviews. This is appropriate in ethnographic research in which the researcher seeks to understand the cultural perspective of the group using participant observation, interviews, and field notes (Morse & Field, 1995). Prior to commencing data collection, the researcher used bracketing to set aside her own personal beliefs and thoughts about the phenomenon being studied. Bracketing is a methodological tool that "requires deliberate identification and suspension of all judgments or ideas about the phenomenon under investigation " (Streubert & Carpenter, 1999, p. 329). What the researcher perceived as being supportive

behaviours in the workplace were documented in reflective notes before the initial observation of the work environment. The purpose of this was to identify the researcher's own ideas and set them aside from what data revealed.

Initial Observation of Work Environment

The researcher spent time on the initial selected unit observing staff report at shift changes over a period of a few days. This allowed the researcher to become familiar with the participants' work environment and its structural design. In addition, the researcher identified the nursing care delivery model used on the unit. The researcher made field notes that were subsequently helpful in planning and conducting the interviews.

Interviews

The researcher's initial contact with each nursing aide was by telephone. The purpose of the call was to explain their role in the study and set up a time and place for the interview. Most interviews were conducted in the participants' homes at their request. One was conducted at the workplace in a private interview room, and another was conducted at the University of Alberta. A written consent was obtained from each participant prior to taping the interview (Appendix D). An audio-taped individual semi-structured interview lasting about one hour was conducted with each participant.

Leading questions focused on co-workers' behaviours that were perceived to be supportive, and on the participant's own actions that were felt to provide support to colleagues (Appendix E). To obtain descriptions of co-worker behaviours that nursing aides perceived as providing them with social support, the term "helpful" was used in the leading questions. Because some participants had difficulty identifying co-workers' supportive behaviours, the interviewer reframed questioning from what was perceived to

be supportive to *what did they do* to be supportive to expand understanding of supportive behaviour by including intended as well as perceived behaviours. Non-supportive behaviours were readily described without solicitation from the interviewer. Data from the interviews included nursing aides' descriptions of co-workers' supportive and non-supportive behaviours, as well as nursing aides' own actions that were intended to provide support to colleagues. All participants consistently expressed both positive and negative consequences of perceived support with the use of probing questions, such as "How did that make you feel?" Demographic data was also obtained from the participant at the conclusion of the interview (Appendix F). Field notes were made following each interview.

Participant Observation

At the end of each interview, the researcher asked the participant if they would agree to being shadowed on one of their shifts. Most said they did not wish to participate as this would identify them as having been involved in the study and they sought total anonymity. A few weeks later when the researcher contacted the one participant who had agreed to be shadowed, that individual refused.

To provide more detailed understanding of the work role of nursing aides, the researcher obtained verbal consent to shadow nursing aides from another facility operated by the same agency in which no one had been interviewed for the study. A unit where residents could give verbal consent for the researcher to be present during the provision of their care was identified. Two senior nursing aides agreed to being shadowed on one of their day shifts. Their written consents were obtained by the researcher prior to the shift (Appendix G) starting. Detailed field notes on the observations and conversations

were made by the researcher immediately following the shadowing experience.

Data Analysis

Data analysis began following the preliminary fieldwork in which the work environment was observed prior to recruiting participants for interviews. An understanding of the unit's structure and the work assignment patterns helped the researcher guide presentation of questions during the interviews and understand the context of the participants' responses.

Interviews

Each audio-taped interview was transcribed verbatim by the researcher. The Ethnograph 5.07 computer software program was used to code the transcribed data from each interview. Analysis of interview data began with open coding in which the data was analyzed line by line for recurring phrases and themes. Code words were developed and defined to describe the identified concepts. As coding evolved, similar concepts were grouped together and a family tree of codes was developed. Codes with similar definitions and intent were joined together and named to form categories. Previously classified types of support were not used; instead, the thoughts and descriptions of the participants were used to develop the categories. The research questions provided a frame of reference for the development of the concepts to a more abstract level. A storyline was developed that identified: 1) co-workers' behaviours which were perceived to be supportive, 2) personal outcomes for nursing aides when support is experienced in the workplace, and 3) contextual influencing factors that led to the behaviours being perceived as supportive.

Data found to be inconsistent with representative cases which regularly

encompassed the range of behaviours found were handled as a negative case. A negative case "appears infrequently and depicts a small range of events that are atypical of the larger group" (Morse & Field, 1995, p.139). Upon identification of a negative case, the data were reviewed and searched for new themes which were coded and linked into the code tree. The new codes were connected to the broader categories. The negative case helped to clarify additional characteristics of the phenomena being studied.

Demographic Information

Information from the demographic data (Appendix F) and the interview field notes was used to develop a face sheet (used in Ethnograph 5.07) profiling each participant. These profiles were referred to frequently and used to compare themes across interviews. Similarities and differences between nursing aides' experiences were explored using the variables on the face sheet.

Field Notes

Field notes on the initial observation of the work environment helped the researcher develop and present guiding questions during the interviews. They were also used to help the researcher understand the context in which identified behaviours occurred. Field notes gathered from participant observation were reviewed and compared to the concepts abstracted from the interview data. The shadowing of nursing aides provided the researcher with the opportunity to observe the supportive behaviours identified in the interviews as well as understand the nature of the influencing contextual factors. Preliminary research findings were confirmed.

Rigor

"The goal of rigor in qualitative research is to accurately represent study

participants' experiences" (Streubert & Carpenter, 1999, p.28). Guba & Lincoln (1985) outlined four processes that contribute to rigor: credibility, dependability, confirmabilty, and transferability.

Credibility

Credibility is related to the trustworthiness of findings in a qualitative research study (Streubert & Carpenter, 1999). Credibility depends on the researcher's ability to faithfully describe and interpret the participants' experiences (Sandelowski, 1986). Collecting data from multiple sources that included initial observation of the work environment, individual semi-structured interviews, and participant observations enhanced the credibility in this study. Credibility was also achieved by the researcher bracketing her thoughts and feelings on supportive behaviours in the work place prior to this study to reveal biases or preconceptions.

Dependability

Dependability is a criterion used to measure trustworthiness and is met through securing credibility of the findings (Streubert & Carpenter, 1999). Dependability focuses on ensuring that the process of inquiry followed was logical, traceable, and documented. Detailed records on the process followed, interview context, participant observations and how data was analyzed contributed to the dependability of the study as well. This organized collection of materials, known as an audit trail (Schwandt, 1997), serves as a record of the study's activities for another individual to follow. Having the thesis supervisor review the coding and discuss coding categories to achieve consensus also ensured consistency and dependability were achieved.

Confirmability

Confirmability is concerned with establishing the fact that the data and interpretations are objective (Schwandt, 1997). The researcher bracketing her own perceptions of supportive behaviours helped ensure objectivity during the process. Confirmability was established by keeping detailed records of the study in the form of an audit trail. When the findings of this study are reported and others find them useful confirmability will also be determined.

Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations (Streubert & Carpenter, 1999). Purposive sampling and the rich descriptions obtained in the interviews will allow other researchers to compare the characteristics of behaviours perceived to be supportive by nursing aides in this study with perceptions of supportive behaviours of other groups. The ethnography approach led to research methods being selected which allowed for valuable detail in data collection. The initial observation of the work environment and participant observation provided for the inclusion of information regarding the context of the work environment. Transferability will have been achieved when the findings are considered relevant for contexts other than the study situation.

Ethical Considerations

Ethical approval for this study was granted by the required institutional review board and the agency's ethics committee. All participants in the interviews and the nursing aides who were shadowed signed consent forms prior to their participation.

Chapter 4

FINDINGS

The presentation of the findings begins with descriptions of the sample of nursing aide participants and the setting in which the observations occurred. An overview of the findings is shown in Table 1. For ease of interpretation of the findings, the contextual influences are presented in the table first, followed by the supportive and non-supportive co-worker behaviours, then the personal outcomes. Because the main focus of the study was supportive behaviours, presentation of the findings begins with perceived and intended supportive behaviours, then non-supportive behaviours, followed by the personal consequences of perceived support, both positive and negative. Finally, discussion of the context in which the perceived supportive behaviours occurred will be presented.

Sample

Participants

The sample consisted of nine nursing aides working in continuing care centers. Eight of the nine participants worked for the same organization. The age range was from twenty to fifty years, and the years of experience as a nursing aide ranged from one to twenty-eight years. Participants worked from half time to full time hours on a weekly basis. Five of the nursing aides worked on the day shift, three on the night shift, and one worked all shifts. Many of the participants had worked on other shifts prior to the positions held at the time of their interview. Eight of the participants were female and one was male. Their education ranged from completion of grade twelve to having a university degree. Four of the participants were single, three were married, and two were

Table 1

Overview of contextual influences, co-worker behaviours and personal outcomes.

Contextual influences	Co-worker behaviours	Personal outcomes
Milieu	Supportive	Positive outcomes of support
individual personalities	[a]helping	belonging
specific unit	assisting	feeling valued
organizational climate	teaching	feeling safe
	rescuing	increased confidence
Position classification	[a]cooperating	enjoyment
RN's	partnering	
casual NA's	responding	Negative outcomes of non-support
	[b]caring	avoidance
Workload assignment	[b]being sociable	frustration
shifts	[b]respecting	feeling disconnected
equity	[c]encouraging	feeling sub-servient
	[c]tolerating differences	burnout
	Non-supportive	
	[a]withholding help	
	[a]being rude	
	[a]ignoring	

[a] perceived only
[b] both perceived and intended
[c] intended only

divorced. Five of the nine participants were parents with children living at home.

Setting

Continuing care centers in Alberta provide long-term institutional-like accommodation for people who are unable to have their medical and personal care needs met in their own homes or other housing options in the community (ie. lodges, assisted living). Participants in the study all worked in continuing care centres that delivered twenty-four hour nursing care for mainly older adults. Residents in these facilities had either physical disabilities and/or dementias that prevented them from independently caring for themselves, thus they needed assistance with dressing, bathing, grooming, feeding, toileting, and mobilizing, as well as having psycho-social, emotional and spiritual needs. All of the centers had three shifts: days, evenings and nights. Staff members worked on one of the shifts permanently, unless they were employed as casual, in which case they could be assigned work on any of the three shifts. A nursing aide working part time could pick up additional hours on any of the shifts. Fulltime and part-time nursing aides worked on one specific patient care unit, whereas casuals worked on a specific unit for a shift and could be placed on another unit for their next shift.

Workload varied by shift in the facilities. On days and evenings, each nursing aide had their own group of residents to care for, whereas on nights, two nursing aides and an LPN worked together delivering care for all the residents on the unit. A nursing aide generally had six to seven residents on days, ten to eleven on evenings, and shared fifty to seventy-five residents with another nursing aide and LPN on nights.

Supportive Behaviours

The behaviours described by the participants in the interviews were of three kinds:

co-worker behaviours perceived to be supportive, behaviours the nursing aides provided intending to be supportive for colleagues, and non-supportive co-worker behaviours. The focus of this study was on co-workers' supportive behaviours, however descriptions of participants' behaviours intended to provide support to co-workers were also solicited to develop a comprehensive description of behaviours considered supportive. For ease of interpretation, supportive behaviours are presented as listed in Table 1. Co-workers' supportive behaviours that were perceived only are discussed first; behaviours that were both perceived as and intended to be supportive are next, then intended only behaviours are presented. Non-supportive co-worker behaviours follow this section.

Perceived Only

Perceptions of supportive behaviours varied among the participants depending on the situations they were in. Nursing aides' expectations, individual needs, personality differences, and stage in their career all influenced their perceptions. Some nursing aides felt they needed only information and not physical assistance to do their work, whereas others required hands-on assistance. Some supportive behaviours appeared to be equally important to all participants as noted by the consistency in descriptions of such behaviours.

Participants referred mostly to supportive behaviours of other NA's, LPN's and RN's. They usually identified who initiated the behaviours. In this discussion the source of behaviour described was either an NA or a LPN unless a RN is specified by the preceding discussion or the quoted text.

Helping

Getting help from co-workers was the most supportive coworker behaviour perceived by all participants. Help could have a physical or an emotional component.

Depending upon the personal circumstances occurring at their workplace, similar help was perceived differently by different nursing aides. Sub-categories of help were developed to illustrate these differences.

Assisting. One form of helping was assisting with patient care. This was found to be extremely helpful, especially for staff new to the job. Assistance with patient care and tasks, such as transferring a patient and tidying up a room or making a bed, were frequently mentioned.

> *They helped me out because the number of residents I was given I could not cope with for the first couple of shifts...they helped me with the smaller items I couldn't get around to – making beds, shaving people.*

> *I was very behind ...they took the patient off me... and I finished on time.*

Agency policy in the setting states that two nursing staff are required to perform a transfer using a mechanical lift. Because many patients in continuing care centers require mechanical lifts, assisting is imperative.

> *They know that the resident is heavy and that he needs two person* [lift] *so they come.*

Teaching. Providing information was another way of helping. Showing or telling co-workers information about patients' care was perceived as supportive.

> *When it's been really supportive is when I've had particularly one nursing attendant who will come and say okay this is the order of your patients. Just some little tidbits about each one to help me.*

> *How to deal with their certain behaviours maybe. Things like that. They were just very helpful with the information.*

The mentoring and teaching by staff helped nursing aides particularly when they were new to either the job or to the unit.

> *The first shift by yourself is terrifying really. And there were members of staff who were very, very helpful to me, and who took time to show things to me because I could not remember.*

For some, getting actual assistance was not as important as getting the information required to do the tasks or care.

> *So often they wouldn't do as much of the physical work, but they gave a lot of information, which is the most important to me.*

Rescuing. Another form of helping was rescuing. Descriptions of such behaviours told of co-workers stepping in to assist with the care or taking it over when the NA was unable to cope any longer. Visual cues, such as a red face, were observed by the staff prompting them to save the nursing aide from further frustration or breaking down.

> *They realized I needed help because I was red in the face, and puffing and almost teary.*

> *I was so fed up that I was ready to leave and not come back... they actually stepped in and took over.*

Participants did not report the rescuing behaviours as having a sense of caring; instead the actions were focused on accomplishing a task for the nursing aide.

Cooperating

The second category of co-workers' behaviours perceived to be supportive was cooperating behaviours. Two sub-categories were developed to differentiate cooperative actions that were solicited from those that were volunteered. Partnering was one form of cooperating in which co-workers would work together without asking each other for help. The second form of cooperative behaviours was delineated by responding to a request for assistance.

Partnering. Partnering took the form of either working in pairs or as a team of three to four staff. The period of time spent working together varied: it could be for the

shift or just for a specific task. Characteristics of the shift influenced the partnering behaviours. Nursing aides working on nights consistently described their cooperative efforts where they would work as a team to make their workload easier.

> *We always work together ... we find it so much easier and less stressful to work together.* [night staff]

Partnering was unsolicited: a co-worker provided assistance when they knew a second person was needed to provide the care, or they worked together because sharing the workload made the job easier for everyone.

> *She sees that you're busy and she'll without being asked come and say I will help you.*

> *They had finished their work, and they could have gone and just taken a break but they didn't. They came and helped and said what is it that you have left to do?*

Responding. Responding was portrayed by taking action when a nursing aide asked for help. Providing assistance when it was requested was perceived as being cooperative.

> *The staff seem to be relatively helpful- not overly friendly, but at least if you ask for help, they'll give it to you.*

Participants frequently identified promptness to be important when responding.

> *I called for the RN right away and she was right there and she helped me.*

> *And it happens sometimes...some immediately leap up if you need help with a transfer.*

Sometimes cooperative behaviours were negotiated, usually between co-workers on other shifts.

> *And its taken a huge amount of time for the night staff to agree to give him the fleet in order that I can go to him as soon as I start my shift ... They're so reluctant to do anything like that.*

Both Perceived and Intended

Participants also described what they did to provide support for their colleagues at work. A number of their intentional behaviours were equivalent to perceived supportive co-worker behaviours. The behaviours that overlapped as both perceived and intended are discussed here. Some intended supportive behaviours were identified as only being performed for new staff. It was not clear whether it was done intentionally. A possible explanation may be that due to the high turnover rate of staff, and the resulting frequency of having new staff, the nursing aides are more aware of performing these behaviours under those circumstances.

Caring

Caring was distinguished by concern, kindness, compassion, and consideration for each other's well being. The nursing aides perceived co-worker's thoughtfulness and concern for their illness or personal problems as supportive.

> *She offered to drive me home, and was very supportive of the fact that I had to leave kind of in the middle of my shift...* [when nursing aide was ill]

> *I recently went through some personal problems ... And at work everybody was happy to see me back. Told me I could talk about anything if I wanted to.*

Co-workers' empathy and consideration for what the nursing aides were going through when dealing with assignments were also perceived as supportive actions. Caring was described as being expressions of compassion for new nursing aides trying to cope with the workload and routines.

> *They knew their own groups and they had gone through what I was going through and realized how I was feeling.*

> *The routine – exactly. They both told me that they can remember their first shift and how it compared, ... and they were looking the same way I as I did. And so she knew how I was feeling.*

Helping behaviours that provided emotional support for the nursing aides were perceived as caring, but not all caring behaviours provided help.

> *They took over and just told me to go take a breather. Because I had dealt with this lady for like seven and one-half hours, and they knew I'd had enough.*

> *On our unit, if somebody dies, ... family members of the workers dies, we always send a card and buy something for the person.*

Some participants perceived being asked by co-workers about their self as caring. Others perceived it as being sociable. The difference appeared to be in how connected the nursing aide felt upon sharing the information.

> *At least it makes a bit of a connection. It shows at least that they're just caring about you and not just only here to do a job.*

Caring behaviours performed by the nursing aides intending to provide emotional support to colleagues included showing compassion for co-workers dealing with deaths that are part of the work.

> *She really got upset about a death that we had. There's two of us that took her aside and gave her a hug and said she's off in a better place now, and comforted her that way.*

Consideration was also shown towards ill co-workers who would still come in for work.

> *If somebody comes in and isn't feeling good, you try to give them a little longer rest, or give them an easier patient to do or you get up more often and answer bells.*

Nursing aides showed concern and kindness for colleagues' well-being noticing if they appeared tired or stressed. Some were willing to carry more of the workload to provide relief to a co-worker.

> *When I noticed they had a lot of studying or they hadn't had enough sleep, I'd say 'Take a longer break', or try to get more bells and encourage them to study.*

> *If I noticed she looked tired or whatever or something ask her how it was going or how she was feeling...*

Being Sociable

Being sociable was characterized by friendliness, informal conversation and companionship. Friendly behaviours were welcoming, pleasant, and polite. Smiling and greeting co-workers upon their arrival at work were perceived as being friendly and sociable.

> *They're just so friendly ... just saying is there anything you need? Or just even smiling...*
>
> *Saying hi and how was it and talking about the weather or you know asking about a new patient or whatever just to keep some lines of communication open.*

Inviting colleagues along for breaks or sharing meals was another form of being sociable. Breaks were pre-assigned and colleagues would find whoever was designated for the same break on their unit and go together.

> *They invited me over for coffee during my break...* [nursing aide on night shift]

It was common practice for staff to share food and time together by holding potlucks at work. Potlucks were frequently held to celebrate birthdays, retirements of a co-worker moving on to a new position. Staff who were unaware of the event due to being off duty when it was planned always reported being welcomed to attend it.

> *A lot of time I'll come in and everyone has a potluck. And they're always so good – oh stay, stay.*
>
> *We celebrate birthdays or people leaving for another position, or retirements or anniversaries. It seems like every week we're celebrating something. So it's good that way.*

Another aspect of co-workers being sociable was displaying interest in the nursing aides as individuals. It was desirable and acceptable by most participants to have a little bit known about themselves, such as where they came from, and who was in their family; but all participants had boundaries on how much they wished to share about their personal

lives. Respect for personal privacy was described by many of the participants. There appeared to be a dichotomy in this sociable intent between their desire to know colleagues and their comfort with being known by colleagues.

> *I'm just interested to hear about people's lives actually, and they're very interested about my past...*
>
> *...a little bit about themselves is always nice to know.*
>
> *I don't give away that much about myself so there's no reason why I should really expect anyone else to be forthcoming about themselves either.*

Sociable behaviours that nursing aides intentionally provided to be supportive consisted of being friendly and welcoming to new staff. They did not relay that the same behaviours were performed for old staff. Nursing aides smiled and introduced themselves to staff new to the unit or to the job.

> *I'll just make myself friendly first. I'll introduce myself, be friendly, offer my assistance if they need it...*
>
> *I usually smile and say hello.*

Respecting

Respecting behaviours included respecting the privacy of each other's personal life and individual space, and respecting the nursing aide as a person. Respect for boundaries around the nursing aides' personal lives was the differentiating characteristic of this behaviour. Co-worker's showing an interest in getting to know their colleagues was supportive when it did not go beyond the nursing aides' limits of how much they wished to disclose.

> *I like the fact that for myself, the majority of them have not asked too many questions about my personal life, my family or whatever. And I like that.*
>
> *I don't really feel that people invade my private – space.*

Boundary rules were generally unspoken and indicated by visual cues, such as continuing on in the conversation or changing its direction.

> *... if they see something they'll show concern, and if I want to take it from there, like open up to them or whatever, I'll do it. If I don't, they respect it.*

Respect for the person was primarily characterized by showing regard when they were speaking. Stopping one's own speaking and paying attention to the person who was speaking was perceived as being respectful.

> *... at least the person is being heard you know. Everybody has stopped and listened to what they had to say and whether they agree or not...*

Another behaviour perceived to be supportive was RN's listening intently when nursing aides reported to them on their patients.

> *They [RN's] are very good with coordinating and listening – cause the NA's give most of the care to their patients... they really listen to see what's going on.*

Participants intended to be supportive by respecting co-workers' capabilities and need for personal privacy. Nursing aides were particularly careful with new staff to not demean their knowledge level and capabilities by clarifying first what help and if help was needed and by not making assumptions about their abilities.

> *I never assume to know exactly what they need because if I come across with all this information to them, they'll kind of look at me and say whoa, this person really thinks they know everything.*
>
> *But only, only if, only if I've asked them first. Like I just don't come right out and give them all this information assuming that they don't know.*
>
> *I'll ask first because I have found myself making beds and that isn't always the most important thing if there's still care to be done for a resident.*

Respecting co-workers' individuality, space and personal privacy were also intentional supportive behaviours.

> *I also realize that there are some members of staff who are not talkers at all, and are quite private people and they really don't want to converse. So you have to be careful, like not everybody wants to socialize. They're just not into it.*
>
> *They don't want to discuss their private life so you just have to – everyone is different – so you just have to tread carefully.*

A mutual agreement for respecting each other appeared to exist.

> *But I know my limitations. Same as with them when they ask me something. I only answer what I want to answer.*

Respect was also expressed as allowing co-workers the opportunity to voice their opinions.

> *You are going to meet a thousand people in your life that you are not going to agree with but you have to give them the respect.*

Intended Only

Participants also described behaviours they performed intending to be supportive for co-workers, which they did not depict as having received from their colleagues. When nursing aides were asked what ideal support would look like, they often described an environment where encouragement and tolerance for differences existed.

Encouraging

Characteristics of encouraging behaviours were giving reassuring statements, and offering hope. Encouragement was provided to new colleagues as they adjusted to the workload and tasks of the job.

> *I reassured her the whole way through that things would come together...*
>
> *I had somebody orientating with me for the first time this week, ... and I couldn't reassure her enough that things would improve.*

Supportive encouragement was also offered to co-workers when they were going through a stressful time in their life, such as returning to school to upgrade.

> *...just trying to encourage them saying come on you can do it. You know you've gone this far.*

... if she said it was finding it really hard I'd encourage her to talk about it.

Tolerating differences

Showing tolerance for people's differences was identified as intending to provide support. Nursing aides described putting up with colleagues' bad days, moods, and different ways of doing things. These actions were meant to accept co-workers as the people they are.

> *Putting up with each other's bitchy days... So I guess just being very tolerant with each other.*
>
> *Tolerance ... and not taking things too personally.*
>
> *Being open to different people's way of doing things and not necessarily assuming just because it is different it isn't not right or not going to work.*

Non-supportive Behaviours

Non-support behaviours were perceived as not providing any help, and/or not having any care or respect for the nursing aides as individuals. Participants identified behaviours of co-workers that they perceived to be non-supportive without solicitation from the interviewer. It was noted that all participants consistently identified similar actions that were not supportive. Some nursing aides explicitly identified co-worker behaviours that failed to provide support, while others gave descriptions that, when analyzed, were identified as being non-supportive. By including the unsolicited non-supportive behaviours in the findings, the contrast between supportive and non-supportive behaviours is demonstrated. Some of the non-supportive behaviours were mirror images of the supportive behaviours and some are unique.

Withholding help

Not receiving help when it was requested or not having help offered were

behaviours nursing aides perceived as non-supportive. Characteristics of this non-supportive behaviour included co-workers not volunteering help or wanting to work alone.

> *They don't voluntarily walk in ... and ask if you need help.*
>
> *There are some who just do their own thing and nothing ... they will not do anything to help.*
>
> *She prefers to work on her own. Like she'll say I'll do this side.*

Although the behaviour was identified as occurring among all three categories of co-workers – NA's, LPN's and RN's, there was consistency in which individuals withheld help. Participants frequently said that many RN's consistently withhold helping with patient care. Nursing aides included their rationale for the RN's non-supportive behaviour as being too busy, having other tasks to do, and feeling it's not their job.

> *The RN's they rarely help. They're there to actually delegate tasks and do paperwork, ... and hand out some meds.*
>
> *But usually they're [RN's] say they're too busy, and sometimes – well I haven't had that role, so I don't know maybe they were totally busy, but – sometimes they could help.*

Nursing aides expected all members of the team to work cooperatively by responding when help was requested or by working as partners.

> *You can have, like as part of a whole team – NA's, LPN's, RN's. You can have some who are so helpful ...and then you'll have some who are - I'm an RN. I don't do that.*
>
> *I feel that we're not working as a team. It doesn't matter how much education you have or how much you get paid an hour, that shouldn't matter. What should matter is the patient care.*

<u>Being rude</u>

Being rude was characterized by being unfriendly and impolite, and could be verbal or non-verbal. Rude behaviours were described most often when staff were new to

a unit, or when they were working as a casual. Not engaging in informal social conversations and not being acknowledged by incoming staff arriving for the next shift were perceived as being unfriendly and impolite. Rude behaviours came from co-workers in all categories of positions - NA's, LPN's , and RN's.

> *And when you're up there like no one says hello to you or anything. They just ... I don't know if it's because they're so busy, or if they're just, they don't like casual staff, or – whatever. But I just don't feel very good when I'm working up there.*
>
> *... they'll be more swift in their movements, or pull the curtain, or whatever. You can get the message usually.*
>
> *Some of the care managers used to come in in the morning and wouldn't even acknowledge night staff. Like there wouldn't even be a hi or how was the night – anything. Like they would walk by you and unless you addressed them there was nothing.*

Being rude was also characterized by lack of respect for the person such as was demonstrated by interrupting the individual when they were speaking. The co-worker's tone of voice and the words used when conversing also influenced the nursing aide's perceiving the behaviour as being rude.

> *Or not even acknowledge as to what's coming out of your mouth before they cut you off and interrupt what you are trying to say.*
>
> *Don't you know what to do? You've done care before.*

Ignoring

Ignoring behaviours involved neglecting or paying no attention to the nursing aides and were all non-verbal actions. Some of the nursing aides indicated that they were ignored when they came on shift, or when working on a particular unit.

> *I know they see me. They don't always say hello. ... Some of them tend to ignore me, but I mean it's pretty hard to ignore me isn't it.*
>
> *Some of them are very closed – like won't even look at you, won't ask how you are, won't ask your name especially when you first come on or anything like that.*

Other nursing aides described being overlooked or disregarded in social conversations when staff members from a higher position were present.

You were kind of ignored if there was someone higher up to talk to.

Nursing aides working nights consistently described feeling ignored by management working on days. Their perceptions were influenced by the frequency of formal meetings they had with management, and the scheduling of meetings and events. The participants pointed out that attending a meeting during the day is difficult for night staff as they need to sleep.

> *I have been there almost five years and I only remember once that management came in at night to talk to the staff.*
>
> *We always felt nights was kind of on the lower rung - everything is planned for days... even the staff meeting ... it is really difficult on nights to do things like that.*

Personal Outcomes

The participants candidly described the effects of their experiences of supportive and non-supportive behaviours from co-workers. All participants identified positive consequences of supportive behaviours and negative consequences arising from the non-supportive behaviours. Both types of personal outcomes are important in understanding support in the work environment.

Positive Consequences Experienced in Response to Perceived Support

When nursing aides perceived co-worker behaviours to be supportive they encountered positive personal outcomes. The main outcome consistently mentioned by all participants was experiencing as sense of belonging. Being valued, feeling safe, having increased confidence and experiencing enjoyment in the job were the other positive effects.

Belonging

Feeling like a team member characterized belonging. Participants' descriptions used phrases such as team, family, and belonging. This feeling of fitting in with co-workers resulted from getting help with on-the-job tasks such as patient care, participating in workplace social events with colleagues, and working cooperatively as partners.

If somebody offers or helps... it feels like a team.

And in our unit you sense like you belong. You belong in one, in one family.

I was very pleased – there were some events that came up very quickly soon after I was taken on and I was very quickly asked why don't you come? And that made me very pleased because I wanted to get on and make friends with my colleagues, and I did.

A participant who had worked before and after the nursing aides joined a labor union, which represents nursing aides for contract negotiations and for disciplinary matters, credited the union with fostering this sense of belonging. The nursing aide pointed out that being part of the team doesn't require everybody liking each other.

Getting the union in helped to make things a lot more cohesive among staff just by its nature of everybody is joined together ... whether they like each other or not.

Feeling valued

Characteristics of feeling valued included being acknowledged, and feeling respected and important. Every nursing aide described feelings of being appreciated when support was received from colleagues, particularly from supervisors. Getting compliments and positive verbal feedback that recognized the nursing aides' contributions and being respected resulted in feeling valued.

And even then it's nice to be told, that you're valued.

It makes me feel important. I think you know, at least one's acknowledging them.

I feel like I'm a good functioning part of the team – contributing.

Appreciated – like you're part of the team. Because when we don't have that you know we often feel like we're – we don't count.

Being asked for their opinions on issues and concerns in the workplace led to nursing aides feeling valued and on top of the world.

I'd say on top of the world ...To me it boosts morale. It just – I mean you hear people leaving with a different tone in their voice and you know eagerness to come back. Like it is a totally different feeling to feel that appreciation ...

An example of feeling valued and appreciated resulted from supervisors nominating a nursing aide for an award recognizing her excellent work performance.

It feels good. It's like it feels good that somebody recognizes you're going the extra mile.

Another participant was in a position of being bumped off her unit due to a more senior staff member applying for the position. Co-workers' supportive behaviours during the event led to the nursing aide feeling valued for her contributions to the unit.

The staff didn't want me to go. They wanted me to stay, and that, that made me feel very good.

Feeling Safe

Feeling safe was characterized by nursing aides feeling protected and free from danger of physical or emotional harm. Getting assistance with aggressive patients provided a sense of emotional and physical safety for nursing aides. Having help with heavy patients resulted in feeling a sense of protection from getting physically hurt.

I feel safer if there's safety concerns with somebody being aggressive or things.

And to me it's a safety issue as well as kind of helping physically like you know your back, when you are turning and changing people and things like that. It's easier to work together.

Knowing the help would be available if needed also resulted in nursing aides feeling safe,

particularly emotionally.

> *It made me feel really secure in my job because it just... it's nice to know that there's relief there, in case I need it.*

Increased confidence

Confidence was portrayed by feeling good at what they were doing, feeling competent in their skills, and feeling comfortable when addressing issues. An increase in nursing aides' confidence resulted from receiving assurance from supervisors that they were doing their job well and their assessments of patients were accurate.

> *It makes me feel competent in my skills and even just, ... confident as an NA.*
>
> *Appreciated in a sense, and good that you 're ... recognizing what was happening.*

Encouraging and reassuring verbal communication about the care provided by nursing aides had positive consequences for them.

> *It makes me feel like I can talk about things as they come up and not have to worry about any body being mad at me - like we're all pretty good. I feel pretty confident.*

Enjoyment

Enjoyment meant taking pleasure in being at work and doing the job. Primarily, working cooperatively as a team led to nursing aides enjoying their work. Knowing their colleagues were willing to work as partners made going to work pleasurable for the nursing aides.

> *It is really nice to go into work and know that you have a partner that will do that. And it just makes it ... an enjoyable workplace when people are willing to do that.*
>
> *Everybody enjoys their jobs when everybody's working together as a team.*

Negative Consequences Experienced in Response to Perceived Non-support

Co-worker behaviours that were perceived as non-supportive by nursing aides consistently resulted in negative outcomes for them personally. The participants candidly

shared their negative feelings when they felt support was absent or lacking. Five main negative consequences were identified: avoidance, frustration, feeling disconnected, feeling subservient, and burnout. Avoidance was a negative consequence described by all participants.

Avoidance

Nursing aides avoided going to work on particular units or with certain co-workers whose behaviours were unsupportive. The consequences of nursing aides getting a rough time or finding things so difficult when working on a certain unit led to those staff not going back there.

> *I see some people that refused to come back because they kind of got a rough time of it.*
>
> *... made things so hard for them they just want to leave and go somewhere else. Some of the staff ended up staying off our unit whenever she was on.*

Nursing aides also avoided working with colleagues perceived to be unappreciative of help or who were rude when help was given to them.

> *I'm not going to go out of my way. Like I'll go and help them, but if they've showed me a few times that they don't want me there, I'm not going to continue to go back.*
>
> *There are some members of staff that I've come across where they do things in a certain way and will not have everything* [anything] *done differently and they're quite rude about the way you might have done something that doesn't suit them, and that would actually put me off helping.*

Nursing aides described literally removing themselves from a non-supportive work environment.

> *They weren't being fair. I got out of that situation.*
>
> *All I have to do is get up and go where I want to be. Because after awhile, I don't want to be there.*

Participants also avoided social functions intended to show appreciation if they perceived

support from management wasn't given on an ongoing basis.

> *You cannot throw an event once a year where you have not appreciated your staff all year long and expect there to be a turn out. No definitely not.*

Frustration

Frustration was evident when nursing aides felt they had no control over things occurring at work. This included how they perceived they were treated by co-workers in higher positions, and repetitive routines in the job.

> *It's quite frustrating... a lot of the RN's around here, they're too busy worrying about paperwork and they don't want to get their hands dirty like we do as NA's. They just think that they are either paid too much or they're too good for that kind of job. And it's really frustrating because if the LPN is gone, and all the other NA's are gone – they're busy doing something, you need that RN there. And they're not there for you then you're stuck.*

> *Same routine over and over again... you see different people all the time ...but you're doing the same tasks and you deal with the same behaviours over and over again and you get frustrated. So it is nice when there is support there.*

Feelings of frustration resulted when nursing aides perceived support was not given equally to staff on all shifts.

> *It does seem like days are considered first ...I don't feel there is any fairness.*

Frustration also arose when they perceived that their concerns were not being heard by their supervisors, or when they felt personally degraded.

> *I think very frustrated and it really dropped morale ... we're doing the majority of the work and have no input on things.*

> *Nobody wants to participate. I mean lots of the NA's were very frustrated because they were belittled half the time.*

Feeling disconnected

Nursing aides who felt disconnected did not have a sense of belonging to their team. They described feeling separate from the work group. Participants who experienced

non-supportive behaviours felt under-valued and segregated from the other nursing staff (ie. NA's, LPN's and RN's). Working as a casual nursing aide often led to feeling detached from colleagues.

> *You don't feel like a team member...*
>
> *...the nursing attendants were not that important...*
>
> *...basically you're the lowest of the low when you work as an NA and you're casual...*

Feeling disconnected from co-workers also occurred where staff worked on different shifts but didn't know each other besides crossing paths at work.

> *Because they're all just names on lists and we mean nothing to each other really.*

Feeling sub-servient

Feeling sub-servient included feeling inadequate, incompetent, and that one is there to be a servant. Four of the nine participants described feeling they were treated in a sub-servient manner due to differences in education, salary and job tasks. Feeling this way resulted in expressions of bitterness and resentment.

> *I just feel, well almost inadequate, or, I just feel like I'm incompetent, or I'm just there to do her grunge work or her dirty work. And that's not what I'm there for.*
>
> *... like a lot of work goes into being an NA but the wage is a huge thing ... I know the responsibility of an RN is huge, but sometimes the work the NA's feel they do – and it is huge, is a lot. And it is sad, and it totally does create a hierarchy ...*

Burnout

Burnout was described as not wanting to go to work due to feeling tired, emotionally drained, and unappreciated. Nursing aides attributed their burnout to heavy workloads and receiving no positive feedback or assistance from management.

You can't give and give and give and get nothing in return. Eventually that will burn you out and become tiring. Eventually you will wake up and say I really don't want to go to work today.

... I turned around and said I am burnt out. I am doing ten people by a quarter to nine with no help and support from any of the management which – they're all over the building. They don't appreciate me nor the people that I work with. I know that they've treated me really good and given me a lot of opportunities but it's not enough.

Contextual Influencing Factors

An analysis of the contextual influencing factors examined the background and surrounding environment in which perceived supportive and non-supportive co-worker behaviours occurred. Information from initial observations of the setting prior to the interviews, interview data, and subsequent participant observations were examined to further understand the concept of support in the workplace. Three main categories of contextual influences that impacted the perceptions of co-worker behaviours were identified: milieu, rank, and workload assignment.

Milieu

Milieu, defined as the social environment of the work setting, was identified as a leading influencing factor in whether co-worker behaviours were perceived as supportive or non-supportive. Three components of the milieu influenced the nursing aides' perceptions: the individual personalities of co-workers, the specific unit in the facility, and the organizational climate.

Individual personalities

The differentiating factor between co-workers who were supportive and those who were not was the individual co-worker's personality. Participants felt the ability to be supportive came from within the individual – it was part of their character. Individuals

with the right attitude, who had energy and enthusiasm, or who liked working as partners were perceived to have supportive behaviours.

> *Simply because of personalities actually...anybody that has helped me, they don't actually necessarily have had to help me but it's their attitude, and I know that they would help me.*
>
> *I think it comes from within- the person's personality. If they're an energetic person and have enthusiasm then they're help you regardless of how long they've been working there.*
>
> *I have noticed that even when I work days or evenings, some staff really like the teamwork or the partner concept.*

The ability to remain calm during a crisis was a personality trait observed in co-workers that led to nursing aides perceiving their assistance as supportive.

> *She was calm. She kept me calm because I was panicky like I just didn't know...that's all she did was keep me calm and assured me that it wasn't my fault.*

Nursing aides noted the consistency in co-workers with supportive behaviours: either a colleague was always helpful or they were never helpful.

> *It's pretty consistent actually. The ones who are usually helpful, continue to be helpful, and the ones who aren't ... never were.*

<u>Specific unit</u>

Some units were identified as being more supportive than others. The atmosphere or tone on the unit explained the difference between units perceived to be supportive and those perceived to be non-supportive by nursing aides. A supportive unit had a relaxed environment with happy friendly staff who were willing to help.

> *It was a very relaxed environment and it was a – maybe it just reduced stress and helped us to get to know each other a little bit more.*
>
> *It's a social floor. I find it's – everybody's social, happy, joking around. And it's a great floor to work on.*

On the other hand, a non-supportive unit was one where staff were known to not treat

casual nursing aides well and weren't willing to pitch in.

> *On a different unit that's been known to not treat casual staff very well - I've just been stressed out because I'm running way behind.*
>
> *They are a funny group actually that way. They aren't willing to pitch in if you ask.*

Organizational climate

Organizational climate refers to the tone within the whole organization and is usually set by managerial processes and policies. Management conduct that greatly influenced the atmosphere in the centres included ways of communicating with staff and methods used in handling problems. At the unit level, supervisors had the most influence on shaping the organizational climate.

Nursing aides' perceptions of how they felt they were treated by supervisors and management influenced their perceptions of supportive and non-supportive behaviours in the workplace. For example, participants' perceptions of how genuine supervisor and management appreciation was impacted how supportive they felt recognition events for staff were. Appreciation shown by management required backing to evoke any credibility from nursing aides.

> *You have to feel it. It just can't be said – with no backing... I mean you have to feel that you're appreciated.*
>
> *Free stuff isn't that important if you really feel that you're not being appreciated.*

Nursing aides in Alberta's continuing care centres joined a labor union to represent them in the contract bargaining process several years ago. The presence of the union had an effect on nursing aides' perceptions of the organization's climate. The union provided a process for disciplinary actions, and its existence changed how staff felt they were treated by supervisors.

Things are talked out a lot. They can't just haul you into the office and tear a strip off you anymore without the union actually sitting there listening in on it all. Oh I am really glad we have a union I'll tell you.

Management's openness to nursing aides' ideas and the sense of belonging the nursing aides felt within the organization influenced how management's behaviours were perceived.

We're changing our unit and everybody is to be there to say this will make my unit too heavy or that unit over there is too light. So everybody is going to have input as to what will work best...*It's our meeting.*

Position Classification

Nursing aides' co-workers belong to one of three position classifications: NA, LPN or RN. Most of the duties of LPN's and NA's are at the bedside and include providing direct patient care, whereas the duties of RN's are at the desk and include coordination and supervision of staff, communicating with all care providers, and managing the overall care of the patients. Thus, nursing aides generally go to another NA or an LPN first for assistance. The researcher concluded that because this is an expected part of being an NA or LPN, less expectation is placed on these positions for responding to a request for help: they are just supposed to do it. This was verified during participant observation in the setting.

RN's

Staff sitting at the desk were perceived to not be working as hard as those at the bedside and therefore were expected to provide help when needed.

I look down the corridor and there might be two RN's sitting there, and at the same time they're calling for one of us to go and attend to somebody that needs something very simple and straight forward and that – it would be so great if sometimes they could get up and do it.

Segregation between the positions, which nursing aides felt existed, may have over-shadowed their perceptions of support. The participants referred to a hierarchy among the positions. References to who exhibited supportive behaviours usually came from NA's and LPN's. Occasionally, specific RN's would be described as being supportive.

There's totally a hierarchy among like the NA's, and the LPN's and the RN's.

The same clasifications of workers sitting together for meals was consistently observed during the shadowing of nursing aides.

> *The RN's from every unit sit together and some- the LPN's and the NA's might mix, but it's usually pretty like – categorized.*

Some participants described having favored relationships with co-workers of a higher position (ie. LPN's or RN's). This influenced the nursing aides' perceptions of support from that rank or individual. Nursing aides who felt they were an RN's pet or were well liked reported getting more support from these colleagues. Consequently, nursing aides who indicated there was no favoritism towards them, perceived less supervisor support.

> *I've seen that it's a great thing to find yourself favored, you know by RN's, because they can make your job a little bit easier.*

> *People that were liked or that management liked were acknowledged...another event would come up for somebody else where there would be no potluck.*

Casual NA's

Casual NA's do not have a permanent position on a specific unit and were scheduled to work on any of the three shifts on any of the units. Participants consistently described the position of a casual NA as being at a disadvantage. The worker initially was unfamiliar with the patients and the routine, thus needed more information. They were not always known by the regular staff and therefore were not always viewed as capable by

their colleagues. Casual nursing aides felt they were the lowest on the scale. Being in a position that required more help, and which was perceived by staff to be inferior to their's, may have resulted in casual nursing aides perceiving co-worker behaviours differently. For example, a colleague intending to be helpful may be perceived as being bossy by a casual nursing aide unfamiliar with their colleague's personality.

> *You even get lower and lower- if you're regular, part time or casual ...basically you are the lowest of the low when you work as an NA and you're casual because you don't know a lot.*

Workload Assignment

The amount of work and how it was assigned over shifts affected the perceptions of support. The shift and even distribution of work among staff influenced workload assignment. The majority of workers on a unit were NA's; as well there were usually two LPN's and two RN's for the day shift. There were fewer staff in all positions on evening and night shifts. In some facilities, a RN covered more than one unit on an evening shift, and therefore was responsible for over seventy residents. The RN usually oversees the whole centre on night shift.

Shifts

Individual work assignments differ on the day, evening and night shifts. On days and evenings, individual assignments are given where one nursing aide provides care for a number of patients, whereas on nights, three staff on the unit share all the patient care. On the night shift, the norm is that co-workers accomplish the tasks as a team working side-by-side, whereas on days, nursing aides work autonomously and when they require help with daily tasks they must look for assistance. Because more teamwork occurs on nights, perceptions of support varied between night and day staff as the norm on nights is that

everyone helps each other - that is the way the work is done. Co-workers on the night shift who didn't follow the norm by working as partners were perceived to be non-supportive.

> *We work more as a team at night because we are only three staff.*
>
> *Because there's so few of us you pretty much have to be supportive, kind of have the teamwork.* [NA working night shift]
>
> *And so you are sort of autonomous in a way that you are off on your own with six or seven people to go find a team player.* [NA working day shift]

Nursing aides on the night shift perceived less management support being available to them than did day staff. This was due to important things happening on the day shift: care managers, the RN's who managed the units, were physically present, and this was when meetings were held and social events occurred.

> *On nights, we have complained for years because we always felt nights was the lower rung on the ladder concerning the whole shift thing because everything is planned for days.*

Because the roles of LPN's and RN's expanded on the night shift due to covering more units and holding more responsibilities, the nursing aides' expectations to receive support from them was less than it was on the day shift.

> *LPN's – they really don't help with rounds and stuff because they float for the whole floor and there's 100 people so they don't really have time to help with the rounds and things.*
>
> *It depends on the nurse ... they have some other things to do too...*

Equity

Even distribution of the work resulted in perceived fairness amongst co-workers. Supervisor's actions were perceived as supportive when assignments were changed to balance the workload. Changes would be made if patient care in a group became heavier or if a worker was ill and subsequently was absent from a shift.

Some people if their group is a little too heavy, we'll try and change the residents around a bit in the groups.

Even if they were short for a day we have to divide up another person's group because they are not there. She'll try to look at who has the easiest group... They're usually really good about that because the RN's take control.

Summary

There is notable variation in co-worker behaviours and the resulting effects upon nursing aides. Perceived supportive co-worker behaviours often have positive consequences for nursing aides. Conversely, co-worker behaviours that are perceived as non-supportive lead to negative outcomes for these caregivers. The perceptions of these behaviours as supportive or non-supportive are greatly influenced by contextual factors in the work environments where they occur.

In the course of this research, the researcher experienced a tension between the principles of ethnography that involve gaining entry to the field to obtain an insider's perspective of the phenomena being studied and developing the credibility critical to obtaining relevant and adequate data. The ethnographic method required immersion of the researcher as the instrument in the field of interest: the long term care center. The acceptance of the researcher as a cultural member is a precondition to accessing the emic perspective of nursing aides. Reflection upon the process followed to gain entry into the workplace of nursing aides revealed accidental barriers which impeded the establishment of credibility and trust among potential participants. The researcher being introduced to nursing aides on the selected unit by management created the perception that the study was initiated by the agency. Restricting the researcher from providing any assistance with care while observing nursing aides also created a barrier to being accepted into the group, and led to the perception that the researcher was there to monitor the care being provided.

Chapter 5

DISCUSSION

This study identified co-worker behaviours that nursing aides perceived as supportive and behaviours that nursing aides performed intending to provide support to their colleagues. Some perceived and intended supportive behaviours were the same. Caring, being sociable and respecting were perceived as supportive and were provided with the intention of giving support. One could conclude that there was a reciprocating effect as nursing aides exhibited the same behaviours they found to be helpful. No other studies were found that examined supportive co-worker behaviours and nursing aides, or identified personal outcomes for nursing aides as a result of workplace support, or explored the contextual influences on supportive behaviours.

Some of the co-worker behaviours perceived to be supportive by nursing aides in this study were also found to be supportive in a study of Canadian nurses (Smith, 1986; Smith & Varoglu, 1985). Using a phenomenological approach, the researchers determined the meaning of support from open-ended interviews with 49 registered nurses working in extended care and 14 nurses working in a hospice unit. The meaning of support among extended care and hospice nurses appears to overlap with nursing aides' perceptions of supportive co-worker behaviours. Extended care nurses and the nursing aides in this study work in similar environments although their roles in providing the care differ. Hospice nurses and nursing aides also share some of the same issues in their work: one example is that both deal with death on a consistent basis. Consistent findings between the two studies included: encouragement, (team) cooperation, and assistance, which were perceived as supportive behaviours by both groups of nurses and by nursing aides.

Guidance [nurses] and teaching [nursing aides] are similar behaviours, and listening [nurses] may be perceived as caring and respecting [nursing aides]. Review of the quotations cited in the article and included in the current study shows that slightly different labels were given to similar categories. In qualitative research, although different categories may be developed from similar data by different researchers, similarity in findings provides confirmation of the phenomenon.

In the current study with nursing aides, receiving help with patient care and nursing tasks was perceived as the most important supportive behaviour because this helped them get their work done. This type of assistance is essential for nursing aides because their workloads are demanding and most patients require two-person transfers. The dual findings of perceived and intended co-worker support in this study are similar to Smith & Varoglu's research (1985), which identified the kind of support hospice nurses received and what they expected to happen when they needed support. Interestingly, the categories for received and expected support were found to be the same. Availability and assistance of another nurse was the most frequent category, followed by the opportunity to talk and be listened to; next was encouragement and reassurance, and getting a break from the situation was the last. To provide support, the nurses reported giving their colleagues concrete physical help with their workloads, followed by being available for listening and talking, and to a lesser extent, checking in on and reassuring colleagues.

After helping and cooperating behaviours, co-worker actions with an emotional aspect, such as caring, respecting and being sociable, were the next group of behaviours that nursing aides perceived as being supportive. Similar results were revealed in a grounded theory study of nurses' perceived support needs (Hartrick & Hills, 1993), where

the most frequently reported support need among 28 Canadian acute care staff nurses was help with physical tasks, then understanding and listening. Consultation and problem solving were next, followed by positive recognition or acknowledgement. A need for extra support services and a clinical coordinator was listed, as were a need for clear roles and policies, and input into changes. Finally a support group for staff nurses and physical changes in the work environment were seen as support needs. As in the current study, after getting the help with patient care, perceived supportive behaviours or support needs became more emotionally-related. Some of the acute care nurses' perceived support needs, in Hartrick & Hills' study (1993), such as the need for consultation and problem-solving and the need for extra support services and a clinical coordinator, could be attributed to their position and circumstances at work, as the acuity of their patients is higher and their scope of responsibilities is broader. The focus of care and workplace circumstances affecting support needs for nurses and nursing aides is evident as not all behaviours that nursing aides perceived to be supportive were identical to those acute care nurses perceived as their support needs.

It is important to acknowledge that there are similar supportive behaviours for all nursing personnel as they are faced with some of the same stressors and challenges in their care-giving roles. But, different types of patients and work environments have unique characteristics which change nurses' and nursing aides' needs and the dynamics of support at work. Comparing findings from the two groups of nursing personnel shows some similarities but also confirms that the amount and type of support needed is based on individual differences as well as on characteristics of the situation (Norbeck, 1982).

Non-supportive Behaviours

Non-supportive behaviours in this study were mirror –like images of some of the supportive behaviours. Withholding help was the opposite of helping. Being rude and ignoring were mirror images of being sociable and respecting. No studies were found that described the characteristics of non-supportive behaviours. Identifying the non-supportive behaviours and realizing that they are opposite to the supportive behaviours adds to the value of the findings as it enables those working in the setting at all levels to be more aware of the dynamics of support.

Personal Outcomes

This study looked at what nursing aides described as personal outcomes resulting from supportive co-worker behaviours. The rich descriptions obtained in the interviews provided participants' personal accounts of how support from colleagues at work benefited them as individuals. These positive findings are congruent with other research in which social support has been positively linked to nursing aides' physical health (Trainor, 1994), and mental health (Bennett et al, 2001); and negatively associated with burnout (Chappel & Novak, 1992; Northrop, 1996; Trainor, 1994), or staff turnover (Douglas et al, 1996; Holz, 1982; Grau et al, 1991; Sheridan, 1985) among nursing aides.

Nursing aides in this study identified an increase in self-confidence when they perceived behaviours to be supportive; and they reported feeling frustrated and disconnected when behaviours were perceived as unsupportive. The other positive consequences that nursing aides in this study reported - belonging, feeling valued and safe, and enjoyment, may be related to the difference in their position or the type of work setting. Similar findings were found in a study of 30 Canadian acute care registered

nurses' perceptions of support and lack of support in the workplace. Using the critical incident technique, Lindsey & Attridge (1989) identified positive outcomes of support that included heightened self-esteem, greater self-confidence, and a motivation to work to the best of their ability. Although, motivation or lack of motivation were not identified as personal outcomes by the nursing aides in this study, Cohen-Mansfield (1989) found that nursing aides enjoyed their work as a consequence of workplace support. The variation in findings is relevant as it helps us to understand the work environment of nursing aides and their distinct needs for support.

In the current study, perceptions of non-supportive co-worker behaviours resulted in nursing aides feeling disconnected, frustrated, and subservient. Similarily, when acute care nurses were not supported, they described anger, frustration, disinterest and lack of motivation to give optimal patient care. Nursing aides' feelings of sub-servience as a result of behaviours being perceived as unsupportive may be a due to the perception of a hierarchy among personnel in the context of the current study.

Contextual Influencing Factors

Examining the background and environment surrounding the co-workers behaviours assisted in understanding workplace support for nursing aides. Factors at the individual, unit and organizational level influenced the nursing aides' perceptions of behaviours. Personalities of individuals also affected whether their behaviours were perceived as supportive: colleagues perceived as having supportive traits were perceived as willing to provide supportive behaviours. This perception suggests a credibility test based on dependability and consistency existed: nursing aides perceived it had to be "in the person" for them to give it.

The social atmosphere both on the unit and within the organization affected nursing aides' perceptions. Specific care units had reputations of being good to work on because the nursing staff were perceived as being supportive; units that were known to be unsupportive were avoided by nursing aides. Staff on a supportive unit were usually helpful, cooperative, caring, sociable and respecting, whereas staff on a unit that was known to be hard to work on, were often perceived as rude and unsociable. One might conclude that the staff on the unit set the tone, but further exploration is required to determine if the social atmosphere of the unit influenced the staff's behaviours.

In a similar manner, the larger organizational climate affects the atmosphere of an individual unit and co-workers' behaviours as it filters through to the nursing aides' level. A negative organizational climate appeared to impede the perceptions of some behaviours as being supportive. An example was described when management held an appreciation dinner that was poorly attended. Nursing aides did not perceive this event as supportive because they felt the appreciation was not genuine. They inferred this because staff had not received positive feedback or felt that their concerns were not heard on a consistent basis. Understanding the relationship between the perceptions of support and the environmental factors affecting it are paramount in creating a positive workplace.

Although the current study did not address specific needs for support, Smith (1986) found that extended care nurses cited significant changes in the condition of the resident as the primary time when they needed support. The next two most frequent times were when they had to make decisions about residents' care and when they dealt with difficult family problems. Three categories received fourth ranking: when there was friction among the staff, the workload was frantic, or the nurse was feeling rundown. Hospice nurses studied

in Smith & Varoglu's research (1985) reported needing support in three different types of emotionally related activities: emotional involvement with patients, dealing with families who were in crisis or conflict, and responding when deaths were distressing. These studies illustrate the influence of workplace changes for support needed from co-workers. Knowing when nurses perceive support to be needed assists in understanding the stressors of their work and also helps identify contextual influences on behaviours that are perceived as supportive.

In this study, nursing aides frequently described situations where RN's were unavailable to provide support, and some even suggested they felt the reasons were due to differences in roles and status. Most of the co-worker behaviours that nursing aides perceived as being supportive were those of other nursing aides. This may partly be because only a few LPN's and RN's are present on the patient care units in continuing care centers. The study by Lindsey & Attridge (1989) also identified people who provided the supportive or unsupportive actions. Head nurses and staff nurses were most frequently involved and were supportive in the majority of their actions. Physicians were the third most frequently cited and their actions were predominantly unsupportive. Higher nursing administrators were generally unsupportive whereas patients' relatives were entirely supportive. One could draw parallels to the work environments of acute care nurses and nursing aides in that a chain of command exists in which nursing and physicians are generally perceived to be at the top of the hierarchy. The settings have similar power disparities between front line staff and management.

Findings from this study are congruent with earlier research on social support that differentiate four types: emotional, instrumental, informational or affirmational. However

what was not known is "how" social support is provided. This study provides preliminary information on specific actions that are perceived by nursing aides in long term care settings as being supportive. Identification of these perceived supportive behaviours can be used in studies to expand the understanding of social support and burnout and turnover among ancillary nursing staff.

Limitations

A limitation of this study is that the researcher was not able as planned to confirm the findings with the participants through a focus group discussion, although partial confirmation occurred with the shadowing of two nursing aides at their workplace. The researcher being an RN may have hampered the recruitment of participants into the study. Another limitation was the nursing aides in the study all volunteered to be participants, and therefore may not be truly representative of this population. Following the interviews, it was noted that not all ethnic groups working in this occupation came forward to volunteer. The dominance of Caucasian participants provided limited diversity and did not reflect the predominance of immigrant women working as nursing aides in continuing care centers. Attempts to recruit from all ethnic groups working in this field were unsuccessful. Reflecting upon the difficulty encountered in recruiting immigrant nursing aides into this study, the researcher would suggest the use of a research assistant or former nursing aide from a similar ethnic background to act as a cultural broker to help foster trust in the research process. Guaranteed anonymity was a key concern for most of the participants, and it is a possible reason why ethnic diversity in the participant group was not attained. The process that was followed to introduce the researcher into the workplace may also have impeded recruitment of participants from all ethnic groups. Hence, the principles of

ethnography should be carefully considered when determining who can best assist the researcher in gaining entry into the culture being studied so that credibility and trust among potential participants is established.

Nevertheless, the strengths of this study were that the findings came directly from nursing aides' descriptions of supportive and non-supportive behaviours and the research focused solely on the experiences of nursing aides working in one particular work environment. The use of semi-structured interviews enabled participants to provide explicit details of events and open expressions of feelings which resulted in clearer interpretation of their meaning. The initial observation period in the setting and subsequent shadowing of nursing aides allowed the collection of data needed to understand and confirm the influencing factors affecting the context in which the behaviours being focused upon occurred. The selected methodology provided the emic perspective sought.

Implications

Findings from this study lay the foundation for additional studies on nursing aides and support in their workplace. A study that differentiates co-worker positions (ie. NA, LPN, RN, manager) and their supportive behaviours would confirm and extend the findings of this study. Further research is also needed to determine the types of relationships between the identified supportive behaviours of co-workers and the personal outcomes. The influence of perceived support on quality of care provided by nursing aides needs to be explored as this study did not reveal any data focusing on this. A study should also be conducted that includes comparison between NA's, LPN's and RN's working in continuing care to explore the variations in expectations for support from colleagues, and examine the impact of the shift worked and tasks assigned to each. Additional research is

required to understand the influence of workplace milieu on social support to determine the degree of significance of perceived supportive behaviours from the individual, unit and organizational levels. Lastly, further research is required on the contextual factors identified in this study which influenced the nursing aides' perceptions of supportive behaviours to more fully understand the impact of the work environment on support. As workplace settings expand for nursing aides into acute care settings, variations in work environments and subsequent support needs for nursing aides should be studied.

There are many personal and organizational level implications for practice that arise from this study. Co-workers including NA's, LPN's and RN's need to be aware of the positive influence on NA's when they perceive their colleagues to be supportive. It is important that colleagues be informed of the specific behaviours that are perceived to be supportive and be encouraged to work as partners. RN's specifically need to be sensitive to the perception of a hierarchy among the staff positions and attempt to dispel it by their own daily interactions with staff. RN's also need to be attentive to the differences in support needs for nursing aides on all three shifts, and the impact of workload assignments on perceived needs.

Results from this study also have implications at an organizational level. Foremost, an increased awareness by upper management of how perceived support from their level influences nursing aides can promote ongoing genuine support on a consistent basis from supervisory staff and management. Recognizing that the atmosphere within the organization as well as on each unit affects staff on the front line will be useful for all levels of management in a variety of ways including how interpersonal staff issues are handled and how appreciation and recognition of staff is shown. Management need to

provide a voice for nursing aides within their organization and respond to their feedback and concerns. Knowledge of which co-worker behaviours are perceived to be supportive will aid management in planning staffing assignments and selecting appropriate staff.

A unique and significant contribution of this study is that there is an increased awareness of the influence of the organizational climate at both the organizational and unit levels on nursing aides' perceptions of their co-workers' behaviours. The complex dynamics in interpersonal relationships among colleagues and between categories of nursing staff influences how actions are perceived, which in turn influences whether the outcomes experienced by the recipients of the behaviours are positive or negative. Nursing aides' perceptions of not having a voice on work-related concerns, of there being a hierarchy among staff positions, of colleagues on one shift being more supported by supervisors than on another shift, all impact the organizational climate. Equally, being respected for ones' ability to provide quality care, ensuring fairness and evenness in work assignments, and sharing a break together, can influence nursing aides' perceptions of the organizational culture where they work.

Conclusion

As there were no other studies known to identify co-worker behaviours perceived to be supportive by nursing aides, the distinct contribution of this study was that it focused solely on nursing aides' perceptions of supportive co-worker behaviours and identified the personal outcomes for nursing aides when co-worker behaviours were perceived as supportive. The study findings portrayed the importance of contextual influencing factors, such as milieu and position classification, on nursing aides' perceptions of supportive behaviours in their work environment.

References

Ahlberg-Hulten, G. K., Theorell, T., & Sigala, F. (1995). Social support, job strain and musculoskeletal pain among female health care personnel. Scandinavian Journal of Work, Environment and Health, 21, 435-439.

Astrom, S., Nilsson, M., Norberg, A., Sandman, P., & Winbald, B. (1991). Staff burnout in dementia care - relations to empathy and attitudes. International Journal of Nursing Studies, 28, 65-75.

Atchison, J. H. (1998). Perceived job satisfaction factors of nursing assistants employed in Midwest nursing homes. Geriatric Nursing, 19 (3), 135-137.

Barber, C. E., & Iwai, M. (1996). Role conflict and role ambiguity as predictors of burnout among staff caring for elderly dementia patients. Journal of Gerontological Social Work, 26, (1/2), 101-116.

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. American Journal of Community Psychology, 14 (4), 413-445.

Beehr, T. A., King, L. A., & King, D. W. (1990). Social support and occupational stress: Talking to supervisors. Journal of Vocational Behavior, 36, 61-81.

Beehr, T. A., & McGrath, J. E. (1992). Social support, occupational stress and anxiety. Anxiety, Stress and Coping, 5, 7-19.

Bennett, P., Lowe, R., Matthews, V., Dourali, M., & Tattersall, A. (2001). Stress in nurses: coping, managerial support and work demand. Stress and health, 17 (1), 55-63.

Berkman, L. F. (1984). Assessing the physical health effects of social networks and social support. Annual review of Public Health, 5 ,413-432.

Berkman, L. F. (1995). The role of social relations in health promotion. Psychosomatic Medicine, 57 (3), 245-254.

Blegen, M. A. (1993). Nurses' job satisfaction: a meta-analysis of related variables. Nursing Ressearch, 42 (1), 36-41.

Boumans, N. P. G., & Landeweerd, J. A. (1992). The role of social support and coping behaviour in nursing work: Main or buffering effect? Work & Stress, 6 (2), 191-202.

Bourbonnais, R., Comeau, M., & Vezina, M. (1999). Job strain and evolution of mental health among nurses. Journal of Occupational Health Psychology, 4 (2), 95-107.

Brooks, E. L., Wilkinson, J. M., Bott, M., & Taunton, R. L. (1993). Situational supports and job stress: a correlational study. Nursing Connections, 6 (1), 39-45.

Carter, M. & Phillips, C. (1987). What's wrong with working in a nursing home? An analysis of nurses' comments. Australia Nursing Journal, 16 (11), 49-51.

Cassel, J. (1976). The contribution of social environment to host resistance. American Journal of Epidemiology, 104 (2), 107-123.

Cavanagh, S. J. (1989). Nursing turnover: Literature review and methodological critique. Journal of Advanced Nursing, 14, 587-596.

Chappell, N. L., & Novak, M. (1992). The role of support in alleviating stress among nursing assistants. The Gerontologist, 32(3), 351-359.

Chappell, N. L., & Novak, M. (1994). Caring for institutionalized elders: Stress among nursing assistants. Journal of Applied Gerontology, 13(3), 299-316.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38 (5), 300-314.

Cohen, S. (1990). Social support and physical illness. Advances, 7(1), 35-48.

Cohen, S., & Smye, S. L. (1985). Social support and health. Orlando, FL: Academic Press Inc.

Cohen, S., & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. Psychology Bulletin, 98(2), 310-357.

Cohen-Mansfield, J. (1989). Sources of satisfaction and stress in nursing home caregivers: Preliminary results. Journal of Advanced Nursing, 14, 383-388.

Cohen-Mansfield, J. (1995). Stress in nursing home staff: A review and a theoretical model. Journal of Applied Gerontology, 14(4), 444-467.

Constable, J. F., & Russell, D. W. (1986). The effect of social support and the work environment upon burnout among nurses. Journal of Human Stress, 12 (1), 20-26.

Cronin-Stubbs, D., & Rooks, C. A. (1985). The stress, social support and burnout of critical care nurses: The results of research. Heart Lung, 12 (1), 31-39.

de Jonge, J., Janssen, P. P. M., Van Breukelen, G. J. P. (1996). Testing the Demand-Control-Support model among healthcare professionals: A structural equation model. Work & Stress, 10 (3), 209-224.

Douglas, M. K., Meleis, A. I., Eribes, C., & Kim, S. (1996). The work of auxillary nurses in Mexico: Stressors, satisfiers and coping strategies. International Journal of Nursing Studies, 33 (5), 495-505.

Duquette, A., Kerouac, S., Sandhu, B., Ducharme, F. & Saulnier, P. (1995). Psychosocial determinants of burnout in geriatric nursing. International Journal of Nursing Studies, 32 (5), 443-456.

Duxbury, M. L., Armstrong, G. D., Drew, D. J., & Henly S. J. (1984). Head nurse leadership style with staff nurse burnout and job satisfaction in neonatal intensive care units. Nursing Research, 33(2), 97-101.

Eastburg, M. C., Williamson, M., Gorsuch, R., & Ridley, C. (1994). Social support, personality, and burnout in nurses. Journal of Applied Social Psychology, 24 (14), 1233-1250.

Ellis, B. H., & Miller, K. I. (1994). Supportive communication among nurses: Effects on commitment, burnout, and retention. Health Communication, 6 (2), 77-96.

Estryn-Behar, M., Kaminski, M., Peigne, E., Bonnet, N., Vaichere, E., Gozlan, C., Azoulay, S., & Giorgi, M. (1990). Stress at work and mental health status among female hospital workers. British Journal of Industrail Medicine, 47(1), 20-28.

Farris, G. F. (1981). Groups and the informal organization. In R. Payne & C. Cooper (Eds.), Groups at work (pp. 97-117). Wiley: New York.

Freudenberger, H. J. (1974). Staff burnout. Journal of Social Issues, 30, 159-165.

Garrett, D. K., & McDaniel, A. N. (2001). A new look at nurse burnout: The effects of environmental uncertainty and social climate. Journal of Nursing Administration, 31 (2), 91-96.

George, L. K. (1979). Quality of care in nursing homes: Attitudinal and environmental factors. Durham, NC: Duke University, Centre for the Study of Aging and Human Development.

Grau, L., Chandler, B., Burton, B., & Kolditz, D. (1991). Institutional loyalty and job satisfaction among nurse aides in nursing homes. Journal of Aging and Health, 3, 47-65.

Greenberger, E., Goldberg, W., Hamill, S., O'Neil, R., & Payne, C. K. (1989). Contributions of a supportive work environment to parents' well-being and orientation to work. American Journal of Community Psychology, 17 (6), 755-783.

Guba, E. G., & Lincoln, Y.S. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Halbur, B. T. (1983). Nursing personnel in nursing homes: A structural approach to turnover. Work and Occupations, 10 (4), 381-411.

Hare J., & Pratt, C. C. (1988). Burnout: Differences between professional and paraprofessional nursing staff in acute care and long-term care health facilities. The Journal of Applied Gerontology,7, 60-72.

Hare, J., Pratt, C. C., & Andrews, D. (1988). Predictors of burnout in professional and paraprofessional nurses working in hospitals and nursing homes. International Journal of Nursing Studies, 25(2), 105-115.

Hare, J. & Skinner, D. A. (1990). The relationship between work environment and burnout in nursing home employees. The Journal of Long-term Care Administration, Fall, 9-12.

Hartrick, G. A., & Hills, M. D. (1993). Staff nurse perceptions of stressors and support needs in their workplace. The Canadian Journal of Nursing Research, 25 (1), 23-30.

Heaney, C. A. (1991). Enhancing social support at the workplace: Assessing affects of the caregiver support program. Health Education Quarterly, 18 (4), 477-494.

Heine, C. A. (1986). Burnout among nursing home personnel. Journal of Geronotlogical Nursing, 12(3), 14-18.

Henderson, M., & Argyle, M. (1985). Social support by four categories of work colleagues: Relationships between activities, stress and satisfaction. Journal of Occupational Behaviour, 6 (3), 229-239.

Holtz, G. A. (1982). Nurses' aides in nursing homes: Why are they satisfied? Journal of Gerontological Nursing, 8,(5), 265-271.

House, J. S. (1981). Work stress and social support. Reading, MA: Addison - Wesley.

House, J. S., Landis, K. R., Umberson, D. (1988). Social relationships and health. Science, 241, 540-545.

Hupcey, J. E. (1998). Social Support: Assessing conceptual coherence. Qualitative Health Research, 8(3), 304-319.

Israel, B. I., & Rounds, K. A. (1987). Social networks and social support: A synthesis for health educators. Advances in Health Education and Promotion, 2 , 311-351.

Janssen, P., de Jonge, J., & Bakker, A. B. (1999). Specific determinants of intrinsic work motivation, burnout and turnover intentions: A study among nurses.

Journal of Advanced Nursing, 29 (6), 1360-1369.

Jones, W. (1980). The staff burnout scale for health professionals. London House: Park Ridge, IL.

Josephson, M., Vingard, E., & MUSIC Norrtälje Study Group. (1998). Workplace factors and care seeking for low-back pain among female nursing personnel. Scandinavian Journal of Work, Environment & Health, 24 (6), 465-472.

Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment roles and social support. In B. P. Baltes, & O. G. Brims (Eds.), Life span development and behavior (pp. 253-285). Orlando, FL: Academic.

Karasek, R. A., Theorell, T., Schwartz, J. E., Schnall, P. L., Pieper, C. F., & Michela, J. L. (1988). Job characteristics in relation to the prevalence of myocardial infarction in the U.S. health examination survey (HES) and the health and nutrition examination survey HANES). American Journal of Public Health, 78(8), 910-918.

Koniarek, J., & Dudek, B. (1996). Social support as a buffer in stress - burnout relationship. International Journal of Stress Management, 3 (2), 99-106.

Landsbergis, P. A. (1988). Occupational stress among health care workers: A test of the job demands-control model. Journal of Organizational Behavior, 9, 217-239.

Leiter, M. P. (1988). Commitment as a function of stress reactions among nurses: A model of psychological evaluations of work settings. Canadian Journal of Community Mental Health, 7 (1), 117-133.

Leiter, M. P., & Meecham, K. A. (1986). Role structure and burnout in the field of human services. The Journal of Applied Behavioral Science, 22 (1), 47-52.

Lindsey, E., & Attridge, C. (1989). Staff nurses' perceptions of support in an acute care workplace. The Canadian Journal of Nursing Research, 21 (2), 15-25.

Lobb, M. & Reid, M. (1987). Cost-effectiveness at what price? An investigation of staff stress and burnout. Nursing Administration Quarterly, 12 (1), 59-66.

Mallett, K. L. (1988). The relationship between burnout, death anxiety and social support in hospice and critical care nurses. Unpublished doctoral dissertation, University of Toledo, Ohio.

Maslach, C. (1976). Burned-out. Human Behaviour, 5, 16-22.

Maslach, C. (1982). Burnout: The cost of caring. Englewood, NJ: Prentice-Hall.

Maslach, C., & Jackson, S. E. (1981). Maslach burnout inventory manual. Palo Alto, CA: Consulting Psychologists Press.

McAbee, R. (1991). Occupational stress and burnout in the nursing profession. AAOHN Journal, 39(12), 568-575.

McIntosh, N. J. (1991). Identification and investigation of properties of social support. Journal of Organizational Behaviour, 12, 201-217.

Morano, J. (1993). The relationship of workplace social support to perceived work-related stress among staff nurses. Journal of Post Anesthesia Nursing, 8 (6), 395-402.

Mor-Barak, M. E. (1988). Social support and coping with stress: Implications for the workplace. Occupational Medicine, 3(4), 663-676.

Morris, H. H., & Snyder, R. A. (1979). A second look at the need for achievement and need for autonomy as moderators of role perception-outcome relationships. Journal of Applied Psychology 64, 173-178.

Morse, J.M., & Field, P.A. (1995). Qualitative research methods for health professionals (2nd ed.). London: Sage.

Motowidlo, S. J., Packard, J. S., & Manning , M. R. (1986). Occupational stress: Its causes and consequences for job performance. Journal of Applied Psychology, 71(4), 618-629.

Mowinski-Jennings, B. (1987). Social support: A way to a climate of caring. Nursing Administration Quarterly, 11(4), 63-71.

Newman, J. E. (1974). Predicting absenteeism and turnover: A field comparison of Fishbein's model and traditional job attitude measures. Journal of Applied Psychology, 59(5), 610-615.

Norbeck, J. S. (1982). The use of social support in clinical practice. Journal of Psychiatric Nursing and Mental Health Services, 2012, 22-29.

Northrop, L. M. E. (1996). Stress, social support, and burnout in nursing home staff. Unpublished doctoral dissertation, West Virginia University, West Virginia

Oehler, J. M., Davidson, M. G., Starr, L. E., & Lee, D. A. (1991). Burnout, job stress, anxiety, and perceived social support in neonatal nurses. Heart Lung, 20(5), 500-505.

Ogus, E. D. (1990). Burnout and social support systems among ward nurses. Issues in Mental Health Nursing, 11, 267-281.

Pisarski, A., Bohle, P., & Callan, V. (1998). Effects of coping strategies, social support and work-nonwork conflict on shift worker's health. Scandinavian Journal of Work, Environment & Health, 24 (suppl 3), 141-145.

Price, J. L. (1977). The study of turnover. Ames, Iowa: Iowa State University Press.

Quittner, A. L., Glueckauf, R. L., & Jackson, D. N. (1990). Chronic parenting stress: Moderating versus mediating effects of social support. Journal of Personality and Social Psychology, 59(6), 1266-1278.

Ray, E. B., & Miller, K. I. (1994). Social support, home/work stress, and burnout: Who can help? Journal of Applied Behavioral Science, 30(3), 357-373.

Revicki, D. A., & May. H. J. (1989). Organizational characteristics, occupational stress, and mental health in nurses. Behavioral Medicine, 15, 30-36.

Riggs, C. J., & Rantz, M. J. (2001). A model of staff support to improve retention in long-term care. Nursing Administration Quarterly, 25(2), 43-54.

Robinson, S. E., Roth, S. L., Keim, J., Levenson, M., Flentje, J. R., & Bashor, K. (1991). Nurse burnout: Work related and demographic factors as culprits. Research in Nursing & Health, 14, 223-228.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Schmieder, R. A., & Smith, C. S. (1996). Moderating effects of social support in shiftworking and non-shiftworking nurses. Work & Stress, 10(2), 128-140.

Schwandt, T. A. (1997). Qualitative inquiry: A dictionary of terms. Thousand Oaks, CA: Sage.

Sheridan J. E. (1985). A catastrophe model of employee withdrawal leading to low job performance, high absenteeism, and job turnover during the first year of employment. Academy of Management Journal, 28(1), 88-109.

Smith, S. (1986). Support for psychiatric nurses in the workplace. Psychiatric Nurse, 27 (3), 8-10.

Smith, D., & Tziner, A. (1998). Moderating effects of affective disposition and social support on the relationship between person-environment fit and strain. Psychological Reports, 82 (3, Pt 1), 963-983.

Smith, S. P., & Varoglu, G. (1985). Hospice: A supportive working environment for nurses. Journal of Palliative Care, 1(1), 16-23.

Spradley, J. P. (1980). Participant observation. New York: Holt, Rinehart & Winston.

Stansfeld, S. A., Bosma, H., Hemingway, H., Marmot, M. G. (1998). Psychosocial Work Characteristics and Social Support as Predictors of SF-36 Health Functioning: The Whitehall II Study. Psychosomatic Medicine, 60, 247-255.

Statistics Canada. (2001). Profile of the Canadian population by age and sex: Canada ages. [On-line]. Available: www.statscan.ca/english/census01

Streubert, H. J., & Carpenter, D. R. (1999). Qualitative research in nursing: Advancing the humanistic perspective (2nd ed.). Philadelphia, PA: Lippincott.

Stewart, M. J. (1993). Integrating social support in nursing. Newbury Park, CA: Sage.

Stewart, M. J., & Arklie, M. (1994). Work satisfaction, stressors and support experienced by community health nurses. Canadian Journal of Public Health, 85 (3), 180-184.

Stewart, M. J., & Langille, L. (2000). A framework for social support assessment and intervention in the context of chronic conditions and caregiving. In M. J. Stewart (Ed.)., Chronic conditions and caregiving in Canada: Social support strategies (pp. 3-28). Toronto, ON: University of Toronto Press.

Tai, T. W. (1996). The effects of staff 's perceptions of social support systems on turnover behavior. Unpublished doctoral dissertation, Texas A & M University, Texas.

Tai,T. W., Bame, S. I., & Robinson, C. D. (1998). Review of nursing turnover research 1977-1996. Social Science & Medicine, 47 (12), 1905-1924.

Trainor, P.A. (1994). Employee/job characteristics and manifestations of job strain in nursing assistants working in long-term-care facilities. Unpublished doctoral dissertation, New York University, New York.

Viswesvaran, C., Sanchez, J.I., & Fisher, J. (1999). The role of social support in the process of work stress: A meta-analysis. Journal of Vocational Behaviour, 54 (2), 314-334.

Walters, V., Lenton, R., French, S., Eyles, J., Mayr, J. & Newbold, B. (1996). Paid work, unpaid work and social support: A study of the health of male and female nurses. Social Science Medicine, 43 (11), 1627-1636.

Waxman, H. M., Carner, E. A., & Berkenstock, G. (1984). Job turnover and job satisfaction among nursing home aides. The Gerontologist, 24 (5), 503-509.

Wethington, E., & Kessler, R. C. (1986). Perceived social support, received support, and adjustment to stressful life events. Journal of Health and Social Behavior, 27, 78-89.

Appendix A

Research Study: Behaviours of Co-Workers Which Nursing Aides Perceive As Being Supportive

Researcher: Mariann Rich
Candidate, Masters in Health Promotion Studies
University of Alberta
Phone: 780-434-9950

Supervisor: Dr. Anne Neufeld
Professor, Faculty of Nursing
University of Alberta
Phone: 780-492-2699

The purpose of this study is to identify behaviours of co-workers which nursing aides working in continuing care centres perceive as being supportive. It is anticipated results from this research will identify ways to create supportive work environments for nursing aides.

You will be interviewed once. The interview is expected to last up to one hour in length. The interview will be taped. You may choose to have the interview either at your home, at the University of Alberta, or during a scheduled work shift in a private meeting room in Capital Care Grandview. The time will be pre-arranged between yourself and the interviewer and will accommodate your work schedule. You will be asked to describe situations when you felt supported by co-workers. You will be asked about specific behaviours of your co-workers which made you feel supported. You will be asked if you are willing to have the researcher shadow you on one of your shifts after the interview to observe helpful interactions. You can choose to participate in the interview only and not have the researcher shadow you.

The interview will be typed out in full, without your name or the names of any co-workers you mention. Your name or names of co-workers will not appear in any reports of the study. Code numbers will be used to identify the interviews, and all documents will be kept in a locked cabinet. Upon completion of the study, the information will be kept for a period of seven years in a locked cabinet, and then it will be destroyed.

Your participation in this study is voluntary. You may refuse to answer any questions during the interview and may withdraw from the study at any time. To indicate your intent to volunteer as a participant in this study, you can leave a message with your name and home phone number at this number: **434-9783**. Only the researcher will have access to this information. You will be contacted by the researcher for the interview over the next two to three months. At the interview you will be given a consent form. Your signature is required for you to participate in this study. You will receive a copy of the consent.

Appendix B

Nursing Attendants

- I would like to talk to you about how others are helpful in your work
- $20.00 available for each volunteer
- One hour confidential interview at time and place of your choice
- Call Mariann Rich, University of Alberta, at **434-9783**

Appendix C

Nursing Attendants

- I would like to talk to you about how others are helpful in your work
- group interview with nursing aides
- one hour interview in private meeting room here or at the University of Alberta
- $20.00 given to each volunteer
- call Mariann Rich @982-3616 and leave your name and home phone number

Appendix D

Consent For Participation in Interview

Title of Project: Behaviours of Co-Workers Which Nursing Aides Perceive As Being Supportive

Principal Investigator: Mariann Rich
Candidate, Masters in Health Promotion Studies
University of Alberta
Phone: 780-434-9950

Supervisor: Dr. Anne Neufeld
Professor, Faculty of Nursing
University of Alberta
Phone: 780-492-2699

To be completed by the research subject.

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from this study at any time? You do not have to give a reason and it will not affect your employment.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____
I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in this study and voluntarily agrees to participate.

_____ _____
Signature of Investigator Date

Appendix E

Interview Questions

1. Tell me about a time in your work as a nursing aide when you felt significantly supported. (Who was involved? What did they do? How did you feel?)

2. I would like to know about the things you do for co-workers to help them. Do you direct certain actions to certain individuals? What specific actions do you do for these people? (Tell me more about the relationship you have with these people.)

3. Describe what you think ideal support would be like at work. (What kinds of things would be happening? What would people do for each other? What are the most important things?)

4. Are there any other thoughts you have about support from co-workers that you would like to talk about?

Appendix F

Demographic Data

1. What is the total number of years or months that you have been employed as a nursing aide?

   _____ months or _____ years

2. What is the number of years or months that you have been employed as a nursing aide at this facility?

   _____ months or _____ years

3. Which shift(s) do you work on a regular basis? Mark with an X.

   Days _____

   Evenings _____

   Nights _____

4. What is your employment status? Mark with an X.

   Full Time _____

   Part Time _____

   Casual _____

   If casual, approximately how many hours a week do you work? _____

5. What is your age? _____ years

6. Please circle your gender: Male Female

7. Please circle your marital status.

   Single Married Divorced Separated

8. What is your highest level of education? _____

Appendix G

Consent For Researcher to Accompany Nursing Aide on His or Her Shift

Title of Project: Behaviours of Co-Workers Which Nursing Aides Perceive As Being Supportive

Principal Investigator: Mariann Rich
Candidate, Masters in Health Promotion Studies
University of Alberta
Phone: 780-434-9950

Supervisor: Dr. Anne Neufeld
Professor, Faculty of Nursing
University of Alberta
Phone: 780-492-2699

To be completed by the research subject.

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from this study at any time? You do not have to give a reason and it will not affect your employment.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to your records?	Yes	No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____

Signature of Research Participant Date Witness

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in this study study and voluntarily agrees to participate.

_____ _____

Signature of Investigator Date