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Bullying and Threats to Belonging: Cultural Challenges in Rural and Remote Nursing Practice

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ABSTRACT

Aim: *To explore perceptions of clinical leadership by nursing staff in areas of remote and rural parts of New South Wales (NSW), Australia.*

Background: *Bullying and threats to belonging in nursing are not new, with evidence suggesting that bullying behaviours are also evident in rural and remote environments.*

Method: *The methodological approach was qualitative and involved a thematic analysis of interviews from 56 nurses in 14 remote and rural health organisations. Ethical approval was secured, and a standard interview schedule was used, following participant consent.*

Results: *A thematic analysis was employed to code and categorise the interview data using a constant comparative method. The results generated 5 themes. A significant thread within each theme was that of bullying and threats to belonging. This article focuses on this thread and associated issues for rural and remote nursing practice.*

Conclusion: *This study identified that some participants held disproportionate power, due to their close relationships to their local community or because of their longevity in the clinical area. This led to threats to the culture of safety and resistance to change, leading to perceptions or experiences of bullying of new or established staff as they struggled to find a way to belong.*

Implications for Nursing Practice: *There is limited empirical data about the implications and impact of bullying and threats to belonging in rural and remote (R&R) areas of practice; this paper adds to the data in this practice domain and supports and confirms previously published findings.*

Practitioners need to recognise the scope and impact that bullying or threats to belonging can have (particularly in R&R areas of practice). This article discusses further evidence of the scope and negative impact of bullying behaviours and offers several recommendations for managers or practitioners to limit or address bullying behaviours. Including: offering more robust educational and clinical support; recognising and limiting bullying; finding ways to bolster staff support; offering appropriate community-focused orientations; implementing of a reward system to support innovation and a positive workplace culture; applying the CRANA plus app and other staff support systems and implementing recruitment and retention strategies and take account of the difficulties faced by new staff moving to R&R environments.

Keywords

Clinical Leadership, Bullying, Belonging, Nursing, Qualitative Methodology.

Introduction

This paper sets out a research study that explored the concept of clinical leadership (CL) from the perspective of nurses employed

in R&R clinical areas, in North-Western NSW [1]. Set out, are the study rationale, the aim, objectives and the significance of the study, the methodology and research process. The body of the paper deals with a thread running through each of the five identified themes; bullying and threats to belonging and is followed by a brief set of recommendations.

Background

A partnership, in place between the Local Health District and the Lead Researcher lead to the establishment of a research study that considered perceptions of clinical leadership in R&R practice environments.

Significance of the study

There are a number of reasons offered that support and justify the initial research;

- Clinical leadership from the perspective of nurses in R&R areas has rarely been studied and is poorly documented.
- When leadership is documented or studied it is often from a management domain, leading to on-going misconceptions about the relationship of leadership to management or clinical/ professional functions.
- It is appropriate to document the culture within R&R nursing practice that seemed to describe or foster bullying and threaten belonging.

Aim / Objectives

This research aimed to explore how the CL was perceived by nurses in R&R environments of New South Wales, Australia. While not a primary objective of the study, aspects of bullying and threats to belonging were seen as having a significant impact on R&R culture and practice and feature as the main focus of this paper.

Literature Review

A search for papers dealing with clinical leadership and R&R nursing practice was conducted in parallel with the initiation of the research study. An integrative literature review [2] was used to search prior published literature. In total 29 studies or review publications linked to CL were identified.

Several previously published studies were identified that described the attributes of clinical leaders, definitions of clinical leadership, models to support an understanding of clinical leadership, the key aspects of clinical leader activity and barriers or factors that hindered effective clinical leadership [3-10]. No research describing clinical leadership in a R&R environment were identified. Several publications that detailed a review of previously published research papers on the topic of clinical leadership were also identified [11-14].

Rural and remote practice and bullying

Considering the main thread identified throughout the themes of the study, literature exploring bullying in a R&R context was also sought. There is a significant body of literature exploring and describing bullying or incivility across the spectrum of nursing practice [15-21] and within this there is a strand that focuses on the manifestation of bullying in R&R practice environments [22-24]. Much of this literature describes high levels of bullying in an environment where health workers working in local health or care services know each other and their privacy may not be maintained [23].

Further, access to security or legal services are restricted and access options for alternative employment are difficult or impossible. In addition, in response to an avalanche of phone calls from nurses in R&R areas of Australia, the Council for Remote Area Nurses of Australia (CRANA) plus Bush Support Services developed an App that supports R&R area nurses who needed help to address their concerns over bullying [25].

Methodology

The methodology underpinning the study had a specific phenomenological approach. This involved using interviews, with the aim of discovering the 'lived experiences' of nurses in R&R locations in North-Western NSW as they applied CL [1]. The full research process/design is described in Figure 1.

An interview guide with 19 questions was used to support the direction of each interview. All interviews were recorded. Each started with several demographic questions related to the participant's location, clinical and other experience, length of time as a nurse and specifically working in R&R practice. The clinical environments involved included a mixture of smaller community health centres, R&R hospitals and/or clinics in towns across North-Western NSW, in an area known generally as New England [1].

Fourteen R&R health facilities in North-Western were recruited to the study. Each was selected because of their remote locations and each offered different clinical profiles in terms of the bed capacity and clinical facilities. Senior clinical staff in all the clinical facilities were contacted by phone to arrange at convenient time to engage staff in the interviews. As a result, 56 interviews were undertaken and recorded.

Ethical Approval

Permission to undertake the interviews was sought and secured from the Executive Director of the relevant health district and from relevant senior clinical staff at each location. Formal ethical approval was also secured from the relevant Human Research Ethics Committee on the 28th of June 2017, approval code (17/06/21/5.02) [1].

Data collection

Interviews took place between September and November 2017. One-on-one, semi structured interviews followed a pre-determined interview schedule following a request to sign a consent form and an overview of the participant information sheet. All interviews took place following the study explanation and receiving participants' consent. Interviews generally took place in a quiet room close to the clinical environment. Interviews lasted between 20 and 63 minutes with the average interview time being 36 minutes. In total, the 56 interviews provided over 2016 hours of interview data.

Data Analysis

All interviews were transcribed and printed. The interview transcriptions were analysed by a manual data analysis process. This resulted in a very through exploration of the data with multiple readings of each interview and a process of thematic analysis. The analysis began as soon as the first interview was complete and each recording was reviewed (to ensure it was audible) and to make notes on the general themes evident. This facilitated the process of a constant comparative process [26].

The researcher also took notes on relevant issues in each clinical location. Interview transcriptions were coded to allow participant anonymity. Interviews were thematically analysed to develop several categories and sub-categories. From the themes, patterns were confirmed, and an integrated picture of the data was established. Five main themes were identified: Leadership in Rural and Remote Areas; The Impact of Clinical Leadership in Rural and Remote Areas; Barriers in Rural and Remote Practice; Training and Development Challenges; and Rural and Remote Practice Challenges. In each theme, elements related to the issue of bullying or bullying behaviours and the impact these have across the area of R&R practice were noted.

Limitations

All studies feature potential limitations, this research was no exception:

- A study of clinical facilities further across NSW or indeed that involved other states of Australia may have supported further insights.
- An opportunist interview approach meant that only staff at work on the day of the researcher's visit were present and able to take part in the study.
- It is possible that while the researchers had significant experience and insights into working in R&R areas and of researching in the area of CL. They may still have been identified by study participants as 'outsiders', remote from the interviewees R&R clinical practice areas. Undertaking research as an 'outsider' (26) can mean that there may be some unforeseen impact on the way participants responded to or feel comfortable with the researchers [1].

Results

This paper offers a brief review of the locations and participant details, before providing information and a discussion about the thread related to bullying and threats to belonging that ran through each of the five themes identified.

Locations

The research occurred in 14 R&R health facilities. Of these, 6 were R&R hospitals, 7 were Community Health Centres or Multipurpose Services and 1 was a rural referral hospital. All offered a significant range of clinical and patient services, while only a few offered limited emergency services [1].

Participants

The majority of participants were Registered Nurses (51.7%). About 23% of interviewees were either senior managers or mangers of some description (e.g. Nurse Unit Mangers), and Registered Midwives made up 7.2% of participants, and Enrolled Nurses (EN) encompassed 17.8% of participants.

Nurses interviewed had worked on average 15.5 years, with one participant having worked only 4 months, while the highest length of service was 42 years. About 60% of the interviewees had worked in R&R practice for over 10 years. Of the 10 ENs interviewed, all had worked in R&R clinical practice since their qualification, with 7 of the 10 EN's working in a R&R area for between 10 and 42 years. The few Director of Nursing/Health Service Mangers interviewed had significant R&R clinical practice/service experience with each of them working in a R&R community for over 20 years [1].

Bullying and Threats to Belonging

The interview data offered results in five themes, each was subdivided into several categories and sub-categories to help gain an understanding of the data. However, one thread ran through or across each of the five themes. This was the threat of bullying and the impact of a threat to belonging in R&R clinical environments.

The discussion offers a conglomeration of information from the results that informed the primary aim of the research; to explore CL in R&R practice areas. However, acting as an undercurrent, particularly for new staff or staff with less exposure to R&R practice, bullying and threats to a sense of belonging undermined many of the positive benefits see from effective CL. It is this thread that features in the body of this discussion.

Leadership in Rural and Remote Areas

Most participants recognised that a CL could be "anybody" or "everybody." With several participants indicating that the nature of the clinically focused work engaged by CL's in R&R practice areas means that they are required to be clinical leaders, simply as a result of their leading small local teams closely engaged with clinical practice, most of the time. New staff seemed to pick up on this requirement quickly and being unable to lead clinically or demonstrating only limited aptitude in this domain was a significant deficit and was seen to place the clients or team members at risk. This also placed new staff at risk as they were expected to be, "up to speed, you know, clinically" within weeks of arriving. New staff, faced with this pressure depended on clinical leaders to support them, although many suggested that they occasionally faced poor leaders, with poor attitudes that were, "lazy, rude, unsupportive, blamed others, were bossy, or passed the buck". In addition, some leaders were poor communicators who, "did not listen, gave poor feedback, or were unclear". Poor leaders were also described as, "lacking confidence, didn't care, were incompetent, were not focused on staff or client needs, were out of touch with clinical practice, or panicked", or were, "not connected or engaged with the team". Suggesting that participants viewed poor clinical leaders as having a negative effect on the clinical team by "micromanaging, bagging people out, being inconsistent, not being a good role model and being dishonest, aggressive or inflexible". Many of

these terms were collectively expressed as "bullying behaviours" and were seen to be more evident and more far reaching when the team was small or operated in remote locations [23] and in times when there was limited medical or managerial back up.

Many prior clinical leadership studies [7-9] and studies of bullying behaviours [27-29] suggest that poor CL results when there is poor communication, a lack of confidence, unclear role boundaries, limited clinical experience and clinicians who are not respected. With these issues compounded by "bullying behaviours."

Clinical Leadership's Impact in Rural and Remote Areas

Clinical leaders it seems can have a significant effect on the quality health care and that if CL's are not effective, "in the rural areas… practice may stay the same for many years…" (and that it may not) "get challenged" [1]. Interviewees suggested that to make changes in practice, or to be effective they need to be supported. Support, it was suggested, was a key factor for building and motivating responsive teams [7-9]. Support was recognised as even more pivotal in R&R practice, were medical back up was often limited or lacking, were feedback was sometimes poor and were new staff were frequently required to learn quickly to assume greater autonomy and responsibility. It was clear that many of those interviewed for this study did feel supported by their managers, senior staff, clinical educators and by the teams they worked with. However, some of those interviewed made it clear they had a powerful perception that their isolation meant that clinical staff were, "getting less support than their metropolitan colleagues" [1]. A perception supported by Hills et al. [23], therefore CL's needed to be "more self-reliant." Strong links to the community were often seen to impact positively or hinder the support new staff felt. With support viewed negatively if the close community or long-established staff relationship meant staff perceived any bias or favouritism in terms of who was supported, who was engaged with, or listened too, or promoted. Support from managers in several clinical locations was viewed negatively, with some new staff describing un-welcoming behaviours.

One participant suggested that:
…paving the way for future leaders was difficult…finding clinical leaders who come here and stay and have a connection with the community is an issue…if they don't have a family to anchor them.

About 1/3 of participants commonly felt like they did not belong and were often faced with permanent or long-standing staff who saw them as a threat (bringing in change or threatening their future promotion opportunities). Fear seemed to be the dominant force behind most acts or displays of bullying. Fear of change, fear of "anything new", fear of "outsiders", fear of "difference". New staff often felt safer not speaking up or not reporting issues. Managers were sometime seen as either the bully or complicit in bullying behaviour, further impacting upon the development of quality care or the implementation of new practices.

Barriers in Rural and Remote Practice

Making service improvements or changes in care practices are dependent upon effective CL [9-10]. However, participants recognised several hurdles that hindered their ability to initiate change in R&R practice. Change was "not seen as easy" and "outsiders" commonly encountered resistance from staff that had longevity in the R&R area, managers, "who did not listen" or simply because innovation, "was not embraced" [1]. "Poor staffing", "limited resources" and "the rural and remote environment itself" were suggested as being pivotal in terms of blocking innovation or facilitating a bullying culture. Few new staff felt they belonged or that CL's failed to have a positive impact when initiating or supporting innovation. CL's needed a "tool kit of skills" [4,12,30-32] as well as the confidence and courage to be "champions of change" [33].

One participant said that the practice of bullying was, "rife" with "staff having strips torn off them in public" by managers who simply "enjoy the power." Another suggested that, "it takes time to feel welcomed," with several participants expressing concern about bullying behaviours that became a hindering force, impacting negatively on their capacity to work effectively, participate well, or provide leadership in the R&R area.

Many of those interviewed described "staffing" as an issue that impacted because of a limited casual pool, limited staff numbers, a deficient skill mix and increased numbers of part-time staff. These issues, in combination with a view that the work load was high, meant that bullying was never far as an issue in terms of staff confidence, limited resources and low staff experience in some areas [1]. Staffing concerns meant that some participants suggested that they were at the "frontline all the time", with limited support or active hinderance from bullies and no respite from the often-constant clinical demands.

Challenges to Training and Development

Interviewees offered copious data describing the hurdles staff encountered when attempting to gain access to training and development opportunities. These included "a lack of time to train", "difficulties with attending training", "training not being offered on site", being "unable to find a staff member to replace them while they studied", "late notification of courses", or "limited places on courses". A number of interviewees indicated that, "funding or scholarships were not always available", "easy to obtain or that permanent staff had preferential treatment" [1]. Others suggested that, "travel and accommodation costs were too expensive."

Another significant hurdle offered by several of those interviewed were that there was limited, "willingness to deal with change", "active resistance to change" and a view that, "things had always been done a certain way and therefore, learning anything new was not required." These comments further supported bullying behaviours that limited equity and generated a sense of resistance faced by new staff or those with CL responsibilities.

Rural and Remote Practice Challenges

More than other themes, views about the tight bond evident

between the R&R health facility and the community in which it was located supported a cultural slant towards further bullying behaviours. Significant numbers of those interviewed said that new staff were not just coming into a new clinical area, but into a new and long-established community. Many permanent staff had close ties to a prominent feature of the community structure; the health facility. As a result, new staff were sometimes challenged early to develop and display their clinical skills and meet the community members expectations of their commitment to the facility and the community. New staff who displayed any sign that they may not settle described being less well supported and felt less welcome. New staff who settle or who had their origins in established local families, settled more easily and were more easily accepted into both the health facility and the wider community.

Some of those interviewed discussed their feelings of "remoteness", while at the health clinical facility and the impact this had on their clinical engagement. Some staff suggested they simply had to, "look after themselves" to survive. Other interviewees described feeling only limited support or viewed the consequences of isolation as having less colleagues on duty and only limited medical back up. Others viewed the isolation as helping generate "closeness" with clinical teams and with the local community. Interviewees suggested that they depended on each other and "become more resourceful or creative" as a result. They suggested, that while accepting the isolation could be "daunting", they also said that, "if new staff overcame the initial challenges and were accepted by the community, married into, or had family in the community, they were more likely to stay" [1].

Several of those interviewed discussed the links between the community and the clinical facility, describing the relationship as "tight" and proposing that "new staff who did not find an anchor to the community commonly left." In R&R communities where "everyone knows everyone", being cast as an "outsider" or not being seen to belong, or finding it hard to settle, made it more difficult to be recognised as a part of the clinical team. R&R health service staff were also described as "less anonymous, because their work often impacted directly on the relatives and friends of people in the community" [1]. Meaning a close community/staff interaction was more likely [23].

Several of the interviewees suggested that the clinical facility culture was often driven by "veterans" who had worked and lived in the area a long time. As well, even if the "veteran" did not have a management or leadership role or title in the health facility they exercised considerable influence. Ragusa and Crowther [34] described this as a "social glue" where shared experiences and inter-dependence fostered a cohesive workplace culture. However, this also meant that in some R&R health areas staff longevity could be seen to have a negative effect on professional relationships. Suggesting that "veteran" staff had powerful bonds with the wider community or power derived from prior or established relationship links in the community. Weakening and negatively impacting on those not welcomed or included in the "social glue" [1].

New staff, across many levels, described the difficulties they faced when starting to practice in the R&R environment. They often felt they were received or perceived as a threat and that they needed to stoically "survive" the pressure brought to bear by long-standing staff to "prove their worth." This was especially so if they were involved in any change initiative or innovation commonly placing the staff in the category of "unwelcome outsider". New staff were often expected to take the role of "passive passengers" in the R&R environment or they were bullied and hindered, to the point of having to live with the "bullying behaviours" or leave. The single most important factor in the interplay of new and established staff was the impact of, or bonds to the community and staff longevity at the clinical area.

Summary

The main goal of the study was to investigate a perception of CL by R&R nurses in R&R areas of NSW, Australia, with this paper focusing on a thread about bullying and threats to belonging in R&R clinical environments that ran through each theme.

Bullying has a dramatic effect upon all staff. Many interviewees proposed that CL's have a powerful effect on the standard of care in R&R clinical areas. They are able to do so if they are well supported, can access up-to-date, relevant training and development and if issues of appropriate and adequate staffing are dealt with [1].

Bullying and threats to belonging were seen as an issue that impacted more significantly on new staff, or staff trying to establish themselves as clinical leaders. Resistance came from a number of spheres. With innovation and change's not always being welcomed, and some "veteran" staff, in a range of positions being able to restrict stop or at least, hinder change. As well, the effect of the community at large to impact upon the delivery of care was significant. When the community and the clinical facility were closely bound or co-dependent, this facilitated disproportionate power to R&R area staff who held tight ties in the community or who had longevity in the clinical facility. Many of these staff were seen to display, "bullying behaviours" to the point that new staff and CL's had to deal with significant challenges when moving to R&R clinical areas and when applying clinical leadership.

The study found that not all established staff demonstrated bullying behaviours, and this was not evident in all R&R clinical environments. However, recognising and developing strategies for tight collaboration or more engaged partnerships between new and established staff and the wider community is essential if new staff and beginning CL's are to initiate appropriate innovation and deliver clear improvements to R&R practice.

Recommendations to limit Bullying and Promote Belonging

Severn recommendations are offered as a result of this aspect of the study:

- Offer more effective education and clinically-based support in R&R practice areas or via external on-line resources. This would allow support from beyond the on-site or established

clinical team and facilitate an avenue for discussion and mentorship from outside the on-site clinical team.

- Recognise, limit or if possible, eliminate bullying. Bullying in nursing and healthcare is a significant concern and it has commonly eluded a resolution. Therefore, if positive progress is to be made in improving R&R practice, more is needed to recognise bullying, how it is manifest and eliminate it is possible (1).
- Evaluate and address staffing needs in R&R environments and link each R&R facility with a metropolitan partner health facility to bolster their support and staff pool.
- It would be useful to provide a community-focused orientation in R&R practice areas, to make clear the bonds between the health facility and the community so that new staff may appreciate the potential influence they may have on each other.
- Implement a reward system to support innovation and reward a positive workplace culture within R&R clinical facilities.
- Apply the CRANA plus app and other support systems for R&R nurses.
- Implement recruitment and retention strategies and take account of the difficulties faced by new staff moving to R&R environments. Specific 'retention' focused staff (not base in any one clinical facility) may be needed to support new staff as they transition to R&R environments.

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