ORIGINAL ARTICLE

Challenging the ethnic pyramid: Golden rules and organisational measures towards a more inclusive work environment

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Abstract

Aim: To contribute to knowledge of how healthcare managers can promote connection and ethnic equality among staff in multicultural organisations.

Background: The increase in migrant care workers often leads to deskilling, discrimination, communication difficulties and harsh working conditions.

Methods: A constructivist grounded theory approach was used to examine the work experiences of healthcare workers in a strategically selected nursing home unit with minority and majority workers well balanced across positions.

Results: *Three golden rules* were identified: (a) take responsibility for the quality of care in the unit, (b) should engage in all aspects of the care work within scope of practice and (c) collaborate and help each other. Organisational measures supporting these norms were also identified.

Conclusion: It is possible, by means of golden rules and organisational measures, to foster connection and cooperation among nursing home staff and to promote an inclusive work environment where the workers' skills and competences are recognized across educational and migration backgrounds.

Implications for Nursing Management: Healthcare managers can contribute to challenge the ethnic pyramid often identified in multicultural institutions by implementing diversity-sensitive measures. This may increase the quality of care and the well-being of residents.

KEYWORDS
diversity management, ethnic equality, inclusive work environment, migrant healthcare workers, multicultural staff, nursing homes

1 | INTRODUCTION

Both historically and still today, nursing homes are often staffed mainly by women organized in hierarchical teams, with the head nurse on top, auxiliary nurses in the middle and nursing assistants on the bottom (Dahle & Seeberg, 2013; Jervis, 2001; Lopez, 2006).

Whereas the head nurse is professionally, ethically and legally responsible for ensuring the quality of care for residents, auxiliary nurses and nursing assistants often provide most of the practical care, as prescribed by those higher in the chain of command (Dahle & Seeberg, 2013; Jervis, 2001; Lopez, 2006; Natsuko, 2011). In addition to being hierarchical workplaces dominated by working-class

women, in recent decades, nursing homes have gradually become more ethnically diverse. Currently, in Norway, where this study takes place, 19% of nursing home staff are immigrants (Statistics Norway 2017); among newly recruited and unskilled assistants working in the sector, this share is even higher.

Research from different parts of the Western world points to various challenges related to the increasing share of migrant staff in nursing homes. Some studies indicate that the lack of proficiency in the majority language may limit the migrant healthcare workers' communication skills in relation to residents or reduce their understanding of tasks and duties (Egede-Nissen, Sellevold, Jakobsen, & Sørlie, 2017; Spencer, Martin, Bourgeault, & O'Shea, 2010). A study of Asian nurses in Australia found that although most of the participants were satisfied with their working conditions, deficits in the majority language coupled with differences in culture could create misunderstandings (Takeno, 2010). Studies from multicultural nursing homes point to discrimination by residents, managers or colleagues (Dahle & Seeberg, 2013; Huang, Yeoh, & Toyota, 2012; Näre, 2013; Timonen & Doyle, 2010), while others identify deskilling (Adhikari & Melia, 2015; Iredale, 2005; Likupe, 2015; Riemsdijk, 2013; Seeberg, 2012). Deskilling in this context is defined as the undervaluing of immigrants' skills, education and experience, which results in various workplace disadvantages (Creese & Wiebe, 2012, p. 58). A recent study from Finland, moreover, showed that migrants are often recruited to precarious work in old-age care, despite their formal qualifications for safer positions (Olakivi, 2019). Thus, research shows that nursing homes with a multicultural staff may struggle with old hierarchies in new bottles, where class as a distinction now intersects with staff members' race and migration backgrounds.

Research from nursing homes has shown that when dialogue and connection among staff are encouraged and arranged for by the management, this leads to higher levels of trust and satisfaction among staff members (Amble, 2013; Forbes-Thompson, Leiker, & Bleich, 2007). The same is also found in research from other workplace contexts (Thuesen, 2017). More specifically, diversity management is an important tool for counteracting ethnically based workplace discrimination and deskilling (Janssens & Zanoni, 2014; Munkejord & Tingvold, 2019; Prasad, Pringle, & Konrad, 2006; Zanoni & Janssens, 2007). The main idea in diversity management, put bluntly, is that multiculturality among staff should be perceived and used by the management as a resource. So far, there exist very few diversity management studies from the healthcare sector. One exception, though, is a study from Australia concluding that it is important to establish procedures, criteria and policies in cross-cultural communication in multicultural nursing homes in order to improve the quality of care for residents (Xiao et al., 2017). Thus, we need more knowledge about how healthcare managers may promote communication, connection and ethnic equality among staff in multicultural organisations. This article addresses this gap from an employee perspective.

2 | RESEARCH METHODS

2.1 | Design

This study explores how minority and majority staff experienced working in a strategically selected nursing home with 15–20 years of experience including minority staff at all levels in the organisation. An interpretative constructivist grounded theory approach was chosen (Charmaz, 1995, 2005, 2009). This approach assumes that multiple realities exist and our perceptions of the reality are co-created by the actors participating in various arenas. The main means of data production was in-depth interviews where the researcher asked open-ended questions. The questions focused on the everyday life as a care worker. Especially, the participants were asked to describe an ordinary day shift, emphasizing their tasks and duties, what they liked and disliked doing and how they worked (e.g., whether they work independently or in collaboration with others). They were also asked about their perceptions of competence and hierarchies among the staff as well as their experiences with the management.

2.2 | Data collection

We started the study by applying for the necessary permissions from The Norwegian Centre for Research Data (NSD, project number 50525), the municipality where the nursing home is located and the top management of the selected nursing home. When the permissions were obtained, the head nurse presented the study to the staff and told them that everyone was allowed to be interviewed during their working hours. Saturation is a widely discussed topic. It usually refers to a point of where additional data collection no longer contributes with much new to the research (Gentles, Charles, Ploeg, & McKibbon, 2015). In this study, all staff members in the twin unit working daytime during the data collection period were interviewed (*n* = 22). Although the researcher, when doing the last interviews, had the impression that many things had already been said by others, we did not consider interrupting the data collection until the voice of every staff member had been heard.

The participants ranged in age from 20 to 55+ and included three nurses in full-time positions, nine auxiliary nurses (with 60%–100% positions), nine nursing assistants on small part-time contracts (also taking extra shifts) and one apprentice. Half of them were born in Norway, and half of them were migrants who had settled in Norway as marriage migrants in most cases or as refugees. For more information, see Table 1 which presents all participants by use of pseudonyms. All participants were informed that partaking in the study was voluntary, that they could withdraw without reason at any time and that anonymity would be secured in publications. The interviews occurred in a meeting room within the unit, often between 10 a.m. and 1 p.m. The interviews were audiotaped, transcribed and lasted between 40 and 150 min, with an average of 70–80 min. The participants were offered the transcript to make any necessary changes or clarifications. Only a few participants provided further comments.

TABLE 1 The origin and position of the participants (pseudonyms are used)

Name, age (approx.)	Region of origin	Education	Position	Years of NH experience
Anna, 22	Norway	Soon-to-be certified aux nurse	Apprentice	Two years in this NH
Bridget, 30	Africa	Has taken 2 years of school (full-time) to become an aux nurse	Nursing assistance	Approx 3–4 years
Celina, 40	Norway	Certified aux nurse	Aux nurse	20 years of experience, 12 years in this NH
Daniela, 55	Eastern Europe	Certified aux nurse (2010)	Aux nurse	15 years in this NH
Emma, 50	Norway	Certified aux nurse (2007)	Aux nurse	13 years in this NH
Frida, 35	Southern Europe	Certified aux nurse (2009)	Aux nurse	17 years in this NH
Gina, 50	Norway	Certified nurse (approx 2005); also cert aux nurse (approx 1995)	Nurse	Long experience, 1 year in this NH
Helga, 22	Norway	Has taken relevant exams but no certificates/degrees	Nursing assistance	5 years of experience, 1 year in this NH
Irene, 35	Asia	Certified nurse from home country; authorization in Norway after 2 years	Nurse	13 years of experience, 8 years in this NH
Jane, 55	Norway	Certified aux nurse (2011)	Aux nurse	13 years in this NH
Klara, 45	Asia	Certified aux nurse (approx 2008)	Aux nurse	15 years of experience, 8 years in this NH
Ludmila, 40	Russia	Enrolled in education to become an aux nurse (1 year left)	Nursing assistant	2–3 years in this NH
Maria, 25	Africa	Has finished formal education to become an aux nurse	Nursing assistant	3–4 years in this NH
Nelly, 20	Norway	Nursing student; has passed the exam in pharmacology measurement	Nursing assistant	2 years in this NH
Oliver, 22	Norway	Student (preparatory courses)	Nursing assistant	4 years in this NH
Patricia, 40	Asia	Certified nurse from home country; never obtained authorization in Norway; certificate as an aux nurse in 2011	Aux nurse	15 years of experience, mostly in this NH
Quamila, 25	Asia	Has taken relevant courses at high school but no certificate; has passed the exam in pharmacology measurement	Nursing assistance	4 years in this NH
Rita, 22	Norway	Student (preparatory courses)	Nursing assistant	1 year in this NH
Stella, 40	Southern Europe	Certified nurse and a university degree from home country; has passed exam in pharmacology measurement in N	Aux nurse	15 years of experience, 1 year in this NH
Ulla, 50	Norway	Certified aux nurse (2009)	Aux nurse	15 years of experience, 10 years in this NH
Tanja, 25	Norway	University student	Nursing assistance	3 years in this NH
Vicky, 50	Asia	Degree in economics from country of origin; educated as a certified nurse in Norway	Head nurse of the unit	15 years of experience, 10 years as a head nurse

2.3 | Data analysis

The interpretative constructivist grounded theory approach entails that the researcher engages in "simultaneous" data collection and analysis. Hence, when conducting the interviews, the researcher listened carefully to the participants' voices in order to grasp what was important *to them*. When all interviews were transcribed, the researcher read the transcripts several times while continuing to tease out themes and subthemes. Thus, for the purpose of this article, the researcher examined rules or measures that contributed to

collaboration and connection as well as a general feeling among staff that 'in this unit, we are all of equal value'. The subthemes relating to this subject were analysed in view of each other, and through this process, the three golden rules presented in this article were identified (Table 2).

The coding and re-coding of data, according to Charmaz, is the 'pivotal link' between collecting data and developing concepts to illuminate these data (Charmaz, 1995, p. 37). The coding was performed in dialogue with previous research, which to some extent redirected the further analysis (Graneheim, Lindgren, & Lundman,

2017). The interpretation of data was also performed in dialogue with engaged colleagues in a larger umbrella project on the "Multicultural workforce in Norwegian nursing homes"[1]. Two colleagues read and commented on some of the interview transcripts, and several read and commented on an earlier draft of this paper. To assure the pertinence of the study, preliminary findings were presented to key actors in the nursing home under scrutiny. In general, we received confirming and supportive feedback.

3 | RESULTS

3.1 | The nursing home context

Data collection for this study took place in a unit within a relatively large municipal nursing home. In addition to having minority staff included at various levels of the organisation, the designated unit had low sickness absence and a low turnover. The unit consisted of a 'twin ward', each ward consisting of ten residents with advanced dementia living in their own room. Most of the residents, according to the staff, had challenges with verbal communication. Some had accompanying diagnoses such as bipolar disorder or schizophrenia, and some of them were restless and at times verbally or physically aggressive to the staff. Each ward had its own kitchen where the ten residents ate most of their meals and a shared living room where the residents often sat in (wheel) chairs and where visitors were welcome to stop by and take a coffee at any time of the day.

When analysing the participants' stories about their everyday life as a care worker in the nursing home unit, "three golden rules" linked with specific organisational measures were identified. They were not written guidelines; rather, the staff used their own words when explaining them and had somewhat different understandings of them as will be illustrated below.

3.2 | Golden rule 1: Everyone should take responsibility for the quality of care in the unit

While the head nurse had the legal and overarching responsibility for all 20 residents and the two certified nurses were accountable for the quality of care for ten residents each, the responsibility for conceiving, writing, sharing and updating the individual care plans had recently been delegated to the auxiliary nurses. Hence, in contrast with what is found in other studies (cf. Jervis, 2001; Lopez, 2006), the auxiliary nurses were not expected to simply follow care instructions from above. Rather, they were designated 'primary contacts' for two to three residents each, for whom they had to make individual care plans. A care plan included "a diet plan" specifying food preferences, special needs and how much help the resident needs to be able to eat; "a grooming and dressing plan" including information about how the resident prefers to be assisted with bathing, toileting and dressing as well as hair care, skincare, make-up, etc.; and "a dental hygiene plan". In addition, being the

primary contact for a resident entailed ensuring regular contact with the residents' next of kin, making sure that the resident had everything that s/he needed, for example clothes and personal toilet articles and being responsible for her/his overall well-being. Emma was one of the auxiliary nurses who said that she appreciated making the care plans and, in addition, having a personal responsibility for the well-being of three residents in the twin ward:

> All of us (auxiliary nurses) have primary patients. That means we are responsible for following up with them. We have to update their care plans, for instance the diet card – that is a nutritional plan specifying what they should eat, and we have to update their car dental hygiene plan... So there are a lot of responsibilities, but that makes the job more fun, I'd say.

Moreover, every week, the auxiliary nurses met with the other colleagues to report on their primary patients regarding their nutrition and weight development, their dental hygiene and whether their residents had fallen or developed bedsores during the last few days. Key information about each resident was marked on a large whiteboard in the staff's meeting room. Sometimes, there were tensions among the staff in this regard. Klara, for example a migrant auxiliary nurse, said that as the primary carer, she had specified in the diet plan that one of her residents, an underweight woman, needed assistance while eating and that she needed to be undisturbed, with her dinner carefully mashed. Therefore, Klara explained to the researcher, she had become very upset when, a couple of days before our interview, she had discovered this resident sitting alone in the living room *not* eating with her dinner in front of her, the TV on and her food not even slightly mashed. On that particular shift, a Norwegian-born nurse, Gina, had been in charge of this resident. Klara explained:

> I was so annoyed when I saw that. 'Why is she eating in the living room? Look – she does not even eat!' And that was a Norwegian nurse! (going back to the conversation with Gina:) 'What? Why is the food not mashed?' We started to give her mashed food since she lost so much weight (...). What's the point of making a diet plan if you don't follow it? (...) You have to read the plan!

Although there were incidents of this kind, in general the participants were quite happy with how the care plan system worked. In general, the auxiliary nurses found it meaningful to make the care plans, although some also found it challenging and time-consuming, especially the technical part of electronically filing the plan. As Norwegian-born Jane said when asked if she felt that she spent too much time on making and updating care plans:

> That kind of work is very time-consuming. I feel that, sometimes, this kind of work is done at the expense of our time with the patients. I understand that

TABLE 2 Coding table

Citations (examples)	Themes/comments	Golden rule
"All of us [auxiliary nurses] have primary patients. That means are responsible to follow them up. We have to update their care plans, their diet cards…" (aux nurse) "I like to keep the contact with the next of kin" (aux nurse) "I give out medications because I have the medication course" (assistant) "It is important that everybody feel responsible at work" (head nurse)	• The auxiliary nurses [and not the certified nurses as is the case in many nursing homes in Norway] make and update the patients' care plans in this nursing home unit • The auxiliary nurses have 2–3 primary patients each • The auxiliary nurses are proud that they make the care plans, and that they are responsible for securing the dialogue with next of kin • Even the assistants, once they have taken the medication course, give out medications. • Everyone should feel responsible for the quality of care delivered to the residents in the unit	Golden rule 1: Everyone should take responsibility for the quality of care in the unit
'Vicky [the head nurse] often helps us with washing the patients or with preparing breakfast in the morning. That is good' (assistant) 'Everybody does everything in this unit.' (assistant) 'So, we have three groups: the kitchen group, the laundry group and the medication group. We circulate between them.' (aux nurse) 'We share the groups among us in the beginning of each shift. And if we don't agree, then we flip a coin. Usually, that goes all fine'. (aux nurse)	• Even the head nurse engages in washing patients or preparing breakfast. Staff who have worked elsewhere say that this is not always the case. Sometimes, the head nurse is not working 'on the floor'. In this nursing home, however, everyone among the staff does all kinds of tasks within scope of practice. • Staff members express that they feel that they are all equally important, no matter their educational level. • All tasks are organized in three groups. Each morning the team agreed on who should be in charge of which group, so that everyone takes care of all the patients in the unit, and so that everyone does all the different tasks related to cleaning, preparing food, giving out medication, washing clothes, etc.	Golden rule 2: All staff members should engage in all aspects of the care work within scope of practice
'In this unit, we are all the same' (repeated by most of the participants) 'So in general, I always try to help. (…) You know, it's rewarding to help out.' (certified nurse) 'If I have extra time, I always help my colleagues' (aux nurse) 'I collaborate with a named colleague. It is good to have someone to discuss things when I need input.' (aux nurse) 'When it is like that, it is more intimate or a little more like belonging. It's a little more like – then they know. It's not vague. Then they know that they're a team and that they have to take care of each other's duties and each other's patients.' (head nurse)	• The staff talked about the importance of helping each other • The staff talked about the importance of collaboration, that it was more fun to go to work when you collaborated and supported each other • The staff worked together in pairs. Several said they appreciated that, because it was easier to ask your partner for help with updating a care plan, or how to deal with a problem, or whatever. • Working in pairs creates belonging. The staff feel that they belong to their partner, to their primary patients and to the rest of the staff group at the unit. They like to help and support colleagues. That creates a sense of togetherness.	Golden rule 3: In this unit, everyone should collaborate and help each other.

documenting our work is important, but we're here to *take care of the patients* (her emphasis).

This dilemma brings us to the next golden rule, which says something about how the more practical aspects of the care work were organized in the unit.

3.3 | Golden rule 2: All staff members should engage in all aspects of the care work within scope of practice

All nursing staff members, from the nursing assistants to the head nurse, worked together in shifts. To facilitate such teamwork, the day shifts were organized around three groups in each ward: the

'medication group' (specific tasks + three patients), the 'laundry group' (specific tasks + four patients) and the 'kitchen group' (specific tasks + three patients). Being responsible for the 'medication group' entailed providing all ten residents in the ward with their medicines at the right times during the entire shift as well as providing all other necessary care for the three residents belonging to this group. This included helping them get up, washing, toileting or changing diapers, dressing and transporting them to the kitchen table in the morning, taking responsibility for making sure that they would eat or be fed at all meals and performing easy housekeeping in the three residents' rooms such as emptying the bin and mopping the floor.

Similarly, being responsible for the 'laundry group' meant providing all necessary care and services for the four residents belonging to this group. In addition, this responsibility entailed, once

a week or more often if needed, changing all of the residents' bed linen and sending dirty sheets and handkerchiefs to the professional laundry or receiving clean handkerchiefs and sheets from the professional laundry to fold and put on the shelves. On other days, being in charge of this group meant washing, drying, ironing and folding all the residents' clothes in the small laundry room within the unit.

Being in charge of the 'kitchen group' entailed providing care and services for the three residents belonging to this group; the tasks included preparing breakfast in accordance with the residents' diet plans, tidying and cleaning the kitchen after the meal, setting the table and preparing a warm lunch at noon according to a planned menu, tidying and cleaning the kitchen again and, before finishing the day shift, setting the table a third time and warming a prefabricated dinner according to the instructions. Emma, a Norwegian-born auxiliary nurse with long experience, explained:

> So, we have three groups: the kitchen group, the laundry group and the medication group. If one day I only work with unskilled colleagues, then there is nothing to share because then I have to take the medication group. Otherwise, it is very okay with those groups because we share the tasks more easily.

She went on to explain that before this system was introduced, the workers on each shift had to agree on how to share the responsibility for residents and tasks. Often, the colleagues preferred the same residents and the same tasks, and while some ended up doing the heavier tasks and caring for the 'difficult' residents, others somehow always succeeded in ending up with the 'lighter residents' and the 'fun tasks'. Several staff members said that they regarded the kitchen tasks as more strenuous than giving out medications.

With the new group system introduced a couple of years ago, each morning the team agreed on who should be in charge of which group, and all other tasks and duties were also automatically divided among the staff. Heavier tasks (such as kitchen tasks) were combined with 'lighter' residents and lighter tasks (such as giving out medication) with 'heavier' residents. The responsibility for the groups circulated among the staff as fairly as possible according to the participants. On the researchers' question of how the staff decided who should take which group, foreign-born Frida answered: 'We circulate. And if we don't agree, then we flip a coin. Usually, that goes all fine'.

3.4 | Golden rule 3: In this unit, everyone should collaborate and help each other

In the nursing home unit, the head nurse had introduced a number of measures to ensure openness and collaboration through what we may call 'an organized togetherness'. An example was how the head nurse had linked the auxiliary nurses in pairs to be each other's primary discussant when care plans were to be made and revised.

One's 'partner in the pair' would also step in as the substitute primary contact for the other's two or three residents if the other were on sick leave or on holiday. The auxiliary nurses said that it was very fruitful and reassuring to have a permanent partner with whom to discuss various issues. The two certified nurses were also coupled in a nurse team in which they were expected to meet with, discuss and help each other when needed. The head nurse herself explained the following:

> When it is like that, it is more intimate or a little more like *belonging*. It's a little more like – then they *know*. It's not vague. Then they know that they're a team and that they have to take care of each other's duties and each other's patients. Like, if someone is on holiday and she forgot to do certain tasks before she left, then the other (her partner in the pair) has to take care of those things. (…) That may create some tensions, and the other may think, 'Why did you not do that (yourself)?' Like, you know what I mean?

Several staff members mentioned that *writing* Norwegian could be a challenge, including for some of the Norwegian-born staff. The head nurse explained that she had teamed the staff accordingly. Moreover, "helping in each other" at large was talked about as something the staff often did or wanted to do. For instance, Norwegian-born Gina said:

> So in general, I always try to help. If I have the medication group, and I have some extra time, I will help clearing the table or help assisting residents to eat. You know, it's rewarding to help out.

4 | DISCUSSION

In the nursing home, there was no social worker to tend to the residents' social care needs, no housekeeper to empty bins or wash the residents' clothes and no full-time or part-time assistant in the kitchen[2]. Moreover, and importantly, no practical care tasks were reserved for the nursing assistants or for the auxiliary nurses only. In terms of ethical responsibilities, there was of course a clear hierarchy among the staff, with the head nurse being the main person responsible for the quality of care and well-being of every resident and, below her, the two certified nurses being responsible for supervising the well-being of ten patients each. Nevertheless, "everyone among the nursing staff" engaged in all practical tasks in the unit including both incontinence care, person care, washing the residents' clothes, setting the table and preparing meals.

In a report on task sharing and competence in Norwegian nursing homes, this method of organizing the work is called 'the everyone does everything model' (Haukelien & Vike, 2015). Although there

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[2] Professional cleaners, however, also cleaned and dusted the nursing home on a regular basis.

might be good reasons for a more competence-based model for task division among staff in nursing homes, this "egalitarian task sharing" was highly appreciated by most of the participants in this study. This was particularly the case among the nursing assistants and the auxiliary nurses of both majority and migrant background. The certified nurses in the unit were also quite happy with this arrangement, explaining that there were very few nursing tasks in a strict sense when working in a nursing home anyway. In case of an emergency in any unit in the nursing home, the nurses would step in if called upon. They would also give injections or measure drugs if there were a sudden change in the medication needs of a resident, but even that sort of thing did not happen often. Normally, the unit received the pre-dosed medication from the pharmacy.

4.1 | Conclusion and implications for managers

Diversity management has long been an important tool for counteracting ethnically based workplace discrimination and deskilling (Janssens & Zanoni, 2014; Prasad et al., 2006; Zanoni & Janssens, 2007). The main idea is that multiculturality among staff should be appreciated and used by the management *as a resource*. The golden rules identified in this study contributed to viewing each and every staff member as a resource. These rules were the following: (a) Everyone should take responsibility for the quality of care in the unit. This norm was supported by, for example the fact that all auxiliary nurses (and not the certified nurses which is often the case in Norway) were responsible for making, revising and implementing the individual care plans for 2–3 residents each. (b) All staff members should engage in all aspects of the care work within scope of practice. This norm was supported by the organisation of residents and tasks in predefined 'laundry', 'medication' and 'kitchen' groups. During the beginning of each shift, the staff would meet and share the three groups among themselves; hence, all tasks that needed to be performed in that particular shift were also automatically allocated. Thus, one would never hear about a shift or a situation where, for example only migrant nursing assistants had to perform more of the less appealing tasks in the unit. (c) Everyone should collaborate and help each other. This norm was supported by, for example the predefined 'colleague pairs' put together by the head nurse. These colleagues were each other's supporters, and this arranged collaboration seemed to foster connection in a very concrete and constructive way.

To conclude, the golden rules identified in this study seemed to foster a decentralization of tasks and facilitated close collaboration among staff members across formal positions. Furthermore, the golden rules seemed to nurture smaller units of togetherness, establishing an inclusive work environment where the various staff members' skills and competences were recognized. Moreover, when dialogue and collaboration among staff are encouraged and arranged for by managers, this may lead to higher levels of connection among staff members and reduce ethically based deskilling and discrimination. Hence, it is possible, by means of golden rules and organisational measures, to foster connection and

cooperation among nursing home staff and to promote an inclusive work environment where the workers' skills and competences are recognized across educational and migration backgrounds.

5 | LIMITATIONS

There are several limitations in this study. One limitation is that the data were collected in only one strategically selected nursing home unit. Gathering data on workers' experiences in different multicultural nursing home (units) with corresponding characteristics such as low turnover, low levels of sick leave and minority and majority staff members well balanced across the organisation would have been interesting for exploring how diversity-sensitive management can be applied and experienced in different, and not necessarily anti-hierarchical, ways. Moreover, although the author of this article collaborated with colleagues in an analysis workshop and in several seminars, it is a limitation that only one person did most of the interpretation of data for this specific article. It should be noted, though, that the author is a scholar in social sciences, and sole-authored articles are quite common among social scientists which have stricter rules for co-authorship[3] than what is often the case in the health and care sciences.

ETHICAL APPROVAL

Ethical approval obtained from NSD, Norwegian Centre for Research Data: 50525.

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REFERENCES

Adhikari, R., & Melia, K. M. (2015). The (mis)management of migrant nurses in the UK: A sociological study. *Journal of Nursing Management*, *23*(3), 359–367. https://doi.org/10.1111/jonm.12141

Amble, N. (2013). Autonomy and control when working with humans - a reflection on sociotechnical concepts. *Nordic Journal of Working Life Studies*, *3*(4), 45–61. https://doi.org/10.19154/njwls.v3i4.3072

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[3]https://www.etikkom.no/en/ethical-guidelines-for-research/guidelines-for-research-ethics-in-the-social-sciences--humanities-law-and-theology/

Charmaz, K. (1995). Grounded Theory. In J. A. Smith, R. Harré, & L. Van Langenhove (Eds.), *Rethinking Methods in Psychology* (pp. 27–49). London, Thousand Oaks, New Dehli: Sage.

Charmaz, K. (2005). Grounded Theory in the 21st century: Applications for Advancing Social Justice Studies. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (pp. 507–535). Thousand Oaks, London, New Dehli: Sage.

Charmaz, K. (2009). Shifting the grounds. Constructivist Grounded Theory Methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing Grounded Theory. The second generation* (pp. 127–147). Walnut Creek, CA: Left Coast Press.

Creese, G., & Wiebe, B. (2012). 'Survival Employment': Gender and Deskilling among African immigrants in Canada. *International Migration*, *50*(2), 56–76. https://doi.org/10.1111/j.1468-2435.2009.00531.x

Dahle, R., & Seeberg, M. L. (2013). "Does she speak Norwegian?" Ethnic dimensions of hierarchy in Norwegian health care workplaces. *Nordic Journal of Migration Research*, *3*(2), 82–90.

Egede-Nissen, V., Sellevold, G. S., Jakobsen, R., & Sørlie, V. (2017). Ethical and cultural striving: Lived experiences of minority nurses in dementia care. *Nursing Ethics*, *34*(6), 752–766. https://doi.org/10.1177/0969733015624489

Forbes-Thompson, S., Leiker, T., & Bleich, M. R. (2007). High-performing and low-performing nursing homes: A view from complexity science. *Health Care Management Review*, *32*(4), 341–351. https://doi.org/10.1097/01.HMR.0000296789.39128.f6

Gentles, S. J., Charles, C., Ploeg, M., & McKibbon, A. (2015). Samling in qualitative research. Insights from an overview of the methods literature. *The Qualitative Report*, *20*(11), 1772–1789. http://nsuworks.nova.edu/tqr/vol20/iss11/5

Graneheim, U. H., Lindgren, B.-M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, *56*, 29–34. https://doi.org/10.1016/j.nedt.2017.06.002

Haukelien, H., & Vike, H. (2015). *Bruddstykker av helhet: Oppgaver og kompetanse i helse- og omsorgssektoren*. TF-Rapport nr. 358. Retrieved from Telemark.

Huang, S., Yeoh, B., & Toyota, M. (2012). Caring for the elderly: The embodied labour of migrant care workers in Singapore. *Global Networks*, *12*(2), 195–215. https://doi.org/10.1111/j.1471-0374.2012.00347.x

Iredale, R. (2005). Gender, immigration policies and accreditation: Valuing the skills of professional women migrants. *Geoforum*, *36*(2), 155–166. https://doi.org/10.1016/j.geoforum.2004.04.002

Janssens, M., & Zanoni, P. (2014). Alternative diversity management: Organizational practices fostering ethnic equality at work. *Scandinavian Journal of Management*, *30*, 317–331. https://doi.org/10.1016/j.scaman.2013.12.006

Jervis, L. L. (2001). Working in and around the 'chain of command': Power relations among nursing staff in an urban nursing home. *Nursing Inquiry*, *9*(1), 12–23. https://doi.org/10.1046/j.1440-1800.2002.00125.x

Likupe, G. (2015). Experiences of African nurses and the perception of their managers in the NHS. *Journal of Nursing Management*, *23*(2), 231–241. https://doi.org/10.1111/jonm.12119

Lopez, S. H. (2006). Emotional labour and organized emotional care: Conceptualizing nursing home care work. *Work and Occupations*, *33*(2), 133–160. https://doi.org/10.1177/0730888405284567

Munkejord, M. C., & Tingvold, L. (2019). Staff perceptions of competence in a multicultural nursing home in Norway. *Social Science and Medicine*, https://doi.org/10.1016/j.socscimed.2019.04.023

Näre, L. (2013). Ideal workers and suspects: Employers' politicas of recognition and the migrant division of care labour in Finland. *Nordic Journal of Migration Research*, *32*(2), 72–81.

Natsuko, R. (2011). Experiences of racism by Female minority and immigrant nursing assistants. *Affilia*, *26*(1), 59–71. https://doi.org/10.1177/0886109910392519

Olakivi, A. (2019). The problematic recruitment of migrant labor: A relational perspective on the agency of care work managers. *Current Sociology*, https://doi.org/10.1177/0011392119837319

Prasad, P., Pringle, J. K., & Konrad, A. M. (2006). Examinig the contours of workplace diversity: Concepts, contexts and challenges. In A. M. Konrad, P. Prasad, & J. K. Pringle (Eds.), *Handbook of workplace diversity* (pp. 1–22). London: Sage.

van Riemsdijk, M. (2013). Everyday geopolitics: The valuation of labour and the socio-political hierarchies of skill: Polish nurses in Norway. *Journal of Ethnic and Migration Studies*, *39*(3), 373–390. https://doi.org/10.1080/1369183X.2013.733859

Seeberg, M. L. (2012). Immigrant carework and Norwegian gender equality: Institutions, identities, intersections. *European Journal of Women's Studies*, *19*(2), 173–185.

Spencer, S., Martin, S., Bourgeault, I. L., & O'Shea, E. (2010). *The role of migrant care workers in ageing societies: Report of research findings in the UK, Ireland, Canada and the United States. Report no 41*. Oxford, UK: IOM International Organization for Migraion.

Statistics Norway (2017). Retrived from https://www.ssb.no/helse/artikler-og-publikasjoner/innvandrerne-sto-for-1-av-6-arsverk-innen-omsorg

Takeno, Y. (2010). Facilitating the transition of Asian nurses to work in Australia. *Journal of Nursing Management*, *18*, 2015–2221. https://doi.org/10.1111/j.1365-2834.2009.01041.x

Thuesen, F. (2017). Linguistic barriers and bridges: Constructing social capital in ethnically diverse low-skill workplaces. *Work, Employment & Society*, *31*(6), 937–953. https://doi.org/10.1177/0950017016656321

Timonen, V., & Doyle, M. (2010). Caring and collaborating across cultures? Migrant care workers' relationships with care recipients, colleagues and employers. *European Journal of Women's Studies*, *17*(1), 25–41. https://doi.org/10.1177/1350506809350859

Xiao, L. D., Willis, E., Harrington, A., Gillham, D., De Bellis, A., Morey, W., & Jeffers, L. (2017). Improving socially constructed cross-cultural communication in aged care homes: A critical perspective. *Nursing Inquiry*, *25*(1), e12208. https://doi.org/10.1111/nin.12208

Zanoni, P., & Janssens, M. (2007). Minority employees engaeing with (Diversity) Management: an analysis of control, agency, and micro-emancipation. *Journal of Management Studies*, *44*(8), 1371–1397. https://doi.org/10.1111/j.1467-6486.2007.00700.x