Addressing Workplace Bullying Among Nurses at a Community Hospital

Manuscript

Susan Downey Luhrmann

University of Massachusetts, Lowell

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Margaret Knight, PhD, PMHCNS

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Abstract

Bullying and incivility are forms of workplace violence (WV) that occur frequently in nursing. This violence is costly and detrimental to the nursing profession, healthcare organizations, and patients. Increasing awareness, education and addressing workplace bullying (WB) immediately and consistently deters the violence. This project included an educational intervention based on the American Nurses Association's (ANA) Code of Ethics (COE) and was designed for staff registered nurses (RN) in non-management roles. The objectives were to measure the RNs' perceived exposure to WB; and to measure the effectiveness of an online educational intervention on RNs' awareness of responsibilities in addressing WB. A quasi-experimental design utilizing the Negative Acts Questionnaire Revised (NAQ-R) was used to measure RNs' perceived exposure to WB. Knowledge of and responsibilities to address these behaviors were assessed and compared in the pre and post-survey. The Michigan Organizational Assessment Questionnaire (MOAQ) was used to measure RNs' intent to leave their current position. Positive responses were elicited in all questions of the NAQ-R. Knowledge improved after the educational intervention by as much as 63%. The MOAQ revealed that over 40% of participants were likely to leave their current position for a new job within the next year related to WB. Addressing WB is crucial in preserving the integrity of the nursing profession.

Keywords: Workplace Bullying, American Nurses Association's Code of Ethics, Zero Tolerance, and Registered Nurses

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Workplace violence (WV) has long been universally recognized as a problem in a variety of settings including hospitals, academic institutions, and businesses. WV is defined as "any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior that occurs at the work site" (OSHA, n.d., para. 2). In the United States (US) WV affects approximately two million people each year (Department of Labor, n.d.). Employees affected by WV requiring days away from work were four times more common in healthcare than in private industry between 2002-2013 (CDC, 2014). Workplace bullying (WB) and incivility are forms of WV.

WB is defined as the "repeated, health-harming mistreatment of one or more persons by one or more perpetrators. It is abusive conduct that is: threatening, humiliating or intimidating; or work interference – sabotage – which prevents work from getting done; or verbal abuse" (WBI, 2015, para. 1). Incivility is defined as "low-intensity, deviant behavior with ambiguous intent to harm the target" (Hutton & Gates, 2008, p. 168). For the purpose of this article WB is defined as any act or threat of violence, including physical or emotional abuse, and or mistreatment of a coworker by one or more perpetrators.

WB is present in all cultures. The Monster Global Poll (2011) surveyed 16,517 workers worldwide. Eighty-three percent of European responders, 65% of American responders, and 55% of Asian responders reported that they had been physically or emotionally bullied. Notations dating back as far as Florence Nightingale's era suggest the presence of WB (Lim & Bernstein, 2014). Far too often these aggressive acts are not reported or taken seriously (OSHA, nd).

Background and Significance

The American Nurses Association's (ANA) Code of Ethics (COE) with interpretive statements for nurses precisely states the obligation, values and ideals of the profession (ANA, 2015). Nurses face threats to their integrity and these threats can include physical or verbal abuse from anyone in the setting (Lachman, Swanson, & Winland-Brown, 2015). A nurse who is verbally abusive to another nurse violates the COE by bullying. When bullying is witnessed but no intervention is attempted the integrity of the victim is not preserved. Unfavorable communication or hostility puts both parties at risk of violating the COE. Lack of respect amongst peers is also a violation of the COE. Each nurse has a responsibility to address bullying. Those who do not address bullying, through their silence, are in violation of the COE (Lachman et al., 2015). WB affects victims both psychologically and physically. Bullying further reduces productivity, increases absenteeism and fosters turnover, all of which lead to fiscal decline in organizations (Keller, Budin, & Allie, 2016). WV, WB and uncivil acts are costly to organizations. The estimated annual costs are over four billion dollars (Armmer & Ball, 2015). Some nurses leave the profession completely due to their struggles with WB, an unfortunate consequence in a time where nursing shortages are a major concern. Peters (2014) reports "job satisfaction has continued to be a critical element of nurses' performance, cost savings, quality of patient care, and intent to remain in current job" (p. 217). Retaining and recruiting nurses is nearing crisis levels due to an aging population, the rising incidence of chronic disease, an aging nursing workforce, and the limited capacity of nursing schools (Grant, 2016).

Purpora, Blegen and Stotts (2015) established that nurses who experienced WB perceived less supportive relationships with peers, lower quality of care, and higher frequency of errors and adverse events. Additionally, Elmblad, Kodjebacheva, & Lebeck asserted that, "incivility in

healthcare facilities erodes team concept" (2014, p. 444). There is an urgent need to identify and appropriately intervene to eliminate this problem. Implementing evidence-based educational programs reduces WB and in turn promotes health, safety and wellness of the nurse, which will ultimately lead to optimal healthcare outcomes for patients (NCSBN, 2016). It is in the best interest of the nursing profession and the public to preserve the integrity and availability of a qualified workforce.

Purpose

The purpose of this project was to measure staff registered nurses' (RN) perceived exposure to WB and to measure the effectiveness of an online educational intervention on staff RNs' awareness of responsibilities in addressing WB.

Methodology

Research Design

A quasi-experimental repeated measure design was used to collect data regarding perceived exposure to WB, turnover intentions, and effectiveness of an educational intervention. Institutional review board (IRB) approval was obtained from the hospital and the University of Massachusetts, Lowell.

Setting

The study took place at a 302-bed acute care teaching hospital affiliated with the University of Massachusetts Medical School that focuses on providing high quality, compassionate primary and specialized healthcare services to people of western Massachusetts, eastern New York, southern Vermont, and northwestern Connecticut. The facility is located in the most rural county in Massachusetts and is geographically isolated from larger communities. As a result, this health system is the primary provider of services to the region. This county has

one of the highest populations of underserved residents and elderly in the state. The majority of the population served is middle to low income Caucasian people.

Sample

The hospital provided a list of RNs currently employed and their work email addresses. Staff RNs in non-management positions at the hospital (n=673) were provided information about the study via email and were asked to complete the pre and post-surveys and an on-line educational program on WB. This project was implemented during a three-month period in 2017. Weekly reminders to complete the educational program and surveys were sent to the participants via email.

One hundred thirty-two (19.6%) responded to the pre-intervention survey and 93 (13.8%) responded to the post-intervention survey. No incentives were offered to complete either survey. The respondents were predominately female (84%) and Caucasian (74%). The mean age was 43.5 years (standard deviation $\pm$ 12.2). The majority (52.7%) had a baccalaureate degree in nursing and 75% worked full-time. The mean years working in the nursing profession was 16.5 (standard deviation $\pm$ 13.1). The largest percentage of respondents (43.5%) worked in specialty areas including the intensive care unit (ICU), coronary care unit (CCU), emergency department (ED), renal, and the operating room (OR).

Intervention

An on-line educational tool based on the ANA's position statement (*ANA*, 2015a) on WV, WB and incivility was available via a VoiceThread configuration. VoiceThread allows demonstration with images, documents, and videos via a more interactive flipped classroom type of learning atmosphere (Brunvand & Byrd, 2011). The program focused on the impact of bullying and incivility, nursing COE responsibilities, eliminating a culture of silence, tools to

combat bullying behaviors including healthy conflict resolution, effective, supportive and assertive communication skills, team building skills, and roles of preceptor, mentor, management, and leader in attaining "Zero Tolerance" for WV, WB and incivility.

Measures

Negative Acts Questionnaire Revised (NAQ-R)

The NAQ-R is the most used survey-measuring WB and has been validated in several studies and countries (Einarsen, Hoel, Zapf, & Cooper, 2011). This standardized 22-item tool quantified the frequency a participant experienced bullying defined behaviors. The internal reliability of the NAQ-R was 0.92 as measured by Cronbach's alpha. The instrument had a Pearson's Product Moment Correlation coefficient of 0.35 with intent to leave job (Einarsen, Hoel, & Notelaers, 2009). Keller et al., (2016) also utilized the NAQ-R and determined this tool to be short, comprehensive, reliable, and valid.

Michigan Organizational Assessment Questionnaire (MOAQ)

Turnover intent was measured using the MOAQ (Camman, Fichman, Jenkins Jr, & Klesh, 1983). A three-item subscale of the RN's intent to leave his/her current job was scored on a seven-point Likert Scale. The items were totaled to produce an overall job satisfaction score. Internal consistency reliability of the intention to turnover subscale is 0.83 as measured by Cronbach's alpha (Camman et al., 1983).

Knowledge Test

A pre and post-test focused on knowledge of WB was administered. This survey was developed based on the content of the educational intervention and included questions pertaining to the ANA's COE responsibilities, and definitions of WV, WB, and incivility. Data was collected and compared based on knowledge before and after the intervention. The post-test also

posed two open-ended questions regarding potential changes the participant would make if experiencing or witnessing bullying in the future.

Demographic data was incorporated and included age, gender, length of time working in nursing, level of nursing education, current shift working, hours per week worked, area working currently, race, ethnicity, and three questions on perceived co-worker support.

Data Analysis

Descriptive statistics described the sample and MOAQ. Pre and post total scores from the Knowledge Test and the NAQ-R were compared. A paired t-test was used to show the mean difference in perception of exposure to WB before and after the intervention and the mean difference in the RNs knowledge when comparing the results of the pre and post-test. A correlation coefficient described the relationship between the pre NAQ-R and the MOAQ. The two open-ended questions on the post-test are reported.

Results

The NAQ-R uses a five point Likert scale (1=never to 5=daily). A score of 2 or higher indicates a positive response. All questions elicited some degree of positive responses. Four questions on the pre-survey yielded a positive response from 50% or more of respondents. Many (68.7%) felt they had been ignored or excluded. More than half (52.3%) felt ignored or faced a hostile reaction when approaching others. The majority (89.9%) felt their opinions and views were ignored and 92.8% reported being exposed to unmanageable workloads. The RNs perceived exposure to WB behaviors increased after the educational intervention in 20/22 questions of the NAQ-R. At least 50% of RNs answered five additional questions positively. Fifty-seven percent reported being humiliated or ridiculed in connection with their work; 58% felt they received repeated reminders of their errors or mistakes; 68% divulged being persistently

criticized about their work and effort; 59% believed their work was excessively monitored, and

54% perceived being the subject of excessive teasing and sarcasm (See table 1). However, there

was no statistical significance (p = 0.14) when comparing the pre and post-survey scores.

The MOAQ revealed that 40.2% of participants were likely to leave their current position

for a new job within the next year. Additionally, 44.3% acknowledged they often think about

leaving. The Pearson Product Moment Correlation between the NAQ-R and the MOAQ pre-

intervention was r = 0.48. Thirty-four percent of respondents believed it unlikely they could find

a job with another employer for the same pay and benefits. When asked about supporting each

other and working as a team, 14% did not feel they were supported and there was not a

cooperative effort to promote teamwork. Eighteen percent of RNs disclosed feeling people did

not respect each other on the units they most frequently worked.

There was significant difference (p = 0.0136) when comparing the pre and post-

knowledge survey scores. Knowledge scores improved after the intervention by as much as

63%. The pre-intervention knowledge survey revealed that participants did not recognize

bullying and incivility behaviors: being rude (12%); not assisting others on your team (14%);

showing resentment towards a co-workers efforts (8%); rolling your eyes while others are

speaking (11%); not returning email or phone messages (58%) and not stopping others from

berating or belittling co-workers (4%). Participants did not believe bullying and incivility: cause

psychological symptoms in victims (4%); decrease quality patient care (2%); and are costly to

healthcare organizations, undermine the nursing profession and harm patients (8%). These

civility best practices were not recognized in participants: the use of clear communication

verbally, non-verbally and in writing (3%); my words and actions affect others (7%); mentoring

others (58%); and being interested and respectful of what others have to say (2%). All

participants recognized that turnover was an indication that bullying may be taking place (See table 2).

The post-intervention knowledge test included two open-ended questions regarding what the participant would do differently if experiencing or witnessing bullying in the future. Of the 63.4% respondents who indicated they would do something differently if experiencing bullying in the future, 81.4% reported they would confront the person or address the situation. Slightly more (66.7%) answered the question to list what if anything he/she would do differently if witnessed bullying behaviors of a colleague. The predominant responses (74.2%) were to speak up/address or support/protect the co-worker.

The post-survey also included five questions that pertained to the educational program. Regarding the program objectives, 100% either strongly agreed or agreed the objectives were clear and the objectives were met. Most (96.8%) felt the information was relevant to practice; 92.4% gained new information about their responsibilities in addressing bullying behaviors; and 98.9% felt the method of delivery of the education was conducive to their learning.

Discussion

Consequences of WB are serious. These behaviors threaten patient safety, RN safety, and the nursing profession. Bullying diminishes self-worth, self-esteem, and confidence. Ultimately, these behaviors put RNs at risk of making deadly errors while delivering patient care. Results of this project indicated that RNs did not always behave professionally.

The ANA recommends a "Zero Tolerance" for bullying behaviors and outlines nurses' responsibilities in stopping this violence (*ANA*, 2015a). Studies showed increasing awareness, education, and addressing WB immediately and consistently deters the violence (Khadjehturian, 2012; Kvas & Seljak, 2014; Lachman, 2014; Stanley, Martin, Michel, Welton, & Nemeth, 2007;

Wilson, Diedrich, Phelps, & Choi, 2011). The educational intervention portion of this project was based on the ANA's Position Statement calling for "Zero Tolerance" and ANA's COE's nine provisions. Both publications recommend increasing awareness and education on ending bullying behaviors (ANA, 2015; *ANA*, 2015a). Policy developments including strategy proposals that promptly and persistently address bullying were incorporated into the educational intervention.

The intervention reviewed terminology and illustrated bullying actions. Positive response to the NAQ-R increased when repeated after the education. This reflected a positive relationship between the education and awareness of bullying behaviors. These findings were expected based on recommendations to incorporate continuing education to increase WB recognition/prevention as a standard for all healthcare organizations (Croft & Cash, 2012; Gillespie, Gates, & Fisher, 2015; Keller et al., 2016; Lachman, 2014).

A review of the provisions indicated the responsibility of the individual nurse in addressing bullying amongst colleagues. Bullying should be addressed immediately and consistently utilizing policies when addressing this healthcare issue (Crabbs & Smith, 2011; Dimarino, 2011; Elmblad et al., 2014; Wilson, 2016). Being cognizant of one's own actions, using clear, effective communication, conflict negotiation, and using a respectful, professional demeanor when addressing others were foci of the intervention. Intervention resources from organizations including the ANA, Joint Commission, the WBI, and OSHA were supplied to participants.

Confronting the bully and *addressing the situation* were stated by participants in response to what they would do differently if experiencing bullying by a colleague following the education. These findings correspond with the recommendations of effective communication

and acknowledgement of the behaviors suggested by the NCSBN (2016) and the ANA (2015a).

Respondents stated they would *support and protect the colleague* and *speak up and address the*

behavior of the perpetrator when asked what they would do differently if witnessing bullying of

a colleague after the education. Promoting healthy interpersonal relationships and being

conscious of own behavior "including actions taken and not taken" is the RN's responsibility to

colleagues and to the nursing profession (ANA, 2015, p. 7).

Exposure to unmanageable workloads was reported by 93% of the respondents.

Contract negotiations were occurring between the institution and the RNs concurrently. Staffing

ratios were the central issue and the parties were at an impasse. The political environment

regarding nurse-patient ratios and the atmosphere during negotiations cannot be discounted as an

issue that may have impacted the responses regarding unmanageable workloads.

WB is costly to organizations and contributes to burnout, absenteeism, intent to leave,

and turnover (Armmer & Ball, 2015; Bacher & Visovsky, 2012). In this study, the relationship

between NAR-Q and intent to leave was in the moderate range (r = 0.48) and was higher than

reported by Einarsen et al (2009). The importance of collaboration and listening to others was

addressed in the education. McNamara (2012) reported that communication and teamwork were

key elements in building a culture of safety, optimizing outcomes, and preventing adverse

events. The project results confirmed that 14% of RNs did not feel there was a cooperative effort

to promote teamwork. Additionally 18% of respondents disclosed feeling that coworkers did not

respect each other on the units they most frequently worked. The results of the MOAQ revealed

that almost half of the respondents intended to leave their current position within the next year.

These results mirror the literature. Staff turnover may diminish trust between remaining staff

members, which causes teamwork to suffer (Dimarino, 2011). In light of the expected nursing

shortage predicted to exceed one million by the year 2022 (United States Department of Labor Bureau of Labor Statistics, 2013), it is imperative that bullying behaviors are addressed to prevent the loss of nursing professionals.

Being ignored or excluded, having opinions ignored, being ignored or facing a hostile reaction when approached, and being exposed to unmanageable workloads comprised highest percentages of NAQ-R positive results in a survey of nurses in three facilities in a university hospital system in the Midwest (Wright & Khatri, 2015). The findings in this study are consistent with the literature.

Limitations

Limitations of this project include lack of generalizability to other populations as it was conducted in a specific place and time. Ongoing attention to this problem by organizations might allow for change. The NAQ-R measures perceived exposure to bullying at a point in time. In this study the tool was administered pre and post-intervention. Participation was another limitation. Email distribution of the survey may have contributed to a low response rate. Nurses may have lacked private access or time to complete the survey while at work and the RNs were in the midst of contract negotiations and unresolved staffing and nurse-patient ratio issues may have impacted participation.

The sensitivity of the subject is also a limitation. Bullying behaviors are underreported due to fear of retaliation and lack of trust. Those feelings may impede an individual from completing a survey (Wright & Khatri, 2015). Lack of gender and ethnic diversity may also be considered a limitation, as the respondents were predominately female and Caucasian. Men and women witnessing bullying react differently (Mulder, Pouwelse, Lodewijkx, & Bolman, 2014). There currently are no definitive data on how bullying exists among male nursing staff.

Conclusion

WB is present in all settings. It is shocking misconduct that leaves the victim fearful and damages self-esteem. In nursing, patient safety is also compromised. Bullying and violence are underreported or under recognized. Often colleagues do not address the perpetrator. Crabbs and Smith (2011) surmised, "taking no action is taking action and results in the passive approval of destructive behaviors" (p. 9). WB causes adverse effects on the entire healthcare team. More than 75% of respondents in this study reported they would intervene in the future by confronting the bully and addressing bullying behaviors.

As a respected profession, nurses need to stand up and speak out about this devastating issue that profoundly impacts their wellbeing and patients' outcomes. The ANA's position statements and COE empowers nurses to live up to the expectation that they will represent nursing, its profession and members, and hold themselves responsible for articulating nursing values, maintaining the integrity of the profession and its practice, and shaping social policy. Additional work is required to sustain programs that help nurses' address and stop bullying. The nursing profession will also need to work together and with legislation to enact laws to enforce punishment of bullying behaviors. Currently there are none. Allowing WB to continue without intervening makes those who ignore these acts as liable as those who commit these acts. It is a nurse's onus to address the needs and safety of their colleagues and themselves.

Table 1
NAQ-R Pre/Post Survey Response Comparisons

NAQ-R Questions The following behaviours are often seen as examples of negative behaviour in the workplace. Over the last six months, how often have you been subjected to the following negative acts at work?	Pre-Survey Results % Positive (n = 132)	Post-Survey Results % Positive (n = 93)
1. Someone withholding information which affects your performance	37.1	49.5
2. Being humiliated or ridiculed in connection with your work	33.1	57
3. Being ordered to do work below your level of competence	35.1	28.6
4. Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	28.1	28
5. Spreading of gossip and rumours about you	29.7	46.7
6. Being ignored or excluded (being 'sent to Coventry')	68.7	91.3
7. Having insulting or offensive remarks made about your person (i.e. habits and background), your attitudes or your private life	22.9	32.6
8. Being shouted at or being the target of spontaneous anger (or rage)	38.5	40.9
9. Intimidating behaviour such as finger-pointing, invasion of personal space, shoving, blocking/barring the way	18.9	28
10. Hints or signals from others that you should quit your job	9.9	18.3
11. Repeated reminders of your errors or mistakes	31.8	58.1
12. Being ignored or facing a hostile reaction when you approach	52.3	77.4
13. Persistent criticism of your work and effort	39.8	67.7
14. Having your opinions and views ignored	89.9	95.6
15. Practical jokes carried out by people you don't get on with	4.6	8.7
16. Being given tasks with unreasonable or impossible targets or deadlines	41.5	46.7
17. Having allegations made against you	20.9	17.6
18. Excessive monitoring of your work	42.3	59.1
19. Pressure not to claim something which by right you are entitled to (e.g. sick leave, holiday entitlement, travel expenses)	29.8	32.3
20. Being the subject of excessive teasing and sarcasm	31.2	54.3
21. Being exposed to an unmanageable workload	92.8	96.8
22. Threats of violence or physical abuse or actual abuse	9.8	16.1

Table 2

Knowledge Pre/Post Survey Response Comparisons

Question	Pre-Survey % Correct Answer (n=132)	Post-Survey % Correct Answer (n=93)
1. It is my responsibility to make sure my colleagues are safe.	78	97.9
2. Bullying and incivility behaviors may consist of:	41.7	97.9
3. Bullying and incivility:	83.3	98.9
4. One indication that bullying and incivility may be taking place.	100	100
5. Civility best practices include:	42.4	97.9
6. Important to respond to anyone that has not been civil to me or colleague	72.3	96.8
7. 4 Provisions of ANA's COE that speak to RNs obligation	14.5	77.8

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