A MODEL TO MANAGE WORKPLACE BULLYING BETWEEN NURSES AT A PRIVATE HOSPITAL GROUP IN SOUTH AFRICA

by

Suseth Goosen

submitted in fulfilment of the requirements for the degree of

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Supervisor: Prof. J.D. Mokoena

Co-supervisor: Prof. S. Lekalakala-Mokgele
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DECLARATION

I declare that the thesis hereby submitted to Sefako Makgatho University for the degree Doctor of Philosophy in Nursing has not previously been submitted by me for a degree at this or any other university, that it is my work in design and execution, and that all material contained herein has been duly acknowledged.

S Goosen

16 January 2019

201221839

Date
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Nurses should be carers but are not always caring for one another. Workplace bullying between the nurses are common practice and is often becoming a discussion topic between nursing colleagues and it is supported by literature. Bullying of nurses in the workplace has different distinctions, but the most prominent was nurse-to-nurse-bullying.

Bullying is a critical issue affecting nurses in various healthcare facilities both public and private. Consequently, bullying always interferes with job performance and quality of patient care, as this have a devastating physical and psychological impact on the nurses. Bullying has been determined as one of the factors that promote staff dissatisfaction and high employee turnover. Addressing bullying between nurses at work becomes necessary to manage the phenomenon.

The study sought to discover solutions to manage workplace bullying in a private hospital group in South Africa. A sequential mixed methods study design was utilised to obtain data with a quantitative questionnaire and qualitative semi-structured face-to-face interviews to add to the richness of the study. The quantitative results and qualitative findings were integrated to arrive at an overall interpretation of the collective and complementary findings and validated by the literature.

The findings indicated that there are trends such as high prevalence of bullying in the private hospital group with the direction that seniors are bullying juniors with mostly psychological techniques. Stress and workload were found to contribute to the bullying that is taking place. The model developed in the study suggested solutions that can be employed such as reporting of bullying, management action when incidents of bullying are reported, and policies to manage bullying. The leadership style also plays a role in curbing bullying. Effective communication, awareness and support in the form of negotiation and counselling can assist to address bullying issues. Motivators for change in bullying behaviour was identified as values such as respect and trust, skills, workplace environment and teamwork.

Moreover, the study proposes a model that can be employed in the management of nurse-to-nurse bullying in the workplace. Concrete solutions and recommendations are also presented in the study. The recommendations are practical solutions that have worked in other settings and can play a crucial role in limiting or curtailing nurse-to-nurse bullying in the workplace.

Keywords: Nurse-to-nurse bullying, model, trends, management, motivators, behaviour change.
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## LIST OF ABBREVIATIONS AND ACRONYMMS

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<tbody>
<tr>
<td>ANA</td>
<td>American Nursing Association</td>
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<tr>
<td>ANOVA</td>
<td>Analysis of variance</td>
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<tr>
<td>CC</td>
<td>Critical Care</td>
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<tr>
<td>CDE</td>
<td>Centre for Development and Enterprise</td>
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<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
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<td>EAP</td>
<td>Employee assistance programme</td>
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<td>Ed</td>
<td>Education</td>
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<tr>
<td>EE</td>
<td>Employment Equity</td>
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<tr>
<td>EI</td>
<td>Emotional intelligence</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>ENA</td>
<td>Enrolled Nurse Auxiliary</td>
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<tr>
<td>FS</td>
<td>Free State</td>
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<tr>
<td>G</td>
<td>Gauteng</td>
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<tr>
<td>GDoH</td>
<td>Gauteng Department of Health</td>
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<tr>
<td>HR</td>
<td>Human Resource Manager</td>
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<tr>
<td>ICN</td>
<td>International Council for Nurses</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>KMO</td>
<td>Kaiser-Meyer-Olkin</td>
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<tr>
<td>KZN</td>
<td>KwaZulu-Natal</td>
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<td>L</td>
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<td>M</td>
<td>Mpumalanga</td>
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<tr>
<td>Man</td>
<td>Management</td>
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<td>Med</td>
<td>Medical</td>
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<td>Mi</td>
<td>Midwifery</td>
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<tr>
<td>MREC</td>
<td>Medunsa Research &amp; Ethics Committee</td>
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<tr>
<td>NAQ-R</td>
<td>Negative acts questionnaire - revised</td>
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<tr>
<td>NC</td>
<td>Northern Cape</td>
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<tr>
<td>NE</td>
<td>Nurse Educator</td>
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<td>NM</td>
<td>Nurse Manager</td>
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<td>NN</td>
<td>Neonatology</td>
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<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
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<td>OT</td>
<td>Operating theatre</td>
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<td>P</td>
<td>Paediatrics</td>
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<td>PSHSA</td>
<td>Public Services Health &amp; Safety Association</td>
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<td>Abbreviation</td>
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<tr>
<td>PSI</td>
<td>Public Services International</td>
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<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>Qual</td>
<td>Qualitative</td>
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<td>Quan</td>
<td>Quantitative</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RSA</td>
<td>Republic of South Africa</td>
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<td>SANC</td>
<td>South African Nursing Council</td>
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<td>SD</td>
<td>Standard deviation</td>
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<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<td>Surg</td>
<td>Surgical</td>
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<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UM</td>
<td>Unit Manager</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VETO</td>
<td>Violence Educational Training Operational</td>
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<td>WC</td>
<td>Western Cape</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1 – ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Nursing is about softening the suffering and celebrating the joy with patients. In the health domain, the concept ‘suffering’ is primarily linked to tragedy, pain, hardship, loss and disfigurement (Oliveira, 2015:223). However, the Vietnamese Buddhist monk and peace activist, Thich Nhat Hanh, not only identifies suffering as “problems of the world like hunger, war, oppression and social injustice” (Hanh, 1998:31), but he also connects suffering to a lack of communication, using words that are untruthful, or words of hatred and division causing suffering. For the nurses of today, their entry into professional practice where they can serve humanity with dignity, compassion and care within “the safe walls of the hospital” (Fink-Samnick, 2015:165) can mean going from a “buddy” experience (Duchscher, 2008:444) to a “bully” experience.

In setting the scene for this study of bullying among nurses, Chapter 1 reviews nurse-to-nurse bullying as a concerning issue. The aim of the study introduced here is to cover information about the nature, extent and consequences of the bullying problem. In this chapter, the purpose and objectives of the current study are presented. It will further give an overview of the research methods used and how the rest of the study was organised.

Bullying in nursing is a serious issue affecting the nursing profession. Consequently, it interferes with nurses' job performance and quality of care (Murray, 2009:273) because of the devastating physical and psychological impact it can have on them (Cunniff & Mostert, 2012:1). Bullying behaviour in hospitals may be the catalyst perpetuating staff dissatisfaction and a high employee turnover (Cunniff & Mostert, 2012:1; Lala, Lala & Dangor, 2017:64). The American Nursing Association (ANA) defines bullying as repeated and unwanted actions designed to humiliate, cause distress, offend and undermine the recipient (American Nursing Association, 2015). Bullying is undeniably categorised as an act of violence similar to, amongst others, physical violence, psychological violence and sexual violence (Momberg, 2011:14, 16). Recent research on workplace bullying points out that workplace violence in the form of bullying occurs in nursing environments worldwide. In fact, Blando, Ridenour, Hartley and Casteel (2015:2) assert that, “It has been documented in the literature that nurses and allied health professionals are at an increased risk of workplace violence compared to other professionals.” Clearly, bullying is abusive conduct and should not be tolerated in any work environment – workplace bullying should specifically not occur in nursing, a career publicly and professionally characterised as a caring profession (Adams, 2016:1-2).
When the term “violence” is used, it is automatically connected with criminal acts such as murder, rape, terrorism, or civil unrest. This is visible violence. Violence like harassment, discriminatory actions, and intimidation are hidden acts of violence directed at targets in vulnerable positions. This is invisible violence (Kristen, Banuelos & Urban, 2015:71). Workplace bullying implies a variety of behaviours that include intimidation, inaccurate accusations, verbal abuse, spreading rumours, social exclusion, and undermining an individual’s professional status (Cunniff & Mostert, 2012:1-15).

Described in the *Concise Oxford English Dictionary* (2006) as the deliberate intimidation or persecution of “those who are weaker”, the act of bullying also robs targets of their human dignity. Human dignity is understood as the right of a human being to have a sense of pride characterised as “the expectation that one is worthy of honour and respect” (*Concise Oxford English Dictionary*, 2006) under all conditions and in any circumstances. Human dignity is one of the fundamental rights entrenched in the South African Bill of Rights contained within the Constitution of the Republic of South Africa as amended by Act 5 of 2005. It is clearly outlined in the Bill of Rights (Republic of South Africa, 2005) that every South African “has inherent dignity and the right to have their dignity respected and protected irrespective of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth”. Every citizen deserves to be treated with dignity and respect in their personal, as well as public life, thus including their place of work.

Workplace bullying is not only unacceptable on moral grounds, but the devastating physical and psychological effects this form of violence has on employees (Cunniff & Mostert, 2012:1) may be a catalyst perpetuating staff dissatisfaction and a high employee turnover. Nurse-to-nurse bullying impacts negatively on the mental and physical health of nursing staff, which in turn may compromise quality of care resulting in patient dissatisfaction (Fink-Samnick, 2015:168). In this regard, the researcher reflects on her own experience.

When this study was conducted, the researcher was aware that bullying incidents were high. It was an everyday occurrence witnessed in practice and it was mentioned in hospital corridors, although no name was given to the practice. Specifically, nurse leaders in South Africa expressed the urgency for bullying to be addressed, reduced and if possible eradicated (Lala *et al.*, 2017:64). This study, however, looked beyond the premise that reducing bullying was a priority. When she realised nurses felt threatened by the culture of bullying which prevailed in their work environment, the researcher concluded that there was an urgent need to develop interventions to reduce this behaviour. It is important that strategies and skills to manage workplace bullying behaviours are identified. Moreover, she was convinced if such
interventions could be developed and implemented, it would reinvigorate interest in nursing as a career in South Africa. Like most countries, South Africa is currently experiencing a nursing shortage (Lala et al., 2017:64; Rispel, 2015:1). Although acknowledging there might be many reasons for the shortage, the researcher believed the fear of being bullied coupled with the subsequent feelings of demotivation and depression which Yildirim (2009:505) states “affect nurses’ performance of their duties and negatively shape their relationships with their patients and peers.” Additionally, bullying negatively affect nurses’ level of job satisfaction which leads to a high staff turnover ultimately resulting in patients not receiving safe and quality care (Lala et al., 2017:64). The aim of this study was to develop a model to manage nurse-to-nurse workplace bullying in a private healthcare group in South Africa based on scientific research findings on the topic.

1.2 BACKGROUND TO THE STUDY

Bullying has become one of the most critical challenges in the workplace today. Yamada (2008:1) argues that bullying often inflicts harm on the employees, as well as the organisation. Bullying in the workplace often inflicts physical and psychological injuries to the employees and such tendencies often affect the productivity and the morale of the workers. As Yamada (2008:1) states, many people in the workplace are likely to be exposed to the tendencies of bullying at some point in their working lives. Workplace bullying presents challenges to various organisations. Samnani and Singh (2012:581) argue that workplace bullying has recently gone past the 20-year mark to the extent that the vice has grown tremendously. Media outlets such as the Wall Street Journal and The New York Times have run feature stories on bullying in the workplace (Yamada, 2008:1). Bullying refers to the deliberate verbal intimidation and/or repetitive psychological mistreatment or harming of a worker by a co-worker or senior worker. Kaminski and Sincox (2012:2) include “yelling, screaming or cursing, social ostracism, unjust criticism of work performance, and withholding information or other resources needed to perform the job” as verbally abusive behaviour in a workplace (Akella, 2016:10).

Workplace bullying was first identified by Heinz Leymann a psychologist, in the 1980s (Cunniff & Mostert, 2012:2). Leymann (1996:165) used the phrase “mobbing others at work” to describe psychological violent behaviour over long time periods directed at targets who are unable to defend themselves due to the unequal distribution of power in an organisation. Bullying in the workplace has been classified under interpersonal community violence by the World Health Organisation (WHO) (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002:6; Shabangu, 2011:5). According to Krug et al., (2002:18), in the United Kingdom (UK) it was found that “53% of employees have suffered bullying at work and 78% have witnessed such behaviour.”
Chang and Daly (2012:182) established that between 1% and 4% of the workforce in Europe experienced some form of workplace bullying, while in Australia workplace bullying was found to be between 50% and 57%. In South Africa, Krug et al. (2002:18) report workplace violence as “abnormally high” with 78% of employees indicating they had at one time or another experienced bullying within their place of work. This finding is similar to that of an Internet survey conducted in South Africa by the Work Dignity Institute in 2000, who reported that 77.8% of South Africans feel bullied in the workplace (Cunniff & Mostert, 2012:3). This high percentage of nurse bullying in the Republic of South Africa (RSA) is confirmed by Meyer and Kirsten (2014:2) who mention that 78% of the employees who participated in a South African survey indicated that they had experienced at least psychological violence in their careers (Cunniff & Mostert, 2012:3; Ellis & Dryden, 2007).

The Occupational Safety and Health Administration (OSHA) in the United States of America (USA) recently reported that workplace violence in healthcare has become a major problem in the whole country. According to OSHA, over a 12-month period physical abuse was reported by 21% of registered nurses and nursing students and “over 50% were verbally harassed” (a category of bullying). In addition, “over a period of 7 days, 12% of all emergency nurses were targets of physical abuse while 59% experienced verbal abuse” (OSHA, 2015:3). The fact that bullying in healthcare has also become a major concern in many European countries suggests that violent practices in healthcare settings are not confined to one country or region and pose a critical problem within the profession (Lowenstein, 2013:22-25). According to Cunniff and Mostert (2013:2), studies done in South Africa on workplace bullying focus mainly on the health sector.

In the nursing profession, workplace bullying is a serious issue, since it makes the target feel defenceless and significantly demoralises his/her right to dignity in the workplace (Murray, 2009:273). Just as any other employees, nurses tend to evaluate themselves in terms of what they have accomplished in their job. If they see their job as hampering the achievement of their full potential, it often becomes difficult to maintain a sense of purpose and accomplish tasks. From the psychological point of view, the work of the nurses can be an important source of identity, self-esteem and self-actualisation for nurses (Murray, 2009:273). Consequently, it can provide a sense of fulfilment by giving them a sense of purpose and by clarifying their value to society (Longo & Sherman, 2007:34). When bullying becomes the norm in the workplace, nurses lose their ability to perform their duties and aspects such as identity, self-esteem and self-actualisation diminish (Murray, 2009:273).
Nurse-to-nurse workplace bullying has a negative effect on the target and his or her family, colleagues who witness it, the healthcare institution, as well as the nursing profession (Kaminski & Sincox, 2012:13). Affected nurses take more sick days, are less satisfied with their jobs, and are more likely to have symptoms of post-traumatic stress disorder (PTSD) (Kaminski & Sincox, 2012:13). In essence, bullied nurses who are anxious, depressed, exhausted and scared of being bullied on a daily basis cannot deliver safe, quality patient care – and nursing remains a human service where the safety of the patient is paramount (Kaminski & Sincox, 2012:13). Patient outcomes make the mental health of the workforce particularly critical because of the way in which the manifesting trauma can reflect on the quality of care and overall patient safety (Kaminski & Sincox, 2012:13). In this regard, Fink-Samnick (2015:172) asserts that when professionals have a feeling of disempowerment in addressing the dynamics of bullying, whether manifesting as insults or threats toward them or patients and their families, the outcomes can have far-reaching implications. Management also pays the price, since nurses who are subject to bullying are more likely to leave their jobs and take more sick days, which consequently lead to staff shortages (Fink-Samnick, 2015:172).

Similar findings on how nurse-to-nurse bullying can affect nursing as a profession and health institutions were found in the literature. These include a lowered safety culture due to the inferior quality of patient care, poor job performance, costly resignations from the job and the profession, low job satisfaction, and unsatisfactory occupational goals (Hutchinson, Jackson, Wilkes & Vickers, 2008:E67; Johnson & Rea, 2009:84; Simons, 2008:E55-56; Stelmaschuk, 2010:4; Walrafen, Brewer & Mulvenon, 2012:7). A central issue in many research studies and surveys on bullying in nursing practice is to determine the “why”. The findings of Di Martino (2002a:Foreword) indicate perpetrators of psychological violence, which includes bullying, are generally employees who “have more power” or feel superior to their colleagues for some reason. But, as Hutchinson et al. (2008:E65) point out, workplace bullying is a negative way of using power. Johnston, Phantharath and Jackson (2010:37), Simons (2008:E49), Stelmaschuk (2010:5) and Walrafen et al. (2012:7) agree that workplace bullying occurs because violence is tolerated, there is a lack of policies and procedures to address the problem, and workers abuse their authority. In addition, they state that employees feel they lack support from management and teamwork is non-existent. These are some of the tendencies that perpetuate acts of bullying.

Nurses may spend 70% to 90% of their time in an environment where they are exposed to repeated and health-harming mistreatment such as verbal abuse (yelling, screaming or cursing), offensive conduct which is threatening, humiliating, or intimidating (social ostracism, unjust criticism of work performance) and/or work sabotage (withholding information or other
resources needed to perform the job) (Kaminski & Sincox, 2012:2). As targets, the nurses can experience negative psychological effects manifesting as emotional exhaustion, depression, and experiencing feelings of anxiety, disenchantedment and demotivation. It can also result in the onset of chronic illness (Johnson & Rea, 2009:84).

Nurse-to-nurse bullying is categorised as either incivility, horizontal (lateral), or vertical violence. The perpetrator can be another nurse, a nurse shift leader or a manager within the same organisation in particular (Johnston et al., 2010:36; Walrafen et al., 2012:6). Whereas civility concerns a value system that promotes safety in healthcare working environments, nurse-to-nurse bullying is categorised as incivility and can present as vertical or horizontal violence (The Joint Commission, 2016:1). Lateral violence occurs when nurses or groups of nurses on the same level (e.g. nurse managers or registered nurses) are both targets of an oppressive situation and, instead of confronting the system, they turn on each other. “Those involved internalise feelings such as anger and rage, and manifest those feelings through behaviours such as gossip, jealousy, putdowns and blaming” (US Legal, 2014). If the perpetrator is someone in an equal or the same position, e.g. a registered nurse within the same unit who incessantly belittles another, interferes with another registered nurse’s provision of care, shouts at, or spreads rumours about staff members, it is known as horizontal bullying (Walrafen et al., 2012:6).

Einarsen, Hoel and Notelaers (2009:29) found the most common bullying behaviours among nurses include being given unmanageable workloads or impossible targets or deadlines, being ordered to carry out work below a nurse’s competence level, being ignored (ignoring a nurse’s professional opinion), withholding information relevant to their work, and being humiliated or ridiculed about their work (often in front of other nurses and co-workers). Furthermore, Ariza-Montes, Muniz, Montero-Simó and Araque-Padilla (2013:3122) state in scientific literature, several types of bullying in health settings have been studied including intimidation, harassment, targetisation, aggression, emotional abuse and psychological harassment or mistreatment. All of these bullying practices (whether singularly or in combination) have a negative impact on nurses ranging from personal suffering to a higher staff turnover and absenteeism, lower productivity and less commitment to the organisation, which in turn impacts negatively on the standard of patient care (Abe & Henly, 2010:120; Magnavita & Heponiemi, 2011:203; Simons, 2008:8; Stelmaschuk, 2010:5).

The literature reveals that there seems to be a stoic perception within the global nursing community that bullying “is part of the job” (Stokowski, 2010:1; Walrafen et al., 2012:7). Confirming these authors’ view, Blando et al. (2015:2) state if employees simply accept that violence (bullying in this context) is “just part of the job”, it can lead to underreporting. Meissner
advocated that specifically novice nurses tend to accept nurse-to-nurse bullying “as part of the job” and this led to the coining of the well-known phrase “nurses eat their young”. The fact that Stokowski (2010:1), as well as Walrafen et al., (2012:7) agree that nursing communities simply seem to accept bullying as “part of the job” echoes Mandela’s words that many “who live with violence day in and day out assume that it is an intrinsic part of the human condition” (Korin, 2016:257). But it is not. Mandela’s assertion that “violence can be prevented” and “violent cultures can be turned around” (Korin, 2016:257) is an important message of hope for nurses bullied and oppressed in the workplace. This message was also inspirational for the current investigation into the phenomenon, since it was perceived that workplace bullying nullified the self-belief and self-worth of nurses who worked in the study setting; which could damage organisational performance and consequently also the reputation of the hospital.

Di Martino (2002b) reflects on a report concerned with framework guidelines for addressing bullying in the health sector developed by the International Labour Office (ILO), the International Council for Nurses (ICN), the World Health Organisation (WHO) and Public Services International (PSI). The report includes studies conducted in Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand. It lists South Africa as the country with the second highest incidence of psychological violence including bullying (after Bulgaria). South Africa has the highest frequency of racial and sexual harassment in the workplace. Murray (2009:273) incorporates his viewpoint in the following statement on workplace bullying in the nursing sector:

This silent epidemic in nursing usually is driven by the perpetrator’s need to be in complete control of an individual, regardless of the pain and suffering inflicted on the target. … Furthermore, the bully strategically plans to involve other employees in the bullying behaviours, either voluntarily or by coercing them into the abusive behaviour. Very frequently these minions cooperate out of fear of being the next target.

(Murray, 2009:273)

In South Africa, the crippling phenomenon of workplace bullying (Hewett, 2010; Steinman 2003) occurs at a time when the profession can hardly afford to lose trained nurses or other healthcare personnel (Walrafen et al., 2012:7).
1.3 SOUTH AFRICA’S HEALTHCARE SYSTEM

The South African healthcare system is fundamentally made up of two different systems, the public health system and the private health system. The public sector serves as the major nurse employer (Smith, 2012:63). The private health system is a large, well-developed, resource-intensive and highly specialised sector made up of hospitals, clinics and private practices. The current study to assess the status of workplace bullying among nurses was conducted in a private healthcare group. The private sector is said to have fewer human resources and less excess capacity than generally claimed (Centre for Development and Enterprise [CDE], 2011:11), and this is one of the key factors that can induce bullying between nurses due to work overload. Both the private and public healthcare sectors play a significant role in providing healthcare services to the South African population. Potential proliferation of bullying between nurses calls for the need to improve the working conditions within the sectors in order to improve the healthcare outcomes for patients and curb the rising shortage of professional nurses (Pellegrini, 2016).

1.3.1 Nurse categories in South Africa’s healthcare system

In the South African healthcare settings, three categories of nurses are employed, namely: registered nurses (RN), enrolled nurses (EN) and enrolled nursing auxiliaries (ENA). According to the South African Nursing Act No. 33 of 2005, the nurse categories have different circumscribed roles and mandated scopes of practice which are not interchangeable. Differences in roles and scope of practice can also induce bullying among the nurses because a group might think they are superior to the other groups based on the type of work they do in the hospital.

1.3.2 Nursing workforce as a resource

Nurses are a scarce resource (Lala et al., 2017:64). It is therefore imperative that the nursing workforce should be treated as a significant strategic resource where they work in harmony and coordinated manner in both public and private healthcare systems. Nurses play a critical role in healthcare settings, and since their roles have significant implications not only for patient outcomes, but also financial implications in healthcare organisations (Smith, Ranchod, Strugnell & Wishnia, 2018:23-24), discord among them in a workplace might be detrimental to provision of health services to the people. Nurses in the private healthcare system promote the corporate brand of the organisation within the competitive private healthcare system by providing quality healthcare to patients (Becker & Huselid, 2006:898; Toffoli, Rudge & Barnse, 2011:338). Furthermore, organisational performance, productivity, turnover, profit and market
value outcomes are positively correlated with individual employee performance (Chakrabarti & Chatterjea, 2017:239). However, discord and hostility among them significantly reduce individual employee performance.

Competitive advantage is achieved when organisations utilise the capabilities, resources, relationships and decisions that facilitate the strategic positioning of the organisation within the operating environment. Therefore, reduction in bullying and related forms of hostility among the nurses can be a stepping stone of healthcare organisations to build competitive capacity among the nurses thus leveraging on their skills, commitment and motivation to achieve exceptional healthcare services (Çalışkan, 2010:102).

Empirical evidence indicates that although employees are a source of strategic advantage to organisations, their attitudes and perceptions regarding their tasks, work environment, organisational structures, feedback and motivation levels, which are also related to the nature of relation between workers, influence organisational failure or success (Shore, Bommer, Rao & Seo, 2009:701). Greyling and Stanz (2010:9). Therefore, health management fraternity is encouraged to treat nurses as humans with specific needs as opposed to “cogs working in a giant machine”.

1.3.3 Working environment

The workplace conditions can have a significant influence on the individual employee and organisational productivity. Taiwo’s (2010:301) interpretation of the workplace is that it is an environment containing all the forces, actions and related influential factors which potentially boost or inhibit employees’ performance. Within the workplace, total interrelationships exist among and between employees and between employees and the physical workplace environment (Taiwo, 2010:301). Healthcare organisations should therefore focus on designing and managing personnel systems by matching human resource practices and policies which will ensure the provision of proper working environments characterised by positive interpersonal relationships for the nursing workforce (Taiwo, 2010:301). The positive interpersonal relationship determines whether there will be elements of bullying or not.

The type of work environment in which employees operate determines the level of their output, which then indirectly affects the level of organisational performance. Human factors within the working environment consist of the labour management relations, social and psychological conditions. Stress and physical fatigue form a significant element of the working environment (Taiwo, 2010:299). The literature emphasises the need to provide proper workplace environments (Bulutlar & Öz, 2009:273; Dillon, 2012:17) and highlights that the work
environment not only affects employee dedication and capabilities, but also has long-term effects on employees’ health (Taiwo, 2010:301). Barker (2011:344) and Steinman (2012) both emphasise that work-related factors causing emotional stress to healthcare personnel can profoundly damage their personal health. For example, this can occur when a nurse attempts to learn a new procedure or complete a task and the supervisor or manager is never satisfied or keeps on interfering with or criticising the former’s work (Murray, 2009:274). That is a kind of bullying, which lower the worker’s morale to work diligently. Furthermore, according to Hutchinson et al. (2008:E60), personal-related factors lead to workplace bullying. They report people tend to observe and copy behaviour, attitudes and emotional reactions to become part of a group, thereby contributing to an acquired bullying workplace culture (Simons, 2008:E50).

Van Schalkwyk, Els and Rothmann (2011:285) state work relationships have been documented as one of the critical components of the work environment. The work environment is characterised into “conducive or toxic” work environments (Van Schalkwyk et al., 2011:285). A work environment that is conducive will motivate employees and facilitate the application of positive behaviours and competencies (Noah & Steve, 2012:36). A conducive work environment also facilitates behaviour change – from irresponsible behaviour such as harassment and bullying to more responsible behaviour (Taiwo, 2010:302). In the health domain, a conducive or healthy work environment is characterised by Moore, Leahy, Sublett and Lanig (2013:172) as having positive interactions (e.g., supportive leadership and good communication among the multidisciplinary team) which heal and empower healthcare workers to achieve personal and organisational goals.

In the case of teamwork, Fink-Samnick (2015:166) states fractured team communication can potentially damage the quality of care, because the team is unable to effectively dialogue with each other. In fact, Yoder-Wise (2014:375) stresses positive collegial relationships between and among nurses result from good communication, mutual acceptance and understanding, persuasive rather than coercive relations, and by maintaining a balance between reason-driven and emotive responses when dealing with others.

On the other hand, toxic work environments induced by negative and irresponsible behaviour such as bullying are a source of unpleasant experiences; it inhibits the application of competencies and facilitates the development of negative behaviour among employees (Noah & Steve, 2012:36). In toxic work environments, employees can adopt irrational and irresponsible behaviour in order to survive (Taiwo, 2010:302). Moreover, conflicting and negative work relationships are nationally and internationally recognised as a relevant and destructive phenomenon. Bullying created negative workplace relations and as depicted by Van Schalkwyk et al. (2011:293), negative work relationships among and between employees
are highly prevalent in the following sectors: academic, financial, government, manufacturing, mining and “other”. The authors emphasise there is a need to promote “supportive positive supervisory relations” and employee inclusion in the work environment as a means of enhancing job satisfaction (Van Schalkwyk et al., 2011:293).

Bullying constitutes negative relations which “poison the work climate” and is therefore negatively correlated with job satisfaction and nurse retention (Noah & Steve, 2012:36). It affects the levels of employee commitment and organisational citizenship behaviours, thus leading to high turnover intentions. Turnover intentions affect the levels of employee productivity. Specifically, in a healthcare setting, less staff equals a higher workload and additional responsibilities and role engagements for existing staff, which does not boost organisational commitment (Davoudi, Fartash, Allahyari & Yarahmadi, 2013:13).

Employee satisfaction is a critical factor in the service industry where employees are in direct contact with customers and are in a position to influence customer outcomes (Davoudi et al., 2013:13). Therefore, healthcare organisations need to improve the workplace conditions for the nurse to ensure that they are positively influenced to meet the needs and demands of the organisation. Moreover, such an initiative needs to be pursued to promote positive patient outcomes. Davoudi et al. (2013:21) argue that it is upon the leadership and management of an organisation to provide a suitable work environment for employees and avoid hostile and unethical issues such as bullying which increase pressure and stress among employees. Nurses are also encouraged to realise that stress affects professional relationships and therefore the need for stress management programmes in the workplace is a matter of urgency (Greyling & Stanz, 2010:9).

1.4 PROBLEM STATEMENT

Bullying is a profoundly challenging phenomenon in the nursing profession. Existing scientific research indicates most researchers have focused on the definition of bullying, its prevalence and the factors leading to workplace bullying. Studies or surveys conducted with the aim to find possible solutions or to obviate – or at least prevent or avoid – workplace bullying in nursing environments are scarce. In fact, Cunniff and Mostert (2012:2) state they could find only one study in South Africa, that of the Work Dignity Institute conducted in 2000, which investigated the prevalence of workplace bullying. In 2002 the ILO, ICN, WHO and PSI made known that specifically healthcare workers are at high risk for workplace-related violence (including bullying), which leads to not only extreme emotional stress and physical harm endured by individual healthcare workers, but also damages the image of the nursing profession, as well as that of the institution (Krug et al., 2002:18). As a result, the researcher
was interested in assessing the prevalence of bullying among nurses and establish a model that would provide solutions to the bullying problem to improve the workplace environment and healthcare services.

If and when nurse-to-nurse bullying occurs, the expected reaction of either the target or witness would be to report it. However, as stated by Dobos (2015), by far the majority choose to “stay under the radar” because they feel vulnerable or simply accept it as “part of the job”. According to Dobos (2015), nurses who stand up for themselves or others such as a bullied colleague, are vulnerable to abusive, bullying behaviours such as verbal abuse, threats, humiliation, intimidation, work sabotage which prevents work from being done, misuse of authority, and the deliberate destruction of relationships (Fink-Samnich, 2015:166). Consequently, this study demonstrates that bullying prevents the nurses from using their talents and sharing their wisdom, knowledge and values to positively influence care and support.

Base on the assertions in the study conducted by Murray (2009:275), because the little action taken towards addressing the problem of workplace bullying is completely inadequate, there is a dire need for institutionalising measures for protecting nurses from workplace bullying. Currently, no model for managing workplace bullying in the private hospital environment in RSA exists. The focus of this study in providing a practical model for managing workplace nurse-to-nurse bullying will assist nurses and nurse leaders in contributing to the creation of a positive work environment (Saam, 2010:52). As a result, the private healthcare sector will enhance a conducive work environment that will have a direct impact on lowering the high rate of nurse turnover in institutions. Also, it will strengthen nursing as a profession and increase job satisfaction, as well as patient safety and satisfaction.

The researcher’s intent to make a positive contribution towards a possible solution for the studied phenomenon by developing a model to manage nurse-to-nurse workplace bullying in a private healthcare group in RSA. To achieve this challenging goal, it was necessary to clarify the contributing factors and motivation needed by nurses to transform the bullying culture in a private hospital environment in RSA into a solid professional culture where teamwork is cultivated, dialogue reinvigorated, professional identity acknowledged and respect for human dignity upheld.
1.6 PURPOSE OF THE STUDY

The purpose of the study was to develop a model for managing nurse-to-nurse workplace bullying in a private healthcare group in RSA. The model will help in managing the workplace bullying and determine the necessary skills and motivating factor nurses viewed as essential for finding solutions to workplace bullying.

1.7 RESEARCH QUESTIONS

The following four research questions guided this study:

- What are the perceptions of nurses towards the contributing factors to workplace bullying between nurses in a private hospital group in RSA.
- How do nurses in a private hospital group in RSA perceive the management of workplace bullying between nurses?
- What are the strategies used by nurses in a private hospital group to manage workplace bullying?
- What are the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses at a private hospital group in RSA?
- What model could be developed to manage workplace bullying between nurses at a private hospital group in RSA?

1.8 STUDY OBJECTIVES

To answer the research questions, four objectives were formulated:

- Determine the perceptions of nurses regarding the contributing factors towards workplace bullying between nurses in a private hospital group in RSA.
- Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
- Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
- Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.
- Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.
1.9 RATIONALE FOR THE STUDY

The World Health Organisation (WHO) framework guidelines were adapted specifically for the South African healthcare sector and the Violence Educational Training Operational (VETO) training programme was developed and piloted by the Gauteng Department of Health (Steinman, 2012). Specifically, the guidelines were aimed at supporting the development of violence prevention policies in non-emergency settings. Consequently, the guidelines were designed to better manage the physical security of the healthcare facilities (Steinman, 2012). Steinman (2012) emphasises that this was a continuous leadership-dependent process.

Ten years after the implementation of the VETO programme, bullying continues to be widespread in South African hospitals. Khalil (2009:210) differentiates between levels and types of bullying in public hospitals in Cape Town, RSA. Of the 471 respondents who participated in the study, 45% indicated that bullying occurred. The perpetrators were mostly nursing managers and registered nurses. In another study by Hewett (2010), 87% of participants stated non-physical violence was often inflicted on student nurses in the clinical setting. Underreporting of bullying is a common finding (Hewett, 2010: iii). Engelbrecht (2012:12) found that only 5% out of a total of 676 undergraduate students never experienced any bullying incidents and that, on average, the respondents experienced between five and ten incidents over a 12-month period. She also found that 70.9% of the respondents decided to do nothing about their experience, while 59.3% indicated that they had developed emotional barriers. The current researcher believed it essential for nurses’ behaviour to change from within and therefore decided to explore a potential solution for managing workplace bullying to be maintained by nurses themselves, rather than by the nursing leadership per se.

Developing a model for managing workplace bullying and using the input of nurses would not only assist private healthcare organisations in RSA, but might also assist the public healthcare sector in RSA and other countries to manage workplace bullying effectively. Such a model might also be applicable in other organisations where bullying is rampant. By assisting the organisations to deal with workplace bullying, the model would enable organisations to avoid the negative impact workplace bullying has on important factors such as financial costs, the declining health of employees, reduced employee morale and high turnover levels. It was envisaged that the study would furthermore contribute towards the existing body of knowledge on workplace bullying, especially through studies focusing on solutions for workplace bullying where paucity has been documented. The study might also serve as a foundation for future research on the management of workplace bullying.
1.10 RESEARCH METHODOLOGY

A mixed methods study design was used to study the phenomenon of workplace bullying among nurses in order to generate empirical data which could be used as scaffolding to develop a model to manage bullying among nurses in a private health care group in South Africa. A sequential mixed methods design incorporating both quantitative and qualitative techniques was used in order to gather different but complementary data on the same topic (Creswell & Plano Clark, 2011:77). In a sequential mixed methods design, the data is collected chronologically in phases with each step dependent on the other (Teddle & Tashakkori, 2009:26). The weaving narrative approach was used to integrate the quantitative and qualitative data to present key findings of the research (Fetters et al., 2013:2143).

This study was conducted in three phases.

- **Phase 1:** The initial phase involved the collection and analysis of quantitative data.
- **Phase 2:** In the second phase, qualitative data was collected and analysed thus building on the quantitative phase. The results of Phase 1 were complemented by the findings of Phase 2.
- **Phase 3:** This integration of the obtained collective data prepared the way for the development of the model and this process led to the model development.

The rationale for the study design was that quantitative data provides a general overview of the research problem, while the qualitative data refines and explains statistical data by investigating the participants’ perspectives in depth (Creswell & Plano-Clark, 2011:53). The mixed methods design assisted the researcher to develop a holistic model for workplace bullying from the research findings.

A brief overview of the research process making use of the sequential mixed methods design is presented in Table 1.1.
Table 1.1: Summary of the research process

<table>
<thead>
<tr>
<th>Phase 1: Quantitative</th>
<th>Phase 2: Qualitative</th>
<th>Phase 3: Model development</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Research objective</strong></td>
<td>Determine the perceptions of nurses regarding the contributing factors towards workplace bullying between nurses in a private hospital group in RSA.</td>
<td>Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.</td>
</tr>
<tr>
<td></td>
<td>Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.</td>
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<td></td>
<td>Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.</td>
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<td></td>
<td>Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.</td>
<td></td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>Quantitative</td>
<td>Qualitative</td>
</tr>
<tr>
<td><strong>Population samples</strong></td>
<td>All positions of nurses working at a private hospital group ±8 000 nurses comprising of: • Registered nurses • Enrolled nurses • Enrolled nurse auxiliaries • Nurse managers • Nurse educators</td>
<td>Nurses working at a private hospital group in Gauteng (N=2221). The nurse positions included: • Registered nurses • Enrolled nurses • Nurse managers • Nurse educators • Human resource manager (with nursing qualification)</td>
</tr>
<tr>
<td><strong>Sampling method</strong></td>
<td>Convenience sampling</td>
<td>Purposive sampling</td>
</tr>
<tr>
<td>Phase 1: Quantitative</td>
<td>Phase 2: Qualitative</td>
<td>Phase 3: Model development</td>
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<tr>
<td><strong>Data collection</strong></td>
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<tr>
<td>Self-administered questionnaire with:</td>
<td>Semi-structured individual interviews and field notes</td>
<td>Validation instrument</td>
</tr>
<tr>
<td>- Demographic data</td>
<td>- Tell me what you and other nurses can do to change the</td>
<td></td>
</tr>
<tr>
<td>- Frequency and type of workplace bullying</td>
<td>bullying at work.</td>
<td></td>
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<tr>
<td>- Factors contributing to workplace bullying</td>
<td>- What changes do you think should happen in the work</td>
<td></td>
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<tr>
<td>- Response to bullying</td>
<td>environment to manage bullying behaviour?</td>
<td></td>
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<tr>
<td>- Current management of bullying</td>
<td>- Tell me what you think management should do in order</td>
<td></td>
</tr>
<tr>
<td>- Managing workplace bullying</td>
<td>to address the problem of bullying at work.</td>
<td></td>
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<tr>
<td><strong>Data analysis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Descriptive and inferential statistics (SPSS, Release 23 statistical package)</td>
<td>Tesch’s data analysis approach</td>
<td>Inductive and deductive reasoning</td>
</tr>
<tr>
<td>Quantifying open-ended data</td>
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<tr>
<td><strong>Rigour</strong></td>
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<tr>
<td>Pilot study of questionnaire</td>
<td>Credibility, confirmability, dependability, transferability and authenticity</td>
<td>Expert review</td>
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<tr>
<td>Cronbach’s alpha testing</td>
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<tr>
<td><strong>Data integration</strong></td>
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<tr>
<td>Data from quantitative questionnaire</td>
<td>Data from quantitative phase and literature review</td>
<td>Data from quantitative and qualitative phases, literature review and control</td>
</tr>
</tbody>
</table>
1.11 SIGNIFICANCE OF THE STUDY

The fundamental significance of this study is based on the fact that it explores nurse-to-nurse bullying in the workplace as an emerging and increasing problem in private hospital groups in South Africa, but with limited attention and research works. The results obtained from this study will provide the private hospitals’ management fraternity with greater insights regarding trends and factors that contribute to nurse-to-nurse bullying in their workplace environment. Through the management model proposed here in, this study tends to provide solutions that would enhance change in negative behaviour leading bully characters among nurses. The ability of the management to use the new proposed model is to influence change of negative behaviour and motivate nurses to focus on their work duties. Currently, no model exists to manage workplace bullying between nurses in the South African private healthcare industry.

1.12 DEFINITION OF KEY CONCEPTS

1.12.1 Bully

A “bully” is the perpetrator of the bullying behaviour, for example, the person using verbal abuse, physical violence and emotional abuse. Daniel (2009:1-16) explains bullies can take the form of individuals in supervisory roles or ordinary employees and involve both genders. Escartín, Zapf, Arrieta and Rodríguez-Carballeira (2010b:1) adopt the definition of Webster’s New Encyclopaedic Dictionary (1995), which defines a bully as “an individual whose alleged strength and valour emanates from intimidating weaker individuals”. Bullying can occur in the form of horizontal or lateral violence, harassment, intimidation and mobbing.

In this study the concept “bully” will mean the person perpetrating negative acts called bullying.

1.12.2 Workplace bullying

Workplace bullying is seen as one aspect of violence in health care and is classified under interpersonal community violence by the World Health Organisation (WHO) (Krug et al., 2002:6, Shabangu, 2011:5). Bullying can be categorised as incivility, horizontal, or lateral violence in the workplace, since the perpetrator could either be another nurse, a nurse shift leader, or a manager within the same organisation (Walrafen et al. 2012:6). The perception within the nursing community is that “it is part of the job” (Stokowski, 2010:1; Walrafen et al., 2012:7).
Although the term “workplace bullying/bullying” was found in literature to be defined in various ways, it is important to note that these differences depended on the contexts of the research studies and surveys. For the purpose of the current study, the meaning that Einarsen et al. (2003) (cited by Notelaers, Einersen, De Witte & Vermunt, 2006:289) attached to the term was appropriate and acceptable, namely:

Bullying at work means harassing, offending, or socially excluding someone’s work tasks. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process, it has to occur repeatedly and regularly (e.g. weekly) and over a period of time (e.g. 6 months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative acts.

(Einarsen et al., 2003, cited by Notelaers, Einersen, De Witte & Vermunt, 2006:289)

Steinman (2003) and Barker (2011:343) accept this definition as suitable to understand the term “bullying in the workplace”.

In this study, “workplace bullying/bullying” will refer to a situation or situations in which a nursing colleague repeatedly causes emotional distress (such as anxiety, fear, or stress) to another by using degrading emotional or physical means. Bullying is viewed as both a one-to-one situation or as propagated by groups of employees in the workplace environment.

1.12.3 Nurse

The International Council of Nurses (ICN) define a nurse as a person trained in “behavioural and nursing science to promote health, prevention of illness, care of physically ill, mentally ill and disabled person of all ages”. They are further responsible for “healthcare teaching”, partake as a “team member”, to supervise care and are “involved in research” (International Council of Nurses, 2018).

The South African Nursing Council defines a nurse in the Nursing Act (2005:6) as “a person registered in a category in order to practise nursing or midwifery”.

The concept “nurse” in this study will refer to a trained person that performs caring actions for patients in his/her care.
1.12.4 Nurse categories

According to the Nursing Act, No 33 of 2005 a nurse is a person who is registered as such in terms of Section 31 of the Act. For this study, a nurse category is the nurse with a specific qualification and the functional role that he/she needs to perform.

1.12.4.1. Registered nurse

For this study, a registered nurse (RN) is a person who is qualified and skilled to practise comprehensive nursing independently in the manner of and according to his/her scope of practice and who is capable of assuming responsibility and accountability for such practice (Republic of South Africa, 2005:25). Registered nurses (RNs) receive four years' training.

1.12.4.2. Enrolled nurse

For this study, an enrolled nurse (EN) is a nurse who is trained to provide basic nursing in the manner of and according to the scope of practice of an enrolled nurse (Republic of South Africa, 2005:25). An enrolled nurse (EN) receives two years' nursing training.

1.12.4.3. Enrolled nursing auxiliary

For this study, an enrolled nursing auxiliary (ENA) is trained to provide elementary nursing care in the manner of his or her scope of practice (Republic of South Africa, 2005:25). An enrolled nursing auxiliary (ENA) receives only one year of training.

1.12.4.4 Nurse manager/management

Refers to the performance of functions of leadership and decision-making within healthcare facilities. Management in nursing also involves directing, staffing, planning, controlling and organising (Murray, 2017:45).

For this study, the nurse manager is a registered nurse that leads a nursing team by performing nursing administration and supervision functions and includes middle and executive management levels.
1.14.4.5 **Nurse educator**

According to the regulations (SANC 1987, R118, para 1(i)), a nurse educator is a person who has undergone a programme of education at an approved education institution and who is registered for an additional qualification in nurse education. For this study, a nurse educator is a registered nurse with an additional nursing education qualification that conducts teaching and coaching functions in nursing theory and practice.

1.12.5 **Nurse-to-nurse bullying**

Nurse-to-nurse bullying can be categorised as incivility, horizontal or lateral violence in the workplace, since the perpetrator could either be another nurse, a nurse shift leader, or a manager within the same organisation (Walrafen et al., 2012:6).

For this study, nurse-to-nurse bullying refers to any and all bullying acts towards another nurse regardless of the direction.

1.12.6 **Private hospital group**

For this study, a private hospital group is a set of hospital buildings, owned and managed by a company outside of the state healthcare sector.

1.12.7 **Management**

Management is the individual or the group of people through which organisations set and carry through their objectives by making use of planning, organising, directing and controlling principles in harnessing physical, financial, human and informational resources efficiently (Akrani, 2011)

In this study management would mean to lead a team of nurses to reach the caring objective.

1.12.8 **Workplace**

The *Concise Oxford English Dictionary*, (2006) defines the “workplace” as “the place where people work”.

In this study, the “workplace” will refer to the private hospital where the participants were employed as nurses according to their nurse categories.
ORGANISATION OF THE STUDY

For the purpose of clarity and enhancing the flow, this study was structured into eight chapters.

**Chapter 1:** The chapter introduces the South African healthcare system and the challenges experienced such as nurse turnover and shortages in RSA's healthcare settings. The chapter also covers the role of nursing and nurse categories in the country's healthcare setting. It further presents views on nurses as a strategic resource in the healthcare environment; hence, a quality work environment is required to ensure job satisfaction. The concept of bullying is introduced, background on the topic is given and the problem statement presents the paucity in research studies focusing on solutions to workplace bullying, as well as the need to develop a model for managing workplace bullying. In Chapter 1, the research questions and objectives are outlined and the limitations, assumptions and key terms are described.

**Chapter 2:** Relevant literature and findings on workplace bullying are presented and discussed. The chapter focuses on the factors for workplace bullying, the prevalence of workplace bullying, impacts of workplace bullying, approaches towards the management of workplace bullying, specific strategies for managing workplace bullying, a history of solutions to workplace bullying and different perceptions towards solutions to workplace bullying.

**Chapter 3:** The research methodology is addressed. Specifically, the chapter presents the research design, research methods, sampling procedures, data collection, data analysis, as well as internal and external validity of the study. The chapter also presents a justification for the adopted research design and methodology. It further presents rigour, trustworthiness and the ethical considerations adhered to in the study.

**Chapter 4:** The data collection process is presented in two chapters. Chapter 4, the first of the two chapters, focuses on the collection and analysis of the quantitative data. It covers data management and analysis, the research findings, an overview of the research findings and a chapter conclusion.

**Chapter 5:** This chapter presents the qualitative data collected for the study purposes. The chapter follows the same structure used in Chapter 4.

**Chapter 6:** The researcher integrates the findings from the quantitative and qualitative data and discusses the main findings in terms of the contribution of this study to the management of workplace bullying, as well as to the body of knowledge on workplace bullying in general. The discussion is structured to address the different research questions and objectives.
Chapter 7: This chapter is dedicated to the researcher’s model for managing workplace bullying. The model highlights the possible strategies for managing the phenomenon and the motivators of workplace bullying.

Chapter 8: This chapter concludes the study by summarising the study findings. The chapter further presents the implications of the findings for nursing practice, policy in private healthcare organisations and the implications for the management of such organisations. The chapter also revisits the research limitations and proposes areas of interest for future studies.

1.14 SUMMARY

The chapter presented an overview of the South African healthcare system which consists of two major sectors, the public and the private sector. Both sectors experience significant challenges. The chapter reviewed the role of the nursing fraternity in healthcare settings. Due to the significant role played by nurses in healthcare settings, the researcher presented an argument for the need to view nurses as a strategic resource assisting healthcare organisations to achieve strategic goals and objectives. Therefore, the need was highlighted to provide a quality working environment and adopt strategies for ensuring job satisfaction among nurses.

The cause of workplace bullying is perceived to be a poor working environment and job dissatisfaction among nurses. Bullying poisons the work environment due to negative interpersonal relationships and therefore has negative effects on healthcare organisations, nurses and patient outcomes. Researchers have called for the establishment of intervention measures to curb workplace bullying. For these reasons, the foundation for this study was laid by presenting the study background, purpose, aims and objectives. The purpose of the study was to develop a model for managing workplace bullying in a private hospital group in South Africa. The chapter discussed the significance of the study together with the theoretical and practical contributions. Specifically, it was stated the study findings would hopefully supplement the limited research on solutions for workplace bullying. On a practical level, the study proposes a model which might facilitate the management of workplace bullying in healthcare settings.
CHAPTER 2 – LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is concerned with providing a comprehensive overview of previously published research on workplace bullying. The presented literature review provides a wider understanding of the concept of bullying and how it manifests in the nursing profession, particularly in hospital settings.

2.2 REVIEW OF PREVIOUS WORKS

A literature review is the exploration and critical analysis of published information to form the theory base of a research topic (Aveyard, 2010:45) which, in the case of this study, was workplace bullying in a specific private hospital group in South Africa. For researchers it is vital to get acquainted with and obtain as much knowledge as possible from available evidence-based scientific resource materials relevant to their study topics. A literature review highlights previous research conducted on the current topic; it can reveal existing gaps in the field of study, it allows researchers to determine the feasibility of their study and promotes new knowledge (Hofstee, 2009:51). Although workplace bullying is a well-researched area, limited information is available on the management of nurse-to-nurse workplace bullying in a private hospital environment, which is the focus area of this study.

Literature was accessed with the use of online databases such as EBSCOhost, ProQuest and ScienceDirect, as well as open access accredited journals and local and international theses and dissertations. Websites were further used to source workplace bullying forums and training material. Keywords used were “bullying”, “workplace bullying”, “nurse-to-nurse bullying”, “bullying and healthcare”, “work violence”, “nursing” and “South Africa”.

Apart from reading broadly in the field of workplace bullying and conducting an extensive literature review with particular attention being paid to bullying in the healthcare arena, the researcher also met and discussed the issue with international experts at the Workplace Bullying Conference in Milan in June 2014. This contributed largely to her knowledge base. The sharing of information and experiences with global leaders in the field of workplace bullying was insightful and reinvigorated her determination to make a positive contribution towards addressing and hopefully eliminating this silent epidemic (Murray, 2009:273) in private hospitals and other healthcare settings.
Presently, a culture of nurse-to-nurse bullying still prevail in hospitals (Hewett, 2010; Hutchinson et al., 2008:E120). According to Hewett (2010:iii), the extensiveness of the problem shows no improvement and protection of nurses has not been achieved. Barker (2011:342) confirms Hewett’s (2010:22) arguments that little progress has been made in curbing this destructive phenomenon. However, Steinman (2012), an experienced and a well-known South African expert on workplace violence, disagrees with these assertions and argues that specifically in the Gauteng Department of Health (GDoH) the adoption of the violence educational training operational programme (VETO) has contributed significantly towards reducing workplace violence, including all forms of bullying.

Barker (2011:342-343) emphasises that earlier research on workplace bullying mostly focused on the causes and effects of workplace bullying with few studies contributing towards developing sustainable solutions for the problem. This is attributed to the failure of leaders and the management of most organisations to realise the injurious effects of workplace bullying, despite reports indicating that organisations suffer high financial losses due to workplace bullying (Barker, 2011:342-343).

Walrafen et al. (2012:7) named the following methods aimed at reducing bullying: awareness, cognitive behaviour techniques, individual resilience improvement and participation in change. Barker (2011:345) advocates for an emotionally intelligent, self-actualised and positive work environment that supports a culture of trust and respect to minimise negative forms of behaviour. The standards put in place by nursing professional bodies require healthcare organisations to ensure codes of conduct and other mechanisms to discourage healthcare workers from engaging in disruptive behaviours and encourage them to report disruptive behaviour (Murray, 2009:275).

Researchers emphasise that bullying within healthcare settings mostly go unreported (McKay & Fratzl, 2011:21; Myburgh, 2007:14). This has been attributed to the lack of management taking action – especially when adopting institutional reporting policies and procedures are concerned (Kircher, Stilwell, Talbot & Chesborough, 2011:16; Lutgen-Sandvik & Sypher, 2009:69). In this regard, Myburgh (2007:14) makes the point that a lack of policies in fact legitimatises bullying as part of the organisational culture, also in healthcare settings. The prevailing organisational culture has a significant influence on the organisational climate. The organisational climate is vital for assuring job satisfaction and nurse retention. The organisational culture and climate dictate the acceptable and non-acceptable behaviours within the workplace environment (Castro & Martins, 2010:2).
The organisational climate is the moral construct within the workplace; however, it is characterised by change (Castro & Martins, 2010:3). The organisational climate also covers the global impressions formed through employee interactions and “adopted organisational policies, structures and processes” and is represented by the shared perceptions, feelings and attitudes adopted by organisational members reflecting the organisational values and attitudes which positively or negatively influence employee behaviours (Castro & Martins, 2010:3). In any organisation, including healthcare, the organisational climate serves as the employees’ abstract frame of reference. Hence, in instances where the organisational climate purports bullying as normal, such a climate assists in propagating a marginalisation culture even among new nurses. The management of healthcare organisations is charged with the responsibility of institutionalising organisational policies and programmes for problem identification, prevention and management of abuse in the workplace (Lutgen-Sandvik, Namie & Namie, 2009:41; Verdasca, 2011:13). There is also a need for validating a bully-free optimal organisational culture in healthcare organisations by validating the organisational values through open dialogue with employees as a means of creating a quality work climate (Lutgen-Sandvik et al., 2009:41; Verdasca, 2011:13). Moreover, most organisations struggle to identify and assuage the problem of workplace bullying (Georgakopoulos, Wilkin & Kent, 2011:1).

Consequently, a need exists for efficient formal reporting systems to assist nurses to acknowledge and identify the causes of bullying incidents. Importantly, bullying reporting systems should be accompanied with bullying protection systems. That means there should also be systems in place protecting nurses from the reprisal of bullies in order to promote or encourage nurses to keep on reporting incidents of bullying to the relevant authorities (Rocker, 2012:1-11). Myburgh (2007:1) states that there is a need to develop and improve the codes of conduct, regulatory measures and disciplinary measures to minimise incidents of workplace bullying.

Ramasodi (2010:2) states hospitals in the Republic of South Africa need to consider extrinsic job factors which affect job satisfaction among nurses. As a means of developing a caring organisational climate, hospitals in South Africa furthermore need to actively engage strategies which will assure a pleasant working environment, develop quality interpersonal relationships among nurses and their superiors and actively provide support to the nursing staff. Cohen, Stuenkel and Nguyen (2010:308) stress the need to provide a healthy working environment for the nursing fraternity in healthcare settings by exploring viable solutions and intervention strategies to workplace bullying. In addition, Carbo (nd:12) states it is essential to provide solutions for workplace bullying, as targets currently have limited solution paths. The author also endorses the strengthening of limited current solution paths by creating clear and
viable solutions for addressing the pervasive problem of workplace bullying, while at the same time protecting reporting nurses from retaliatory attacks by reported bullies.

Challenging unacceptable behaviours in the work environment, Murray (2009:275) advocates for appropriate and effective ways of addressing problematic issues such as workplace violence. According to this author, failure to take action against bullying deeply embeds bullying activities into the organisational culture, thereby creating situations where bullying is perceived as acceptable and normal behaviour by all employees. Murray (2009:275) propagates the adoption of zero-tolerance policies and continuous training programmes to empower nurses to recognise the signs and symptoms of workplace bullying in healthcare settings. The author thus supports the development of a model for encouraging and ensuring ethical behaviour in healthcare settings.

Considering the presented facts and information on the phenomenon of bullying in the health sector and “its adverse cumulative effect on nurses’ holistic health and on the systems in which psychological violence occurs” (Meyer & Kirsten, 2014:1), the need is amplified to investigate the phenomenon and develop a bullying intervention model aimed at minimising workplace bullying through effective intervention measures.

2.3 OVERVIEW OF BULLYING

Bullying is a form of violence. When the term ‘violence’ is used, people automatically connect it with criminal acts such as murder, burglaries, domestic violence, physical fights and civil unrest. This is visible violence. On the other hand, violent tendencies such as harassment, discriminatory actions and intimidation are hidden acts of violence directed at targets in vulnerable positions. This is considered as invisible violence (Krug et al., 2002:3).

As early as 1983, the International Labour Organisation (ILO), a United Nations (UN) agency, defined bullying as a form of insidious violence. Although there are no visible scars at times, in essence this behaviour leaves the target with invisible scars and it is therefore nothing less than violence. The WHO reaffirms that violence is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (Krug et al., 2012:5).

Bullying is defined in the Concise Oxford English Dictionary (2006) as “the deliberate intimidation or persecution of those who are weaker”, which connects the act of bullying directly to the words “intentional”, “force”, “power” and the phrases “another person” and
“psychological harm” in the WHO’s definition of violence. Hence, it can be posited that bullying is a silent form of violent behaviour that occurs in a situation between two people or groups of people where the side who yields the power (whether it means the perpetrator is in a senior position, older or more domineering) is intent on manipulating a target (the person in the junior position, who is younger, or more withdrawn) into submissiveness despite the emotional pain and suffering it causes the target.

In 2002, the WHO released its first comprehensive summary on violence and its consequences on people’s health on a global scale. Ms Gro Harlem Brundtland, the then Director-General of the World Health Organisation, writes in the preface to the report that violence has many faces and occurs in many settings; it is not distributed evenly across population, race, gender or age groups, educational or socioeconomic status, and environments or settings (WHO, 2002a:Preface). In the context of this study, Brundtland’s remark that “where violence persists, health is seriously compromised” (WHO, 2002a:Preface) has bearing on how people’s emotional pain can manifest as both psychological and physical illness.

The act of bullying further robs targets of their human dignity. Human dignity is understood as the right of a human being to have a sense of pride self-characterised as “the state or quality of being worthy of honour or respect” (Concise Oxford English Dictionary, 2006) under all conditions and in any circumstances. Human dignity is one of the fundamental rights entrenched in the South African Bill of Rights contained within the Constitution of the Republic of South Africa as amended by Act 5 of 2005. It is clearly outlined in the Bill of Rights (Republic of South Africa, 2005: Chapter II, Section 10:6) that every South African “has inherent dignity and the right to have their dignity respected and protected … irrespective of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.” Every citizen deserves to be treated with dignity and respect in their personal and public life, including their place of work.

Although in many countries such as South Africa no specific legal definition of bullying exists, bullying is globally generally understood as the behaviour of a person (or persons) who uses force, threats, coercion, intimidation or aggression to dominate another (Farmer, 2011:197, Harris, 2009:57, Pietersen, 2007:59,). Frequently recognised as being repetitive (Leo, Reid, Geldenhuys & Gobind, 2014:6059, Notelaers, 2010:16) and habitual behaviour (Jenkins, 2011:4, Salin, 2006:2, Smith, 2004:98;) it is also seen as the creation of an unequal balance in terms of social or physical power (Sheridan-Leos, 2008:399). In effect, bullying is thus characterised by real or perceived power differences between bullies and targets.
Direct bullying manifests as behaviour that happens on a face-to-face, interpersonal level. It includes acts of verbal abuse like belittling remarks, public humiliation, criticism, inaccurate accusations, as well as threatening behaviour and intimidation (Einarsen et al., 2009:24). Indirect bullying is subtler. It aims to harm people on an emotional level and to manipulate relationships intentionally, leaving the target feeling they have no way of defending themselves (Escartín et al., 2010b:8).

Power disparities may result from formal supervisory positions held by bullies or from peer pressure originating from ongoing harassment (Lutgen-Sandvik & Sypher, 2009:46; Namie & Lutgen-Sandvik, 2010:345-346; Purpora & Blegen, 2012:2; Salin, 2003:1213; Smith, 2004:98; WHO, 2002b:3). Bullying thus manifests as a collection of verbal and non-verbal acts which create a pattern between bullies and targets. Groups or individuals are targeted on the basis of any of the following: their religion, gender, sexual orientation, class, race, size, strength or ability (Leo et al., 2014:6059). Bullying may also be overt or via more subtle means of intimidating the intended target (Cohen et al., 2010:308) and as Swearer, Espelage and Napolitano (2011) note, is frequently unprovoked by the target.

In terms of understanding the definition better, four main types of bullying behaviours are recognised – emotional (or relational), verbal, physical and, more recently, cyber bullying (Jóhannsdóttir & Ólafsson, 2011:319). Verbal abuse is closely connected with emotional abuse, since it includes psychological bullying and coercion (Jenkins, 2011:19; Leo, et al., 2014:6059). An important distinction made by the ILO (2011:53) is that the definition of bullying is an all-encompassing term for physical and emotional abusive behaviours which manifest as psychological harassment (Lutgen-Sandvik & Sypher, 2009: 65).

Verbal bullying hinders effective communication and is considered as negative communication and negative interactions in organisations (Lutgen-Sandvik & Sypher, 2009:48; Pietersen, 2007:59). In the workplace, the bullying behaviour may come from peers, superiors and potentially even from subordinates (Einarsen, Hoel, Pera & van Tonder, 2005:88; Zapf & Cooper, 2011:14). For this study, the term bullying was used to denote ongoing, unwanted and unprovoked behaviours which intend to create (or maintain) a power imbalance between either groups or individuals in the healthcare work environment (Joubert, Du Rand & Van Wyk, 2005:40; Salin, 2006:10).
2.4 WORKPLACE BULLYING

Workplace bullying is broadly divided into two behavioural categories: direct and indirect behaviours. Whereas direct bullying behaviour is more confrontational face-to-face belittling or public humiliation between the bully and the target, indirect bullying behaviours tend to be more subtle, vindictive actions or words intended to emotionally hurt or damage the target. Nonetheless, both direct and indirect bullying causes psychological damage to the target who struggles to understand why he/she is ignored, misinformed, belittled or not included in social activities or work-related decisions (Cunniff & Mostert, 2012:3). According to these authors, workplace bullying is normally observed to follow a hierarchical pattern in that it spirals downwards from higher ranking individuals (e.g. management) to lower level employees (e.g. secretaries and workers). This stance reaffirms the statement of the South African Department of Labour that a pattern exhibiting bullying behaviours from “top, senior, middle and junior management levels to skilled, semi-skilled and unskilled workers” allows for a clear division in “power relations within the organisation” (Department of Labour, 2010).

Since 1919, the International Labour Organisation (ILO), a United Nations (UN) agency, has brought together governments, employers and worker representatives of 187 member states to set labour standards, develop policies and devise programmes promoting decent work circumstances for all employees. South Africa was a member of the ILO from 1919 to 1966 and then since 26 May 1994 (ILO NORMLEX, 1994). The ILO states in its Declaration on Fundamental Principles and Rights at Work that psychological violence and physical violence should receive the same recognition, since both have severe consequences for the health of employees (ILO, 1998:3). Bullying in the workplace has also been classified under interpersonal community violence by the WHO (Krug et al., 2002:6, Shabangu, 2011:5), as it includes acts of violence in institutional settings like schools, prisons and healthcare institutions (Krug et al., 2002:6). Psychological violence is not only a critical form of violence in the workplace, but also has consequences as severe as physical violence (Krug et al., 2002:6).

Cunniff and Mostert (2012:2) state bullying in the workplace was first identified in the 1980s by the psychologist Heinz Leymann. In an article published in 1996, Leymann describes psychological violent behaviour directed at targets by a few colleagues or a group of people in the organisation over long time periods, or “mobbing at work”, where targets are unable to defend themselves due to the unequal distribution of power in the work environment (Leymann, 1996:165). As Bowie, Fisher and Cooper (2012:12) points out, the original conceptual distinction between bullying and mobbing has given way to a conceptual assimilation of the two concepts. According to Bowie et.al., (2012:12), in current research
endeavours most researchers make no distinction between bullying and mobbing with regard to the number of perpetrators or targets involved. According to this view, one may argue that even if a distinction was accepted, the psychological processes – and the considerable impact on the target involved – appear to be the same for employees all over the world. What is clear is that any activity, whether referred to as “mobbing at work” or “bullying at work”, defies Articles 1 and 5 of the Universal Declaration of Human Rights (UDHR) – adopted after World War II by the General Assembly of the United Nations (UN) in Paris, France on 10 December 1948. Article 1 of the UDHR reads, “all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” Article 5 specifies: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment” (UN, 1948).

Determining the incidence and prevalence of workplace bullying is very difficult, mainly because most cases are unknown to anyone outside of the situation. Nevertheless, estimates from research studies provide some indications of the extent of workplace bullying. Krug et al. (2002:18) state that in the United Kingdom, “53% of employees have suffered bullying at work and 78% have witnessed such behaviour.” In Australia, workplace bullying was found to be between 50 and 57% (Chang & Daly, 2012:182), while Cunniff and Mostert (2012:4-5) discovered between 1% and 5% of the workforce in Scandinavia experienced some form of workplace bullying. Worldwide research on the topic of workplace bullying has notably intensified during the last three decades in countries such as Sweden, Norway, Germany, Austria, Australia and Britain (Fox & Stallworth, 2010:928). Despite the fact that Steinman (2003) mentions that there is a scarcity of studies on the prevalence of workplace bullying per se in South Africa, evidence from the literature reviewed indicates most research on workplace bullying in the country focused on the health sector. For example, Krug et al. (2002:18) report workplace violence that includes bullying as “abnormally high” in South Africa, with 78% of nurse employees indicating they had at one time or another experienced bullying within their place of work. This finding is similar to that of an Internet survey conducted in South Africa by the Work Dignity Institute in 2000 which reported that 77.8% of South Africans nurses feel bullied in the workplace (Cunniff & Mostert, 2012:3). This high percentage of nurse bullying in SA is confirmed by Ellis and Dryden (2007) who mention that “78% of employees who participated in a South African survey indicated that they had experienced psychological violence at least once in their careers.”
In the 1980s, workplace bullying in the teaching and nursing professions in particular became of interest as research areas in Scandinavian countries (Calvert & O’Connell, 2008:3). This led to governments and societies in general becoming increasingly aware of the highly complex issue of workplace bullying in not only these two professional domains, but also in organisations in general (O’Rourke & Antioch, 2016:6). In the view of both Johnson (2009:34) and Notelaers (2010:11), as awareness of workplace bullying increased in the higher echelons of organisations, professions and society, it gradually also heightened the interest of the mass media on the subject which subsequently led to raised public awareness. Sorlin (2013:118) defines the term “mass media” as forms of communication such as radio, television, newspapers, magazines and films that simultaneously reach a large audience of listeners or readers. In the opinion of Oosthuizen (2012:50), readers are especially interested and influenced by newspapers, because the content focuses on community stories and societal issues on both a national and an international level.

The significance of the mass media in shaping the professional image of nurses cannot be ignored. In television dramas, soap operas and movies Oosthuizen (2012:50) states nurses are stereotyped as “unintelligent women in traditional, even obsolete, roles.” From a purposive sample of 161 out of 1 841 newspaper articles on nurses and nursing which appeared in national, regional, daily, weekly and Sunday newspapers, Oosthuizen’s (2012:52,55,57) findings show that, among others, nurses in South Africa were portrayed as lacking leadership; they seemed demotivated, lazy, ruthless and uncaring and in general demonstrated negative attitudes in their relationships with patients and each other. Hospital management also seemed to be uncooperative and under strain, “images of nurses as caring, compassionate and knowledgeable professionals were present, but were overshadowed by negative reporting” (Oosthuizen, 2012:49). Referring to the International Council of Nurses’ (ICN, 2007:1) stance that “unhealthy work environments and the poor organisational climate characterising many workplaces have contributed to the global health crisis” which is also experienced in South Africa, Oosthuizen (2012:49) concludes “newspaper coverage of nursing in South Africa pointed towards unhealthy work environments where nurses suffered from burnout or simply did not care.”
2.5 BULLYING IN NURSING

Duchscher’s (2008:442) doctoral work covered the first 12-months’ transition experiences of Canadian graduate nurses as they entered professional practice. Her research, “A process of becoming: the stages of new nursing graduate professional role transition”, is the result of a 10-year evolving programme exploring new nurse graduates’ transition experience from being a nurse student to being a professional nurse in practice. The experiences of new graduates in the real world rendered some interesting facts related to bullying and harassment in hospitals. Bearing in mind they had just entered clinical practice, the “relentless requests to either assist with or perform procedures for which they had little or no reference” made some anxious and scared to be exposed as “incompetent and subsequently reducing their credibility in the eyes of their colleagues” (Duchscher, 2008:445). Seeking to become accepted and valued by senior or more experienced colleagues, an overwhelming majority of the new graduates experienced “a growing discontent with what they perceived as professional devaluing.” When they started hearing rumours about how senior nurses would chastise and become abusive towards junior staff members, they became uncertain of whom they could trust (Duchscher, 2008:444). One particular graduate nurse was stunned and upset when “new colleagues” gave a detailed description of how they “got rid of” a co-worker (Duchscher, 2008:444):

And then, within my orientation week I was told that the staff had just run off this nurse who wasn’t doing very well. They told me that they had made it so miserable for her that she would leave … and I think they were proud of it – that they had gotten rid of her.

(Duchscher, 2008:444)

Evidence was found in literature that nurse-to-nurse bullying can damage the reputation of health institutions, as well as affect nursing as a profession leading to a lowered safety culture due to the inferior quality of patient care, poor job performance, costly resignations from the job and the profession, low job satisfaction and unsatisfactory occupational goals (Hutchinson et al., 2008:E67; Johnson & Rea, 2009:88; Simons, 2008:E55-6; Stelmaschuk, 2010:4; Walrafen et al., 2012:7). On the contrary, a central issue in many research studies and surveys on bullying in nursing practice is to determine the “why”.

The findings of Di Martino (2002a) indicate perpetrators of psychological violence, which includes bullying, are generally employees who “have more power” or feel superior to their colleagues for some reason. But, as Hutchinson et al. (2008:E65) points out, workplace bullying is a negative way of using power. Johnston et al. (2010:37), Simons (2008:E49), Stelmaschuk (2010:5) and Walrafen et al. (2012:7) agree workplace bullying occurs because violence is tolerated, there is a lack of policies and procedures to address the problem and workers abuse their authority. In addition, they state employees feel they lack support from management and feel teamwork is non-existent.

Nurse-to-nurse bullying is categorised as lack of civility, horizontal or lateral violence. The perpetrator is another nurse, a nurse shift leader or a manager within the same organisation in particular (Johnston et al., 2010:42; Walrafen et al., 2012:6). Whereas civility concerns a value system that promotes safety in healthcare working environments (The Joint Commission, 2016:1), nurse-to-nurse bullying is categorised as incivility and can present as lateral or horizontal bullying or violence. Lateral bullying occurs when nurses or groups of nurses on the same level (e.g., nurse managers or registered nurses) are both targets of an oppressive situation and, instead of confronting the system, they turn on each other (Walrafen et al., 2012:6). Employees involved adopt feelings such as antagonism and anger, and the emotions become evident through behaviours such as gossip, jealousy, insults and accusations (US Legal, 2014).

Einarsen et al., (2009:29) found the most common bullying behaviours among nurses include being given unmanageable workloads or impossible targets or deadlines, being ordered to carry out work below a nurse’s competence level, being ignored (ignoring a nurse’s professional opinion), withholding information relevant to their work and being humiliated or ridiculed about their work (often in front of other nurses and co-workers). Furthermore, Ariza-Montes et al. (2013, cited by The Joint Commission, 2016:2) state in scientific literature, several types of bullying in health settings have been studied including intimidation, harassment, targetisation, aggression, emotional abuse, and psychological harassment or mistreatment. All of these bullying practices (whether in isolation or in combination) have a negative impact on nurses, ranging from personal suffering to a higher staff turnover and absenteeism, lower productivity and less commitment to the organisation, which in turn impacts negatively on the standard of patient care (Abe & Henly, 2010:110; Magnavita & Heponiemi, 2011:203; Simons, 2008:E55; Stelmaschuk, 2010:4).
What is more troublesome is that literature reveals there seems to be a stoic perception within the global nursing community that bullying is acceptable (Stokowski, 2010:1; Walrafen et al., 2012:7). Confirming these authors' view, Blando et al. (2015:2) state if employees simply accept that violence (bullying in this context) as just part of the job, it can lead to underreporting. New nurses tend to accept nurse-to-nurse bullying as they way it should be in the workplace (The Joint Commission, 2016:2). The fact that Stokowski (2010:1), as well as Walrafen et al. (2012:7) agree that nursing communities simply seem to accept bullying as standard practice echoes Mandela’s words that many “who live with violence day in and day out assume that it is an intrinsic part of the human condition” (WHO, 2002b: Foreword). But it is not. Mandela’s assertion that “violence can be prevented” and “violent cultures can be turned around” (WHO, 2002b: Foreword) is an important message of hope for nurses bullied and oppressed in the workplace. This message was also inspirational for the current investigation into the phenomenon, since it was perceived that workplace bullying invalidated the self-belief and self-worth of nurses who worked in the study setting, which could damage organisational performance and thus the reputation of the hospital as well.

According to Ariza-Montes, Muniz, Leal-Rodríguez and Leal-Millán (2014:2657-82), to understand workplace bullying one has to recognise its three main stages, namely focus on the nature of the bully, examination of the target dynamics, and examination of the organisational context and wider cultural factors. The earliest works found on the three stages distinguished by Ariza-Montes et al. (2014:2657-82) include that of Adams (1992:6) which centres on understanding why bullies exhibited abusive behaviours. Subsequently, perceptions that the targets’ own behaviours (Field,1996:330) and characteristics might also play a part in bullying behaviours were investigated by Demir and Rodwell (2012:382). In particular, the research of Demir and Rodwell (2012) highlights the emotional and social experiences and negative results of workplace bullying for nurses. More recently, the seemingly wider acceptance of employees’ and people’s implied and apparent behaviours and characteristics by organisations and societies in which bullying occurs and is accepted, has become of greater interest among researchers (Einarsen et al., 2010:437). This suggests that an understanding has developed recognising that certain human characteristics exist that influence both individual and organisational bullying in the work environment. To shed more light on the negative psychological impact workplace bullying has on employees, as well as the consequent impact on the organisation (specifically on nurses and the private hospital in the context of this study) necessitated a better understanding of the factors associated with bullying, as well as the different forms of bullying behaviours in the workplace.
2.6 FACTORS ASSOCIATED WITH WORKPLACE BULLYING

In the opinion of Blando et al. (2015:1) some serious difficulties are experienced specifically in the healthcare work environment which prevent the successful implementation of programmes to stop workplace bullying. These researchers identified some major barriers to the effective implementation of workplace violence programmes in healthcare settings in the USA. Some of these barriers include "a lack of action despite reporting; varying perceptions of violence; bullying; profit-driven management models; lack of management accountability; focus on customer service; and weak social service and law enforcement approaches to mentally ill patients" (Blando et al., 2015:1). Some of these barriers confirm Salin’s (2003:1213) earlier opinion that bullying in the workplace is due to a complex mix of organisational and societal cultures, the different individual characteristics employees possess, as well as the influence of workloads and job roles. Importantly, the biggest challenge is that these factors interact and in some way or another connect or overlap to create a culture of workplace bullying. What is also important is that workplace bullying usually occurs in the vicinity of other employees who are either prone to bullying behaviour themselves, have been bullied, or are bullied themselves, or colleagues who simply witness the abuse (Salin, 2003:1213).

In sections 2.6.1 to 2.6.4 organisational factors, work environment and psychosocial-culture, and personal characteristics of bullies, their targets and bystanders as factors leading to workplace bullying are described.

2.6.1 Organisational factors

Organisational change is defined by Bamberger, Vinding, Larsen, Nielsen, Fonager, Ryom and Omland (2012:2) as modifications made to the core systems of an organisation, including traditional ways of working, values, structures and strategies including work hours or shift changes, increased employee monitoring, job role changes that can lead to fear over job security, blame, distrust and financial concerns. All these factors can lead to individuals becoming less tolerant of those with whom they are in competition; hence, the potential for bullying is heightened. While this may only manifest in terms of verbal bullying, it can escalate into physical bullying (Hughes & Durand, 2013:165).
Becke (2014:435) states any reorganisation in the workplace can lead to competition among employees for positions and a potential increase in conflicts which may result in bullying behaviours. When major organisational changes occur, a subsequent increase in workplace bullying may be imminent as individuals struggle to maintain a level of control and power in their working segment (Litchfield, Cooper, Hancock & Watt, 2016:7; Sparks, Faragher & Cooper, 2001:489). From an organisational perspective, role conflict and job insecurity are essentially factors which can create a feeling of loss of control and power and therefore individuals may resort to bullying behaviour to re-establish a feeling of control (Baillien, Neyens & De Witte, 2008:132; Balducci, Fraccaroli & Schaufeli, 2011:500; Litchfield et al., 2016:7; Sparks et al., 2001:489). Aspects such as competition for jobs, lack of autonomy, unfamiliarity with technology and routine change have particularly been indicated to increase bullying on a peer-to-peer basis (Boya, Demiral, Ergor, Akvardar & De Witte, 2008:614; De Cuyper, Baillien & De Witte, 2009:206; Mitchell, Ahmed & Szabo, 2014:148; Nolan & Smojkis, 2003:375; Pietersen, 2005:20). Where an individual’s job role and task load are dependent on others, there can be an increased level of coercion through threats of dismissal, disciplinary action, negative performance reviews and a feeling of isolation (Verdasca, 2011:11). In a working environment such as the private hospital group in RSA where this study was conducted, nursing staff are dependent on their superiors and others in authority who could – and sometimes do – abuse their level of formal power by bullying subordinate staff (Botha & Basson, 2010:6).

However, it is not just bullying of subordinates which emanates from organisational politics, but the culture and politics in an organisation can also lead to peer bullying through a desire to sabotage competition or maintain group-agreed conditions. Moreover, if an individual appears to be outside of the accepted group parameters and thus threatens overall cohesion through his/her age, gender, sexual orientation, or race, peer bullying can follow (Leo et al., 2014:6060; Roberts, Demarco & Griffin, 2009:291). On another level, Branch, Ramsay and Barker (2006:9) state allegations of bullying or coercive behaviour are sometimes used as weapons by frustrated staff members who wish to find reasons to cause problems for managers, and thus may make allegations of bullying to voice their dissatisfaction with new organisational practices. Although only allegations, it does not mean it should be ignored, since all allegations and reported cases of bullying must be investigated (Yamada, 2008:1).

Furthermore, a lack of policy and its communication with regard to bullying can increase a target’s feelings of isolation (Branch et al., 2006:7). Especially if poor communication or interaction exists between departments, the potential for increased peer-to-peer bullying is high due to a lack of control (Branch et al., 2006:7). In fact, Dumay and Marini (2011:287)
found that if communication practices and patterns within an organisation are not open and collaborative, day-to-day conversations can be distorted among departments and healthcare staff alike. Poor communication practices increase interpersonal conflict which may escalate to bullying behaviours due to a lack of clear communication policies (Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012:7; Tracy, Lutgen-Sandvik & Alberts, 2006:150; Verdasca, 2011:10). Also, there can be a high level of inter-organisational politics where some individuals withhold information as a means of increasing their own perceived power and alienating others which in essence is a covert form of bullying (Verdasca, 2011:10). When this is combined with feelings of low empowerment or involvement, the target’s isolation increases.

Power is regarded as a central element in workplace bullying (Verdasca, 2011:10). The author emphasises that the power issue plays a definitive role in workplace bullying. Power imbalances in the workplace allow individuals to be in a position to bully those under their control by means of humiliation or social isolation which undermines the targets’ confidence, feelings of self-worth and self-control. In relation to organisational politics, if the overall culture is one which accepts this division of power, then reporting and investigating bullying can be difficult (McGrath, 2010:3; Verdasca, 2011:10). In the case of a hospital environment such as in the current study, nurses frequently feel a lack of power or control in their working environments. The loss of control or feelings of “being in competition with each other” can be precursors of bullying behaviours due to interpersonal conflicts and conflicts within teams and across departments (Demerouti & Bakker, 2011:4; Lin, St John & Mcveigh, 2009:299; Vand den Broeck, Baillien & De Witte, 2011:5).

Bullying behaviour can be displayed by the target’s colleagues and/or supervisors. The latter represents the hierarchy of the organisation and refer (in broad terms) to the top, senior, middle and junior management levels (Department of Labour, 2010). The skilled, semi-skilled and unskilled workers follow, allowing for clear dividing power relations within the organisation. How these power relations play out has important consequences for organisations, because bullying by supervisors can be devastating to maintaining trust (Granstra, 2015:252; Hodson, Roscigno & Lopez, 2006:382-415). However, it seems that supervisors might not be the main culprits. Studies have found that co-workers comprise 3.4% to 71.5% of the aggressors or bullies (Ortega, Høgh, Pejtersen & Olsen, 2009:417). Acts of humiliation, sarcasm, rudeness, practical jokes, isolation and gossiping are the types of bullying behaviour that colleagues practise (South African Board for People Practices, 2018:4).
Organisational factors such as organisational change, the lack of communication, a poor working environment and/or a strained psychosocial environment cannot be singled out as factors which necessarily mean bullying will manifest in the workplace (Skogstad, Torsheim, Einarsen & Hauge, 2011:475). This was confirmed by Becke’s (2014:435) assertion that it is crucial to recognise that the impact of changes within organisations, including healthcare organisations such as hospitals, may be one of many factors contributing towards nurse-to-nurse bullying. What this suggests is that organisational culture may play an integral part in whether bullying manifests and how it is dealt with when raised (Tambur & Vadi, 2012:754). As these authors indicate, the norms and rules of the organisation will inform overall behaviours. Specifically, if a culture of fear and harassment is the dominant approach, then bullying behaviours are more likely to arise (Becke, 2014:435). In addition, if action is not taken when bullying is reported, bullying is seen as an acceptable or even potentially required practice which perpetuates staff behaviours (Gillen, Sinclair & Kernohan, 2008:17). As a result, bullying becomes an ongoing cycle within the organisation with those who may have been bullied becoming bullies if they are promoted (Simons & Mawn, 2011:308).

In order to avoid an ongoing cycle of bullying within an organisation, O’Farrell and Nordstrom (2013:6-17) believe a culture of transparency, accountability and clear practices for dealing with workplace bullying is required. This means ensuring accountability across the organisation for any behaviour which causes negative feelings or powerlessness in employees at all levels. What this does in effect is to assist with managing the psychosocial environment of a workplace which is an additional factor causing bullying.

### 2.6.2 Work environment

When relationships among nurses in a hospital are characterised by abusive tendencies such as bullying, it may impede the provision of quality healthcare to patients. According to Osterman (2010:227), an unsatisfactory psychosocial environment is a risk factor for increased workplace bullying. Interpersonal conflicts in the work environment predispose employees to negative behaviours and attitudes (Braithwaite, Ahmed & Braithwaite, 2008:72) which can include, among others, acts of bullying such as verbal abuse, threatening or belittling co-workers, targetisation, work sabotage (preventing work from being done) and isolation (withholding information) (The Joint Commission, 2016:1).

The nursing profession is commonly associated with shift work, which is work that occurs outside the accepted normal eight-hour (9 to 5) working day. Shift work can disrupt the natural rhythms of the body which can lead to job stress which, in turn, impacts negatively on one’s physiological and psychological state of well-being (Harrington, 2013:279). Job stress together
with high levels of job dissatisfaction, a high workload and little or no support from management can disrupt nurses’ overall health; subsequently, nurses can exhibit negative emotional and/or physical behaviour towards each other (Admi, Tzischinsky, Epstein, Herer & Lavie, 2008:250; Farzianpour, Nosrati, Foroushani, Hasanpour, Jelodar, Keykale, Bakhtiari & Sadeghi, 2015:167). As a result of these disruptions, Ariza-Montes et al. (2013:3122) suggest that shift work can increase the chances of workplace bullying in the nursing profession due to variable work schedules, physical strain and the frequency of working in small teams (Campbell, Messing, Kub, Agnew, Fitzgerald, Fowler & Bolyard, 2011:3). Mitchell et al. (2014:148) agree with Abendroth and Flannery (2006:346) that nurses suffer from high stress levels created by poor working conditions, antisocial working environments and high workloads. Together, all these factors can lead to emotional distress, fatigue and exhaustion compounded by high levels of tension from conflicting service demands, increasingly stringent professional standards and high nurse-to-patient ratios (MacKusick & Minick, 2010:339; McIntosh & Sheppy, 2013:35). In this context, Stelmaschuk (2010:17) identified a significant correlation between emotional exhaustion and increased rates of bullying, as well as indications that age may be a factor with older nurses being subjected to higher levels of compassion fatigue and increased downward bullying to younger staff. However, it is important to note that Stelmaschuk’s (2010:2) study was done in China and therefore cannot be generalised to all nursing environments.

Skogstad et al. (2011:475) argue that the social climate and interpersonal conflicts within a workplace have a stronger correlation to bullying than leadership or role demands. This finding contrasts with Braithwaite et al. (2008:72), who state that one of the causes of bullying closely aligned with organisational factors is that of the leadership approach. Stouten, Baillien, Van Den Broeck, Camps, De Witte and Euwema (2010:19) also recognise that the leadership of an organisation plays a strong role in ensuring an organisation, department or micro-working environment is positive and not conducive to the development of bullying behaviour. In fact, researchers Hoel, Glasø, Hetland, Cooper and Einarsen (2010:453) examined correlations of leadership behaviours with incidents of reported bullying in autocratic leaders. They found specifically these types of leaders showed a higher level of observed bullying practices, but lower levels of reporting. On the other hand, more collaborative and open types of leadership indicated higher levels of reporting against observed bullying practices.
Leadership style is manifested in how conflicts are managed and resolved within an organisation. Where confrontation is the conflict management approach, there is a greater likelihood of aggressive behaviours being adopted. In contrast, a collaborative conflict approach and a low tolerance of bullying demonstrated through organisational practices and policies will encourage reductions in conflict, improve the psychosocial environment and autonomy and thus lower levels of bullying will be observed (Brown, Treviño & Harrison, 2005:118; Bulutlar & Öz, 2009:73; Stouten et al., 2010:18).

Workplace bullying is a serious problem affecting nursing and “involves abuse or misuse of power and authority within an organisation” (Murray, 2009:273). Abusive workplaces contribute to the increasing rate of job dissatisfaction, poor retention, absences from work, lost productivity, and adverse patient outcomes (Murray, 2009:273). Organisational factors can create a work environment where bullying thrives (Di Martino, 2003:7). It can thus be posited that the two distinctive features which should interact well in a hospital to assure safe care and quality patient outcomes are its workforce and their work environment. The achievement of excellence in a hospital therefore depends on the successful interplay among organisational, environmental (work climate) and human factors. According to Coyne (2011:336), it has been recognised that certain personality factors may contribute to be the cause of bullying, while Di Martino (2003:7) suggests the personality of both the target and bully plays a significant role in workplace bullying incidents.

### 2.6.3 Personal characteristics of bullies, their targets and bystanders

Human dignity is one of the fundamental rights entrenched in Chapter II, Section 10 of the Constitution of the Republic of South Africa (Republic of South Africa, 1996) and it must be respected and protected. Everyone in the workplace, irrespective of their position, deserves to be treated with dignity and respect. This right is also set out in Chapter 11, Section 5(3) of the Employment Equity Act, No.55 of 1998 (Republic of South Africa, 1998).

Olsen (2007) highlights the importance to understand bullies, what make them bully others and further states:

> Another surprising feature of those who have been targeted by workplace bullies in management positions is that they do not usually question what is actually happening to them in that they do not understand the clear difference between an acceptable management style and abusive behaviour. They often blame themselves for the bullying because they imagine their personality is incompatible with that of the bully and they think they have somehow brought this on themselves because they lack personality traits that other normal people may have.

(Olsen, 2007:1)
Demographic factors such as age, gender and culture may impact on bullying for targets, bullying perpetrators and bystanders. In discussing the demographic issues that may influence individuals to be perpetrators, targets or witnesses of bullying, it is important to bear in mind that in healthcare settings, there is a “a complex interplay of concerns including organisational issues, professional insecurities, perceived need to assert ‘control’ over the environment and sanctioning of the use of coercive and punitive measures to do so” (Gilmore & Williams, 2012:216). The demographic factors that may impact on bullying for perpetrators, targets and bystanders (or witnesses to bullying actions) are perceived as age, gender and culture, because they are some of the fundamental elements that fuel bullying (Gilmore & Williams, 2012:216).

It seems as if determining targets’ age as a factor related to workplace bullying is a difficult issue globally. Cunniff and Mostert (2012:4) state worldwide researchers have not been able to pinpoint exactly whether the chances of nurses in younger age groups are higher to be targets of bullying and harassment than those of the older nurses or vice versa. For example, Ortega et al. (2009:417) could find no connection between age and “the experience of workplace incivility”. Similarly, Lim (2011:4) conducted a cross-cultural comparison and examination study in Singapore and the USA on workplace bullying, observing that older employees seem to be more susceptible to workplace bullying than the younger generation of nurses. The author nonetheless concluded age to be less of a defining factor than some studies indicate. In South Africa, up till the time of the current study, no research had been done providing evidence-based results that bullying is more prevalent in any specific age group (Cunniff & Mostert, 2012:4).

Investigating the bullying experiences of American navy personnel, Magerøy et al. (2009:344) found the prevalence highest in the younger age group (34 and younger). The findings of Einarsen and Rakness (1997, cited by Cunniff & Mostert, 2012:4) similarly indicate that the younger the employees are, the higher their chances to be targets of harassment and bullying. Notelaers (2010:75) suggests employees between 35 and 44 years old are “more likely to be targets” of bullying. But, acknowledging the contribution of Ortega et al. (2009:417), who reason that age is less important than the level of power held by individual irrespective of their age group, employees are categorised as bullies, targets or bystanders according to the level of “power” they have in the work environment. In Tampa, Florida, Crosby (2015) found that 76% of nurses with at least ten years’ experience reported they had experienced some form of workplace assault in 2013 alone.
With regard to gender, authors Haffner (2009:1), Lim (2011:16) & Zapf, Einarsen, Hoel and Vartia (2003:110) all suggest in general males are more likely to be the perpetrators and females the targets of verbal and physical abuse, i.e. bullying. Females are more likely to exhibit covert bullying behaviours such as emotional intrusion, negativity and spreading rumours (Sepler & Associates 2010, n.p.). What Leymann (1996, cited by Lim, 2011) found interesting from a gender perspective is that there are low levels of cross-gender bullying; it seems males usually bully males and females bully females, a view shared by the work of Gamble and Gamble (2013:416) and Leo et al. (2014:6064). However, all the aforementioned authors’ results present an international perspective on bullying in the workplace. The situation specifically in private hospitals remains largely unknown, despite the fact that it has been “documented in the literature that nurses and allied health professionals are at an increased risk of workplace violence compared to other professionals” (Blando et al., 2015:2).

The third demographic factor is culture. While the scope of this work did not allow for a wider discussion of different cultures and how they perceive bullying, it is important to consider that cultural beliefs and ideologies can impact on whether an individual submits to bullying, perpetrates bullying or chooses not to intervene (Haffner, 2009:11, Oetzel, Ting-Toomey, Masumoto, Yokochi, Pan, Takai & Wilcox, 2001:235).

Elias (2013:130) argues that there are three main types of bullying that include conquerors, performers and manipulators. In the view of Georgakopoulos et al. (2011:3), bullies lack both social competence and emotional intelligence. The authors’ view ties in with the earlier discussed perspectives that bullying demonstrates a lack of empathy for others concomitant with power and control issues. The view of Georgakopoulos et al. (2011:3) resonates with the types of bullying behaviours identified by Carbo (2017:38), who suggests that bullies’ behaviours may be grounded in their own lack of understanding or control of the working environment. Bullies lack empathy, have short tempers and may have been bullied themselves, making them defensive and negative which then manifests in the bullying of others.

Therefore, in the context of the nursing profession, if superiors characteristically lack empathy, have struggled with job roles, organisational changes and/or emotional and physical exhaustion brought about by compassion fatigue and burnout (Hutchinson et al., 2008:664) and they lack emotional intelligence, they are more prone to exhibit bullying behaviours towards peers and/or subordinates (Hutchinson, 2013:569). This is particularly the case in nurses with low self-esteem who feel that bullying behaviour will give them a form of leverage for personal advancement or autonomy (Georgakopoulos et al., 2011:3-4). Conversely, some of these characteristics may also manifest in the target thus contributing to acceptance and
non-reporting of bullying behaviour, thereby reaffirming what Hoel et al. (2010:453) refer to as “the bullying circle”. Georgakopoulos et al. (2011:4) agree that targets of bullying frequently exhibit low self-esteem and a lack of social competence. In addition, Linton and Power (2013:738) argue although bullies and targets share many characteristics, conflicts in the framework of race, gender, as well as the mentioned organisational factors or other perceived differences determine who will be the bully and who will be the target.

Further highlighted by Hughes and Durand (2013:100) is that individuals can be both perpetrators and targets depending on the individual relationships with each employee. In the context of nursing and healthcare, this statement implies that a nurse who is bullied by a doctor or another superior may very well bully her/his colleague(s), thus emphasising the presence of horizontal and downward bullying.

Within the bullying paradigm, the third group consists of the bystander. The bystander may observe bullying behaviour, but does not get involved, nor reports the behaviour. Exhibiting such detached or standoffish behaviour, according to Linton and Power (2013:738), is normally associated with fear and mistrust in individuals who suffer feelings of lack of control. For some, a lack of action is grounded in the fear of being bullied themselves and they therefore use detachment as a form of protection thus tacitly supporting bullying behaviour. According to Haffner (2009:25), the ability to defend a target of bullying or report incidents of bullying behaviour requires high levels of self-confidence, self-belief and faith in the organisational culture and practices where dealing with bullying is concerned. Haffner (2009:22) points out that if there are several bystanders; responsibility is seen as shared. Consequently, no-one takes responsibility – particularly when the bully is an individual with authority. However, with regard to peer bullying in nursing, there are concerns about social exclusion or impacts on workload demarcation that may prevent intervention if the bully is perceived to be “high in social status” (Haffner, 2009:25). The significant issue in a situation like this, however, is that the perception of what small-scale bullying constitutes, as opposed to severe bullying, is subjective to the bystanders (Haffner, 2009:25).

The factors which affect bullying in the workplace appear to be related to an integration of organisational and cultural factors, as well as the individual characteristics of those who bully, or who are targets or bystanders. In the context of bullying in nursing, research on the relationships between healthcare professionals has been investigated over time from various perspectives. For example, Kaminski and Sincox (2012:2) state that nursing has a high level of peer-to-peer bullying. Adams (2014:206) again found nurse-to-nurse bullying behaviour may be downward where supervisors bully subordinates.
2.7 FORMS AND PATTERNS OF WORKPLACE BULLYING

Overt or covert workplace bullying includes behaviours such as verbal abuse (leading to social isolation and exclusion through rumours), physical violence or aggressive behaviours (Farmer, 2011:196; Longo, 2010:S9). Covert bullying is more frequent and mostly occurs where there are no bystanders to witness it (Thompson, 2011:2). However, in all cases of bullying behaviour it is the repetitive, ongoing and incremental nature of the behaviours that cause the most damage (Hufton, 2010:16). According to Thompson (2011:2), the label “bullying” applies when there is interaction or processes that occur repeatedly and regularly over time.

Moreover, it has been established that verbal abusive behaviour is not necessarily confined to one perpetrator, but collective bullying or “mobbing” (where a group bullies a targeted individual) is recognised in Australia, Austria, Denmark, Germany, Sweden, the UK and the USA (Chappell & Di Martino, 2006:21). According to these authors, because the psychological processes and the subsequent impact on the target is similar, the conceptual distinction between bullying (usually individual harassment) and mobbing (usually collective harassment) has blurred into an assimilation of the terms. Little distinction is made in research studies between the terms with “bullying” being representative of both individual and group harassment of an individual (Ariza-Montes et al., 2014:2657-82). However, Cunniff and Mostert (2012:3) warn that it is important to understand the term “group” does not imply ethnicity or racial orientation, but rather refers to gender (men vs. women or vice versa), age discrepancies (the older generation vs. the younger or vice versa) and educational status where “people with higher education feeling superior to unskilled employees and engaging in bullying behaviour” (Cunniff & Mostert, 2012:3). They do not mention differences between shifts such as day shift and night shift.

Cooper, Hoel and Faragher (2004:369) argue that certain types of bullying may be less damaging than others is in stark contrast with many other evidence-based results. Whether one of these bullying behaviours or a combination of them are used is not the issue; the issue is that any form of bullying makes the target feel intimidated and powerless (Purpora & Blegen, 2012:2). Furthermore, any form of bullying has negative and detrimental consequences for targets as they experience it as stressful and suffer severe short- and long-term effects like lowered self-esteem, depression and post-traumatic stress disorder (PTSD) (Meyer & Kirsten, 2014:2).
Moreover, the impact of workplace bullying on the healthcare organisation is profound. The following statement of The Joint Commission (2016:2) highlights the significant impact workplace bullying can have on healthcare organisations, healthcare environments and healthcare employees:

The impact of bullying behaviours on the Organisation are lower morale, lower productivity and increased absenteeism (due to physical, psychological and emotional harm), followed by rapid and increased turnover, which compromises patient safety. Workplace bullying also leads to lawsuits, compensation for disability, loss of profits, negative impact on Organisational reputation, and a corrosion of the patient to health care worker relationship. Employees, patients and families who witness behaviours that are not civil are concerned about how care can be impacted. For example, a nurse who is openly critical of another nurse, or a physician who is openly critical of a nurse.

(The Joint Commission, 2016:2)

The recognition that all forms of bullying causes immeasurable damage to individuals and organisations alike, calls for each of the various types to be identified and examined. According to Namie and Namie (2011:23) and Escartín, Rodríguez-Carballeira, Gómez-Benito and Zapf (2010:532), there appears to be a continuum of bullying behaviours (as shown in Figure 2.1).

![Figure 2.1: Adapted Bullying Continuum (Escartín, Rodríguez-Carballeira, Gómez-Benito & Zapf, 2010:532, Namie & Namie, 2011:23)](image-url)
While a bully may not exhibit all the behaviours, or even work their way through the continuum, recognising that there can be escalation to more severe and thus damaging behaviours can be a useful approach for developing strategies to deal with the problem.

2.7.1 Verbal bullying

Verbal bullying has been identified as a potential early indicator of escalating psychological bullying which could culminate in workplace bullying (Huber, 2013:416; Pye, 2016:3). The highest reported disruptive behaviours in this respect are emotional and verbal bullying grounded in abusive language, as well as demeaning and degrading comments which create an environment of verbal intimidation (Bennett & Sawatzky, 2013:149). Verbal bullying may be used by peers, supervisors, customers, clients or people within the healthcare establishment (Becher & Visovsky, 2012:210; Gimeno, Barrientos-Gutierrez, Burau & Felknor, 2012:30; Joubert et al., 2005:40; Pera & Van Tonder, 2005:88). One of the difficulties with verbal abuse is that no wide consensus exists in terms of defining this practice.

In general, as agreed upon by Gimeno et al. (2012:30) and Rowe and Sherlock (2005:243), verbal bullying is understood as yelling, name-calling, criticism, and the use of language which is humiliating, intimidating or derogatory. Hughes and Durand (2013:100) also include backstabbing, giving unfair criticism or blame and defamatory statements made about individuals or groups as verbal bullying. The highest reported disruptive behaviours in this respect are emotional and verbal bullying grounded in abusive language and demeaning and degrading comments which create an environment of verbal intimidation (Bennett & Sawatzky, 2013:149). In effect, as Braverman (2013:50) highlights, verbal abuse can be recognised as any verbal communication which is perceived as harsh or negative by the receiver. Further examples include gossiping, spreading rumours and manipulating the information targets receive (Cunniff & Mostert, 2012:3). Verbal bullying can adversely affect the work environment, individual health outcomes of targets and in the context of a healthcare setting, and nursing in particular, potentially affect patient outcomes (Bartholomew, 2006:10; Longo, 2010:S9-10).

Studies have highlighted the high prevalence of verbal bullying within the nursing profession (Bartholomew, 2006:10; Gimeno et al., 2012:30). It has been identified as a major cause of high turnover and rising turnover intentions among nurses according to Hughes and Durand (2013:100). The healthcare sector appears to be particularly at risk of staff being exposed to psychological and all forms of harassment, bullying and mobbing (Ariza-Montes et al., 2014:2657-82). In the USA, for example, a report from OSHA (2015:3) indicates that 50% of registered nurses and nursing students admitted they had been “verbally abused (a category
that included bullying) in a 12-month period", while 59% of emergency nurses experienced verbal abuse during a seven-day period. Perpetrators of bullying conduct in this instance included patients, their families, physicians, colleagues and managers or supervisors (The Joint Commission, 2016:1).

Of further significance is the following statement made by Blando et al. (2015:7), "Members of the group can exert more influence because they are acting together and can also reduce the risk of consequences by defending one another should the situation become public knowledge." These authors state that the majority of their focus group participants believed workplace bullying was not effectively addressed in the hospitals, because perpetrators were not being held accountable. Instead, regardless of hospitals' guidelines, bullying has continued because those complaining about the negative behaviour were regarded as problem employees and other nurses have regard it as acceptable practice (Blando et al., 2015:7).

Referring to a ground-breaking study of health care workers across seven countries (Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an affiliated Australian study) which was conducted in 2002 (Di Martino, 2002b:18), Chappell and Di Martino (2006:58) write that this particular study opened the eyes of the rest of the world to the fact that psychological violence in the form of verbal abuse (including bullying) also occurred in the healthcare sector in developing countries or countries in transition. In fact, as these authors state, the key new finding was "the widespread presence of psychological violence in health sector workplaces with verbal abuse at the top of the list." The South African healthcare worker respondents’ results showed 60% of them had been abused by some health workers at some time or another, which placed them second to Australia’s 67% affected respondents (Ariza-Montes et al., 2014: 2657-82).

From exploring available literature, it can be posited that verbal bullying in a private hospital is used by physicians, patients, colleagues, supervisors and subordinates (Brewer et al., 2013:414; Chappel & Di Martino, 2006:58; Joubert et al., 2005:40; The Joint Commission, 2016:2). According to Cuniff and Mostert (2012:3), the bullying behaviours of co-workers typically include “acts of humiliation, sarcasm, rudeness, isolation and gossiping". This suggests that verbal bullying in the health profession has not diminished over the last 20 years, which justifies the relevance of the current study.
2.7.2 Physical bullying

According to Adams (2014:206), physical bullying or violence is any act which is intended to cause some discomfort to colleague/s which results in an imbalance of power within the working environment. The behaviour itself may be automatically thought of as physical assault or threats of assaults, but Reynolds (2009:1) adds that confrontation and property damage can also be considered as physical violence or bullying. Those who suffer physical bullying through sustained physical attacks can suffer permanent or temporary injuries, disability and long-term psychological trauma. In terms of who perpetrates physical bullying in the workplace, Alkadry and Tower (2015:153) posit it may be existing or past employees. The authors further state physical bullying in the workplace accounts for around 7% of global workplace homicides. Reflecting on the findings of an OSHA report from 2015 on workplace violence, including bullying, which indicates that 21% of registered nurses and nursing students reported being physically assaulted in a 12-month period and 12% of emergency nurses experienced physical violence in a seven-day period, The Joint Commission (2016:1) states workplace incivility expressed as bullying behaviour is at epidemic levels.

The apparent lack of uniform definitions of bullying behaviour undoubtedly contributes to the potential reduction of incidents being reported (Gacki-Smith, Juarez, Boyett, Homeyer, Robinson & Maclean, 2009:340). According to Blando et al., (2015:2), if employees (including nurses) simply accept that bullying such as physical violence “is just part of the job”, it can lead to underreporting. In the nursing profession, anxiety is frequently the result of physical bullying (Pai & Lee, 2011:1406). In fact, Murray’s (2009:274) concern is that if a nurse experienced constant stress because she/he is always fearful, nervous and waiting for acts of bullying, she/he may suffer significant anxiety, depression and feelings of isolation. Although literature acknowledges that customers or service users such as patients or their families may also commit bullying acts, in the context of this study the focus was on workplace bullying by those employed in an organisation.

The concern of the International Labour Organisation (ILO, 2011) is indeed justified that violence such as bullying is a serious occupational risk and is showing rising levels in work environments in multiple sectors. In their study done on workplace bullying among nurses, Kaminski and Sincox (2012:6) found that peer-to-peer bullying still occurs. These authors discovered that nurses are more likely to experience physical violence from other nurses (23%) than from in-charge nurses (12%), doctors (12%) and other staff (9%). As Carbo (2017:73), Quigg (2012:1) and Szutenbach (2008:32) agree in healthcare particularly, bullying is seen as commonplace and it is almost as if it is “expected” for an abusive culture to reign in a healthcare environment. It is further suggested by Hills, Joyce and Humphreys (2012:336)
that peer-to-peer bullying occurs particularly in cultures and organisations where the locus of control is external to the individual; a situation frequently identified in healthcare settings where patient demands and needs may come before those of employees. This lack of putting employee well-being first (i.e. employee protection) can potentially incite the aforementioned violent types of behaviours targeted at peers, colleagues or subordinates, because the bully believes the former is responsible for her/his feelings of frustration, fear or competition (Caravita, Di Blasio & Salmivalli, 2009:143). As with verbal abuse, physical bullying may not necessarily be exhibited in isolation and may also be combined with more covert forms of bullying such as emotional bullying or social isolation (Quigg, 2012:1).

2.7.3 Covert bullying

Covert bullying is more difficult to identify than verbal or physical abuse, because it is often hidden, subtle and underhand. Consequently, the damaging effects are much harder to identify, since targets may feel a lack of confidence in reporting incidents even if sustained over a long period of time (Rex-Lear, Knack & Jensen-Campbell, 2012:225). The problem with identifying covert bullying is the way the bully may play on the target's emotions by making jokes at their expense and then saying they have no sense of humour. Other subtle forms of this emotional bullying acts include giving nurses unrealistic deadlines to complete nursing tasks, social isolation, or impossible workloads and then implying that the target is incompetent (Hutchinson, Vickers, Jackson & Wilkes, 2006b:239; Lutgen-Sandvik & Sypher, 2009:42; Neuman & Baron, 2011:206). This type of bullying is subtle and it is the long-term ongoing nature of the process that creates the loss of self-confidence and self-esteem that characterises targets of covert, emotional abuse in the workplace (Hershcovis, 2011:501). Sustained exposure to emotional and other covert bullying can, as Mata (2012:77) notes, erode the target's reputation, professional competence and confidence.

The effect covert bullying can have on individuals is that of creating a level of exclusion from the workplace society due to increasing fears of being humiliated and a reduced likelihood of speaking out in case allegations are belittled. Mata (2012:77) therefore posits covert bullying behaviours can potentially create obstructions to doing a good job. According to this author, to deliberately create blocks to achievement of tasks may in some cases in fact be the whole objective of the bullying behaviour. Mata (2012:77) argues in many workplace settings, thus including healthcare settings, the culture may preclude identification of bullying particularly where those in authority are the perpetrators and their subordinates are expected to comply with behaviours.
As shown in the literature, any form of bullying behaviour within healthcare work settings catalyses a process of progressive deterioration in healthcare delivery, subsequently tainting the nursing profession’s reputation as a caring and healing service to humanity. When an authoritarian and hierarchical superior-subordinate culture prevails among nurses and managers who care for the sick, the health outcomes of patients are seriously compromised (Granstra, 2015:252). Unfortunately, as The Joint Commission (2016:2) declares, bullying in any healthcare environment exacerbates “the stress and demands of an already stressful and demanding profession”. Bullying contributes to burnout and drives talented and caring people out of the health professions. The kinds of improvements needed in patient safety and health care cannot be achieved if talented people are lost. Nurse-to-nurse bullying has a devastating effect on a nurse’s work performance and personal health. Repercussions include that nurse targets who have no support system may resign from their jobs, be pushed out if they complain, may leave the profession altogether, or relocate to another healthcare setting.

2.8 BULLYING TRENDS IN NURSING

Although inpatient hospital settings have received significant attention regarding workplace bullying programmes, it has been documented in the literature that nurses and allied health professionals are at an increased risk of workplace bullying compared to other professionals (Blando et al., 2015:1-2).

Nurse employees have the right to be treated with respect and dignity at their place of work. They also have the right to work in a harmonious and supportive environment. Bullying behaviour breaches the employer’s duty under common law to provide a safe and a secure work environment both physically and psychologically. What makes it difficult for managers to manage bullying is that it has no tangible results, but bullying leaves the target with psychological and emotional problems which lead to anxiety, stress and depression if not properly treated (Mata, 2012:77). The results of this research project further reveal that the majority of bullied employees are reluctant to speak out or end up not reporting the incidents, because when they do report problems, they believe that they will not be taken seriously. There are many reasons for underreporting, including the feeling that bullying is “just part of the job”; that nothing will be done about the problem reported; and that the person in the position of power to whom the report would be sent is the perpetrator (Gallant-Roman, 2008:51). In an imbalance of power, whether created through vertical or hierarchical power networks, the workplace culture is inevitably influenced and leadership styles are manifested in how conflicts are managed and resolved within an organisation (Granstra, 2015:252).
In healthcare, particularly the hospital culture is highly patriarchal (O’Lynn, 2012:52) and nurses are low in power. Professional disparities lead to an environment of bullying where nurses are powerless to prevent downward forms of bullying behaviour if no organisational policies exist for reporting and dealing with the behaviours (Purpora & Blegen, 2012:2; Sheridan-Leos, 2008:399).

Despite the fact that the majority of studies have focused on downward bullying, (Escartín, Salin & Rodriguez-Carballeira, 2011:157), this does not mean that upward bullying does not occur (Branch, Ramsay & Barker, 2007:9; Daniel, 2009:3). In this instance, the bullying comes from subordinates who wish to improve their working environment, but find their superiors uncooperative or ineffective. However, instances of upward bullying are rare, although Wallace, Johnston and Trenberth (2010:66) identified that in recent years there has been an upward trend in this form of bullying. According to Birks, Budden, Stewart and Chapman (2014:1685), part of the reason for this is the increasing attention paid to bullying, but also the release of frustration with the superior being seen as a representative of the organisation and thus a target for abusive and bullying behaviours that are grounded in frustration.

Of particular interest is the situation of horizontal (or lateral) bullying. According to Sheridan-Leos (2008:399), this is where the bullying behaviours are not hierarchical in nature, but occur in a nurse-to-nurse context. Escartín et al. (2011:157) suggest that there may be high prevalence of this type of bullying due to power imbalances in working relationships. In any working environment, an individual’s power and satisfaction is achieved partially through their work, but also through the informal social networks they create with colleagues. These networks are important for effective team working, which is crucial in nursing environments where skills and abilities may be interdependent (Becher & Visovsky, 2012:210; Purpora & Blegen, 2012:2).

However, if there are individuals within the group who may feel threatened by others on the grounds of race, gender, sexual orientation, or even professional competence, this may result in bullying behaviour. Whilst these factors have already been highlighted as being precursors to bullying in general, the integrated team reliance that is crucial to effective nursing and patient care means that the costs of bullying behaviour in the nursing environment may be high (Purpora & Blegen, 2012:2). Not only will this potentially impact the individual’s stress, reduced confidence and social isolation, but the team dynamic will suffer with consequences for patient care as noted by Yildirim (2009:1444).
From the review of types of bullying and their specific manifestations, it is clear that bullying upwards, downwards and peer-to-peer is a major problem in the working environment and appears to be particularly prevalent in the health care setting. Whilst the focus of this study is on nurse-to-nurse bullying in South Africa, there is a clear indication from other studies that the practice is of global concern in relation to the nursing profession (Notelaers, Vermunt, Baillien, Einarsen & De Witte, 2011:73). ILO figures indicated that in Europe the issue of bullying within healthcare is of concern in many countries, suggesting that the practice is not confined to one country or region and is becoming a major issue within the profession (Lowenstein, 2013:22).

Specifically, Pai and Lee (2011:1405) found that in a group of 102 nurses, 51% had experienced verbal abuse in the workplace from either superiors or colleagues and a further 19% had experienced physical violence. A similar picture emerged from an American study by Vessey, Demarco, Gaffney and Budin (2009:299) with 24% of the survey respondents indicating they had experienced bullying behaviours from superiors and colleagues. From Canada, studies by Wilkinson and Miers (2016:87) indicated a similar environment of power imbalance and bullying.

Furthermore, in the Australian nursing environment, research by Wilkinson and Miers (2016:87) and O’Lynn (2013: 52) indicate a similar pattern, with nurses indicating high levels of verbal bullying created through hierarchical power structures which contributed to behaviours that undermined colleagues and subordinates. These different global studies, when combined with the European data from the ILO, suggest that bullying may be a major global problem with a high impact on the nursing profession. As this study is focused on nurse-to-nurse bullying in South Africa, a more detailed discussion of the practice in the country is required.

2.9 BULLYING IN SOUTH AFRICAN NURSING

At the 22nd Annual Labour Law Conference held from 12 to 14 August 2009, workplace bullying was aptly addressed by Prof. Alan Rycroft, Professor and Chair of Commercial Law, Faculty of Law, University of Cape Town, South Africa as “any unfavourable or offensive conduct on the part of a person or persons, which has the effect of creating a hostile workplace environment” (Rycroft, 2009, slide 6). According to Yoder-Wise (2018:152), verbal abuse is one of the major concerns, particularly in respect to subordinate bullying by medical practitioners and this has been the major focus of literature in the area (Yoder-Wise, 2018:152), whilst less consideration has been given to nurse-to-nurse bullying. As with other studies already highlighted, the root cause is again power imbalances and this may also be a
factor in nurse-to-nurse bullying. Despite increased attention to the problem (Stark, 2011:431), including conferences on the issue, health sector workers still feel that workplace bullying is a major problem. Whilst the focus has been on verbal abuse, there is also a recognition of the growing problem of physical bullying mostly in the public sector according to Yoder-Wise (2018:152). Workplace violence is common and seen as part of the job in many public hospitals, in line with earlier findings of Escartín et al. (2010b:8). Part of the problem in the country is that as nurses have gained access to international labour markets, turnover is high (Rycroft, 2009, slide 6), increasing workloads and reducing nurse-to-patient ratios which lead to increased stress, reduced autonomy and thus feelings of powerlessness, which as noted above, can be a precursor to bullying.

What this means in the context of South Africa specifically, but clearly can be applied in a global context, is that bullying within the nursing profession is likely to have a major impact on the profession if strategies for dealing with the problem are not developed. As such, consideration is now given to the impact of bullying in nursing.

Yildirim (2009:505) describes the feelings of demotivation and depression that affect nurses’ performance of their duties and negatively shape their relationships with their patients and peers. These feelings in turn lower their levels of job satisfaction, which could lead to a high staff turnover in the profession (Johnson & Rea 2009:87; Khan & Aleem, 2014:24; Shmailan, 2016:2; Simons, 2008:EE55). Like most other countries, South Africa is currently experiencing a nursing shortage. The shortage will most likely worsen, because the population is burgeoning and the country needs to deal with the heavy burden of a changing disease profile while interest in nursing as a career is waning (Fokazi, 2016:2). Hospitals should therefore seek to reduce workplace bullying in an effort to retain trained nurses.

2.10 IMPACT OF BULLYING ON THE NURSING PROFESSION

Dellasega (2011:11) raises concerns about the potential negative impact of bullying on the nursing profession, particularly in the context of the growing shortage of nurses worldwide. It is vital that nurses understand the aspect of bullying before entering the profession, because of the major impact on turnover and retention as Duffy (2013:102) notes. However, Gatchel and Schultz (2012:231) suggest that bullying in the profession has not risen; instead, the practice is being more openly recognised and dealt with, creating a more open environment for reporting.
The difficulty with any approach, as Martyn and Kieran (2015:144) suggest, is that bullying is embedded in the nursing profession worldwide and thus experience of some level of bullying behaviour is almost an accepted part of a nurse’s training. This can lead to high attrition rates for young or newly qualified nurses, reaffirming the impact of bullying on employment levels noted by ILO figures. In a similar vein, Burke, Fox and Cooper (2016:182) and Kingma (2018:70) identified that new nurses entering the profession experience a form of culture shock when they are exposed to bullying tactics by peers or superiors and this has increased the numbers of those leaving the profession before qualification, subsequently contributing to a growing shortage of nurses worldwide.

Furthermore, as Lekalakala-Mokgele and Caka (2015:2), Pellico, Brewer and Kovner (2009:194), Salin (2014:78) and Peterson (2009:7) all indicate, new nurses who are faced with stress from applying theory in practice, high patient demands and long hours, find this overwhelming experience compounded by being the target of workplace bullying. This can have a negative impact by inhibiting their ability to integrate with a new team, leading to isolation and a lack of confidence or reduced self-esteem (Degenais-Desmarais & Courcy, 2014:304; Roter, 2017:37; Salin, 2014:79). In effect, the impact of nurse-to-nurse bullying on new graduates can be extremely high as they struggle to meet the expectations of superiors and more experienced nurses, which underlines the importance of strategies to deal with bullying in the nursing environment.

There are three main areas where the effects of bullying are felt according to Haffner (2009:22): organisational, individual and society levels, which lead to decreases in productivity, increased turnover, low motivation and increased absenteeism (Dupré & Barling, 2003:24, Georgakopoulos et al., 2011:4). Particularly in nursing this is a concern, due to the stressful nature of the job which is compounded by workplace bullying (Stark, 2011:424).

From a societal perspective, as Hughes and Durand (2013:55) note, targets of bullying will suffer effects on their relationships with family and friends, and their low motivation at work can extend into a lack of confidence in other areas of their lives. In this respect, Stark (2011:424) notes that bullying targets reported higher levels of interpersonal conflict outside of work, although this appears to be dependent on the individual’s own personality, the intensity of the bullying and the prolonged nature of bullying behaviour. Nevertheless, there remains a connection between reduced satisfactions with home life and being a target of workplace bullying as Haffner (2009:12) highlights.
2.11 RESPONSES AND STRATEGIES FOR DEALING WITH BULLYING

According to Longo (2010:S9-10), health organisations are responsible for dealing with disruptive behaviours which threaten the safety of both patients and members of staff, and despite under-reporting in the past, there is as McKay and Fratzl (2011:21) acknowledge, a responsibility to adopt strategies to manage workplace bullying.

2.11.1 The contingency approach

According to Rahim (2011:57), the contingency approach is based on the assumption that there is no single best approach of dealing with workplace decisions, since the effectiveness of the adopted measures are affected by the prevailing circumstances in the work environment. The approach acknowledges the effects of bullying on the organisation as a whole. In effect, it recognises that leaders must understand the history and prevalence of bullying in the workplace environment so that intervention strategies can be developed which minimise the impact of bullying and work on rebuilding working relationships. Whilst in principle this appears to be a vital approach, as Einarsen et al. (2010:437) indicate, this can be difficult to enforce if the organisational culture has a history of low-level reporting or high indecision against bullying.

Lutgen-Sandvik and Sypher (2009:66) encourage assessment of bullying practices within an organisation through anonymous surveys, worker interviews or focus groups in order to develop action plans for implementing solutions to workplace bullying. Once an assessment of the prevalence of bullying and the reasons for its occurrence are identified, intervention is required, and this may be either structural or process-based. The process-based intervention approach aims to minimise workplace bullying by altering the intensity of affective, process and substantive conflicts and employees’ styles of handling interpersonal conflicts (Rahim, 2011:61). The process intervention approach calls for changes in organisational processes such as culture and leadership.

The structural intervention approach mitigates workplace bullying by changing the organisational design characteristics, including differentiation and integration mechanisms, hierarchy, procedures and reward systems. The approach attempts to deal with workplace conflicts by changing the perceptions of organisational members regarding the intensity of conflicts at different levels (Rahim, 2011:64). However, whichever approach is adopted, it is vital that communication is clear, transparent and open as it has already been identified that structural and process changes within an organisation can lead to escalations of bullying.
behaviours if individuals feel disempowered. However, there are alternative approaches that can be adopted such as empowerment of the employees.

2.11.2 De-escalation approach

The de-escalation approach is another approach that can be adopted, based as Baillien, Bollen, Euwema and Witte (2013:519) note on the fact that workplace conflicts are viewed as a cycle whereby the effects of conflict change the initial causes or generate new ones. This creates a scenario where conflicts escalate and de-escalate since subsequent conflicts emanate from the original disputes, thus fuelling further conflicts (Collins, 2012:1; Harris, 2011:57). Conflict escalation is thus characterised by increased conflict intensity and deterioration of the situation.

De-escalation strategies therefore involve decreasing the intensity of workplace conflict. However, de-escalation does not reverse conflict escalation or return the issues leading to conflicts to their former scales. The factors which promote de-escalation include stalemates and weariness of workplace conflicts, or perceptions of impending catastrophe by conflicting members (Collins, 2012:2). De-escalation however can be achieved through the adoption of problem-solving approaches such as avoidance, compromise, accommodation, direct discussion and debate (Medina & Benitez, 2011:729).

Avoidance involves putting off the problem while accommodation involves acceptance of the wishes of the opponent. Compromise involves proposition of solutions which gratify both parties, while problem-solving involves arriving at a common decision through effective analysis of the problem (Medina & Benitez, 2011:729). Clearly, compromise and accepting the views of other people are the most desirable paths to choose for conflict resolution, rather than avoidance or direct fighting.

2.11.3 Pragmatic approach

The pragmatic approach, like the contingency approach, recognises that the occurrence and management of interpersonal conflicts differ in relation to the environment in which they occur and therefore the conflict management approach should reflect these variable circumstances (Rahim, 2011:57). The approach therefore considers all variables within the working environment and how they are connected so that all parties are seen as relative to the problem and the solution. Variables in this context may be the individual parties, the reasons for the conflict, the working environment and the approaches taken by the individual parties (Einarsen et al., 2010:437; Rahim, 2011:58). In terms of how this manifests, Hubert (2003:307) proposed
the Systematic Approach Model for preventing and overcoming undesirable interaction through five key stages as indicated in Figure 2.2.

![Systematic Approach Model Diagram]

**Figure 2.2: Systematic approach to bullying (adapted from Hubert [2003] and Krestelica [2005])**

What is important in this model is that it is an ongoing process, with the initial setup of codes of conduct, encouraging reporting, providing support to targets of bullying, and ongoing interventions to discourage the practice and aftercare to targets, but also regularly reviewing all processes to ensure that bullying does not continue after the first intervention and reporting.

In all strategies of dealing with bullying, it is important to recognise that there may be more than one factor that creates the environment where bullying occurs and is accepted. As such, Saam (2010:66) highlights, a multi-level approach is necessary to ensure that any strategies, whether contingency, pragmatic or de-escalation, are covering the individual, organisational and interpersonal levels of bullying. Lipinski and Crothers (2014:306) highlight that intervention strategies may need to be adapted for different levels to ensure that bullying is effectively dealt with through approaches such as coaching, mentoring, or whole group training about the practices, company policies, reporting and consequences of bullying. This ensures that a full organisational focus is given to dealing with bullying and thus an organisational culture can evolve from one where bullying is accepted to one where it is dealt with quickly and efficiently to minimise negative effects (Rosinski, 2011:50).

Hughes and Durand (2013:137) argue that one of the most important strategies for dealing with bullying in any workplace is to have a climate where bullying is not condoned and reporting of incidents are encouraged (Bulutlar & Öz, 2009:273; Dillon, 2012:17; Linley, Harrington & Garcea, 2010:267; Wiedmer, 2011:40). In effect, the most effective strategies are those that are backed by clear and highly communicated anti-bullying policies which are regularly reviewed and audited. By making visible changes to a working environment, targets are more likely to report incidents and bullies may recognise that their behaviour is
unacceptable (Kircher et al., 2011:16). As part of these practices, there should also be a clear indication that bystanders have a responsibility to the organisation and their colleagues to report incidents of bullying as well (Boynton, 2017).

The strategies discussed thus far have focused on internal approaches to dealing with bullying; however, it should also be recognised that there may be legal recourse for targets of bullying and thus this area needs brief discussion.

2.11.4 Legal measures

Salin (2014:80) emphasises that different countries provide targets of workplace bullying with legal avenues for financial and non-financial amends to workplace bullying, with Scandinavian and North European countries having a broad range of legislation that prohibits workplace bullying based on occupational health and safety regulations. Less success has been achieved in the USA in creating legal precedents for dealing with bullies (Carbo, 2009:116). Although civil rights legislation does provide some minimal protection for individuals as noted by Carbo (2017:155); Lutgen-Sandvik and Sypher (2009:74), and Meglich-Sespico, Faley and Knapp (2007:32). What this means for many organisations globally is that there is confusion about which area of the law covers best practices and bullying behaviour (Sugrue, 2012:1).

In the South African context, the Constitution of the Republic of South Africa, the Occupational Health and Safety Act, the Labour Relations Act, the Basic Conditions of Employment Act, and the Compensation for Occupational Diseases and Injuries Act among others are the main legal frameworks that deal with working conditions (Sieberhagen, Rothmann & Pienaar, 2009:5). Though the Occupational Health and Safety Act does not specifically highlight workplace bullying, the Act compels employers to provide safe and healthy working conditions, whilst the Labour Relations Act compels organisations to provide workplace forums where employees can voice their concerns and where their health and wellness issues can be addressed, suggesting that either of these may provide legal recourse for targets of bullying. In addition, the Compensation and Occupational Disease and Injuries Act may also provide compensation to targets of workplace bullying in South Africa, as the Act calls for compensation of employees whose health is negatively affected during engagement in work-related activities (Sieberhagen et al., 2009:5). To this extent, there have been no major cases involving the nurses that have been brought before the courts in South Africa with regard to bullying.
2.12 CHAPTER SUMMARY

The high incidents of workplace bullying within healthcare organisations is a global concern, and this chapter has highlighted the various ways that bullying can manifest. This chapter has examined the factors which lead to bullying behaviours, including the organisational, social and personal characteristics of both targets and bullies. The reasons behind peer-to-peer bullying according to previous research are due to power imbalances, lack of empathy or emotional intelligence and a desire to exert a level of control over individuals in the working environment to compensate for these factors. From the target’s perspective, however, there is also a fear of not being believed, a cultural acceptance of the practice of bullying and a lack of self-esteem and confidence which is compounded by the bullying behaviour. In addition, workplace bullying in healthcare organisations is caused by organisational characteristics such as organisational change, communication patterns, organisational politics and power imbalances, role conflicts, job insecurity, organisational culture, social climate and adopted management styles. Role demands and job control also influences the occurrences of workplace bullying in healthcare organisations. Individual nurse’s personal characteristics such as emotional intelligence and interpersonal skills also influence the levels of workplace bullying by escalating conflicts in the work environment. Where bullying exists in an organisation such as a healthcare setting and is not dealt with by effective policies and interventions, there is a negative impact on overall organisational performance and productivity affecting the performance and productivity of individual nurses or teams of nurses.

Workplace bullying is thus a clear organisational challenge, since individual employees respond either by failing to report bullying incidents, or voluntarily leaving the negative work environment. In order to rise to the challenge, healthcare organisations can adopt different approaches in dealing with workplace bullying, such as the contingency, de-escalation or pragmatic approach. However, it is evident that any intervention must cater for the whole organisation, be transparently communicated and recognise the importance of culture change if they are to be successful. Having identified the definitions of bullying, the manifestations of the behaviours and the high prevalence and reasons for this within nursing both globally and in the South African context, a brief indication of legal, rather than institutional, recourse has been provided.

The next chapter deals with the methodology of the study.
CHAPTER 3 – METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research methodology is explained and motivated. It describes in detail the research design and methods used to execute the research. The validity and reliability of the quantitative data and the trustworthiness of the qualitative data are discussed. Ethical aspects are also expounded.

The design and methods adopted in the study guide and support the research leading to the development of a model for managing workplace bullying at the private hospital group are described. Insight was needed about what nurses perceive contribute to nurse-to-nurse workplace bullying (whether as targets or bystanders) and the management thereof prior to developing a model for managing workplace bullying. It was envisaged by the researcher that the input with nurses from these hospitals would render authoritative information for developing a model for managing workplace bullying not only at the private hospital group, but also to assist other private hospital nurses and even those in the public healthcare sector in RSA and other countries to manage workplace bullying effectively. The methodology consisted of three phases with different settings to explore the issues being investigated from different perspectives and contexts. The method followed by data collection and analyses are chronologically presented in this chapter.

3.2 RESEARCH PURPOSE AND OBJECTIVES

The research and findings informed the model development. To achieve this purpose, the researcher developed five research questions. Focusing on these questions the researcher designed five objectives which guided the choice of a suitable research design and methodology that would eventuate in the development of the intended model to manage nurse-to-nurse workplace bullying in a South African private healthcare group. The objectives were reached through three phases as discussed in the research methodology (Section 3.4) to allow for systematic and sequential data collection.
The five objectives were to:

- Determine the perceptions of nurses regarding the contributing factors towards workplace bullying between nurses in a private hospital group in RSA.
- Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
- Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
- Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.
- Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.

3.3 RESEARCH DESIGN

A research design ensures that the collected evidence assists a researcher to address the research problem in an unambiguous manner by collecting, analysing, interpreting and reporting data in research studies in a specific manner (Teddlie & Tashakkori, 2009:7; Creswell & Plano-Clark, 2011:53). The research design is the arrangement of elements that serve as the blueprint for a study to yield rigorous results to address the research questions (Grove, Burns & Gray, 2013:214; LoBiondo-Wood & Haber, 2010:158).

In this study, a sequential explanatory mixed methods research design was used. A mixed methods approach to research is founded on the primary philosophy of pragmatism. Pragmatists view mixed methods research as considerate of the diverse viewpoints, outlooks, attitudes and standpoints encompassed in both qualitative and quantitative research designs (Creswell & Plano-Clark, 2011:40-41; Johnson, Onwuegbuzie & Turner, 2007:113; Polit & Beck, 2012:604).

3.3.1 Mixed methods research

Using mixed methods as the research technique involves the integration of quantitative and qualitative findings as opposed to treating them as separate entities or domains (Creswell & Plano-Clark, 2011:77; Johnson et al., 2007:113) and integrating findings during the interpretation phase (Kroll & Neri, 2009:41). The findings from the qualitative phase are used to contextualise and explain quantitative findings. Mixed methods research therefore involves gathering and studying data, integrating findings and drawing understandings using both quantitative and qualitative methods in a single study (Teddlie & Tashakkori, 2009:7).
According to Jeanty and Hibel (2011:636) the principal objective of mixed methods research is to obtain a comprehensive understanding of human behaviour and views by using more than one method within a research study. Moreover, using mixed methods in this study was to integrate quantitative results and qualitative findings to enhance the understanding of the research problem (Connelly, 2009:31; Tashakkori & Teddlie, 2010:494). The integration enables researchers to determine whether the collected quantitative and qualitative data collaborate and enhance or clarify each other (Bryman, 2007:9; Creswell & Plano-Clark, 2011:77).

Another characteristic of mixed methods research is that words can give meaning to numbers, while numbers add precision to words (Creswell & Plano, 2011:53). In the quantitative component (Phase 1), numbers, descriptive and inferential statistics were used to describe the data pertaining to the contributing factors and management strategies to bullying. In the qualitative component (Phase 2), words were used to describe the analysis and interpretation of the perceptions and information shared by participants on how management, nurses and the work environment should change to address workplace bullying.

### 3.3.2 Sequential approach

In mixed methods, research strategies are pinned to sequential, concurrent and transformative procedures (Creswell, 2009:208-9). For this study, the sequential explanatory strategy was adopted. Sequential procedures involve the investigation of the research problem in such a manner that the findings from either the quantitative or the qualitative phase elaborate on the other; the findings are then assimilated to provide interpretations of the overall findings (Grove et al., 2013:208).

This two-stage mixed methods research design (Creswell & Plano Clark, 2011:53) was carried out with the aim of interpreting the evidence of quantitative research from the study of management of nurse-to-nurse bullying in the private hospital setting. In the first phase of the study, the questionnaire of bullying management practices was used to gather quantitative data. After statistically analysing the quantitative data, the second phase of the study, namely the qualitative stage, was designed and carried out for the purpose of interpreting and explaining the results of the quantitative phase. This model typically starts with the data collection and analysis of a quantitative data, which is then followed by the qualitative data collection and analysis. This type of mixed methods study is designed and used when qualitative data is valuable for explaining or expanding the quantitative findings, particularly in the context where further explanation is merited concerning significant or non-significant differences among groups or patterns (e.g. bullying management strategies by different role
players), distinguishing demographic characteristics, possibilities and relationships, or unexpected results and outliers. In fact, the researcher gives priority to the primary quantitative stage and the subsequent qualitative phase is used to help explain the quantitative results.

Sequential mixed methods design is where one methodology follows another data collection method. For this study, based on the findings of the first phase, the second phase follows to lead to a better understanding of the quantitative (numerical) data and qualitative (human views) data. The integration phase (Chapter 6) aided the development of the model, but the researcher also gained a deeper understanding of the management of workplace bullying, because the qualitative method was used to clarify, corroborate and enhance the quantitative results on workplace bullying (Ivankova, Creswell & Stick, 2006:5; Polit & Beck, 2012:603; Tashakkori & Teddlie, 2010:494).

Bearing in mind Hofstee’s (2009:113) warning that all research designs have strengths and weaknesses, the implementation of a sequential mixed methods design was considered as the most appropriate approach to elicit data that was necessary, reliable and of sufficient quality and quantity to guide and support the development of a holistic model for managing workplace bullying at the private hospital group. The reason for using specifically this design was that a single set of data would not be adequate to answer the research questions satisfactorily.

Figure 3.1: Sequential mixed methods design (adapted from Creswell & Plano Clark, 2011:70)

Designing and doing a mixed methods study goes beyond simply collecting and analysing quantitative and qualitative data. Rather, these different aspects require integration to develop a more comprehensive picture of the findings than when they are implemented in isolation (Fetters, Curry & Creswell, 2013:2142). Hence, at the integration stage of the research, the researcher made use of both staged integration and weaving integration to both expand and confirm findings. The staged integration is the separate analysis and interpretation of both data sets – quantitative and qualitative – and through weaving a narrative, the qualitative findings support the quantitative results (Fetters et al., 2013:2142).
3.3.3 Explanatory approach

Quantitative research is more objective than qualitative research because it depends on numerical data, whereas qualitative research is based on human understanding, attitudes and perspectives with regard to the research phenomenon (Creswell, 2009:3; Polit & Beck, 2012:739). Morse and Niehaus (2009:29,136) refer to the quantitative information as the “core component” and the qualitative information as the “supplemental component” in an explanatory sequential mixed methods design.

Grove et al. (2013:209-210) explain that the QUAN→qual sequential explanatory strategy involves the collection of quantitative data followed by the collection of qualitative data and integrating the findings during the interpretation phase. The rationale for using the QUAN→qual sequential explanatory strategy in the current study was that the quantitative numerical data would provide a general overview of the research problem, while the qualitative data in the form of semi-structured face-to-face interviews would refine and explain the statistical data by exploring the participants’ perspectives in depth (Gerrish & Lacey, 2013:349). For this study, the qualitative stage elicited a deeper understanding of the study phenomenon, because it was best suited for explaining and interpreting relationships (Creswell, 2009:13; Henning, Van Rensburg & Smith, 2004:31) and testing elements of emerging theories (Grove et al., 2013:210).

Making use of the sequential explanatory strategy enabled the researcher to use the collected qualitative information to enhance the understanding of workplace bullying and its management, as well as to explain and interpret the relationship between different factors in the work environment where workplace bullying occurs (Grove et al., 2013:209). The sequential explanatory strategy further allowed the researcher to establish relationships between the management of the specific factors in the workplace environment which cause bullying and the overall management of workplace bullying in the private hospital group. Making use of this strategy augmented the integration of the findings with the theoretical perspectives (Grove et al., 2013:209).

This study was done in three phases. In Phase 1, the researcher first collected the quantitative data. The results and analysis of the quantitative data are presented in Chapter 4. The researcher then proceeded to collect the qualitative data in Phase 2. The analysis and findings of the qualitative data are presented and discussed in Chapter 5. This is followed by the weaving narrative approach of integration of the findings from the quantitative and qualitative approaches as described in Chapter 6. Phase 3 is addressed in Chapter 7 and covers the
concept analysis and the inferred interpretations provided for the development of the model for managing workplace bullying.

As depicted in Figure 3.2, this chapter was therefore organised to reflect the research design of the quantitative data collection followed by the qualitative data collection with the analysis and merging of the data (presented and discussed in Chapter 6) as the final stage before model development.

![Figure 3.2 Sequential explanatory mixed methods research design (adapted from Creswell, 2009:209; Morse & Niehaus, 2009:118)](image)

### 3.4 RESEARCH METHODOLOGY

The research method is the process or plan for conducting the specific steps of the study (Grove et al., 2013:707). According to Given (2008:516) and Polit and Beck (2012:741), researchers have a strategy they follow to achieve the study purpose and objectives. This methodological, planned approach consists of tools and techniques researchers use to structure a study, collect relevant data and analyse the collected data systematically to achieve the study objective(s) and answer the research question(s). If successful, the purpose of the study has been achieved.

The research approach to address the research questions was a sequential mixed methods design which comprised of a quantitative (Phase 1) and a qualitative (Phase 2) component and the integration of the quantitative results and qualitative findings. The strategies used for implementation of this design include sampling, data collection, data analysis and the interpretation of the findings (Teddlie & Tashakkori, 2009:21).
3.4.1 Research setting

The setting is the physical location in which data is collected according to Polit and Beck (2012:743). The setting for this research includes hospitals in a private group since limited research was previously done on the private hospital industry. All departments where nurses function in the hospitals were included, e.g. medical and surgical wards, intensive care and theatres, as well as management and education departments. Hospitals of the private hospital group in eight of the nine provinces in South Africa were selected as participating hospitals to provide a country wide perspective on workplace bullying management. Only the provinces where the hospital group has hospitals could be included. This setting applies to the first and second phases and is therefore discussed before splitting the phases. The only difference is that in Phase 2, the setting was limited to Gauteng hospitals to allow the researcher to conduct face-to-face interviews.

3.4.2 Phase 1: Quantitative data

In Phase 1, a quantitative design was used to obtain data from respondents. Quantitative research renders numeric information that result from making use of some type of formal measurement and is analysed with statistical procedures. The researcher follows a logical series of steps according to a set plan of action, thereby ensuring the process is formal, objective and systematic to gather and analyse the numerical data to test relationships, differences, causes and effects, and interactions between variables (Burns, Grove & Gray, 2011:247, LoBiondo-Wood & Haber, 2010:584; Polit & Beck, 2012:13,17).

In quantitative research, data is rigorously examined through simulation, inferential or experimental approaches which involve establishing relationships between the research variables and evaluating the similarities in characteristics among the study populations (Creswell, 2009:145; Oliver, 2010:24). Quantitative data focuses on the numerical representation and manipulation of the research phenomenon. The aim was to explain the nurses’ perceptions on management and strategies used to manage bullying by making use of the applications of empirical evaluations as a means of establishing the degree to which the research problem under study aligns or deviates from the standard or norm (Polit & Beck, 2012:4; Sukamolson, 2007:3). Rationality, objectivity, prediction and control are emphasised by Walker (2005:572) as advantages of a quantitative research methodology.
In Figure 3.3, the components of the quantitative research design used in this study are summarised. It also clarifies where in the research process each component occurred. The components of the research design as noted are then discussed in sections 3.4.2.1 to 3.4.2.6.

Figure 3.3: Quantitative design of study (adapted from Morse & Niehaus, 2009:118; Creswell, 2009:209)

3.4.2.1 Population

Population is described by Brink et al. (2012:131), Burns and Grove (2009:42), and Polit and Beck (2012:59) as the total group of individuals, groups or events that meet certain inclusion criteria in a given universe. A study population, also known as the target population, is the sum total or aggregate of the study subjects who conform to pre-set specifications determined by the researcher (Babbie, 2008:221; Burns & Grove, 2009:42).

The private hospital industry in the RSA consist of many hospital groups namely, Mediclinic Southern Africa, Netcare, Life Healthcare and many independent private hospitals. In the current study, the population for the quantitative data collection referred to all of the nurses who worked in hospitals operated by one of the private hospital groups in RSA. The targeted population worked in hospitals of the private hospital group in the following provinces: Gauteng, Limpopo, North West, Mpumalanga, the Western Cape, KwaZulu-Natal, the Free State and the Northern Cape. Eastern Cape province was left out because the private hospital group does not have a hospital in the province.
The inclusion of all nurse positions from different provinces strengthened optimal data collection from respondents whose input stemmed from a diversity of perceptions, strategies and motivators. It was purported that in terms of the prevalence of nurse-to-nurse bullying in different working environments in hospitals, the acquisition of solid qualitative numerical data from a large study group (the core component) would inform the qualitative (supplemental component) substantially. This would encompass knowledge of the bullying phenomenon, personal experiences as targets or bystanders (witnesses), perceptions about current management of the problem (or the absence thereof) and possible avenues for intervention.

The sum total of the nurses working in the private hospital group at the time of the study was 8 385 and composed of enrolled nurse auxiliaries (ENA), enrolled nurses (EN) and registered nurses (RN), as well as unit managers (UM), nurse managers (NM), and nurse educators (NE) registered with the South African Nursing Council (see Table 3.1).

Table 3.1: Summary of total quantitative study population – Phase 1

<table>
<thead>
<tr>
<th>Provinces</th>
<th>ENA</th>
<th>EN</th>
<th>RN</th>
<th>UM</th>
<th>NM</th>
<th>NE</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>445</td>
<td>687</td>
<td>917</td>
<td>89</td>
<td>55</td>
<td>28</td>
<td>2 221</td>
<td>26.48%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>120</td>
<td>156</td>
<td>174</td>
<td>18</td>
<td>8</td>
<td>5</td>
<td>481</td>
<td>5.73%</td>
</tr>
<tr>
<td>North West</td>
<td>39</td>
<td>73</td>
<td>100</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>232</td>
<td>2.76%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>143</td>
<td>255</td>
<td>225</td>
<td>26</td>
<td>14</td>
<td>5</td>
<td>668</td>
<td>7.96%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>537</td>
<td>812</td>
<td>1 124</td>
<td>115</td>
<td>62</td>
<td>27</td>
<td>2 677</td>
<td>31.92%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>145</td>
<td>197</td>
<td>291</td>
<td>25</td>
<td>14</td>
<td>3</td>
<td>675</td>
<td>8.05%</td>
</tr>
<tr>
<td>Free State</td>
<td>259</td>
<td>260</td>
<td>469</td>
<td>43</td>
<td>20</td>
<td>12</td>
<td>1 063</td>
<td>12.67%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>84</td>
<td>113</td>
<td>149</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>368</td>
<td>4.38%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1 772</td>
<td>2 553</td>
<td>3 449</td>
<td>339</td>
<td>188</td>
<td>84</td>
<td>8 385</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total %</strong></td>
<td>21.1%</td>
<td>30.4%</td>
<td>41.1%</td>
<td>4.0%</td>
<td>2.2%</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Table 3.1, the distribution of the total quantitative study population is summarised according to the eight provinces, nurse positions and number of nurses working in hospitals operated by the private hospital group. Most (31.92%) of the targeted population worked in the Western Cape. In terms of the distribution of nurse educators, Gauteng had one more (28) than the Western Cape (27). All five other nurse category numbers were highest in the Western Cape. The population in North West constituted only 2.76%, which was the smallest population that was targeted.
3.4.2.2 Sample and sampling technique

A sample is a set of individuals that accurately reflects the population under study. Sampling is done because of difficulties encountered when attempting to involve the entire population in the research study process (Babbie, 2008:223; Brink et al., 2012:131-132; Polit & Beck, 2012:275). A sample was derived from the target study population for the study purposes. The alignment in characteristics between the sample and the population enhances the validity and objectivity of a research study (Brink et al., 2012:132; Polit & Beck, 2012:275).

The sampling plan, which describes the techniques for obtaining the sample, uses either probability (random) sampling or non-probability (non-random) sampling. For this study, non-probability sampling was used, based on subjective judgement of the researcher rather than random selection. Non-probability sampling refers to individuals (known as subjects) from the targeted population that the researcher can reasonably access. The researcher’s access to the targeted population was restricted, because the hospitals were located across RSA. The non-probability sampling technique used was convenience sampling method, which is also referred to as “availability sampling” (Brink et al., 2012:140).

Convenience sampling involves the selection of a study sample based on ease of accessibility and participants’ willingness to participate in the study (Gravetter & Forzano, 2012:151; Hair, Celsi, Money, Samouel & Page, 2011:175; Teddle & Yu, 2007:87). Convenience sampling is mostly adopted in behavioural sciences as it is easier to use, less expensive and saves time (Gravetter & Forzano, 2012:151). However, the biggest drawbacks of convenience sampling are that the available subjects might not be representative of the targeted study population (Polit & Beck, 2012:276) and equal opportunity for every subject to be included in the study cannot be assured. However, convenience sampling was appropriate to ensure subjects that are accessible and willing to participate which is exemplified by volunteer hospitals. Also, considering the wide geographical area in which the private group’s hospitals operated, convenience sampling was the most suitable technique to obtain a representative sample of permanently employed nurses falling under the six nursing positions.

To counteract any possibility of convenience sampling resulting in bias or non-representativeness during the sampling process, the sampling criteria were strictly followed to guarantee the inclusion of all nursing positions.
Table 3.2: Sampling size

<table>
<thead>
<tr>
<th>Province</th>
<th>Population (N)</th>
<th>Number of hospitals</th>
<th>Number of sample hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>2221</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Limpopo</td>
<td>481</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>North West</td>
<td>232</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>668</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>368</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>675</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Free State</td>
<td>1063</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Western Cape</td>
<td>2677</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>8385</strong></td>
<td><strong>49</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>

Each of the eight provinces where the private hospital group operates was targeted to receive a portion of the questionnaires for distribution to the hospitals that were willing to participate at the particular time.

A confidence interval (CI) is a term used in inferential statistics to measure the probability that a population parameter will fall between two set values. It measures the deviation between the opinions of respondents (sample) and the opinion of the entire population (Hazra, 2017:4126). Confidence levels inform how often the percentage of the population lies within the boundaries of the margin of error. It can take any number of probabilities, with the most common being 95% or 99% (Hazra, 2017:4126). A CI of 95% means that there is a 95% chance that the data will fall within the population parameters (Polit & Beck, 2012:406). In order to acquire a CI of 95% in scenarios with a known 50-70% incidence of workplace bullying (Cunniff & Mostert, 2012:3; Khalil, 2009:210; Krug et al., 2002:18), the aim was to obtain a sample size of 300-400 nurses for the quantitative phase of the study. A two-sided interval was used for achieving the required accuracy.

In order to reach a sample size of at least 300, the researcher decided to target 50% more subjects to counter the expected low return rate (Brink et al., 2012:153; Polit & Beck 2012:311).

### 3.4.2.3 Inclusion criteria

The inclusion criteria highlight the characteristics that the subjects in a study population should have in order to participate in a research study (Brink et al., 2012:131; MacNee & McCabe, 2008:134; Polit & Beck, 2012:274). The inclusion criteria followed by the researcher contain the aforementioned nursing positions of ENA, EN, RN, NM and NE, be registered with the South African Nursing Council and currently working with the private hospital group in one of
the aforementioned regions. The nurse participants had to have been in permanent employment with the private hospital group for at least six months. The researcher considered six months’ experience with the private hospital group as adequate for the participating nurses to be familiar with the prevalence of bullying and bullying intervention strategies adopted in the private hospital group.

3.4.2.4 Data collection

Data collection is the actual gathering of the information to make decisions or to find information needed for the study (Polit & Beck, 2012:725). The study aimed to establish the perceptions of nurses towards workplace management practices in a private hospital group. Primary data fit the study purpose as it enabled the researcher to capture the nurses’ perceptions and recommendations towards the management of workplace bullying. Primary data further enhanced the quality and defensiveness of the study findings with regards to management of workplace bullying in the private hospital group because it is based on the practical knowledge and experience of the study participants from whom the researcher collected the data (Chisnell, Rubin & Spool, 2013:313). In the quantitative phase, numerical data was collected by using a questionnaire as the data collection tool.

3.4.2.4.1 Data collection instrument

Data refers to chunks of evidence that is collected during a study (Polit & Beck, 2012:755). Instrumentation refers to the tools adopted for collecting primary data for research purposes (Collins, 2010:126). For Phase 1, a bullying questionnaire was utilised for data collection purposes. Questionnaires are written responses (Polit & Beck, 2012:305). A questionnaire was used for this study due to the ease of use (Pawar, 2004:21), the large potential sample base to increase representativeness, consistency during data collection (Burns & Grove, 2009:406), the absence of interviewer bias, lower cost than interviews, and anonymity (Polit & Beck, 2012:305). However, the information gathered might have less depth (Burns & Grove, 2009:406).

Polit and Beck (2012:293) emphasise that research tools should cover the research questions as a means of enhancing the validity of the study findings. To enhance objectivity, the questionnaire was structured to cover the research problem, purpose and the research questions (Pawar, 2004:21; Mertens, 2010:383). The questionnaire used simple and clear language to facilitate understanding by the respondents (Polit & Beck, 2012:307).
The questionnaire used was available in English. The questionnaire was composed of closed-ended multiple-choice questions to ensure the researcher’s objectivity during data analysis, effective comparison of responses (De Vos, Strydom, Fouché & Delport, 2011:191) and that the study objectives were reached. The questionnaire (Addendum F) comprised two sections. The introductory section introduced the participants to the study purpose and acquired the participants’ demographic information, while the second section sought information on the prevalence, patterns and management of workplace bullying:

- Demographic data
- Question 1: Frequency and type of workplace bullying (NAQ-R)
- Question 2: Factors contributing to workplace bullying
- Question 3: Response to bullying
- Question 4: Current management of bullying and its effectiveness
- Question 5: Proposed management of workplace bullying

With permission from Bergen University, the questionnaire for this study included the Revised Negative Acts Questionnaire (NAQ-R) which is recommended for evaluating the exposure to workplace bullying (Einarsen et al., 2009). The NAQ-R items, an ordinal scale (Polit & Beck, 2012:380) were used to measure frequency of bullying. For the purpose of this study, the question was included to determine objectively if bullying was taking place at the private hospital group.

Amendments were made to the questionnaire to accommodate the study context of a private hospital and not an office environment. Polit and Beck (2912:307) agree that amendments to an existing questionnaire can be made to suit the specific context. Eighteen of the original 22 questions were included in this study and one question was split to determine work allocation outside scope of practice to above and below scope of practice as bullying strategy in nursing. The excluded questions were not applicable to the hospital environment, but apply to an office environment.

Following the NAQ-R question, all further questions were developed based on previous research. Questions were developed by the researcher based on a comprehensive literature review done in preparation for Chapter 2 and focussed on determining which factors contribute to bullying, responses to the act of bullying, current management and preferred management of workplace bullying. The questions were also formulated to address the study objectives and purpose.
The following principles were kept in mind during the development of the latter part of the instrument (Polit & Beck, 2012:307, 308):

- Wording of questions were kept brief and clear.
- Questions were phrased in such a manner to minimise response biases.
- Questions were limited to the purpose of the questionnaire and objectives of the study.
- Demographic data questions were asked first before moving on to more sensitive and personal questions.
- The close ended questions chosen were a fit the type of information needed.
- A range of alternative options were made available within the questions.

3.4.2.4.2 Pilot testing

Pilot testing involves administration of data collection tools in the manner to be used in the study, establishing participant feedback on ambiguous or complex questions, determining the time consumed by completion of questionnaires, establishing whether the captured answers provide meaningful insights to the research problem and informing revision of data collection procedures and tools (Kim, 2011:192; Polit & Beck, 2012:195). Pilot studies are based on the research design or methods that the researcher aims to adopt in the main study (Kim, 2011:190). It is carried out using participants who share characteristics with the future study population.

According to Kim (2011:191), the piloting process therefore establishes possible problems with the data collection or instrumentation procedures. Gudmundsdottir and Brock-Utne (2010:359) and Polit and Beck (2012:195) emphasise that the piloting process is very significant in the research process, as the challenges and complexities established through the piloting phase is equally important to the researchers, the participants and the consumers of the research findings.

A draft of the questionnaire was made available for peer review to two study colleagues, the supervisors and the statistician for comments. The draft questionnaire was then administered to 25 nurses from the aforementioned categories of nurses in Gauteng. The pilot study was conducted 1-14 May 2014, before the main study and served as a small-scale version of the main study (Brink et al., 2012:216; Polit & Beck, 2012:195).

The pilot group of nurses were a small group to whom the consent forms and the questionnaires were distributed. Each questionnaire was issued with a self-seal envelope to ensure confidentiality. The consent forms were handed in separately from the questionnaires. The participants had the opportunity to answer the questionnaires during a break as it took
fifteen to twenty minutes to complete. All questionnaires were returned within five days in the sealed envelope that was provided. The researcher was available for any enquiries and feedback from the participants.

The nurses who participated in the piloting phase were naturally excluded from the main study and information provided by them stored in a secure drawer where it will be safeguarded for the next five years for protection purposes and to ensure an evidence trail. The feedback provided by the participating nurses, supervisors and statistician was used to improve the questionnaire. The questionnaire was revised to capture the different strategies that are applied in different work environments to deal with workplace bullying. Duplicate questions were removed, the numbering was corrected and questions were grouped under headings to structure it more logically. Two questions were also rephrased to clarify the meaning.

The impression of the researcher was that the piloting served its purpose to ensure clarity of the questionnaire, especially the reliability of the developed questions (Questions 2-6). Based on the feedback received from the pilot group participants, the necessary corrections were made and communicated to supervisors for input and permission to make the needed changes.

3.4.2.4.3 Data collection process

Data is the pieces of information obtained in a study. Data collection is therefore defined as the assembly of evidential information to answer the research questions. For a quantitative study, mostly numerical information is collected (Polit & Beck, 2012:52, 53, 725).

To collect the data for this study, the researcher compiled an email that included the purpose, objectives of the research and the ethical clearance certificate (see Addendum A) from Sefako Makgatho University (previously known as University of Limpopo – Medunsa Campus) and the hospital group to send to all the hospitals’ nurse managers for permission to use their nurses in the study. The first email was sent on the 24th of March 2014 and a reminder with a link to the SurveyMonkey® questionnaire was sent on the 2nd of April 2014. A total of 25 nurse managers and three heads of nursing schools owned by the hospital group gave permission for their institution to be included in the study.

Questionnaires and consent forms were printed and packed with individual self-seal envelopes for each questionnaire for each hospital and the nursing schools. In the pack that was sent was a note explaining the process, an addressed envelope with paid postage and tracking number for the return of the completed questionnaires.
In order to ensure that the required sample size was reached, a total of 982 questionnaires and electronic questionnaires were distributed in the private hospital group. Printed questionnaires (750) were sent via the Post Office with tracking numbers, or delivered by hand by the researcher if physically possible due to geographical reasons to the different hospitals that indicated willingness to participate.

A total of 232 email addresses were received from the different hospitals, educators and individuals for electronic completion of the questionnaire. SurveyMonkey®, an internet-based research tool which allows a data collection instrument to be sent to participants through an internet link, was used to reach participants whose email addresses were obtained from the private hospital group. Hospital names in Table 3.3 were replaced by alphabet letters to ensure confidentiality.
<table>
<thead>
<tr>
<th>Province</th>
<th>Hospitals and training centres</th>
<th>Questionnaires sent</th>
<th>Questionnaires returned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Hard copies</td>
<td>Electronic</td>
</tr>
<tr>
<td>Western Cape</td>
<td>A</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E</td>
<td>40</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Gauteng</td>
<td>G</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>H</td>
<td>40</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>J</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>K</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>30</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>Limpopo</td>
<td>L</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>North West</td>
<td>U</td>
<td>40</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>V</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>O</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Free State</td>
<td>P</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Q</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>S</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>T</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td>34</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>750</strong></td>
<td><strong>232</strong></td>
</tr>
</tbody>
</table>
Hospitals with more than 100 beds received 40 questionnaires, while those with less than 100 beds received only 30 and those with less than 50 beds received 20 questionnaires.

The first paper-based questionnaire was returned via the post on 24 April 2014 and the last on 30 May 2014. A total of 576 paper-based questionnaires and 125 electronic (total 701) questionnaires were returned, which means there was a 71.38% return rate.

3.4.2.5 Data analysis

To answer the research questions, the collected data must be explored, organised into a logical order and combinations or patterns should be found to give it meaning and to communicate the findings (Brink et al., 2012:57,177; Polit & Beck, 2012:379,725). The fundamental purpose of the study was to present information on the presence of workplace bullying, current workplace bullying management practices, perceptions of nurses towards the adopted bullying management practices and recommendations for improving the management of workplace bullying as comprehensively and conclusively as possible.

The data was captured on an Excel worksheet from both the paper-based and SurveyMonkey® questionnaires before it was coded by the researcher. Raw data needs to be converted to a useful format for data analysis. A statistician was used to assist in the analysis of the data.

3.4.2.5.1 Descriptive statistics

To analyse data, statistical techniques should be used depending on the level of measurement of the variables. The four levels of measurement are nominal, ordinal, interval and ratio (Brink et al., 2012:178; Polit & Beck, 2012:379). To describe and summarise the quantitative data of the study, nominal and ordinal descriptive statistical analyses were used. The variables will be presented by means of frequency, percentages, means, medians and standard deviations of the different items on the questionnaire. IBM Statistical Package for the Social Sciences (SPSS) Version 23, Release 23.0.0, a statistical analysis programme, was used to allow the researcher to establish the frequencies of all the collected data. Descriptive statistics was used to organise data to give meaning and insight to numerical data (Brink et al., 2012:179; Polit & Beck, 2012:399).

Demographic data and the results for questions 1-5’s frequencies were totalled to determine the popularity and interpreted using the explanation descriptions. To add value to the measurements, central tendencies and variability were used to express the averages using mean and median scores (Brink et al., 2012:185; Polit & Beck, 2012:385) and standard deviations (Polit & Beck, 2012:387). To obtain the mean, a full set of scores were added and
divided by the total number of scores. The median measures the variability of data using the average and is therefore the midpoint in a set of scores. Standard deviation indicates the average deviation of values from the mean, whereas a deviation score is the difference between an individual score and the mean (Polit & Beck, 2012:387).

3.4.2.6 Validity and reliability

Research validity is the accuracy and integrity of the collected data and whether the collected data conclusively and comprehensively answers the research problem and the interpretation thereof (Creswell & Plano Clark, 2011:210; Ellis & Levy, 2009:332; Polit & Beck, 2012:236). Reliability refers to the consistency or dependability with which an instrument measures an attribute (Polit & Beck, 2012:331).

3.4.2.6.1 Validity

The research design and the instrument/s used in qualitative studies influence validity. To minimise bias, different types of validity threats should be prevented. Different types of validity were used for the quantitative part of study. The table below explain how validity was ensured.
Table 3.4: Internal and external validity

<table>
<thead>
<tr>
<th>Type of validity</th>
<th>Definition</th>
<th>Research decision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Research design</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal validity</td>
<td>The degree to which change can manipulate a researchers' data (Brink et al., 2012:109; Creswell, 2009:230).</td>
<td>Mostly used in experimental designs and therefore did not fit this study.</td>
</tr>
<tr>
<td>External validity</td>
<td>The degree to which data can be generalised (Brink et al., 2012:109; Creswell, 2009:230).</td>
<td>A large representative sample was obtained by using strict selection criteria to ensure external validity. The study was also spread over a wide geographical area at different hospitals.</td>
</tr>
</tbody>
</table>

| **Instrument** | | |
| Construct validity | The ability to measure what it is intended to measure (Brink et al., 2012:210). | The instrument used for this study measures the constructs of current bullying management practices and the individual’s preferences to management practices, as well as contributing factors to workplace bullying. |
| Content validity | The degree to which the instrument covers the range and scope of information that is sought (Brink et al., 2012:210). | A thorough literature review was done to determine the aspects to include in the instrument. The instrument was then given to an expert in the workplace bullying field to identify strengths and weaknesses before the finalising of the instrument. The instrument was also piloted to ensure that the items measure the aspects of relevance. |
| Face validity | Subjective determination that an instrument has the correct and adequate information (Brink et al., 2012:212). | The instrument was scrutinised by the supervisors, the statistician, peer doctoral students and the pilot group for readability and clarity of content. |
| Criterion-related validity | The measurement between scores of known and the unknown criteria (Brink et al., 2012:213). | The Negative Acts Questionnaire (NAQ-R) is a frequently used and recommended workplace bullying instrument that is used to measure the frequency of bullying. |

### 3.4.2.6.2 Reliability

Reliable information is obtained when an instrument is repeatedly used for the same subject when administered and measured in an identical manner (Creswell, 2009:211) and result in the same answers. Statistical tests can be performed to determine a standard test’s reliability coefficient or random error. Cronbach’s alpha is such a test. Cronbach’s alpha is used to test the internal consistency, e.g. the extent that the same trait is being measured (Polit & Beck, 2012:724). The score is between 0 and 1, with 1 being a high correlation (Polit & Beck, 2012:724).
The standardised Negative Acts Questionnaire (NAQ-R), as well as questions developed by the researcher were used to compile the instrument. The NAQ-R enhances the reliability of the data, since the Cronbach’s alpha consistency measurement is between .87 and .93. A previous study by Einarsen et al. (2009) has proven the NAQ-R has satisfactory reliability and construct validity.

3.4.3 Phase 2: Qualitative data

Qualitative researchers aim to gain knowledge from participants’ understanding and meaning of experiences, while at the same time maintaining a certain measure of neutrality (Marshall & Rossman, 2011:21; Polit & Beck, 2012:487). Qualitative research facilitates the understanding of the psychological and social aspects of human reactions, as well as underlying motives and desires resulting from participants’ perceptions towards the research problem (Mertens, 2010:225; Oliver, 2010:2). Holloway and Wheeler (2010:3) assert that qualitative approaches are useful in the exploration of change or conflict, and that the basis for qualitative research lies in the interpretive approach to social reality and in the description of the experiences or perceptions of the human being. However, this research design is subjective, as the process of developing themes and generalisations is primarily based on the researcher’s interpretations and claims, as opposed to the deductive manner in which conclusions are drawn in quantitative studies (Creswell, 2009:99,175). Holloway and Wheeler (2010:4) add that in qualitative research, the process is inductive, in that researchers gather data to build concepts, hypotheses and theories.

In Figure 3.4, the components of the qualitative research design used in this study are summarised. It also clarifies where in the research process each component occurred. The components of the research design as noted are then discussed in sections 3.4.3.1 to 3.4.3.6.

![Figure 3.4: Qualitative design of study](image-url)
3.4.3.1 Target population

The target population includes all the individuals who meet the sampling criteria or certain specified properties (Burns & Grove, 2005:714; LoBiondo-Wood & Haber, 2010:583). The population for this study included all nurses working for the private hospital nursing group. Given the organisational complexity and geographical location of the private hospital group and the various hospitals, the accessible population was of necessity narrowed down to the nurses of Gauteng hospitals. The eligible nurses for inclusion in this study’s qualitative stage (N=2221) were those who were working for six months or longer for any of the eleven (11) private hospitals in the hospital group in Gauteng.

3.4.3.2 Sampling

A sample is defined as a subset of the target population that is selected for a particular study (Lukenbill, 2012:256). The selection of a sample must be consistent and representative of the population. Lukenbill (2012:256) states that a sample signifies a selected group of people from a defined population.

In non-probability sampling, participants are selected based on their contribution especially to data required (LoBiondo-Wood & Haber, 2010:91; Polit & Beck, 2006:509). Purposive sampling is mostly adopted in qualitative studies and involves deliberate selection of the study participants based on the participants’ ability to provide the required information (Teddlie & Yu, 2007:87). Purposive participants were selected on the basis of the study setting, participant characteristics and intentionally selected by the researcher on the basis of the importance of the information likely to be provided by the selected participant which cannot be derived from other choices (Brink et al., 2012:139, 77). The selection in this study depended on the researcher’s knowledge about the population (Burns & Grove, 2005:344-345; Polit & Beck, 2006:355) since she worked previously with these nurses. This sampling technique suited the study, since the researcher aimed to understand the management of bullying of the nursing population and the researcher looked for participants who had relevant knowledge and were willing to share this. This decision was made based on the literature, qualitative results and personal experience of the setting.

Purposive sampling of six nurses from six different hospitals was utilised in the qualitative phase of the study. In order to determine the sample four initial participants were selected from hospitals in Gauteng under the categories of unit manager (UM), registered nurse (RN), enrolled nurse (EN) and nurse educator (NE). The next two participants, a human resource manager (HR) and another nurse educator (NE), were selected based on findings during the
interviews to ensure depth in findings. The human resource manager is also a registered nurse registered with the South African Nursing Council and could therefore be included in the study. The enrolled nursing assistant (ENA) invited to the interview cancelled more than once.

The deliberate selection of nurse participants from the aforementioned categories enabled the researcher to capture the nurses’ perceptions towards management, motivators and possible solutions of workplace bullying in the private hospital group. Purposive sampling also enhanced the richness of the collected data through the acquired different perceptions of workplace bullying. It provided the researcher further with an opportunity to recruit nurses who expressed interest in improving the work environment and who were best placed to understand the workplace bullying problem and could therefore provide valuable information for the study purposes (Creswell, 2009:178).

Qualitative studies utilise small sample sizes, as they usually involve extensive data collection which is burdensome to collect and analyse (Mason, 2010:1). Qualitative studies further focus on acquiring the meaning of the participants’ experiences as opposed to representativeness and therefore adopt small samples (Crouch & McKenzie, 2006:485; Mason 2010:1). They also view the qualitative research framework as necessitating extensive involvement in the research work in order to establish meanings for social phenomena. This is facilitated by a small sample size, which further enhances the validity of qualitative research.

Creswell and Clark (2011:185) advise that the participants for the qualitative phase of a sequential explanatory mixed methods study should ideally be individuals who participated in the initial quantitative data collection. A sample of six individuals who consented to participate in the study from those who were requested to participate were identified by rank (EN, RN, two NEs, NM and HR (with a nursing qualification and registered with SANC) to collect rich information to identify meaningful themes. The participants were identified from six different hospitals and only those who did participate in the quantitative research were included in the study. The sample was therefore suitable for the qualitative phase of the study given the distribution of the study population. Also, the use of interviews provided participants with opportunities for providing extensive information on possible solutions to workplace bullying as the instrument for data collection. The small sample size further minimised the cost of the research process by reducing travelling costs that could have been incurred travelling from province to province and one hospital to another to interview more participants to the widespread hospitals in the private hospital group.
3.4.3.3 **Qualitative data collection**

The qualitative data collection process entailed the non-statistical collation of the thoughts and opinions of the sampled research participants (Creswell, 2009:15) in relation to the nurses’ workplace bullying management experiences. Qualitative studies make use of interviews, documents, audio/visual material or observations (Creswell, 2009:181) as data collection methods, which fundamentally serve to establish participants’ experiences, meanings and feelings towards the research problem (Brink et al., 2012:157).

3.4.3.3.1 **Interviews as data collecting instrument**

Interviews, unlike questionnaires, allow participants to explain complex answers to questions and enhance the scope for asking unstructured questions where the researcher feels the need to probe for more detail (Brink et al., 2012:153). Semi-structured face-to-face individual interviews were chosen to collect data during this stage of the research (Brink et al., 2012:153, 157).

Semi-structured interviews were scheduled in advance at a designated time and location outside of everyday events. The interview was organised around a set of predetermined open-ended questions, with other questions emerging from the dialogue between the interviewer and interviewee/s.

Due to the nature of data collection namely interviews, the researcher utilised a recording device during the interviews. All interviews were conducted within a time frame of three weeks in June 2017. Each interview lasted for about thirty minutes. The interviews were conducted at each participant’s choice of date, time and place in a safe environment free from distractions. The number of interviews were continued up to the saturation point as determined by the researcher, the study supervisors and an independent coder. A total of six interviews were conducted. Saturation was achieved when no more new knowledge was obtained from an increased sample size (Fusch & Ness, 2015:1408; Holloway & Wheeler, 2010:341).

3.4.3.3.2 **Interview guide**

An interview guide was developed after the initial analysis of the quantitative data on workplace bullying. Topics that needed more clarification for inclusion in the interview guide were identified. The questions were then formulated to encourage participation and exploration of the topics in depth. The areas for discussion were based on the findings of the quantitative findings of the study where the researcher required further clarity and depth about the questionnaire findings.
The questions were:

- Can you tell me what you understand by workplace bullying?
- Tell me what you and other nurses can do to change bullying at work.
- What changes do you think should happen in the work environment to manage bullying behaviour?
- Tell me what you think contribute to workplace bullying.

The interviews were directed by the semi-structured interview guide (Addendum I: Interview guide), which assisted the researcher to carry out semi-structured face-to-face interviews and acquire detailed perceptions of the current workplace bullying management practices and elicit participant recommendations towards effective management of workplace bullying in the future. Clarification of quantitative findings were also sought.

3.4.3.3.3 Permission to interview

Permission was obtained from the hospitals’ nursing managers to conduct the interviews and to arrange for a quiet, private space to perform interviews away from the direct work environment should the interviewees prefer the work environment as venue. They were also asked to assist with the identification of the best candidates to interview according to pre-set criteria of working longer than six months at the hospital and having previously participated by completing the questionnaire.

Written informed consent was obtained from the six interviewees prior to the interviews. Only one nurse previously confirmed did not arrive for the interview, but was replaced by another nurse. Prior to the interviews, consent was re-confirmed with the interviewees.

3.4.3.4 Pilot interviews

Pilot studies or pilot interviews enable researchers to familiarise themselves with the interview guide and assess its applicability and effectiveness for the purpose of their study topic (Polit & Beck, 2012:195; Silverman, 2016:22). Three interviews were piloted in June 2017 to test whether the questions generated appropriate responses. A registered nurse (RN), unit manager (UM) and a peer doctoral nursing student educator (NE) from the private hospital group were used for a pilot of the qualitative interview questions. The specific nurses were chosen because of their insight into the practice and understanding of the issue of workplace bullying. They were first interviewed as participants to test if there was a logical flow to questions. The researcher met two days after the interviews with the interviewees individually to listen to the recorded material for orientation, to make the interviewee understand the
process and to refresh their recollection of what was asked and answered. The nurse educator suggested that a short explanation be added before the questions, because time had passed between the quantitative data collection and the interviews. All three participants helped to simplify the wording and suggest synonyms to be used with the different nursing ranks during interviews. The adjusted interview guide was handed to them for approval after the changes were made.

The researcher and supervisors studied the transcribed interviews. It was established in the pilot study that the interview questions were unambiguous and no questions had to be changed, adapted or deleted. In the opinion of the researcher and the supervisors, the existing interview guide would enhance the collection of information related to the management of workplace bullying. The interview guide was therefore not revised, as it captured the research questions adopted in the study. The pilot interviews were subsequently included in the main study due to the valuable information obtained from them during the interviews.

3.4.3.5 Role of Interviewer

The process of the interview was initiated by the researcher with the welcoming of the interviewee, confirming confidentiality in information-sharing during the interview, the recording of the proceedings and note-taking by the researcher, followed by an explanation of the topic (management practices of workplace bullying). The interviewer further had to establish trust and respect with the interviewees and to obtain as much information about the topic discussed by asking focused open-ended questions in a safe environment.

As a means of stimulating the discussions and to set a positive tone for the interviews on a negative topic, participants were allowed to share their views and experiences freely and without judgement. It also contributed to focus participants’ attention on finding solutions to the problem and not on the bullying itself.

3.4.3.6 Field Notes

As a field worker, the researcher prepared detailed field notes during the interviews as a means of placing the interviews in perspective (De Vos et al., 2011:359). The field notes covered verbal and non-verbal communication and assisted the researcher to explore, examine and remember the process of each interview (Greeff, 2011:298).
This role of a field worker includes to prepare the environment for the interviews. The best placement of the recording device and the seating arrangements are also part of the researcher’s job. During the interviews, the researcher as field worker took notes on the key findings and non-verbal cues from the interviewees.

3.4.3.7 Interviews

Six nurses were interviewed. Recorded interviews were conducted face-to-face in the participants’ preferred venues outside the work environment. Each interview was conducted at a date and time that suited the participant best. On average, every interview lasted around 30 minutes depending on how actively the participant took part and how much information he/she shared. All interviews were conducted in English.

By collecting data on participants’ perceptions of bullying at the workplace, qualitative interviews add meaning to the data of the human experience about the effects of bullying (DiCicco-Bloom & Crabtree, 2006:316). Understanding generally includes four stages namely “apprehension, exploration, co-operation and participation” (DiCicco-Bloom & Crabtree, 2006:316) between an interviewer and an interviewee.

The individual semi-structured interviews allowed the interviewer to probe intensely into bullying management matters to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to this specific phenomenon. These interviews can inform a wide range of research questions. Between five and ten questions are usually developed to probe into different aspects of the research issue (DiCicco-Bloom & Crabtree, 2006:316).

The initial apprehension phase is often characterised by uncertainty emanating from the strangeness of a context in which the interviewer and interviewee do not know each other. During this phase, the goal was to get the interviewee talking. The first question was broad and open-ended, and reflected the nature of the research as non-threatening. If necessary, this question was repeated with some embellishment, giving the interviewee time to hear what was asked and to think about how to respond. As responses were given, the interviewer in turn responded with prompts that repeated the words used by the interviewee. This process signalled the need for further clarification without leading the interviewee. Questions that can be interpreted as leading or that prompt the interviewee through the use of words other than those used by the interviewee can result in misleading answers. Throughout the interview, the goal of the interviewer was to encourage the interviewee to share as much information as possible unselfconsciously and in his/her own words. The exploration phase was when the
interviewee became engaged in an in-depth description. This process was accompanied by learning, listening, testing and a sense of bonding and sharing. The next phase, the co-operative phase, was characterised by a comfort level in which the participants were not afraid of offending the interviewer and found satisfaction in the interview process. The interviewer took the opportunity to clarify certain points and the interviewee corrected the interviewer as they both made sense together of the interviewee's world. During this time, questions were asked that were too sensitive to ask at the beginning. If the interview process continued for a long time, or if the interviewer and interviewee developed rapport rapidly, the participation stage occurred within the time limit of the in-depth interview. This stage of the process was reflected by the degree of rapport between the interviewer and the interviewee and at this point the interviewee took on the role of guiding and teaching the interviewer.

### 3.4.3.8 Data analysis

Qualitative data analysis is the methodical organisation and synthesis of studied information with the aim to develop a structure of information to prompt the meaning of the study topic using the data collected (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014:1; Vaismoradi, Jones, Turunen & Snelgrove, 2016:101). Qualitative data analysis involved establishing relevant themes on the management of workplace bullying from the collected data. Thematic analysis involved grouping the participants’ responses into related concepts and the creation of structural descriptions of the participants’ perceptions and the significance of the perceptions to the management of workplace bullying (Omari & Paul, 2015:187).

Two methods of analysis were used in Phase 2. Firstly, Tesch’s method of data analysis (Tesch, 1990 cited in Creswell, 2009:186 and Theron, 2015:9) was used to analyse the data and secondly this analysis was confirmed by an independent coder.

The audio-recorded interviews were transcribed verbatim to enhance the identification of emerging themes. The researcher listened to each recorded interview several times while reading the transcripts to ensure accuracy and to ensure the reliability of the transcription (Horst & Houston-Price, 2015:185). The researcher read the participants’ verbatim transcript to ensure the accuracy of the transcript, ascertain the emergent themes and understand the themes. Reading and understanding the transcribed verbatim interviews enabled the researcher to appreciate how the various themes knit together and facilitated the connection of individual themes to other ideas.
The researcher used coding to establish emerging themes that would address the research objectives of the study. According to Creswell (2009:186) and Vaismoradi et al. (2016:101), coding is the process of breaking down, examining and categorising data before significance is added to it. Coding is the process whereby repetitive themes from all collected data are grouped together. A theme is a group of codes and codes are the creation of categories in relation to data. Lofland, Snow, Anderson and Lofland (2006:201) advise that when coding is used, the following questions should be asked:

- Of what general category is this item of data an example?
- What does this item of data represent?
- What is this item of data about?
- Of what topic is this item of data an example?

Figure 3.5: Application of the eight steps of Tesch’s approach to data analysis
As suggested by Creswell (2009:191), an agreement was reached between the researcher and an independent coder (co-coder) with extensive experience in qualitative research methods to independently code the data to increase the reliability of the coded data. The independent coder was given the recorded and transcribed data. The independent coder was meticulous in coding the data, finding items resembling each other and relevant to the research questions. The researcher and the independent coder met to discuss the analysed data. They reached consensus on the main themes and categories identified in the transcripts. To reach this point, the researcher and co-coder refined the codes by analysing the data within them to finalise the themes. The themes were organised to reflect the purpose of the study and provide answers to the research questions (Ruona, 2005:240). The titles of the themes were finalised. The theme titles were concise, consisted of words the participants actually used (as opposed to technical terms), and gave an indication of what the theme was about (Braun & Clarke, 2006:99; Ruona, 2005:241). The co-coder supplied the researcher with a confirmation of coding (see Addendum J).

3.4.3.9 Trustworthiness

Trustworthiness is the integrity of the data by using multiple approaches to ensure the accuracy of data (Creswell, 2009:171). Trustworthiness is said to exist if the findings of the study accurately reflect the perception of the participants and not that of the researcher (LoBiondo-Wood & Haber, 2010:128).

Bracketing was used to isolate pre-conceived ideas on workplace bullying because the researcher was already emerged in bullying as a subject from the literature review and data collected during Phase 1. The researcher made reflective notes which enhanced the study’s confirmability (Polit & Beck, 2008:220, 336). Throughout the qualitative phase of the study, the researcher implemented bracketing by being conscious of knowledge obtained through personal experience, Phase 1 and the literature. Reflecting on the study and the processes helped the researcher to keep her bias in check, even though it could not be eliminated.

Member checking was adopted as described in Creswell (2009:191) and was done to ensure the accuracy of the collected data. In July 2017, the participants were provided with the verbatim transcriptions to affirm their responses to the interview questions in order to ensure dependability by ensuring the authenticity and accuracy of the data collected (Polit & Beck, 2008: 359). Participants were made aware of the process during the interview process conclusion. The transcripts were emailed to the participants with their permission. No changes were made by participants.
Credibility refers to the truth-value of the study. Under the qualitative phase, the participants’ perceptions were described as accurately as possible in order to enhance internal validity (Langbein, 2014:51). Interviewing nurses who had been employed by the private hospital group for six months or more prior to the study also enhanced the study’s credibility. Credibility was further accomplished by allowing the study to continue until data saturation was achieved (Fusch & Ness, 2015:1411).

Transferability refers to the degree to which the findings can be generalised to a larger population. The thick descriptions of the data and the following literature control improved the generalisation of the data to a larger population. Transferability of the study findings is enhanced by the adopted methodological procedures which can be used to replicate the findings in other healthcare contexts (Margottini, Canuti & Sassa, 2012:395). A detailed, thick or dense description was used as an audit trail of the research methodology and research findings (Greenfield & Greener, 2016:65; Holloway & Wheeler, 2010:310) to assist with transferability.

Inter-coder reliability is generally considered the defining element for measuring the quality of analysis (Jensen, 2016:299). The data for the study were coded by the researcher and one independent coder.

Dependability is to determine whether findings would be consistent if the research were to be replicated with the same subjects in a similar context (De Vos et al., 2011:421). The rich description of the research setting and methods for this study will allow other researchers to test the dependability of the study. Some degree of inconsistencies can be expected, as the researcher and interviewees are the instruments in qualitative research. The research findings will therefore depend on the experience towards management of workplace bullying should the research be repeated.

Authenticity is related to legitimacy, fairness and the ability to demonstrate a range of different truths to present all participants’ viewpoints and voices (Brink et al., 2012:127). Fairness was followed by leaving an audit trail and making an effort to include all the participants’ voices.

Peer debriefing (Creswell, 2009:192) was also made use of by the researcher to increase reliability. A fellow doctoral student reviewed the data and asked questions about the study and findings.
3.4.4 Phase 3: Model development

The procedure followed included concept development, identification and definition (Meleis, 2013:371). Consequently, this step involved exploring and describing workplace bullying solutions based on detailed information obtained from the nurses through the adopted data collection instruments on the management of bullying. The second step included the description of interrelated statements (Keller, 2013:49). Lastly, the use of the interrelated themes, concepts and statements were used to develop the model.

3.5 ETHICAL CONSIDERATIONS

The research process is grounded on various ethical considerations which dictate upholding of research participants’ rights. Researchers are therefore obliged to uphold ethical considerations at different stages of the research process (Miller, 2012:14). This point of view is upheld by Iphofen and Tolich (2018:2), who emphasise that for research studies to be acceptable, researchers must observe ethics, standards of behaviour and other practical procedures. Researchers in studies involving human participants are obliged to observe the participants’ right to privacy, confidentiality and protection from harm (Miller, 2012:14).

In accordance with the ethical considerations in research, the researcher acquired permission to conduct the research from the Sefako Makgatho University Research and Ethics Committee (previously known as Medunsa Research Ethics Committee [MREC], see Addendum A). The researcher wrote to the management of the private hospital group to acquire permission to conduct the study. The researcher did not coerce participants to participate in the study. The participants were informed that participation in the study would be voluntary and they were free to withdraw from the study at will. The participants were provided with written consent forms to acknowledge their participation in the study (Creswell, 2009:178).

The researcher also briefed the participants about the research, the objectives of the study and provided the participants with an opportunity to ask for clarifications about the study process. The participants, some of whom may have experienced bullying in the past, were informed that counselling would be provided by the private healthcare group’s employee assistance programme should any post-traumatic experiences be re-lived due to participation in the study. In order to uphold the participants’ confidentiality, the participants were not required to provide their names for the study purposes. The sealed questionnaires ensured the anonymity of the respondents, as they were sealed in the provided envelope by the respondent after completion but before handing it back to the nursing manager/trainer. In
addition, there was no space provided on the questionnaire for the respondents to write either their names or other identifiable information.

The collected data from the pilot study, as well as the quantitative and qualitative stages, has been stored in a secure password-protected file on a private computer and data will be safeguarded for five years to secure a conformability audit trail. For each of the methods employed, a similar procedure of ensuring data confidentiality and privacy was employed. All the methods ensured that the standard ethical research procedures were applied.

The researcher further upheld objectivity and integrity in reporting the research findings and acknowledges the challenges experienced in the study process. The collected data was locked in a drawer while a password-protected personal computer was used to protect soft copies of the collected data. The data will be stored for a period of five years.

3.6 CHAPTER SUMMARY

The study adopted a sequential explanatory mixed methods deductive reasoning approach. The latter enabled the researcher to develop a model for managing workplace bullying grounded on the factors related to workplace bullying and proposed solutions to workplace bullying. The study population was the nursing workforce in a private hospital group in South Africa.

Two distinct sampling methods for the two data collection phases were used, namely quantitative and qualitative. The quantitative phase utilised convenience sampling, while purposive sampling was adopted for the qualitative phase. Primary data was collected from the nurses in the private hospital group. The data fit the study purpose by enabling the researcher to capture workplace bullying in private healthcare settings and the different perceptions and recommendations towards bullying management. Data collection was done through a semi-structured questionnaire for the quantitative phase, while an interview schedule was adopted for the qualitative phase. The data collection instruments were objectively structured to answer the research questions. The chapter also set out the study piloting process and the data analysis procedures adopted for the study.
The chapter highlighted the measures adopted to ensure trustworthiness, rigour and the validity of the study findings. Ethical considerations followed during the study process were discussed. The study aimed to develop a model for bullying management in the workplace. As part of the methodological procedures, the chapter covered the steps and activities involved in developing the model. The next two chapters present the findings of the data collected during the quantitative and qualitative phases of the study.
CHAPTER 4 – QUANTITATIVE RESULTS

4.1 INTRODUCTION

This chapter deals with Phase 1 of the study design, namely the collection and analysis of the quantitative data. It addresses the demographic data, frequency and type of bullying behaviour, aspects that contribute to workplace bullying, nurses’ response to bullying, the then current bullying management strategies and preferred strategies for dealing with bullying behaviours. The quantitative data addressed the following study objectives:

- Determine the perceptions of nurses regarding the contributing factors towards workplace bullying between nurses in a private hospital group in RSA.
- Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
- Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
- Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.

4.2 QUANTITATIVE DATA PRESENTATION AND ANALYSIS

A quantitative design is a formal, objective, systematic process according to which numerical data is gathered and analysed to provide findings that tell in numerical terms what a phenomenon looks like (Vogt, 2011:181); the phenomenon under investigation in this study being nurse-to-nurse workplace bullying in a private hospital group in RSA.

The quantitative data was collected by means of the revised Negative Acts Questionnaire (NAQ-R) (adapted with permission from Bergen University in Norway) (refer to Addendum F, section 3.4.1.4) and four self-developed questions and sub-questions. Of the 982 self-administered questionnaires distributed to 982 nurses of different ranks in 20 hospitals in eight provinces (refer to Table 3.4) of a private hospital group in South Africa, a total of 701 completed questionnaires (576 paper-based and 125 electronic responses) were returned over a period of just over two months (from 24 March 2014 to 30 May 2014). Envelopes that were returned empty, as well as emailed and paper-based questionnaires received with only the demographic data completed, were eliminated from the study resulting in a total of 664 (n=664) questionnaires that could be used. Questionnaires with missing answers within
questions were accepted due to the value that was added by the information shared in other answers. The return rate of completed self-administered questionnaires was 71.38%.

The researcher proceeded to capture the data of the 664 questionnaires in an Excel spreadsheet. The statistical technique used to describe and summarise the quantitative data of a study is dependent on the four levels of measurement (nominal, ordinal, interval and ratio) of the variables (Brink et al., 2012:178; Polit & Beck, 2012:379). To describe and summarise the quantitative data of this study, nominal and ordinal descriptive statistical analyses were used. The variables are presented in this chapter by means of the frequency, percentages, means, medians and standard deviations of the different items in the questionnaire. The assistance of an experienced and professional statistician was acquired to statistically analyse the data using the statistical analysis software programme IBM Statistical Package for the Social Sciences (SPSS) Version 23, Release 23.0.0. The established inferential statistics (ANOVA and t-tests) and descriptive statistics (frequencies and percentages) of the collected quantitative data are organised and presented in tables, figures and bar graphs with supporting descriptions allowing the researcher to derive narrative meaning and insight from the numerical data (Polit & Beck, 2012:399).

The data collected included seven demographic, as well as 19 closed-ended questions to determine whether bullying was taking place and four multiple choice questions relating to the management of workplace bullying among nurses. The quantitative data is presented and summarised in the same order in which it appeared in the questionnaire.

Table 4.1: Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Topic</th>
<th>Number of questions or options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic data (Section 4.2.1)</td>
<td>Demographic data</td>
<td>7 questions</td>
</tr>
<tr>
<td>Question 1 (Section 4.2.2)</td>
<td>Frequency and type of workplace bullying (NAQ-R)</td>
<td>19 sub-questions</td>
</tr>
<tr>
<td>Question 2 (Section 4.2.3)</td>
<td>Factors contributing to workplace bullying</td>
<td>11 sub-questions</td>
</tr>
<tr>
<td>Question 3 (Section 4.2.4)</td>
<td>Response to bullying</td>
<td>3 sub-questions</td>
</tr>
<tr>
<td></td>
<td>a) Response to bullying observed or experienced</td>
<td>11 options</td>
</tr>
<tr>
<td></td>
<td>b) Do you think you acted correctly in above situation?</td>
<td>2 options</td>
</tr>
<tr>
<td></td>
<td>c) Reason for reaction</td>
<td>6 options</td>
</tr>
</tbody>
</table>
### 4.2.1 Demographic data

The demographic information was an important starting point in data analysis, since it provided geographical data on the workplace settings and enabled the researcher to put together a representative profile of the subjects. The demographic data collected included the province, nursing area allocated during time of data collection, nursing experience, shifts, rank, age and gender. The reason for including the demographic data was to determine whether there were any differences in the experience of bullying and to contextualise the pattern of bullying among the various nursing categories.

#### 4.2.1.1 Province

The study aimed to target nurses working in different provinces within the private healthcare group in SA. The locality of the participating hospitals was Gauteng, Western Cape, Limpopo, North West, Mpumalanga, KwaZulu-Natal, the Free State and Northern Cape. The responses (n=661) from the eight different provinces as illustrated in Table 4.2 clearly show that nurses who responded from the urban areas in Gauteng and Western Cape were by far the majority.

<table>
<thead>
<tr>
<th>Province</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free State</td>
<td>101</td>
<td>15.3%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>207</td>
<td>31.3%</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>27</td>
<td>4.1%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>93</td>
<td>14.1%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>40</td>
<td>6.1%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>31</td>
<td>4.7%</td>
</tr>
<tr>
<td>North West</td>
<td>36</td>
<td>5.4%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>126</td>
<td>19.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>661</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td><strong>3</strong></td>
<td></td>
</tr>
</tbody>
</table>
As can be seen in Table 4.2, the majority of the respondents were from Gauteng (207; [31.3%]) and the Western Cape (126; [19.1%]) respectively followed by the Free State (101; [15.3%]) and Limpopo (93; [14.1%]). The lowest representations were from Mpumalanga (40; [6.1%]), North West (36; [5.4%]), and the Northern Cape (31; [4.7%]). A very low response rate was from KwaZulu-Natal (27; [4.1%]). Three respondents did not indicate the province in which they worked.

### 4.2.1.2 Nursing fields allocated to during time of data collection

Ten fields of nursing were represented in the study encompassing various speciality areas. The percentages of respondents for each nursing field where the subjects were working during the time of data collection in the private hospital group are presented in Table 4.3.

<table>
<thead>
<tr>
<th>Current nursing field</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community healthcare (clinic)</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Neonatology</td>
<td>30</td>
<td>4.9%</td>
</tr>
<tr>
<td>Midwifery</td>
<td>41</td>
<td>6.7%</td>
</tr>
<tr>
<td>Management</td>
<td>39</td>
<td>6.3%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>45</td>
<td>7.3%</td>
</tr>
<tr>
<td>Education</td>
<td>43</td>
<td>7.0%</td>
</tr>
<tr>
<td>Operating theatre</td>
<td>57</td>
<td>9.3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>57</td>
<td>9.3%</td>
</tr>
<tr>
<td>Medical</td>
<td>81</td>
<td>13.2%</td>
</tr>
<tr>
<td>Surgical</td>
<td>96</td>
<td>15.6%</td>
</tr>
<tr>
<td>“Other”</td>
<td>124</td>
<td>20.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>615</td>
<td>100</td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td>49</td>
<td></td>
</tr>
</tbody>
</table>

Forty-nine nurses did not indicate their nursing field. Only two (0.3%) nurses worked in community healthcare in clinics. The majority (124; [20.2%]) of the nurses were from the nursing field indicated as “Other”. The reason for creating the field “Other” was that some nurses experienced difficulty in grouping themselves as working specifically in either the medical or surgical department. The researcher therefore manually categorised those that indicated their work area and marked this on the paper-based questionnaires to ensure an audit trail. For example, it was mainly respondents working in orthopaedics, oncology and gynaecology that were listed under “Other”. In fact, the surgical (96; [15.6%]) and medical (81; [13.2%]) fields also rendered the highest percentages overall. Interestingly, an identical number of responding nurses worked in the fields of critical care (57; [9.3%]) and the operating theatre (57; [9.3%]). Paediatrics (45; [7.3%]), education (43; [7.0%]) and midwifery (41; [6.7%])
were relatively well-represented, whereas respondents from management numbered only 39 (6.3%). The lowest response came from the field of neonatology (30; [4.9%]). The low response from respondents in the management category (39; [6.3%]) was disappointing.

4.2.1.3 Nursing experience

Nursing experience in terms of the number of years was also included in the study to determine the views of various periods of exposure to bullying behaviour (Flateau-Lux & Gravel, 2013:25). Nurses who had been in the permanent employ of the private hospital group for at least six months prior to the study met the inclusion criteria. This timespan was deemed a reasonable period by the researcher to have exposure to workplace bullying – if it occurred in the workplace – and to ascertain whether existing intervention strategies existed in each of the hospitals. To ensure only permanent employees completed the questionnaire, it was suggested to managers in the letter accompanying the questionnaires that it be administered before cardiopulmonary resuscitation (CPR) training which is done only for permanent employees. The nurses’ years of experience is shown in Table 4.4 below.

<table>
<thead>
<tr>
<th>Years of experience</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7–12 months</td>
<td>26</td>
<td>4.2%</td>
</tr>
<tr>
<td>13 months–5 years</td>
<td>197</td>
<td>31.6%</td>
</tr>
<tr>
<td>6–10 years</td>
<td>134</td>
<td>21.5%</td>
</tr>
<tr>
<td>11+ years</td>
<td>255</td>
<td>42.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>615</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td>49</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.4 shows a total of 49 nurses did not indicate their years of nursing experience. Only 26 (4.2%) had worked for between 7 months and one year (12 months). Considering that a split between the remaining 586 shows 331 (53.1%) of them had between 5–10 years’ experience and 255 (42.7%) had more than 11 years of experience in nursing, it could be posited that enough subjects had sufficient experience as nurses in the various hospital departments to be aware of and understand the problem of workplace bullying and anti-bullying strategies.
4.2.1.4 Shifts

Ariza-Montes et al. (2013) investigated the constant predictors of bullying in nursing and found that chances of bullying increase with the frequency of shifts, rotation of tasks in the hospitals or service stations. Shift work and night shift are known to increase stress, sleep disorders and mental/emotional health issues (Admi et al., 2008:251; Farzianpour et al., 2015:167) that act as contributors to workplace bullying, because of the increased likelihood of exposure to a bullying experience (Estryn-Behar, Van der Heijden, Camerino, Fry, Le Nezet, Conway et al., 2008:111; Pai & Lee, 2011:1410). Shift work is associated with sleep disorders that can lead to mental health issues and stress. The nurses’ schedule indicates a day shift can be either an 8-hours shift, or a 12-hours shift. There are also mixed shifts where nurses work day and night shifts on a rotating basis (Kisting, Dalvie & Lewis, 2017:78-79). In the hospital group studied, the staff complement in nursing units during the day is larger than that of the night staff. Additionally, the day staff included the educators and management team who are not usually part of the night shift or mixed shift groups.

Table 4.5: Percentages of participating nurses working the different shifts (n=591)

<table>
<thead>
<tr>
<th>Shifts</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day shift</td>
<td>405</td>
<td>68.5%</td>
</tr>
<tr>
<td>Night shift</td>
<td>23</td>
<td>3.9%</td>
</tr>
<tr>
<td>Mixed shifts</td>
<td>163</td>
<td>27.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>591</td>
<td>100%</td>
</tr>
<tr>
<td>Missing</td>
<td>73</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.5 shows that more than half of the subjects (n=405; 68.5%) worked the day shift. Almost one third of the sample worked mixed shifts (n= 163; 27.6%) (day or night duty) with a few (23; 3.9%) who worked night shift. A total of 73 subjects did not indicate which shifts they worked.
In Figure 4.2, the percentages of the participating subjects working the different shifts are illustrated in a graph.

![Graph showing percentages of participating nurses working different shifts]

Figure 4.1: Percentages of participating nurses working the different shifts (n=591)

### 4.2.1.5 Rank

The inclusion criteria for this study required representation of all nursing ranks, because workplace bullying in nursing reportedly occurs from higher ranks to lower ranks and vice versa, but also between members of the same rank (Escartín et al., 2010:9-10; Hutchinson et al., 2006a:120; Johnston et al., 2010:36; Petersen, 2007:62). In Table 4.6, the distribution of the ranks among the nurse respondents are summarised.

Table 4.6: Distribution of ranks (n=655)

<table>
<thead>
<tr>
<th>Rank</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled nurse auxiliaries (ENAs)</td>
<td>103</td>
<td>15.7%</td>
</tr>
<tr>
<td>Enrolled nurses (ENs)</td>
<td>194</td>
<td>29.6%</td>
</tr>
<tr>
<td>Registered nurses (RNs)</td>
<td>228</td>
<td>34.8%</td>
</tr>
<tr>
<td>Unit managers (UMs)</td>
<td>76</td>
<td>11.6%</td>
</tr>
<tr>
<td>Nurse managers (NMs)</td>
<td>22</td>
<td>3.4%</td>
</tr>
<tr>
<td>Nurse educators (NEs)</td>
<td>32</td>
<td>4.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>655</td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

As shown in Table 4.6, most subjects were registered nurses (228; [34.8%]) followed by enrolled nurses (194; [29.6%]). Few nurse educators (32; [4.9%]) responded to the questionnaire with even less nurse managers (22; [3.4%]) completing and returning questionnaires. Six subjects did not indicate their ranks.
The rank percentages of the subjects are graphically presented in Figure 4.2 below.

![Figure 4.2: Percentages of subject ranks (n=655)](image)

### 4.2.1.6 Age

The researcher found contradictory results for age and workplace bullying in international research. Some studies found that younger employees experience more workplace bullying than older employees (Magerøy et al., 2009:344). However, others found no significant differences between age groups (Ortega et al., 2009:422). As indicated in Table 4.7, five age groups were used for this study.

Table 4.7: Age distribution of nurses (n=632)

<table>
<thead>
<tr>
<th>Age group</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–29 years</td>
<td>180</td>
<td>28.5%</td>
</tr>
<tr>
<td>30–39 years</td>
<td>220</td>
<td>34.8%</td>
</tr>
<tr>
<td>40–49 years</td>
<td>127</td>
<td>20.1%</td>
</tr>
<tr>
<td>50–59 years</td>
<td>89</td>
<td>14.1%</td>
</tr>
<tr>
<td>60+ years</td>
<td>16</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>632</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td><strong>29</strong></td>
<td></td>
</tr>
</tbody>
</table>
Figure 4.3 indicates the age groups were 18–29 (n= 180; [28.5%]), 30–39 (n= 220; [34.8%]), 40–49 (n= 127; [20.1%]), 50–59 (n= 89; [14.1%]) and lastly 60 years and older (n= 16; [2.5%]). Twenty-nine subjects did not indicate their age. For this study, the two age groups 18–29 and 30–39 were most likely to be best represented. A graphic representation of the subjects’ age frequency and percentages is given in Figure 4.4.

![Age distribution in years](image)

**Figure 4.3: Age distribution in years (n=632)**

### 4.2.1.7 Gender

Figure 4.4 shows a total of 569 (90.7%) female nurses and only 58 (9.3%) male nurses completed the questionnaires. Thirty-seven nurses did not indicate their gender. Pietersen (2007:63) found no statistically significant differences between the. Nursing is predominantly a female career domain and therefore the gender distribution is unsurprising (El-Houfey, El-Maged, Elserogy & El Ansari, 2015:7; Marks, 1994:212).

![Gender distribution](image)

**Figure 4.4: Gender distribution of the sample**
4.2.2 Question 1: Frequency and types of workplace bullying

Workplace bullying was measured in terms of frequency (which could be weekly or daily) or duration (which could be six months) (Ariza-Montes et al., 2013:3122). Workplace bullying arises from mistreatment at the workplace, intimidation, harassment, aggression, as well as emotional abuse (Ariza-Montes et al., 2013:3122). Based on the bullying definition it was decided to tally the daily, weekly and monthly frequency totals to determine percentages of frequent bullying acts as indicated in Table 4.8.

The frequency and type of workplace bullying are presented by discussing the following aspects: descriptive statistics followed by inferential statistics and reliability testing of the constructs. Question 1 was used in this study to determine the occurrence of workplace bullying and its frequency in the private hospital group. The 19 questions asked related to physical, personal and emotional bullying. For the questionnaire, a 5-point Likert scale was used where 1 = “daily”, 2 = “weekly”, 3 = “monthly”, 4 = “occasionally” (every six months) and 5 = “never”. The subjects indicated the frequency experienced for each bullying type by marking their choice in the designated area.

In determining the frequency of bullying it was indicated that, among the negative acts considered in this study, spreading gossip and rumours occurred most frequently with a mean of 2.94 (SD = 1.55) followed by ordering someone to work above his/her level of competence/qualification with a mean of 3.26 (SD1.62). These were followed by ignoring other people’s opinion (3.41; SD = 1.46) and, to an extent, repeatedly reminding people of their mistakes and criticising them (3.46; SD =1.4) as shown in Table 4.8.

Physically pushing/shoving occurred the least frequent in the private hospital group with a mean of 4.53 (SD = 0.98). Table 4.8 indicates workplace bullying exposure that mostly happened “monthly” to “occasionally” were pushing and shoving followed by blocking the way (4.44; SD = 1.02); hinting or signalling that someone should resign (4.38, SD = 1.02); pressurising someone not to claim a benefit the person is entitled to (4.26, SD = 1.08); and exposing someone to excessive teasing and sarcasm (4.02, SD = 1.21). “Monthly” exposure to workplace bullying included all the rest of the criteria, except spreading gossip and rumours which is indicated as “weekly”.

---

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### Table 4.8: Summary of frequencies of Negative Acts Questionnaire (NAQ-R)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Mean</th>
<th>SD</th>
<th>SUM</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Withholding information</td>
<td>648</td>
<td>135</td>
<td>60</td>
<td>24</td>
<td>263</td>
</tr>
<tr>
<td>Finger pointing</td>
<td>656</td>
<td>117</td>
<td>72</td>
<td>38</td>
<td>209</td>
</tr>
<tr>
<td>Invasion of personal space</td>
<td>648</td>
<td>115</td>
<td>58</td>
<td>53</td>
<td>198</td>
</tr>
<tr>
<td>Pushing/shoving</td>
<td>659</td>
<td>24</td>
<td>20</td>
<td>29</td>
<td>97</td>
</tr>
<tr>
<td>Blocking the way</td>
<td>650</td>
<td>26</td>
<td>24</td>
<td>31</td>
<td>124</td>
</tr>
<tr>
<td>Giving someone tasks with unreasonable/impossible targets or deadlines</td>
<td>659</td>
<td>107</td>
<td>55</td>
<td>53</td>
<td>209</td>
</tr>
<tr>
<td>Subjecting someone to excessive monitoring of his/her work</td>
<td>657</td>
<td>114</td>
<td>69</td>
<td>57</td>
<td>213</td>
</tr>
<tr>
<td>Pressurising someone not to claim a benefit the person is entitled to (e.g., leave)</td>
<td>659</td>
<td>37</td>
<td>18</td>
<td>44</td>
<td>199</td>
</tr>
<tr>
<td>Exposing someone to excessive teasing and sarcasm</td>
<td>658</td>
<td>45</td>
<td>48</td>
<td>60</td>
<td>198</td>
</tr>
<tr>
<td>Ordering someone to work below her/his level of competence/qualification</td>
<td>657</td>
<td>68</td>
<td>63</td>
<td>61</td>
<td>177</td>
</tr>
<tr>
<td>Ordering someone to work above her/his level of competence/qualification</td>
<td>616</td>
<td>168</td>
<td>50</td>
<td>42</td>
<td>166</td>
</tr>
<tr>
<td>Spreading gossip and rumours</td>
<td>662</td>
<td>200</td>
<td>84</td>
<td>73</td>
<td>169</td>
</tr>
<tr>
<td>Ignoring, excluding or isolating someone from a/the group</td>
<td>654</td>
<td>129</td>
<td>53</td>
<td>55</td>
<td>217</td>
</tr>
<tr>
<td>Shouting at someone or making her/him the target of spontaneous anger</td>
<td>659</td>
<td>96</td>
<td>78</td>
<td>65</td>
<td>227</td>
</tr>
<tr>
<td>Hinting or signalling that someone should resign</td>
<td>653</td>
<td>24</td>
<td>31</td>
<td>28</td>
<td>163</td>
</tr>
<tr>
<td>Repeatedly reminding someone of his/her errors or mistakes</td>
<td>660</td>
<td>109</td>
<td>65</td>
<td>73</td>
<td>238</td>
</tr>
<tr>
<td>Constantly criticising someone's work and effort</td>
<td>660</td>
<td>118</td>
<td>61</td>
<td>67</td>
<td>221</td>
</tr>
<tr>
<td>Ignoring someone's opinions and views</td>
<td>659</td>
<td>126</td>
<td>60</td>
<td>67</td>
<td>227</td>
</tr>
<tr>
<td>Playing practical jokes on someone the person does not get along with</td>
<td>660</td>
<td>40</td>
<td>25</td>
<td>30</td>
<td>185</td>
</tr>
</tbody>
</table>

1 = “daily”; 2 = “weekly”; 3 = “monthly”; 4 = “occasionally” (every six months); 5 = “never”
4.2.3 Question 2: Factors contributing to workplace bullying

Question 2 investigated the aspects contributing to workplace bullying. More than one option could be selected with this question. In Table 4.9, the data indicates that most nurses selected poor communication (67.9%) as a cause of workplace bullying. Leadership behaviours (52.4%) followed poor communication while job insecurity/lack of job control and/or autonomy was selected by only (19.1%) of the nurses.

Literature shows that lower level nurses are likely to experience aggression from nurses at a higher hierarchical level due to low self-esteem and poor group identity (Stelmaschuk, 2010:5). In addition, certain factors such as the inadequate organisational policies and procedures aimed at addressing workplace bullying, misuse of authority, as well as tolerance of bullying behaviour exacerbate vertical bullying behaviour. The findings in this section are similar to what others have revealed. For instance, challenging unacceptable behaviours in the work environment, Murray (2009:275) argues that failure to take action against bullying deeply embeds bullying activities into the organisational culture, thereby creating situations where bullying is perceived as acceptable and normal behaviour by all employees.

Table 4.9: Contributing factors

<table>
<thead>
<tr>
<th>Contributing factors</th>
<th>Number of subjects selecting the option</th>
<th>% of subjects selecting the option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job insecurity/Lack of job control/Autonomy</td>
<td>127</td>
<td>19.1%</td>
</tr>
<tr>
<td>Shift work</td>
<td>147</td>
<td>22.1%</td>
</tr>
<tr>
<td>Role demands</td>
<td>165</td>
<td>24.8%</td>
</tr>
<tr>
<td>Changes in the work environment</td>
<td>182</td>
<td>27.4%</td>
</tr>
<tr>
<td>Organisational politics/Culture</td>
<td>203</td>
<td>30.6%</td>
</tr>
<tr>
<td>Poor conflict management</td>
<td>257</td>
<td>38.7%</td>
</tr>
<tr>
<td>Leadership behaviours</td>
<td>348</td>
<td>52.4%</td>
</tr>
<tr>
<td>Poor communication</td>
<td>451</td>
<td>67.9%</td>
</tr>
</tbody>
</table>
4.2.4 Question 3: Response to bullying

The third question was a three-part question investigating how the nurses responded to bullying experienced as a target or bystander, if they think they acted correctly in those situations and lastly the reason they acted that way. It tested some of the nurses’ perceptions, as well as the motivators for bullying behaviour.

Figure 4.5 shows the majority of the nurses, namely 283 (42.6%) confirmed that when they experienced bullying, they reported the incident to a manager or shift leader while 249 (37.5%) kept it to themselves or ignored it. A further 239 (36%) confronted the bully and 147 (22.1%) expressed their feelings and rights to others whether they are co-workers or family. Eleven (1.7%) indicated that they considered resigning, while only 3 (0.5%) indicated they insulted the person responsible for bullying them.

<table>
<thead>
<tr>
<th>Response to observing or experiencing bullying</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report the incident to a manager/shift leader</td>
<td>42.6%</td>
</tr>
<tr>
<td>Keep quiet / ignore it</td>
<td>37.5%</td>
</tr>
<tr>
<td>Confront them</td>
<td>36.0%</td>
</tr>
<tr>
<td>I express my feelings and rights to others</td>
<td>22.1%</td>
</tr>
<tr>
<td>Document the incident</td>
<td>21.1%</td>
</tr>
<tr>
<td>Avoid the person (s) participating in the behaviour</td>
<td>18.7%</td>
</tr>
<tr>
<td>I withdraw from the team</td>
<td>13.6%</td>
</tr>
<tr>
<td>I ask to be transferred to another unit</td>
<td>3.9%</td>
</tr>
<tr>
<td>Resign</td>
<td>1.7%</td>
</tr>
<tr>
<td>Insult the person participating</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Figure 4.5: Response to observing/experiencing bullying

The second part of Question 3 was when asked whether they thought they had acted correctly in their response to the bullying situation, 161 (24.81%) of the nurses responded negatively (No) and 487 (75.19%) responded positively (Yes). A total of 16 nurses did not answer this question. Table 4.10 indicates the nurses’ reactions as to whether they believed they reacted correctly or incorrectly in the aforementioned situation (refer to Figure 4.5 above).
The last section of Question 3 dealt with the nurses’ motivators for reciprocal action taken as targets or witnesses of bullying behaviour. It gave insight into why the nurses acted the way they did when they observed or experienced bullying behaviour. Six options were given (refer to Table 4.11). The respondents were instructed to choose the options closest to the reason why they reacted in the way they did at the time and in the situation when the bullying occurred. The option most nurses (48.02%) chose was “I do not tolerate such behaviour”. A total of 16.16% responses indicated they acted in the chosen way because they did not want to become involved. Similarly, the same percentage (16.16%) indicated they were afraid of confrontation. Of the responses, 10.98% indicated nurses were unsure how to handle a situation in which bullying occurred. A lack of self-confidence and peer pressure contributed to how they reacted towards being bullied with responses of 5.03% and 3.66% respectively.

Table 4.11: Reasons for reciprocal actions

<table>
<thead>
<tr>
<th>I acted the way I do because ...</th>
<th>All the other nurses act this way</th>
<th>I do not have the self-confidence to act differently</th>
<th>I am unsure how to handle these situations</th>
<th>I am afraid of confrontation</th>
<th>I do not want to become involved</th>
<th>I do not tolerate such behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
<td>No. (%)</td>
</tr>
<tr>
<td>All the other nurses act this way</td>
<td>3.66%</td>
<td>5.03%</td>
<td>10.98%</td>
<td>16.16%</td>
<td>16.16%</td>
<td>48.02%</td>
</tr>
</tbody>
</table>
4.2.5 Question 4: Management of bullying

In Question 4, the respondents were asked to indicate their perception of how bullying was managed in their workplace at the time of the study. This question was included to determine the management strategies of workplace bullying in the private hospitals at the time of study. The question was divided into three parts:

- strategies used for preventing workplace bullying,
- how bullying was being managed at the time of study, and
- how effective the measures to manage workplace bullying in a department was.

The respondents could choose as many of the given options as they thought applicable and were not limited to choosing only one.

4.2.5.1 Strategies used for preventing workplace bullying

The data summary in Figure 4.6 indicates the strategies applied to manage bullying varied considerably. Counselling for targets, bystanders and perpetrators were noted by 247 (37.2%) as the strategy used most often. Open negotiations between targets and perpetrators was mentioned by 200 (30.1%), while adopting problem-solving behaviours was marked by 187 (28.2%) nurses. The option of management siding with the perpetrator was marked by 142 (21.4%) of the subjects and encouraging the target and perpetrator to compromise was added by 110 (16.6%) subjects. The two strategies applied the least in the departments to manage workplace bullying were to tolerate bullying (n=89; [13.4%]) and discouraging the target to report the bullying incident (n=30; [4.5%]).

![Figure 4.6: Strategies used for preventing workplace bullying](image-url)
Strategies and ways to measure the management of bullying at the time of study were explored with this question. A total of 992 responses were received from the 664 respondents who completed the question. The data in Table 4.12 shows the majority (n=270; [40.7%]) indicated that in their hospital, reporting was the measure used to address (and the way their hospital managed) bullying behaviour. Following the code of conduct to manage bullying rendered a response of 254 (n=254; 38.3%), while the least-used measure for managing bullying was to petition policies (n=88; 13.3%). A total of 168 (25.3%) of the subjects indicated nothing was done to manage bullying.

Table 4.12: Measures used to manage bullying at the time of study

<table>
<thead>
<tr>
<th>Current prevention measures</th>
<th>Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying policies</td>
<td>88</td>
<td>13.3%</td>
</tr>
<tr>
<td>Nothing is done</td>
<td>168</td>
<td>25.3%</td>
</tr>
<tr>
<td>Investigation of allegations</td>
<td>212</td>
<td>31.0%</td>
</tr>
<tr>
<td>Use of code of conduct</td>
<td>254</td>
<td>38.3%</td>
</tr>
<tr>
<td>Reporting procedures</td>
<td>270</td>
<td>40.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>992</strong></td>
<td></td>
</tr>
</tbody>
</table>

4.2.5.3 Effectiveness of measures to manage workplace bullying in a department

The third sub-question related to the respondents’ perceptions on the effectiveness of existing measures to manage workplace bullying in their respective departments. The results are presented in Table 4.13. A rating scale with four categories was given on the questionnaire, namely “effective”, “highly effective”, “highly ineffective” and “ineffective”.

Table 4.13: Effectiveness of bullying management (N=664)

<table>
<thead>
<tr>
<th></th>
<th>Effective</th>
<th>Highly effective</th>
<th>Highly ineffective</th>
<th>Ineffective</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>284</td>
<td>65</td>
<td>95</td>
<td>194</td>
<td>638</td>
</tr>
<tr>
<td>%</td>
<td><strong>44.50%</strong></td>
<td><strong>10.17%</strong></td>
<td><strong>14.87%</strong></td>
<td><strong>30.36%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>n</td>
<td>349</td>
<td>289</td>
<td></td>
<td></td>
<td>638</td>
</tr>
<tr>
<td>%</td>
<td><strong>54.77%</strong></td>
<td><strong>45.23%</strong></td>
<td></td>
<td></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

“Highly effective” (n=65; [10.17%]) received less support than “highly ineffective” (n=95; [14.87%]) while “effective” was indicated by 285 subjects (n=285; [44.6%]) and “ineffective” was the choice of 194 nurses (n=194; [30.36%]). The aggregate on the “effective” (”effective” and “highly effective”) and “ineffective” (”ineffective” and “highly ineffective”) groups indicate
that 349 (n=349; [54.77%]) nurses considered the current practices as “effective”, whereas 289 (n=289; [45.22%]) perceived current practices as “ineffective”.

Table 4.14: Effectiveness of preventative bullying management

<table>
<thead>
<tr>
<th>Measures Used for Preventing Bullying</th>
<th>Effective (n=349)</th>
<th>Highly Effective (n=349)</th>
<th>Highly Ineffective (n=349)</th>
<th>Ineffective (n=349)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing is done</td>
<td>14.29%</td>
<td>1.19%</td>
<td>32.14%</td>
<td>52.38%</td>
</tr>
<tr>
<td>Use of code of conduct</td>
<td>60.25%</td>
<td>14.75%</td>
<td>7.38%</td>
<td>17.62%</td>
</tr>
<tr>
<td>Investigation of allegations</td>
<td>55.56%</td>
<td>14.49%</td>
<td>9.66%</td>
<td>20.29%</td>
</tr>
<tr>
<td>Reporting procedures</td>
<td>49.23%</td>
<td>14.23%</td>
<td>13.46%</td>
<td>23.08%</td>
</tr>
<tr>
<td>Bullying policies</td>
<td>54.65%</td>
<td>17.44%</td>
<td>15.12%</td>
<td>12.79%</td>
</tr>
</tbody>
</table>

To achieve an understanding of what the respondents considered was needed to achieve a desirable and successful way of managing bullying in the work environment necessitated a comparison of the measures they perceived as successful or not. Therefore, the positive (“effective” and “highly effective”) and negative (“ineffective” and “highly ineffective”) variables regarding the management of workplace were totalled separately and compared in Table 4.14.

Table 4.15: Comparison between positive and negative results of management of workplace bullying

<table>
<thead>
<tr>
<th>Measures Used for Preventing Bullying</th>
<th>Effective (n=349)</th>
<th>Highly Effective (n=349)</th>
<th>Total %</th>
<th>Highly Ineffective (n=349)</th>
<th>Ineffective (n=349)</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing is done</td>
<td>14.29%</td>
<td>1.19%</td>
<td>15.48%</td>
<td>32.14%</td>
<td>52.38%</td>
<td>84.52%</td>
</tr>
<tr>
<td>Use of code of conduct</td>
<td>60.25%</td>
<td>14.75%</td>
<td>75%</td>
<td>7.38%</td>
<td>17.62%</td>
<td>25%</td>
</tr>
<tr>
<td>Investigation of allegations</td>
<td>55.56%</td>
<td>14.49%</td>
<td>70.05%</td>
<td>9.66%</td>
<td>20.29%</td>
<td>29.95%</td>
</tr>
<tr>
<td>Reporting procedures</td>
<td>49.23%</td>
<td>14.23%</td>
<td>63.46%</td>
<td>13.46%</td>
<td>23.08%</td>
<td>36.54%</td>
</tr>
<tr>
<td>Bullying policies</td>
<td>54.65%</td>
<td>17.44%</td>
<td>72.09%</td>
<td>15.12%</td>
<td>12.79%</td>
<td>27.91%</td>
</tr>
</tbody>
</table>

From Table 4.15 it is clear the subjects believed following a clear code of conduct (75%) and adherence to bullying policies (72.09%) were essential. “Nothing is done” (84.52%) shows they experience no effort was made to address bullying, and that bullying should be reported (63.46%) to be effective and allegations should be investigated (70.05%). The fact that nothing is done is considered the most ineffective strategy to prevent bullying behaviour.
4.2.5.1.4 Current bullying management practices and their effectiveness

The data in Table 4.16 shows that the three negative practices were considered ineffective, while the four positive practices were considered more effective.

The most effective bullying management practices were the adoption of problem-solving behaviours (61.83%); open negotiations (60.31%); counselling (54.77%); and encouraging compromise (51.4%). Management sides with the perpetrator resulted in 20%; discouraging reporting rendered 13.33% of the responses; and to tolerate bullying was the lowest percentage at 14.77%.

Highly effective practices reported were the adoption of problem-solving behaviours (7.2%); open negotiations (15.46%); counselling (15.35%), followed by “management sides with the perpetrator” (3.57%) and to tolerate bullying (3.41%). Discouraging reporting (3.33%) rendered the lowest percentage.

Highly ineffective practices were to discourage reporting (53.33%); to tolerate bullying (36.36%); and when management sides with the perpetrator (33.57%). Other ineffective practices included encouraging compromise (15.89%); counselling (7.88%); and adopting a problem-solving behaviour (7.53%). Open negotiations (56.19%) were considered “highly ineffective” by the subjects. The use of a code of conduct was regarded as a “highly ineffective” measure by 7.38% of the nurses.

Ineffective management practices were ranked as follows: tolerating bullying (45.45%); management sides with the perpetrator (42.85%); and discouraging reporting (30%). This was followed by encouraging compromise (22.43%); counselling (21.99%); open negotiations (18.04%); and, lastly, adopting problem-solving behaviours (13.44%).

Table 4.16: Effectiveness of current bullying management practices

<table>
<thead>
<tr>
<th>How effectively is bullying managed in your work environment?</th>
<th>Effective</th>
<th>Highly effective</th>
<th>Highly ineffective</th>
<th>Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open negotiations</td>
<td>60.31%</td>
<td>15.46%</td>
<td>6.19%</td>
<td>18.04%</td>
</tr>
<tr>
<td>Encouraging compromise</td>
<td>51.40%</td>
<td>10.28%</td>
<td>15.89%</td>
<td>22.43%</td>
</tr>
<tr>
<td>Adoption of problem-solving behaviours</td>
<td>61.83%</td>
<td>17.20%</td>
<td>7.53%</td>
<td>13.44%</td>
</tr>
<tr>
<td>Counselling</td>
<td>54.77%</td>
<td>15.35%</td>
<td>7.88%</td>
<td>21.99%</td>
</tr>
<tr>
<td>Discourage reporting</td>
<td>13.33%</td>
<td>3.33%</td>
<td>53.33%</td>
<td>30.00%</td>
</tr>
<tr>
<td>Management sides with the perpetrator</td>
<td>20.00%</td>
<td>3.57%</td>
<td>33.57%</td>
<td>42.86%</td>
</tr>
<tr>
<td>Tolerate bullying</td>
<td>14.77%</td>
<td>3.41%</td>
<td>36.36%</td>
<td>45.45%</td>
</tr>
</tbody>
</table>
4.2.6 Question 5: Preferred strategies to manage workplace bullying

Question 5 was included to determine the strategies and motivators subjects would prefer to be implemented for managing workplace bullying between nurses at a private hospital group in SA. Question 5 comprised of five sub-questions, namely:

- strategies nurse managers and leaders use,
- values and skills needed by nurses,
- support required to change bullying behaviour,
- how nurses preferred being addressed if negative behaviour is portrayed by them, and
- recommended reporting procedures.

4.2.6.1 Strategies to deal with workplace bullying

The findings presented in Figure 4.7 show typical organisational procedures used in solving cases of bullying. The results for creating awareness on workplace bullying counted 431 (64.9%) responses; improving interpersonal relationships and communication was the wish of 398 (59.9%) subjects; while 356 (53.6%) subjects advocated for promoting the creation of a positive organisational culture and climate. A total of 325 (49%) subjects motivated for the adoption of ethical behaviours by all healthcare staff and 326 (49.1%) of the subjects felt coaching and counselling employees would be positive strategies. Changing leadership and management style were raised by 239 (36%) subjects and adopting specific anti-bullying policies was raised by 206 (31%) subjects. Instilling a reporting procedure was important for 204 (30.7%) of subjects, while mediating workplace conflict and emphasising legal measures for extensive bullying were viewed as significant by 164 (24.7%) and 182 (27.4%) respectively.
4.2.6.2 Values and skills needed by nurses

The second sub-question on managing workplace bullying related to the values and skills needed by nurses to minimise workplace bullying. This question was asked to determine which values and skills needed to be focused on to empower nurses to become more motivated to minimise bullying behaviours. The responses are reflected in Figure 4.8.

To value human dignity and respect others were seen by 434 (65.4%) subjects as vital. Good communication skills were desired by 409 (61.6%) subjects and honesty was viewed by 327 (49.2%) as significant. Fairness was chosen by 299 (45%); acting as a team player by 251 (37.8%); and to have a positive mindset by 219 (33%). Learning to be patient was the wish of 183 (27.6%). The wish to receive constructive feedback was mentioned by 131 (19.7%). Of the subjects, 136 (20.5%) also indicated they wanted to be empowered with objectivity/impartiality and 140 (21.1%) responded they would be motivated if they experienced more willingness to assist among the nurses. Sincerity was observed by 102 (15.4%) as a valuable motivational factor.
Figure 4.8: Values and skills needed to minimise bullying

4.2.6.3 Support required to change bullying behaviour

The aim of Sub-question 5.3 was to determine the supportive role player(s) or mentor(s) needed by nurses to change bullying behaviour. From the results presented in Figure 4.9, the majority, namely 441 (66.42%), needed the nursing management’s support. The number who required support from their colleagues totalled 329 (49.55%) and from their shift leaders, 281 (42.32%) wanted support. From their nurse trainers, 165 (24.85%) wanted support. Only 74 (11.14%) indicated support from external mediators was required. Only 32 (4.82%) indicated they needed their families’ support. Clearly, the preference for all subjects was to be supported by somebody who shared their immediate work environment.

Figure 4.9: Support needed to change bullying behaviour
4.2.6.4 Awareness of own bullying behaviour

The responses from Sub-question 4 showed who the subjects would prefer to make them aware of their bullying behaviours if they as nurses exhibited bullying behaviour towards others in their work environment.

Figure 4.10 represents the subjects’ preferences on who they would like to inform or address them if they as nurses overstepped the line and demonstrated bullying behaviours towards any other employees (whether senior or junior staff or nurses on the same nurse level). The 557 (73.1%) who preferred to be addressed and admonished by the target of their bullying behaviour face-to-face was by far the majority. The second option given was to have a unit manager informing them: 142 (18.64%) chose this option. Thirty-eight (4.99%) wanted a friend to make them aware that they are exhibiting a bullying attitude. Being informed by somebody outside the nursing team that she/he was bullying was not an agreeable arrangement as only 13 (1.71%) subjects indicated this approach was acceptable. Receiving an anonymous letter was not considered a proper way to make a nurse aware of his/her bullying behaviour, as only 12 (1.57%) subjects found this way of communication acceptable.

Figure 4.10: How should an individual be made aware about own bullying behaviour
4.2.6.5 Recommended reporting procedures

Sub-question 5 was the last under Question 5. This data was essential to determine which procedure the subjects were most willing to follow when witnessing bullying behaviours and subsequently report it.

The data in Figure 4.11 shows a total of 395 (50.71%) would prefer to verbally inform the unit manager of the bullying behaviour they either experienced or witnessed. Completing an event report on the occurrence was preferred by 293 (37.61%). Sixty-five (8.34%) felt that they would prefer to post a letter to the perpetrating bully from outside the unit. For 26 (3.34%), the best way of reporting bullying behaviour was to not become personally involved themselves, but they would be willing to report the bullying by asking a friend to report it on their behalf.

Figure 4.11: Recommended reporting procedures

4.3 MAIN FINDINGS

The quantitative study (Phase 1) results were essential to the investigation of nurse-to-nurse bullying in the private hospital group, as it contributed towards the formulation of strategies to curb bullying. The results provided deeper insight into and a better understanding of the bullying contributing factors in the hospital group. It was vital to obtain data on the types, contributing factors and strategies which instigated bullying behaviour between nurses in the hospital group, as having this knowledge would assist with the formulation and development of a suitable and workable model to deal with workplace bullying between nurses employed by the private hospital group.
Workplace bullying between nurses was found to be present in the various hospitals of the private hospital group. Various contributing factors, strategies and motivators to curb bullying behaviours were suggested and supported by the nurses who responded to the questionnaire. To ensure their work environment was safe and free from bullying behaviours, they needed to be skilled in clear and effective communication, value each other by showing respect, build solid teams, have clear policies and focused guidelines to assist them to report bullying behaviours, and have clarity about each employee's scope of practice.

The quantitative data showed that spreading gossip and rumours were perceived the biggest contributor followed by allocating someone work above his/her competence or qualification. Pushing and shoving were least favourite bullying techniques. Poor communication and leadership behaviour were the major factors to contribute to bullying behaviour.

The nurses further indicate that when they experience or witness bullying, they report it to a manager or a shift leader, but almost an equal number of respondents indicated that they ignore the incident or confront the bully. Unpredictably, many indicated that they do not want to become involved. Nurses also remark that to document the incident was important and perceive it the correct thing to do because they do not tolerate bullying behaviour. Nurses further indicate that they are afraid of confrontation and do not know how to address the bullying behaviour.

Strategies to manage workplace bullying between nurses were divided into what was happening already in the hospitals and what they perceive could be possible solutions to bullying management, what strategies could be used to prevent bullying and what they perceive as successful. Counselling and negotiation were the mostly used prevention management strategy while their perceived strategies to address bullying going forward were creating awareness on workplace bullying and to improve on the relationships and communication within the hospitals. Respect as a value and improved communication skills were needed as motivators to change bullying behaviour. To implement the strategies the support of nursing management and colleagues. The preferred strategy to inform a bully about his/her behaviours was face to face verbal confrontation.

The above issues were used to formulate appropriate questions which were addressed by means of qualitative interviews in Phase 2 of the study.
4.4 CHAPTER SUMMARY

This chapter addressed the phase 1 quantitative data collected and analysed. The data collected included demographics of the subjects, frequency and types of bullying experienced by the nurses of the private hospital group. This was followed by the factors contributing to bullying and the perceptions of the nurses on the management of bullying. The then current and preventative strategies to manage bullying were also collected. The quantitative results led to the questions about what nurses and management can do to reduce bullying and how the work environment should change to reduce bullying behaviour. These questions were addressed during the qualitative phase of the study. The qualitative data collection and analysis are presented, discussed and supported by literature in Chapter 5.
CHAPTER 5 – QUALITATIVE DATA FINDINGS

5.1 INTRODUCTION

This chapter deals with the findings of data collected from six nurses during the Phase 2 of the study. The objective of this phase was to obtain clarity on contributing factors to workplace bullying, perceptions on management and the strategies used. The rest of the chapter will reflect on the themes, sub-themes and categories that emerged during the analysis of the transcribed data. The participants were asked to respond to the following three open-ended questions:

- Tell me what you and other nurses can do to change bullying behaviour at work.
- What changes do you think should happen in the work environment to manage bullying behaviour?
- Tell me what you think management should do in order to address the problem of bullying at work.

5.2 QUALITATIVE DATA PRESENTATION AND ANALYSIS

After an initial description of the motivation of the study, namely to find solutions to workplace bullying between nurses in the private hospital group the individual interviews commenced with the following invitation that served as an encouragement for a free and open discussion: “Tell me what you and other nurses can do to change the bullying at work”.

Six participants from Gauteng were included in the qualitative study through purposive sampling. To guarantee participants’ anonymity and maintain confidentiality, the transcribed interviews were numbered as Interview 1B up to Interview 6B.

In no particular order, the six participants consisted of an enrolled nurse (EN); a registered nurse (RN); a registered nurse working as a human resource manager (HR); a unit manager (UM); and two nurse educators (NEs). Five of the participants were females. Two participants were in the 31- to 40-year-old age category; two were between 41-50 years old, while the remaining two were between 51-60 years old. All participants were employed by the private hospital group at the time of the study. All six reported to have had at least ten years’ experience in the private hospital industry and five participants completed and returned the study questionnaire used in Phase 1 (quantitative phase). Under the heading “Nursing rank” in Table 5.1, the six participants are alphabetically listed to maintain anonymity and prevent
any misunderstanding that the number used might reflect the coded numeral allocated to a participant during his/her interview.

Table 5.1: Profile of participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Nursing rank</th>
<th>Gender</th>
<th>Age</th>
<th>Area of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enrolled Nurse (EN)</td>
<td>Female</td>
<td>35</td>
<td>Medical ward</td>
</tr>
<tr>
<td>2</td>
<td>Registered Nurse (RN)</td>
<td>Female</td>
<td>55</td>
<td>Human Resources (HR)</td>
</tr>
<tr>
<td>3</td>
<td>Nursing educator (RN &amp; NE)</td>
<td>Female</td>
<td>52</td>
<td>All group hospitals in Gauteng</td>
</tr>
<tr>
<td>4</td>
<td>Nursing educator (RN &amp; NE)</td>
<td>Female</td>
<td>49</td>
<td>Hospital</td>
</tr>
<tr>
<td>5</td>
<td>Registered Nurse (RN)</td>
<td>Male</td>
<td>32</td>
<td>Intensive care</td>
</tr>
<tr>
<td>6</td>
<td>Unit Manager (RN &amp; UM)</td>
<td>Female</td>
<td>41</td>
<td>Intensive care</td>
</tr>
</tbody>
</table>

The qualitative data was obtained by transcribing the six recorded individual interviews into written verbatim transcripts and by using Tesch’s method of data analysis (Tesch, 1990 cited in Creswell, 2009:186) and Theron (2015:9). As suggested by Creswell (2009:191), an agreement was reached between the researcher and an experienced independent coder to independently code the data to increase the trustworthiness of the coded data. From the transcriptions of the interviews the data was coded and duplications had been grouped and differences were highlighted. Data was recoded several times until the themes become clear. The discussion with the co-coder helped to crystallise the themes that emerged. The researcher and the independent coder reached consensus on the main themes, sub-themes and categories that emerged from the analysed data. The themes were organised to reflect the purpose of the study and provide answers to the research questions (Ruona, 2005:241).

In this chapter each section is preceded by a table summarising the theme, sub-themes and categories. The theme titles were concise and consisted of words the participants actually used (as opposed to technical terms), which gave an indication of what the theme was about (Braun & Clarke, 2006:22; Ruona, 2005:242). The co-coder supplied the researcher with a coding confirmation letter (refer to Addendum J).

After the data collection and coding, the researcher engaged with the relevant literature and compared the data with the findings reflected in the literature cited as a control to the findings of this study. The relationship between the literature reviewed and the main concepts derived from the analysis of the collected data was pointed out.
5.3 THEMES, SUB-THEMES AND CATEGORIES

The themes that emerged from the interview data are indicated in Table 5.2. The findings are presented according to the themes and sub-themes identified during the analysis process when the data sources were turned into information via reliable theme identification techniques and processes. Four themes and 15 sub-themes were identified.

Table 5.2: Themes of the study

<table>
<thead>
<tr>
<th>Theme 1</th>
<th>Contributing factors to workplace bullying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 2</td>
<td>Management and organisational actions</td>
</tr>
<tr>
<td>Theme 3</td>
<td>Nurse-related aspects</td>
</tr>
<tr>
<td>Theme 4</td>
<td>Work environment improvements</td>
</tr>
</tbody>
</table>

5.3.1 Theme 1: Contributing factors to workplace bullying

In Theme 1 (Contributing factors to workplace bullying), four sub-themes were identified, namely abuse of power; harmful communication; high workload; and negative attitudes. Table 5.3 shows Theme 1 together with its sub-themes and categories.

Table 5.3: Theme 1 - Nurses’ perceptions of contributing factors to workplace bullying

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3.1 THEME 1: Contributing factors to workplace bullying</td>
<td>5.3.1.1 Sub-theme 1: Abuse of power</td>
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It must be noted here that the terms “senior”, “experienced”, or “older” nurse used by the six participants in their interviews referred to higher level nurses who had trained for four years and who had many years’ experience in the nursing field. Also, the terms “junior” and “younger” nurse pertained to either the category enrolled nurse (two years’ training) or an enrolled auxiliary nurse (one years’ training) and, in both cases, the nurses had been working for less than six months in the nursing environment. A “new” nurse is any of the levels of
nurses transferred from one unit to another unit in the same hospital. Because the qualitative data was in the narrative form, participants were not limited or advised to use specific words or terminologies, as they could speak freely and openly. Subsequently, it was normal for them to use unit- or department-specific nomenclature.

5.3.1.1 Sub-theme 1: Abuse of power

In the hospital setting, having “power” means a staff member with a controlling attitude targets a co-worker and asserts certain authoritative and controlling attitudes and behaviours to force a co-worker into doing something she/he does not necessarily have to, want to or need to do (Walls & Berrone, 2017: 294).

Under Sub-theme 1, abuse of power, three categories emerged, namely nurse-to-nurse bullying; bullying by managers and bullying by doctors.

5.3.1.1.1 Category 1: Nurse-to-nurse bullying

Participants shared that they encountered peer nurse-to-nurse bullying (same level nurses, also known as horizontal bullying behaviours) and top-down nurse-to-nurse bullying (senior level to junior level, also known as vertical bullying behaviours) in their hospital work environments. It seemed to the participants as if nurses who believed they were in a power position in the hospital believed this “power” gave them the right to mistreat colleagues.

Same-level nurse colleagues who bullied each other were mentioned by the participants:

“… I need to bully her so it’s about positions of power. ... But, I feel nurse-to-nurse bullying is about ‘I’m not comfortable in the position that I am in’. You know, ‘my position of power, my base from where I work, I don’t feel safe in it’ and therefore, I bully those around me. ... I think there are nurses on the same level bullying one another as well.” P3

“I think ... colleagues bullying one another. I think that is the main culprit at the moment.” P2

Murray (2009:273) states bullying in the nursing environment is in general ascribed to the bully’s need to be in control of “all aspects of the work environment”, thus including the staff. Bullying is also often a way the perpetrator tries to cover up her/his own weaknesses and/or insecurities (Public Services Health & Safety Association [PSHSA], 2010:7). Power is seen as authoritative control; it occurs when individuals or groups of employees feel they are more important than others in a unit or any area in a hospital setting and they use this false or skewed sense of power to influence colleagues or groups of colleagues into submissiveness (Sepasi, Abbaszadeh, Borhani & Rafiei, 2016:10).
Blando et al. (2015:7) state horizontal bullying is often more likely to be a group effort. According to these authors, nurse peers tend to “gang up” because they find that, as members of a group, their influence increases and they can target an “outsider”. In this study, a participant reported an incident where student nurses harassed a very domineering peer:

“The one was victimising a nurse in a particular department she ... she was student ... The situation was ... she [the student] is quite verbal and would tell the others that they were doing things incorrectly ... the ward staff didn’t like it. So they started sabotaging her motorbike and eh... not damaging it but it was found on its side, they had stuffed leaves and grass and rubbish into her helmet.” P4

According to Fink-Samnick (2015:167), individuals or groups exposed to the same domineering circumstances do not confront the system. Instead, they turn on each other and subsequently, horizontal bullying occurs. Acting together means if there are consequences, they can defend each other and it is also easier to blame the target as the instigator of the problem. Unfortunately, hospital employees who think and act as if they are in power positions compromise patient safety and positive patient outcomes (Koh, 2016:215).

Assuring each healthcare professional knows he/she is valued, supported and empowered could prevent a bullying culture from taking root in a hospital environment with power struggles and rank (Rocker, 2008:3) issues. The participants are of opinion that bullying can easily shift the focus from “passionate patient care and patient safety” P5 and “for the patients’ sake because that’s ultimately why we are at work” P2 to the patient not being “at the forefront of what our nurses are doing today” P4.

Because the nursing staff in a unit or department consists of diverse categories of nurses (Nursing Act 33 of 2005:23), senior nurses often perceive themselves as having a higher status and thus more power in the group. This false sense of power can promote their bullying behaviour towards juniors in the group (Cunniff & Mostert, 2012:2).

Lower category or junior nurses indeed mentioned senior category nurses bullied them. Similarly, nurses new to the ward or unit confirmed they experienced the same abusive behaviours from seniors who had for years had the unit “under their control” as illustrated in the quotes:

“Especially the registered nurses that are bullying us the enrolled nurses and the auxiliary nurses, because they know you cannot say anything back.” P1

“I think there are nurses on the same level bullying one another as well... but it's very often, senior, junior”. P3

“... because that's the other thing that sisters [registered nurses] do, is they choose, it's almost like they choose vulnerable students and then those little students are like the little extra hen in the nest, you know, what bird is it that kicks out the young one, 'arend' [eagle], anyway...” P3
“... because a professional nurse can easily bully an enrolled nurse or an enrolled nurse auxiliary, obviously because it's not on the same level.” P2

“... people that have been working there [in unit] for years and with the bullying, [it] unfortunately makes it difficult because now you bring in new staff, that they [older or senior nurses] don't know, younger staff and I think many of them feel threatened causing the bullying to be more aggressive…” P6

Blando et al. (2015:5) confirm vertical bullying occurs in hospital units when senior or older nurses with more experience think they have authority because it is their “domain” where they have worked much longer than junior nurses or novices. Botha and Basson (2010:6) agree senior staff in authority can abuse their levels of power by bullying their subordinates. According to Verdasca (2011:10), nursing staff who are in higher positions bully those under their control through social isolation, humiliation and undermining the self-confidence and self-control of nurses in lower positions as verified in the next quotes:

“Bullying for me is being ignored, staff think they are better than you, especially the seniors, or you can see when you irritate somebody, they [are] kind of rude to you.” P1

“Because nurses, we don’t like confrontation. We are there for patients ... And we are scared that people will walk over us and, because we were taught how to take care of patients and when we are getting bullied, we are not sure how to react to it.” P5

When asked how higher category nurses use their position of power to bully lower category nurses, it was mentioned by delegating work to the juniors outside their scope of practice, being allocated to perform the least favourite tasks, or by simply refusing to attend to the young nurses’ training needs as indicated in the next few quotes:

“By delegation ... they give them the ... not so nice work to do...And they [senior nurses] let them [junior nurses] work out of their scope of practice so they need to do stuff that is not in their scope of practice. Like enrolled nursing assistants that need to give injections or medication that is not in [their] scope .... They're [enrolled nursing assistants] not allowed to do that.” P2

“Yes [laughing] but under direct supervision. I can quickly give you an example with our enrolled nurses, where we know according to their scope they are not supposed to give IV [intravenous] injections. But they do. “ P1

“So, now the registered nurse does not bully the educator … She bullies the junior when [the educator is] not there, ‘I won’t sign your book, I won’t sign your hours, I don’t have time to do assessments with you.”’ P3
Effective delegation in healthcare assists in understanding the responsibility and authority of nurses in their scope of practice (Mueller & Vogelsmeier, 2013:22). Moreover, instructing nurses to assist or do a procedure without them having the skill, knowledge or experience is irresponsible and can be detrimental to the patient’s health. It could also affect the new nurse’s sense of self-esteem and self-worth (Duchscher, 2008:445). According to the Registered Nurses Association of Ontario (PSHSA 2010:13), unit managers/registered senior nurses who enjoy being in control and are held accountable by management for their units may want to assert their control and authority and therefore they turn on junior nurses or nurses new to the unit and intimidate or bully them. Fink-Samnick (2015:173) argues that despite much propaganda and immense efforts to place safe quality patient care at the forefront of healthcare in hospitals, workplace violence in the form of bullying discredits such efforts.

The participants in this study shared the view that senior nurses felt their experience gave them the power to bully the less experienced nurses, because the latter, although they might have more updated and recent knowledge, had less practical hands-on experience as illustrated by the following:

“...especially older nurse don’t always keep up with the theory and the science so the younger nurses, that, especially like the student nurses, ... because they [older nurses] feel threatened then they revert to bullying ... ‘I gave you instructions, I know better than you. We’ve done it like this for twenty years, so who are you now to tell me’. That’s bullying.” P3

Again, the “power” theme surfaced. The senior nurses did not want to “feel threatened” P3 or “the moment they [junior nurses] push the boundaries beyond our comfort levels that's when we start bullying, maybe because we, ourselves feel unsure” P3. These seemed to be the two main driving forces behind senior nurses reverting to bullying as a form of possible self-protection.

The generation gap between nurses working in the same hospital, department and/or unit (Kim, 2017) has been a ubiquitous dilemma in hospitals for a long time, with the older nurses considering their outdated knowledge as most correct (Brown-Crowder, 2017:52). Already in 2008, graduate nurse participants found themselves “frustrated by what they perceived as archaic ways of thinking about nursing by some senior colleagues” (Duchscher, 2008:445). A participant also perceived vertical bullying as an inherited culture:

“...why I think there's still bullying in nursing, is exactly because the culture is still there. The older nurses learnt to bully... we weren't raised that way ... you did not question authority, where the younger generation do so I think between the generations and the older nurses, it's going to be very difficult but we seem to repeat the same mistakes. We seem to reduce the young ones to these submissive little things that they must do as they are told instead of supporting them and saying, that's a good question, let's go and explore, okay you taught me something.” P6
It seemed from the participants’ verbatim quotes as if it was usually the older, more qualified nurses with many years’ on-hands practice experience – who qualified years before and therefore had outdated knowledge – who bullied the neophyte nurses who might not be as experienced in practice, but were equipped with more updated knowledge and skills. It further emerged from the quotes that the older generation nurses who had been working in a unit for many years felt they had control over “their” unit when nurses from other units were allocated to “their” units. The older nurses saw the newcomers – regardless of their category levels or years of experience – as “new” nursing staff. The quotes substantiate the claim:

“… I’m working in what is an older unit, people are set in their ways … The system we have makes it difficult because it’s people that have been working there for years, knowing each other for years and with the bullying, unfortunately makes it difficult because now you bring in new staff that they don’t know. Younger staff and I think many of them feel threatened causing the bullying to be more aggressive … Because some of them are the junior staff. If you suddenly draw the junior person into that senior circle the bullying comes out. They are really asking, ‘Don’t you want to take over this patient and manage them’ so sarcasm openly in that team effort and that means next time that patient comes out [of theatre] that person withdraws [junior staff] not willing to go and help anyone.” P6

“I think we must also be polite to new people, entering our environment, and … nurses or the older people in the unit must be the role models. They must … help those people to be part of our team.” P5

Ostensibly some older nurses are very firm that their knowledge must not be questioned. However, junior nurses want to know more about practising care and patient treatments, so they ask questions or use technology to acquire more knowledge:

“I think the younger generation of nurses are much more inquisitive and they can Google and they are less submissive in how they question authority.” P6

The older generation is not necessarily comfortable with this way of learning and it may cause aggressive bullying if the more experienced nurse feels threatened in any way by the inquisitiveness of the younger nurse. If older nurses find themselves in the awkward position of not being able to explain or answer a question from junior staff, they use bullying as a weapon to protect themselves (Bardakçı & Günüşen, 2016:168, Fink-Samnick, 2015:115, Lim, 2011:14).

Of note is Reinbeck and Fitzsimons’ (2014:12) contribution that the expertise of multiple generations in the hospital leads to the generation of an age-diverse environment which creates a challenge in terms of motivation and management. Instead of combining current knowledge and experience gained over many years to advance practices and ensure better patient outcomes in the hospitals, top-down bullying may permeate the nurses’ work environment creating a negative, unhappy and unfulfilling workplace. The Joint Commission (2016:1) categorises nurse-to-nurse bullying as incivility which surfaces as either horizontal or
lateral bullying. The perpetrator can be another nurse, a nurse shift leader or a nurse manager within the same organisation (Walrafen et al., 2012: 6).

Furthermore, younger, inexperienced nurses often exhibit disrespect and arrogance towards older nurses who have little or no technological skills (Cunniff & Mostert 2012:2). The more experienced senior nurses perceive this as unacceptable behaviour and a disrespectful attitude from the junior nurses and they reciprocate in a similar abusive manner. Before long, a bullying culture is established in the ward, department or hospital which compromises safe quality patient care (Threadgill, 2013:116).

Thus, top-down or bottom-up vertical and horizontal disrespectful behaviours and attitudes may permeate the nurses’ work environment creating a negative, unhappy and unfulfilling workplace. The statements given by the participants demonstrate that bullying in the workplace was associated with the power position of the nurses in the hierarchical structure of the healthcare organisation.

5.3.1.1.2 Category 2: Bullying and management

The second category identified in the data analysis under Sub-theme 1, position of power, was bullying and management.

Managers have the hierarchical position which may easily lend itself to abuse of power (Granstra, 2015:252). When bullying and management were discussed, participants explained some managers were bullies themselves, but they protected each other, e.g.:

“I was called in to management with the nursing manager, the deputy nursing manager, the unit manager of the ward where I removed the student from and the unit manager of the ward where I placed the student in. So... because this specific unit manager... she is protected by management ... it's not only me who says it the entire group of unit managers say that, so she is gotten in to management...” P4

A second participant shared reporting a bullying incident, but it seemed the complaint was not attended to (implying the protection of co-managers). Thereafter, the participant expected feedback:

“I think the management should investigate ... I also think they should give feedback to me as the staff member reporting it on what did they do ... [so] that I know that something is done about the problem, and not that they just said that they are doing something.” P5

According to Ditmer (2010:11-12), it is the moral, legal and ethical obligation of nurse leaders to ensure all category nurses can practise their skills and learn in an environment that is safe and healthy. If bullying occurs, they must take immediate steps to rectify the situation; they
need to make use of their leadership positions and make a commitment to zero tolerance of an unhealthy working environment.

The current participants’ perceptions were that the nurse management team contributed to bullying by not taking any serious action to address the actual problem of bullying in the hospital departments. In this regard, nurses did not mention or report their concerns within the workplace because they felt intimidated by management. This is clearly signified in the next two quotes:

“I think management plays [a] big role in how intimidation, bullying, victimisation, harassment whatever you want to call it, is addressed in the workplace and when issues are brought to the attention of management, nothing is done about it, it weakens the voice of the people because they don’t feel that if they have a problem it’s going to be addressed. … in virtually every workshop I deal with, victimisation comes up as one of the issues, one way or another, and from strangest of places sometimes and yeah creating awareness, when its unit managers victimisation or management because there has been an incident of a manager victimisation over a stupid issue with hair being platted or put into a bun and not ponytail.” P4

The same participant admitted nurses in management positions were undoubtedly guilty of demonstrating bullying behaviours. She said:

“… as I sit here talking, I was thinking about who has been victimised that I know of and as I talk more and more comes out and I didn’t realise that management is part of the victimisation to the extent that it is.” P4

The data confirms the lack of good management behaviours from the leaders across the departments contributed to the bullying behaviours the subordinate staff members had to endure. This information is supported by various studies in the literature. Hoel et al. (2010:453) state autocratic leaders in organisations have lower levels of managing bullying practices in the work environment. In addition, Hutchinson (2013:569) indicates that leaders whose personality traits show a lack in empathy and emotional intelligence are most likely to demonstrate bullying behaviours towards peers and lower category staff members.

Additionally, the participants mentioned that management used their authoritative power to bully by not supporting the targets in the form of failure to report, not investigating accusations of bullying reported to management, and not giving feedback. Among 629 respondents on bullying in hospitals in Michigan, USA, only a small percentage (26%) reported it to management (Kaminski & Sincox, 2012:10-11). The reasons given by those who did not report it included feedback like, “after a while I feel scared to keep complaining and sick of not seeing resolution to the same issues” and “because nothing is ever done about it.” In this study, a participant echoed the fact that there was no support from management, because nothing changed after a complaint and nothing was done about it:
"I went through HR [Human Resources] because I knew that there would be repercussions. Nothing was done about the victimisation from a person in authority." P4

It is posited as a problem if nurse leaders are confused about how to demonstrate discipline without a bullying attitude. This implies management cannot discern between strict behaviour and tyrannous behaviour which does not promote a supportive and safe working environment for nurses. Because no action is taken when they report a bullying incident, nurses may feel they are not valued and, moreover, will not report another incident whether they witness it or are the targets.

Interestingly, it was mentioned by a participant that a bottom-up bullying approach was emerging in their hospital. This mirrors the stance Delobelle, Rawlinson, Ntuli, Malatsi, Decock and Depoorter (2010:371) took, namely that leaders can be on the receiving end of bullying – in other words, a bottom-up bullying approach. The participant explained a lower category unit manager known for bullying had a union representative present when she had to meet with the management. Consequently, since then, every time an employee is scheduled to have a meeting with management, a union representative tag along (P6). Accordingly, as the participant concluded:

"It get[s] intimidating to the management if someone is always just coming along. It's not necessarily that somebody is in trouble but now you can't really discuss a problem without somebody interfering the whole time... probably power...wanting to show you [management] 'we're not going to back off'." P6

5.3.1.1.3 Category 3: Bullying by doctors

The third category identified in the data analysis under Sub-theme 1, position of power, was bullying by doctors.

The participants voiced that the doctors also played a part in contributing towards bullying in the workplace. One participant shared that doctors abuse their power when they are not in agreement with a nurses' attitude or action. Reporting such incidents generally resulted in management siding with the doctor:

"... you are faced now with the doctor that's now upset because the nurse is asking him about the medication. She's got the right to ask because she needs to know what she's giving. ... They [doctors] don't at all accept that, so now they bully... especially [in] private hospital care. If the doctor feels unhappy about the nurses' attitude then he goes to the nursing management and unfortunately, currently the nurses perceive the management as being supportive of the doctors' view, not the nurses' view." P3

"... but I'm constantly faced with the management and the doctor's power that's more than that of a nurse." P5
“I’ll take the MIMS, for example, and I’ll show the doctor and say, but here in the MIMS, this is what is stated and if I compare with your script, why are we doing this different. Don’t scream at me, just explain the difference. If you give me an acceptable explanation, scientifically, I’ll do it, if not, I’m going to say to you, sorry but I’m not going to do it.” P3

According to the participant, when nurses sought clarification from the doctors, they were put down because the doctors disliked being questioned on their requests and/or prescriptions for patients. Nurses tend to avoid questioning doctors’ actions, because they are trained to keep quiet due to the dualism in health services in that doctors are superior and nurses inferior. This is evidenced in the following quotes:

“... especially in the health environment where the doctor is perceived as the know-it-all demigod of the place... you’re not going to get a lot of nurses, male or female, who will challenge a doctor, especially if [they] know that their management is not going to support them.” P3

The participants’ responses with regard to doctors’ bullying behaviour are evidenced in the literature. According to McKay and Narasimhan (2012:53), doctors are not always willing to assist the nurses, because they perceive themselves to be in a superior position (Granstra, 2015:254). Gillen et al. (2008:13) also assume that nurse managers and other nurse professionals perceive that doctors’ power is above that of nurses. As Gillen, Sinclair, Kernohan, Begley and Luyben (2017:6) further explain, regarding the knowledge and opinions of other experts such as registered nurses in a ward (who are indeed those closest in contact with the patients’ physical and emotional progress) as unimportant is unethical and can contribute to workplace conflicts. In a study conducted by Sobekwa and Arunachallam, (2015:2) on the role of professional nurses, participants stated caring for a patient encompasses physical, psychological and emotional care.

The participants also believed it was their duty to advocate on behalf of their patients “to solve patients’ problems, such as speaking on behalf of their patients to stop doctors from providing unsafe treatment or mismanagement” (Seboni, Magowe, Uys, Bi Suh, Djeko, Djeko & Moumouni, 2013:7). In exploring the barriers which prevent the effective implementation of programmes to avoid workplace violence in hospitals, Blando et al. (2015:3) mention the example of Vogelpohl, Rice, Edwards and Bork (2011), who studied new graduate nurses’ perceptions of their workplace and asked them whether they had experienced hostility. These
new nurses responded that they found bullying by fellow nurses and physicians as the most challenging issues they had to deal with.

In fact, the occurrence of doctors bullying nurses is not a “secret” hushed up in the hospital corridors. Oosthuizen (2012:57) conducted a qualitative content analysis of 161 newspaper articles from daily, weekly and Sunday newspaper articles on a regional and national basis to determine how nursing in SA is portrayed in the media. Reporting on her findings, she stated poor relationships with “hospital management, doctors and other members of the multidisciplinary team”, as well as reports of “nurses who had been verbally abused by doctors” influenced the declining healthcare system (Oosthuizen, 2012:57). The division of power due to varied skills and capabilities and the age-old perception that nurses are merely “‘handmaidens of the doctor, and secondary in status to the physician” (Marks, 1994:212) lead to the lack of power or control among nurses in their work environment (Demerouti & Bakker 2011:4; Van den Broeck et al., 2011:5). This kind of hierarchical dualism can result in interpersonal conflicts between the professionals across departments and this, in the opinion of Van den Broeck et al. (2011:5), is one of the main causes of physician-nurse bullying in the workplace.

5.3.1.2 Sub-theme 2: Harmful communication

The second sub-theme identified under Theme 1, perceptions on contributing factors, was harmful communication.

Communication in this study was perceived as verbal (spoken/oral) communication, as well as non-verbal (body language, attitude, behaviour) which had a negative and upsetting effect on the target of bullying. Verbal communication constitutes spoken words, but includes the tone of voice used to deliver the message. Non-verbal communication is mostly seen as body language which can either support or contradict the verbal message, e.g. rolling the eyes. Another component of communication is active listening to receive the message. Interactive communication between individuals or groups of individuals can therefore be perceived as positive or negative by an individual or a group; if negatively perceived it can be experienced as harmful or abusive in nature. Effective communication skills are vital for effective health care provision (Goosen, 2015:18).
The participants experienced harmful communication as contributors to workplace bullying as the following quotes confirm:

“I think you must make people attend to [aware] the way they talk to one another is not conducive.” P6

“I actually had high hopes that this deputy nursing manager will break the mould, in the sense of communicate effectively, stop bullying the staff.” P3

‘...if higher categories communicate properly to lower categories they can handle conflict...” P2

“Some people like to work in silos and don’t communicate information.” P4

Yun, Kang, Lee and Yi (2014:219) state skilled communication makes up a significant part of a healthy working environment. In agreement, Bao, Zhu, Hu and Cui (2016:543) confirm good communication can prevent workplace bullying if parties involved in a conflict are skilled to set the right tone for conversation, rather than resorting to raising their voices or maintaining a silent attitude and becoming withdrawn (Branch et al., 2013:289). Branch et al. (2013:286) also indicate that individual behaviours can contribute to the reduction of workplace bullying. Although individuals have their own characteristic way of communicating, nurses need to be made aware that in the workplace they have to engage in a collaborative, appropriate and respectful communication style to curb workplace bullying behaviours.

5.3.1.2.1 Category 1: Verbal bullying

The first category identified under Sub-theme 2, harmful communication, is verbal bullying.

The participants voiced that they undoubtedly experienced verbal communication as a contributory factor to bullying. According to them, bullies were verbally abusive as this was a technique to belittle and make the participants feel inadequate and unworthy as illustrated:

“I think verbal bullying, because we don’t tolerate any physical abuse, so I think it’s more verbal, that’s because you cannot see it.” P2

“...this is how we talk to one another, that they speak to one another that way [intimidation] as well. So that’s really the one hospital that [where] the bullying is unbelievable.” P3

Overton and Lowry (2013:2) found in their study on conflict management among nurses in colon and rectal surgery clinics that nurses experienced verbal abuse from both colleagues and superiors in their workplace. In a recent study in Pennsylvania, USA, Gueguen (2017) found bullying by medical professionals reduces quality of care. According to Gueguen (2017), the Pennsylvania Patient Safety Authority investigated complaints medical companies received over a period of two years (1 July 2014 to 30 June 2016). Of the 44 complaints, 34 events were linked to verbal abuse. The intent of 32 of those events was to scare the target.
On the contrary, it is vital to realise that when nurses bully or act in ways that are threatening to colleagues and other healthcare providers, it not only negatively affects the person but also the quality of care she/he provides to the patient.

Elaborating on the subject of verbal abuse, the participants confirmed shouting was a common bullying tactic used by senior nurses and doctors. They shared colleagues shouted at each other and at junior nurses especially in situations when tension levels were high. The problem that arises is that shouting may cause the other healthcare staff member not to hear, and subsequently not receive the message clearly. Shouting in hospitals results in lower self-esteem and is psychologically disturbing to the target (Cheung & Au, 2011:287). The following quotes verify these claims:

“I think some other form of bullying can be shouting at one another, especially if tension is high and you’re unsure, then shouting can also be a part of bullying.” P2

“People must not shout at us or one another. I … then I can’t think and I can’t hear, I just shut down, then I don’t listen anymore because I am so scared I don’t know what to do.” P1

“… he just shout [at] me in front of everyone…” P5

“And the other thing is like they must not … if there’s a problem we don’t want people to shout at us everywhere…” P6

One participant in particular explained her sensitivity to tone of voice adding that she withdraws without hearing the message:

“You know what, I’m very sensitive to tones. I’m very sensitive to the way the message, not what the message is, but how it is carried over. I don’t like aggressive behaviour around me. I shut down … I’m going into my cave…” P1

As explained by Swaab (2011:41), shouting in a healthcare working environment is especially disturbing to the new nursing professionals. Verbal bullying where one changes one’s tone of voice to shout contributes to bullying because raising one’s voice is a harsh and domineering way of communicating. Such verbal bullying easily affects the ability of nurses – in particular junior neophyte nurses – to fulfil their duties to the required levels.

Furthermore, supporting the findings found in Phase 1 (Chapter 4), participants expressed gossiping as a major harmful communication method used to bully other nurses as the following quotes signify:

“Gossiping behind people’s backs and then the story gets distorted on the way as the story gets tails.” P6

“… there must be less gossip. If there is less gossip, then there will not be saying the wrong things or the gossip about other people and then other staff members starts to think that that is the reality.” P2
“… gossip opens up … for, I think for bullying, because you hear something from somebody and then you start, using that against that person.” P3

“If we can find the origin of the gossip, it is not that easy …” P2

The problem with gossip is that the bully starts a false rumour about the intended target and, as the rumour spreads (“the story gets tails” P6) through the workplace the target – often innocent – suddenly finds him/herself the subject of suspicion. The findings provided by Becher and Visovsky (2012:210) and Koh (2016:213) confirm gossiping is a common tactic in workplace targetisation. Gaffney et al. (2012:7) add that competent and senior nurses spend a lot of time gossiping or engaging in rumours about new nurses and other colleagues which not only humiliates and intimidates the targets (Kaminski & Sincox, 2012:2), but also compromises quality patient care. An individual’s perception of how he/she experiences a situation contributes to how severely the situation affects him/her psychologically. Qualifying as psychological or emotional violence (PSHSA, 2010:3), gossiping can be experienced as extremely stressful in both the short- and long-term to junior and senior nurses, while the severity thereof is increased when gossiping emanates from seniors and management (Meyer & Kirsten, 2014:1).

5.3.1.2.2 Category 2: Non-verbal bullying behaviour

The second category identified under Sub-theme 2, harmful communication, was non-verbal bullying.

The participants said they experienced being ignored and excluded by colleagues and the latter’s use of body language as personally harmful and devastating. They mentioned that in cases of conflict within the workplace, nurses just ignored each other because nobody wanted to address the issue/s, as reflected in the following quotes:

“I think especially where there’s conflict, they ignore one another. Because you don’t want to address the conflict then the best other way is ignoring one another. It’s very bad to work if you’re being ignored during the day or night. And I see this [as] bullying. … because if somebody ignores you the whole day or night, then yes, you do have to work on your own.” P2

“I was thinking the other day of a colleague, nurse-on-nurse and somebody said the junior said something wrong and the senior just said, ‘Really?’ But it was the way she said it was actually … it broke that person [junior nurse] … It was derogative. That student won’t ask again because just with that one word and the eye contact and the body language. The student won’t ask, simply won’t.” P3

The participants’ experiences aligned with Overton and Lowry’s (2013:2) findings and Koh’s (2016:213) view that making use of intimidating body language precipitates a demoralising, stressful and psychologically harmful healthcare environment. It sets the wrong tone for cooperation and open communication among colleagues and leads to frustration and
disharmony among the team. Undermining the efforts of another to do their best, eye-rolling or avoiding eye contact (Becher & Visovsky, 2012:210; Meyer & Kirsten, 2014:2), unreasonable silences (Koh, 2016:213) and isolation (exclusion or ignoring another) (De Wet, 2014:4), or not listening to her/him are subtle yet very successful bullying tactics used to unnerv or intimidate the target. Gaffney et al. (2012:5) add that eye-rolling is used by nurses as a method for public humiliation and censure. The nurse managers or administrators use eye-rolling or “the look” to bully young nurses and make them feel incompetent (Gaffney et al., 2012:5).

“... your body language and then your normal body language ... So I try to talk to the people, I'm trying to schedule formal interviews with people just to have a short discussion so that we can talk about concerns. I really try never to fold my arms because people see that as a negative sign. That's something, I'm trying to do that I don't cut them off." P6

“I think the body posture. The way how they come to you, it shows that this person is not threatening you." P5

“It’s something that others cannot verbalise, but the body language will be able to tell me here I am troubling this person.” P3

Using one’s body language to convey messages or as a communication tool is a powerful way of intimidating another. Examples of ways in which the body is seen as a communication tool includes narrowing one’s eyes or avoiding eye contact; an insincere smile or sneer, and making gestures like folding one’s arms or pointing fingers (PSHSA, 2010:11), and raising the pitch of one’s voice (one participant specifically mentioned the tone of the bully’s voice). According to the PSHSA (2010:11), body language “often communicates a person’s attitude more forcefully than words.”

5.3.1.3 Sub-theme 3: High workload

The third Sub-theme identified under Theme 1, perceptions on contributing factors, was high workloads. One category was identified, namely a stressful environment.

5.3.1.3.1 Category 1: Stressful environment

The participants confirmed hospitals are high-stress environments. Nurses are confronted daily with stressful situations – whether it is a high workload, staff shortages, or a difficult patient (Çalışkan & Ünlübay, 2016:46) – and yet they are still expected to exhibit qualities of care, comfort and concern. Also, in some units the work is more stressful than in others, for example, in the emergency and intensive care units the strain can be enormous as the following quotes indicate:
"We work in a high-stress environment, so people must be aware of that, also awareness and help people manage their stress, management can do something like that." P1

Ariza-Montes et al. (2013:3122) showed that the workload in shifts can contribute to job stress and dissatisfaction which can increase the chances of bullying in the workplace due to physical strain, variable work schedules and the frequency of working in the hospital.

In the sub-theme of high workloads, participants mentioned hospitals are high-stress environments and that the workload nurses have contributes to stress and leads to bullying behaviour or leaving the profession. One participant went on to say that the workload and stress influenced her ability to communicate and were expressed as bullying. Another found that due to the workload, there is no fun to assist with teambuilding in nursing any more.

"... ICU [intensive care unit] is busy; it's a high-stress environment." P5

In their book Violence at Work, Chappell and Di Martino (2006:125) include bullying and verbal abuse as aggressive acts in the workplace. They explain stress due to a heavy workload can initiate bullying behaviour in a person, which in turn “may lead to misunderstandings or misleading behaviour which precipitates aggressive responses” (Chappell & Di Martino, 2006:125). A study by An and Kang (2016:237) indicates higher incidents of bullying among nurses is associated with the work stress, since nursing is an intense and a stressful job. Higher levels of work stress, managing conflict situations and a high workload are all linked to higher levels of workplace bullying in healthcare (Ariza-Montes et al., 2013:3122; Mitchell et al., 2014:148; Overton & Lowry, 2013:260). If the highworkload contributes towards continuous bullying behaviours, it is not uncommon for some older nurses in senior positions to experience burnout or to leave the profession altogether as voiced by a participant:

"I think, it also it’s stress, maybe the workload for the older or for the senior nurse in charge becomes so much that we either have burnout or we convert to bullies. We either burnout and leave the profession and that [bullying] expresses itself maybe in there. But, yes, I do feel, nurse on nurse bullying is very evident …" P3

"Now there is a new unit manager and she's not the unit manager anymore but on personal leave, the stress was getting too much so she decided to step down as the second in charge…" P6

Karatza, Zyga, Tziaferi and Prezerakos (2016:5) and Wilson (2016:303) agree with Mosadeghrad’s (2013:212) assertion that occupational stress from bullying behaviours and workload results in many nurse professionals leaving their profession. Fink-Samnick (2015:167) states “workforce retention is another casualty of bullying and lateral violence”. She mentions the finding of the Robert Wood Johnson Foundation’s RN Work Project (2013) that nurses who are targets of verbal abuse by doctors and nurse colleagues tend to experience their work environment as “negative” and for this reason they are often prone to
leave their jobs. Of similar importance is the contribution of a participant, who explained if a bullying culture prevails in a specific unit, the unit may lose experienced staff. The following quote reveals bullying in a specific unit was quite severe:

“I have lost about two [staff members] in the last six months. … And the one is really a good sister, a good shift leader, so it’s a senior person that was lost. … [The bully was] a senior person also a shift leader, but been in the unit much longer than the fairly new shift leader ….” P6

Another participant shared due to the high workload there was no more “fun” in the nursing profession, which is associated with a positive way of team building among nurses. The following quote verifies the statements:

“There is no time for … camaraderie which has left nursing now … so there is no time to actually build team relationships in the working environment. … it’s just work, work, work, work [clapped hands] there is no moment for the staff to have fun, put somebody in the linen trolley and go tearing down the passage, put citrus soda … we did things like that.” P4

It is no secret that being a professional nurse is hard work with long hours, much strain and adherence to many rules and regulations. Ariza-Montes et al. (2013:3122) and Çalışkan and Ünlübay (2016:46) assert workload in shifts can contribute to job stress and dissatisfaction, which can increase the chances of bullying in the workplace due to physical strain and the variable work schedules. According to Stanley (2017:170-175), it may be difficult to imagine there can be fun in a nursing career; however, creating opportunities to develop one’s sense of humour (or to have “fun”) in a workplace where emotional and physical closeness to human suffering is part of one’s daily existence, is a vital strategy to enhance an individual's or a group’s coping skills. To see the funny side of a situation is, in fact, simply using a different kind of logic or perspective which helps healthcare workers to cope with the strain and oftentimes painful situations encountered in the health profession.

5.3.1.4 Sub-theme 4: Unprincipled behaviour (incivility)

The fourth sub-theme identified under Theme 1, perceptions on contributing factors, was unprincipled behaviour. The two categories identified in the responses were disrespectful behaviour and unfair practices.

5.3.1.4.1 Category 1: Disrespectful behaviour

Disrespect is displayed as unkind behaviour resulting in dehumanising behaviour (Johnstone 2012:31). Nurses have a need to feel respected and treated as a valuable team member (Johnstone 2012:31). With regard to the category disrespectful behaviour, the participants associated the lack of respect with bullying. The place and lack of privacy when being
disciplined or corrected were perceived by the younger targets as indicative of the disrespect senior nurses held towards them. The following verbatim quotes reflect the damaging effects disrespectful behaviour can have on the nurse as an individual, as well as a team member:

“And we must have respect for one another as we are all human beings.” P2

“… because structure and respect and discipline is important to nursing but it’s how we bring the lesson across that’s either bullying or supportive.” P3

Interestingly, in the interviews a senior, as well as a junior nurse participant, mentioned the “passage” as an area where disrespectful behaviour occurred:

“… but look how often we [senior staff] will address … very sensitive issues with junior nurses in the middle of the passage and that in itself is bullying in a disrespectful way. The fact that, maybe we as seniors must learn that we should show respect to the juniors because bullying, I think occurs from a place of disrespect. It communicates disrespect for this to the junior.” P3

“They make me feel like I cannot do my work and I am worthless. And they will never talk to you about this alone, it is always in a passage or in front of patients, they belittle you.” P1

Public humiliation is a common technique used in vertical bullying:

“… where they [bullies] don’t have an audience, because I think they use the audience to patronise you. So if there is no audience I don’t think they will talk to me like that.” P1

Behaviours of some nurses undermine the role of others in the workplace and promote bullying. The participants mentioned that some nurses perceived themselves as more competent than others and showed open aggressiveness and humiliation by not allowing new nurses to enter the team.

“Open aggressiveness towards others, not allowing new people to come into a unit, making them off to be … Kraak hulle af, kraak mense af [Afrikaans language meaning to shame/belittle/humiliate another human being] … they don’t know anything, they are stupid, they’re incompetent.” P6

The quote mirrors the view of Hodgins, MacCurtain and Mannix-McNamara (2014:54) that disrespectfulness in the work environment contributes to workplace mistreatment such as verbally abusive insults. Disrespectful behaviours and negative attitudes towards colleagues may permeate the nurses’ work environment creating a gloomy, strained workplace which is not ideal for job fulfilment or enjoyment. Management is supposed to influence change of behaviours by intervening to help nurses cope with stress and creating a platform where nurses can raise their issues without fear. A functional and operating environment influences behaviour change through engaging in coaching, counselling and support. Implementing codes of conduct through coaching and training leads to the minimisation of disruptive behaviours (Longo, 2010:S9).
Category 2: Unfair practices

Unfairness in the workplace was seen and experienced by participants. They mentioned favouritism in the workplace. They expressed the management team had different sets of rules applicable to different category nurses. Favouritism and different standards applied in the units were reported as a major concern for the participants as reflected in the quotes. This is an ethical issue that requires further interrogation.

“And I'm not only talking about top management now ... I also look at some of the unit managers ... there is favouritism ... blatant favouritism ... different rules for top management in simple things like time keeping, ... top management can have doctors' appointments, go shopping in on duty time, let’s have a look at the new Menlyn Maine [a shopping centre] ... and for the rest of us we have to clock in and clock out, work the time back, and people, we don't say anything to the staff, but they are not stupid. So when they look at things like that it [bullying] started creeping in. ... You hear a nurse in high care over the weekend who went shopping for four hours, her lunch was four hours.” P4

“People have been calling the ethics line on four occasions that I know of to report management for favouritism ... for different standards, and for me that’s a big issue.” P4

The evidence of this statement is presented in the study performed by Nwaneri, Onoka and Onoka (2016:77), which showed that unfairness in terms of duty schedules contributed to workplace bullying.

Seniors expected from the inexperienced to perform duties that they could not perform yet; the latter needed support or guidance and not a workplace with bullies expecting them to work outside of their (juniors’) standard operating procedures (SOPs):

“When she finishes with her degree or her course and then you put that 23-year-old in a ward full of patients, with anxious family members, with challenging nursing care decisions to make, difficult doctors, a challenging workload, and you say to her, ‘be self-assertive’. And then we add the older bullying nurses.” P3

Some nurses undermined the work of other nurses and said they were not working in accordance to the standards of nursing. The participants elaborated on being micro-managed in decisions made and brought into unfavourable positions with other colleagues like the doctors as illustrated:

“She still wants to see what's happening, 'I don't like the way you're doing this' and 'I don't like the way you're doing that'; 'I don't agree that you've got enough staff, so I booked extra staff'. When they’re not happy with the way something is being done, they send messages to the doctors to complain and then the doctors come in angry about something.” P6

The information given by the participants was also found in the study by Yun et al. (2014:220), namely that unfair work expectations lead to nurses’ bullying behaviours. Nurses assigned to work on many patients compared to others have higher incidents of bullying experiences in the workplace. Additionally, Glambek, Matthiesen, Hetland and Einarsen (2014:257) explain...
that in the workplace, bullying behaviours such as unfair criticism, excessive workload, or being reassigned to other departments lead to humiliation. Disrespect may flourish, and fear of bullying makes targets reluctant to report the humiliating incident (Plonien, 2016:108).

### 5.3.2 Theme 2: Management and organisational actions

The first theme dealt with the contributing factors related to bullying in the nurses’ workplace, while the next three themes deal with the proposed strategies to deal with workplace bullying. Theme 2 focuses on the insights of nurses regarding the management and organisational actions against workplace bullying.

As shown in Table 5.4, under Theme 2 four sub-themes with relevant topics were identified, namely create bullying awareness; approaches to bullying; management competencies needed and changing of staff. The categories identified under the sub-themes are also indicated in Table 5.4.

Table 5.4: Theme 2 - Management and organisational actions

<table>
<thead>
<tr>
<th>Theme</th>
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| 5.3.2 Management and organisational actions| 5.3.2.1 Create bullying awareness | 5.3.2.1.1 Policy as a management tool  
5.3.2.1.2 Recognition of bullying behaviour  
5.3.2.1.3 Reporting of bullying behaviour |
|                                            | 5.3.2.2 Approaches to bullying | 5.3.2.2.1 Being approachable  
5.3.2.2.2 Listen to both sides  
5.3.2.2.3 Treat us the same |
|                                            | 5.3.2.3 Management competencies needed | 5.4.2.2.4 Visible management actions  
5.3.2.3.1 Good communication skills  
5.3.2.3.2 Work together as a team  
5.3.2.3.3 Practice conflict management |
|                                            | 5.3.2.4 Change staff in units |                                                                           |

**5.3.2.1 Sub-theme 1: Create bullying awareness**

In relation to the sub-theme of awareness, the participants emphasised their need for increasing nurses’ awareness of bullying behaviours in the workplace. Three categories emerged, namely policy as a management tool; recognition of bullying behaviours and reporting of bullying behaviours.
The participants wished for greater awareness to be raised about what constitutes bullying. From the verbatim quotes of three participants who each held a senior position, it was clear nursing staff (both top-down and bottom-up) had no understanding or clear perception of what bullying was; they did not recognise bullying behaviours; and some were not even aware that a bullying culture was present in their place of work:

“The other thing is … what is bullying. Do we understand the word bullying? I don't think we recognise what bullying is … It's not something that we are taught in a curriculum.” P3

“I think something else that we need to make one another aware of bullying. … We need to make them aware of it. They need to know that it is a problem and that we can do something about it. … First they need to understand what is bullying, they must know how to identify behaviour that's bullying and change the perception of that and also know that they can communicate about it.” P2

“I think there must be better awareness on bullying, what is bullying, and it do exist in the workplace, and we also need to know how does people, what is bullying behaviour. So that we know if somebody talks to me in this way, its bullying, so they also know. And then I also need to know how to react to being bullied.” P5

Yun et al. (2014:219) indicate the workplace environment determines the nurse job satisfaction and quality of nursing care. Creating awareness in the workplace environment is a measure of reducing workplace bullying (Yun et al., 2014:219). Ditmer (2010:11) emphasises that it is the responsibility of all staff members to comply with ethical codes of conduct, standards of care and regulatory guidelines in order to deal with incidents of bullying behaviours. Georgakopoulos et al. (2011:1) state organisations have the responsibility of safeguarding their workforce from physical harassment of workplace bullying. Legal laws and anti-bullying policies must be integrated to reduce workplace bullying behaviours.

5.3.2.1.1 Category 1: Policy as a management tool

Bullying behaviours increase due to a lack of appropriate policies in place. The manager participants in the group were aware of the workplace behaviour policies, but the lower categories of nurses were unaware of such policies as evidenced in the quotes:

“Because there is no policy on bullying in our workplace …” P1

“We try to make use of the [workplace behaviour] policy in orientation to strengthen the importance of the policy.” P2
The participants explained why and what should be included in such policies to make staff aware about bullying behaviours and the expected action from management to curb such behaviours, so that this particular problem is eventually obviated from the nursing workplace. Verbatim quotes from participants support this stance:

“I think there need to be proper policies in place. Because policies give you direction in the workplace as all of us are not from the same background or the same values that we need to have a clear policy that states how we must handle everybody … Awareness [of bullying] and I think also there must be some kind of guidance on how to address the problem. I think proper policies.” P2

 “[The workplace behaviour policy should] help, reporting lines and what, how must management deal with the situation, that they also know how to do it.” P5

 “[The policy should include] what do we want the staff members to do, that they need to be aware and not tolerate it [bullying] in the workplace.” P2

 “Structure and respect and discipline is important to nursing but it’s how we bring the lesson across that’s either bullying or supportive and constructive criticism. So what’s the difference between constructive criticism and bullying? It’s a thin line, especially if it’s verbal.” P3

The statements on the adoption of clear policies in the workplace are reaffirmed by the findings of a study conducted by Fapohunda (2016:39) which confirmed that reviewing workplace policies and procedures ensures that all the employees gain awareness of bullying occurring in their workplace, but also makes it clear that bullying behaviour is unacceptable and not tolerated in the workplace. Putting in place the appropriate policies guarantees that workplace bullying is addressed effectively by the management team to reduce workplace injuries and harm (Fapohunda, 2016:46; Plonien, 2016:108).

Nurse leaders have the moral, legal and ethical obligation of providing a safe working environment, as well to report every incident of bullying (Ditmer, 2010:12). Nurse leaders are expected to familiarise themselves with employment laws and instil policy and procedure processes during the hiring process to reduce unforeseen unethical behaviours. In addition, organisations are entitled to generate policies that reduce bullying behaviours. Moreover, nursing education and hospital orientation to harness professional development in the workplace environment are measures which could be put in place to reduce workplace bullying behaviours (Ditmer, 2010:13).

The adoption of appropriate and relevant policies is the best practice for improving the knowledge of nurses about workplace bullying (Escartin, 2016:2). According to Plonien (2016:108), the implementation of workplace policies on bullying assists nurses to determine, assess and intervene in situations where the behaviours of others are considered disruptive. Laschinger and Grau’s (2012:282) interpretation of a functional, healthy work environment in which operations run smoothly, is to provide a workplace where fundamental policies and
systems are in place. Expounding on this view, Laschinger and Grau (2012:290) explain employee stress, which is one of the contributors to incidents of bullying in the nursing workplace, will be greatly relieved. In the current study, an educator’s honesty confirms how work stress can influence a nurse’s attitude:

“I think there is a lot of burnout and stress and as I say, especially, I think if you become stressed you cope less with pressure and it’s easier to lose your temper and explode and that’s when the bullying starts." P3

5.3.2.1.2 Category 2: Recognition of bullying behaviour

Creating bullying awareness is the recognition of bullying behaviours. Participants explained that nurses should have greater awareness of bullying behaviours by understanding what bullying is, its existence and the management and actions that should be taken in workplace.

“If it’s an extreme case of bullying, very verbal or even physical, then we recognise it and say, shoo, that guy’s bullying, but if it's a subtle bullying which nurses and women are very good with, that we can actually hurt one another and look very friendly. And that is not perceived as bullying in the working environment." P3

“I think there must be better awareness on bullying, what is bullying, and it do exist in the workplace, and we also need to know how does people [bully], what is bullying behaviour. So that we know if somebody talks to me in this way, it's bullying, so they also know. And then I also need to know how to react to being bullied.” P5

“What are … the signs or the symptoms like in diseases. People need to know that what does a person do that’s bullying other people. What do they need to look out for? We need to make them aware of it. They need to know that it is a problem and that we can do something about it.” P2

Akella (2016:1) is of the opinion that understanding workplace bullying in terms of people’s intention to hurt others and create a hostile environment assist the employees with managing bullying behaviours. The same author further explains that understanding determinants such as individual and dyadic futures of bullies and targets in the workplace is an effective approach to manage bullying. Being able to and having the knowledge to recognise nurse-to-nurse bullying (lateral and horizontal bullying) in nursing apparently successfully empowered “newly licensed nurses to depersonalise it, thus allowing them to ask questions and continue to learn” (The Joint Commission 2016:1-3).
Participants also wished for the forming of cliques to be addressed, because group-forming was a dangerous tool empowering nurses who demonstrated bullying attitudes, as illustrated:

“… I think also would help for you break up those cliques … there has been movement and that has created a new dynamic as well, so it supports the theory that the nurses [cliques] need to be … just shaken up, break up the cliques yah.” P4

Acting together means if there are consequences, they can defend each other, and it is also easier to blame the target as the instigator of the problem. An interesting opinion for targets to “fight back” was shared by one participant who suggested targets should also form groups to get rid of a bullying culture in a hospital:

“Then… because then if we stand together as a group, we can change the behaviour of just being bullied. … Because if all of us can stand together against the person that is bullying us, then that person won’t have the … won’t have the power, to bully us.” P3

Maidaniuc-Chirilă and Constantin (2013:1176) assert that the management of bullying in the workplace is achieved through firstly clarifying what bullying behaviour is. Awareness of bullying in the workplace can be enhanced by understanding the concepts of bullying, e.g., humiliation, persecution, aggression, abuse, and victimisation (Maidaniuc-Chirilă & Constantin, 2013:1176-1177). Nurses who are bullied can suffer from a wide range of disturbing reactions such as “anxiety, feelings of vulnerability and helplessness, disturbed sleep, difficulty in concentrating, increased fear, irritability, obsessive thoughts and images, feelings of shame, anger, frustration, guilt, changes in beliefs and values, and a desire to retaliate” (Chappell & Di Martino, 2006:212). Yildirim (2009:505) states bullied nurses often experience feelings of demotivation and depression which negatively affects (i) their performance of their duties; and (ii) their relationships with their patients and peers. These feelings in turn lower their level of job satisfaction, which could lead to a high staff turnover in the profession (Johnson & Rea, 2009:87; Khan & Aleem, 2014:124; Shmailan, 2016:2). Like most other countries, South Africa is currently experiencing a nursing shortage that will most likely worsen because the population is burgeoning, the country needs to deal with the heavy burden of a changing disease profile, and interest in nursing as a career is waning (Volmink, 2016:2). Hospitals should therefore seek to reduce workplace bullying in an effort to retain trained nurses.
5.3.2.1.3  Category 3: Reporting of bullying behaviour

Nurses do not always report bullying incidents, which in turn influences management taking action to address condescending behaviours. When asked during the interviews in this study to explain how the nurses could report bullying behaviours, they were advised to talk about it, share their experience with somebody else and demonstrate their awareness about bullying behaviours. The sharing should, however, be factual. An important factor emphasised was that there needed to be structure in reporting bullying behaviour.

“...if I tell her how I feel, she can understand and be aware of the way I am feeling. But I think I can also go and report her to the unit manager or the matron [nursing manager] so that they know how we feel.” P1

“I think … they must talk about it, tell somebody else, because the minute you start talking about it, you make people aware of that, but you must, when you tell somebody, you must have your facts correct, you must be factual and you mustn’t react with emotions. You must really tell your unit manager, your line manager … how did it happen, but if the unit manager is not always on duty you must write it down in a diary, or just so that you can recall it later when you give in [report] the incident. If you always report it, you write the event, you must report it to somebody, then the management can see that there is trend or follow the trend or it’s the same person or the same group of staff that is always a problem.” P5

According to the participants, nurses needed to know how and where to report. They should also be assured they would be protected from any further bullying if they reported the unacceptable behaviours. Nurses must also be assured action would be taken by management when reporting a bullying experience.

“I think they [management] must protect us against people bullying us. They must know how to handle situations. And there must be a way to report bullying. And not be victimised if you reported somebody.” P1

“Yes … yes, they need to feel safe so confidentiality which is a thing that is also problematic … yeah, safety and confidentiality for me for the person brave enough to report the incident.” P4

“People need to know [be aware of] the reporting line. I think they must know that … there must be a way that they can go and report bullying, and I think they must know where to go and report and how to report.” P5

Fapohunda (2016:46) asserts that it is vital for targets of bullying behaviours to make certain the managers are made aware of the perpetrators by reporting such incidents. This implies that workers should be willing to report bullying experiences to make it easier for management to act against perpetrators, while at the same time working towards creating a bully-free culture in the work environment. Importantly though, is that participants required feedback. A participant voiced:

“they [management] should give feedback to me as the staff member reporting … [so that] I know that something is done about the problem, and not that they just said that they are doing something.” P5
Reporting of bullying behaviours is highly supported in the literature. Carter, Thompson, Crampton, Morrow, Burford, Gray and Illing (2013:2) and Koh (2016:213) point out that reporting is the best way to promote fruitful investigation into bullying behaviours. Implementing the culture of reporting in a healthcare setting environment helps in assessing the levels of workplace bullying and the type of measures to be adopted in the organisation (Koh, 2016:213). Reporting bullying incidents further results in improving the safety of patients and nurses, as well as enhancing a healthy workplace (Dillon, 2012:17).

In the opinion of Kassem, Elsayed and Elsayed (2015:26) and Bennet and Sawatzky (2013:149), employees (nurses in this study) need to report disruptive behaviours like emotional and verbal bullying (the use of abusive language, demeaning and degrading comments), since to refrain from reporting may result in an environment of verbal intimidation. These authors agree establishing effective communication and reporting channels will ensure that workplace bullying in terms of conflicts are effectively managed.

Unfortunately, as shared by a senior participant, nurses in this study seemed hesitant to report bullying:

“I think nurses keep quiet about being bullied because they feel powerless to do something about it and the new ones are simply not self-assertive enough to stand up and say, ‘but you are bullying me.’” P3

The feeling of powerlessness mentioned by the younger targets resonates well with findings from the literature. Nevertheless, reporting a bullying incident is important, because when no one knows about it, it cannot be managed. Chappell and Di Martino (2006:216) state “the importance of reporting workplace violence is emphasised by all experts”. If bullying behaviours are not reported, it means they cannot be addressed, which could eventually hamper the quality of patient care (Fink-Samnick, 2015:168), as well as be detrimental to the target’s health and the nursing profession overall (De Wet, 2014:13).

5.3.2.2 Sub-theme 2: Approaches to bullying

Participants disclosed being ready to assist to address bullying issues in the workplace. The participants provided their perceptions based on the nature of bullying in the healthcare environment. Four categories were identified, namely being approachable; listening to both sides; treating everyone the same and visible management actions.
Acting professionally during conflict resolution is an approach towards reducing bullying behaviours. Professionalism, together with emotional maturity and intelligence, contributes to reduced conflicts (Danarson, 2014:168). Nurses, particularly junior nurses or nurses new to the unit, must always endeavour to act professionally by having unemotional discussions with managerial staff about bullying behaviours (Killoren, 2014:8).

5.3.2.2.1 Category 1: Being approachable

The participants agreed adopting an approachable strategy would be an effective method to address and manage bullying in the workplace. In their concerted opinion, managers who had an open-door approach made nurses feel welcome, as it represented the managers’ willingness to communicate with all nurse categories. This approach made nurses feel their opinions and feelings were important to management, which in turn improved the trust between management and nurses. Participants indicated having an approachable management system in place provided nurses with the opportunity to also share bullying issues that arose in the units as verified in the quotes:

“I think what we can also do to change the culture, the management need to be approachable, as well as the unit manager, so if there arises a problem like this that we need to talk to that person that did that. They need to have a kind of an open-door policy, they must be approachable.” P2

“… that [is] trust building relationship for me and they know they can come to you with a problem and maybe you can find a solution. Available, approachable and maybe having set appointments as well, as people say that they can discuss things with you, behind a closed door, without feeling threatened.” P6

“… because although you are the manager, I think, in a sense you should also be a friend to the people there, which might assist them to come to you when there is really a problem. I’m not a friend that’s doing you favours. They need to see you as an open person to come and discuss these problems with …” P2

The literature confirms approachable managers create an environment where nurses feel comfortable asking for help or assistance (Pope, 2010:117). The adoption of an open-door policy encourages the nurses to share their work experiences in a healthy and safe work environment (Berry, Gillespie, Fisher & Gormley, 2016:3; Essen, Esquivel & Jha, 2014:836). In other words, employing an open-door policy is a positive approach, as it affords management an opportunity to help nurses working in a unit where bullying occurs to cope with stress while creating a platform where nurses can raise their issues about disruptive behaviours without fear (Longo, 2010:S9-10). Moreover, it is an effective strategy to encourage reporting bullying incidents. Approachable managers promote trust and facilitate trusting communication between nurses and management without the former fearing reprisal or becoming the next target of the bully (Murray, 2009:274). The health of nurses can influence
how they interact with each other and patients (Chappel & Di Martino, 2006:125). If inexperienced junior nurses are stressed due to a heavy workload or bullying behaviours, it may exacerbate misunderstandings or misleading behaviour which precipitates aggressive responses. Therefore, managers who are older and have previous experience of handling similar difficult situations should indeed be more approachable and react more wisely than inexperienced staff (Chappel & Di Martino, 2006:125).

5.3.2.2.2 Category 2: Listen to both sides

Emphasising the listening approach, participants shared it was important for managers to listen to both sides of bullying issues (i.e. the bully perpetrator and the target). It is only by listening to both sides that listening in the workplace can act as a successful approach to manage bullying behaviours. Quotes confirm this standpoint:

“I think as a nurse I know now how the people work, but as an HR manager, I need to also listen to both sides.” P2

“So, it’s almost like, I hear your voice and you hear my voice and if we don’t keep to that … as older nurses we must be willing to listen to the young nurses and their voices, their opinions.” P3

“So, for me, it’s about we, as seniors and nurse management, have to be willing to listen before we judge.” P3

“I think if management gave more support and recognise the validity of what nurses say … think that is a step in the right direction but …” P4

This clarification is supported by the information given by Clark and Kenski (2017:65), who state willingness to listen to all employees and effective communication aids in the management of bullying. Listening should be non-judgemental and with an open mind to encourage all workers to provide their views and maintain effective interactions with other staff members (Clark & Kenski, 2017:65). Active listening is important during conflict resolutions to enhance communication. Effective communication runs in both directions – speaking and listening. Managers should make a concerted effort to listen to subordinates and show the latter they understand them by making appropriate gestures and showing appropriate facial expressions (Kahn, 1993:489-490).
5.3.2.2.3  Category 3: Treat us the same

Bullying was seen by the participants as representative of the power inequalities or identity differences (like minority groups) in the units. The participants wanted equality to be maintained throughout the workplace. They expected nurses to be treated the same as management in order to reduce bullying that could arise as a result of misuse of positions of power, as illustrated below:

“… as all of us are not from the same background or the same values that we need to have, have a clear policy that states how we must handle everybody. We must be equal in our approach to everybody.” P2

“I think they might, however, I think if you have a fair system, where you can have more than one person’s input in the end where a person does a self-review and then the manager review[s] you after that. That might be a good one or to actually do it with, together with the HR manager, that there’s an independent person sitting in the performance management to make sure that nobody is being in a disadvantaged, nobody is being bullied. They don’t need to do the review, but they can sit with you as an observer, plus that will then make the good invest and not be perceived as bullying.” P6

We must be equal in our approach to everybody. What is good for the goose must be good for the gander.” P2

“how they [management] treat people, I want to be treated, and then I want to treat my colleagues the same way.” P5

“I think professional nurses [RN] or the sister in charge [UM], or the shift leader must know we are also people and they must talk to us as we are colleagues. Not lower than them.” P1

“And I think managers, our unit manager must be fair to everybody, like I said, some is always late and it’s okay and others is not and that is not okay. We must be handled the same. There must be fairness. And people must know that we are all the same, one cannot be better than the other person.” P1

Workplace bullying arises from a combination of factors such as the absence of strong prevention programmes, protective regulations and upholding the ethics of nursing. According to Fink-Samnicken (2015:187), one such ethical tenet of nursing practice is to treat everybody fairly or equally. Chappell and Di Martino (2006:24) write it is time to realise violence in any form in any workplace can no longer be tolerated or accepted as “a normal part” of the job. “Bullying is not [own emphasis] a normal part of a nurses’ job as many nurses, particularly new or novice nurses, tend to believe and accept,” (The Joint Commission, 2016:2). Unfair treatment defies the very core of nursing, namely care.
5.3.2.2.4 Category 4: Visible management actions

The participants wanted management to be more visible. They wished for management to be more aware of what was going on in the hospital, the units and among staff members. They explained:

“I think, more senior management, more visibility might help. I’m not saying they must come and have coffee with every person but doing rounds throughout the hospital, a ward a day, five minutes, that staff can see them, they can address something in management, just a quick hello, how’s everyone doing, might make the people start seeing management also as more human and will be able to start communicating with people easier. Because unfortunately, the only time we see our management is when there’s a problem or a special patient …” P5

Shabazz, Parry-Smith, Oates, Henderson and Mountfield (2016:2) state good management in an organisation promotes a culture of openness which improves working relationships. Nurse leaders are also expected to take the lead to reduce bullying behaviours by creating interpersonal relationships with the other nurses (Yun et al., 2014:224). Hence, management should not only be visible in the work environment, but the actions they take should be visible and transparent. In this study context, management’s actions should be visible regarding workplace bullying, its origins and measures adopted to prevent such behaviours. The participants experienced that when they reported bullying, no action was taken to stop this behaviour, as illustrated:

“Reported it to management with her permission and management did nothing.” P2

“I think management plays [a] big role in how intimidation, bullying, victimisation, harassment whatever you want to call it, is addressed in the workplace and when issues are brought to the attention of management [and] nothing is done about it, it weakens the voice of the people because they don’t feel that if they have a problem it’s going to be addressed.” P4

Some participants mentioned management did address bullying situations. Reports of bullying were investigated, and actions were taken to spread the message that bullying is unacceptable behaviour as evidenced by the quotes:

“So if people start reporting, it’s acted upon and people are dismissed and I don’t believe in punitive management, but that also needs to be a message that we take this [bullying] seriously.” P4

“I would create an access for somebody to report victimisation and if it is brought to the attention, then it needs to be investigated.” P2

“But I think in the end it ends up in communication, one needs to communicate with the bully. If we start getting a lot of complaints about the one person, either, you as the unit manager needs to address it.” P6

“If we [management] know what the problem is and we hear about it, we address the problem. If we can find the origin of the gossip – it is not that easy – but we try to have a meeting with the unit or a department and tell them about what the real facts are.” P2
Lack of visibility of the individuals with the capability or capacity of handling the bullying situation makes the management of bullying behaviours difficult (Mikaelian & Stanley, 2016:962). Visible active management of bullying is supported by Tolentino, Garcia, Lu, Restubog, Bordia and Plewa, (2014:40) who state that making visible changes in the work environment assists targets to report bullying incidents. This also allows the bullies to understand that their bullying behaviours are not accepted in the working environment.

A study by Shabazz et al. (2016:2) showed good management in the organisations included adopting and following good policies and procedures; staying informed about bullying, allowing nurses to resolve bullying issues, and stopping such behaviours in the nurses’ working environment. In any case, as asserted by Ditmer (2010:12), nurse leaders have the moral, legal and ethical obligation of providing safe working environments, as well as reporting every incident of bullying.

5.3.2.3 Sub-theme 3: Management competencies needed

In relation to the sub-theme of management competencies, the participants mentioned the need for all professionals to be competent and acquainted with different sets of management competencies. Three categories emerged, namely good communication skills, working together as a team, and practicing conflict management.

Effective, appropriate communication styles reflecting emotional maturity and intelligence (Danarson, 2014:168) by the parties involved in conflict resolution are required to set the right tone for conversing about bullying issues in a professional manner (Bao et al., 2016:543).

5.3.2.3.1 Category 1: Good communication skills

According to the participants, maintaining good communication between nurses and management helps to effect proper management and address workplace bullying. Concerning communication skills, the participants mentioned the need for management, as well as nurses working in the units, to be competent in using effective communications skills to promote work relationships and teamwork. Participants shared their opinions of how a message is communicated as a skill that can make a difference to how the message is received in the following quotes:

“They [management] must have good communication skills, as well as listening skills that you can talk to them about what is happening in your ward or your unit. … they specify how must your communication skills be. I think it's something that is needed in your [management] position.” P2
"I think although one learns communication skills, I think some communication, more advanced communication skills might be an advantage." P6

"… if higher categories communicate properly to lower categories, they can manage conflict."

"Actually we [nurses] have to have good manners in talking to one another, communication; working together. I think people should talk clearly, in a normal tone, even if we are stressed about things in the workplace." P5

"So communication skills in young nurses is important, we must teach them that and if they go into management it's important." P3

"The communication should be clear and [in a] normal tone, no shouting, no gossiping …" P5

Clearly, the quotes show a need for effective and professional communication skills for all professional nurses (from management at the top to the junior enrolled and auxiliary nurses). In the literature, great emphasis is placed on the effectiveness that good communication skills can have to deactivate conflict situations. For example, Knudson (2014:C3) states nurse managers should have effective communication skills in order to promote communication, which is essential for the achievement of professional behaviours among other nurses. Escartín (2016:166) and Woodrow and Guest (2017:227) agree that to achieve constructive management of bullying, open communication between the managers and other group members in the organisation is needed. Developing good communication skills ensures a reduction in bullying and improves the communication process. Communication challenges contribute to the misinterpretation of challenges, thus leading to conflicts (Logan, 2016:48).

Moreover, Abdollahzadeh, Asghari, Ebrahimi, Rahmani and Vahidi (2017:159) and Knudson (2014:C3) explain if nurses can communicate effectively and understandably in the workplace, e.g., if a senior nurse’s requests are clearly given and clearly understood by a junior nurse, the latter’s response should be professional and normal, and no conflict would result. However, if the requests are shouted out, the junior may experience it as bullying. It is therefore a simple matter of knowing how to communicate clearly, professionally and respectfully not only with one’s voice, but including one’s body language, facial expressions, voice tone and mannerisms (Berry, 2009:513).
5.3.2.3.2 Category 2: Teamwork

The category of working together as a team formed part of management competencies and was also found to be effective in the management of workplace bullying. The participants mentioned that all nurses in the workplace should develop good interrelations by accepting that all people are not the same in terms of position. They further explained that working together as a team would lead to less conflict, as illustrated:

“Is how we work together in our team. Within our group. And you must look forward to come and work with your colleagues and you must be able to talk to one another.” P1

“I think we [nurses] must also be polite to new people, entering our environment. They [management] must … help those people to be part of our team.” P5

“I think people need to get along with one another, accept that everybody’s not the same. We all differ but we need to make it work in a working environment.” P2

“People need to get along with each other and accept their differences. We all differ but we need to work together.” P6

“Because positive feedback, competencies, all that stuff get to make you work better in a team because if everybody has got good competencies, they get positive feedback, in a team they will work well together and there will be less conflict because they know what to do and what is expected of them.” P2

Almost, Wolff, Mildon, Price, Godfrey, Robinson, Ross-White and Mercado-Mallari (2015:e007686) and Leon-Perez, Medina, Arenas and Munduate (2015:253) assert teamwork as an interpersonal work relationship is an essential element in minimising bullying behaviours like violence and bullying harassment in the nursing environment. Logan (2016:48) indicates that effective teamwork is an essential requirement in the field of nursing. Effective teamwork is facilitated through efficient communication, a cohesive and trusting team climate, as well as strategic leadership styles. Communication is essential in teamwork in order to handle bullying behaviours. Moreover, as asserted by Rocker (2008:3), team spirit facilitates a safe environment for working and encourages a bully-free environment. Nursing management needs to actively engage in the reduction of bullying in the workplace by promoting teamwork and teambuilding among nurses. It is important for nurses to have a great sense of belonging and loyalty to their work to encourage teamwork.
5.3.2.3.3 Category 3: Practice conflict management

The participant explained they found conflict skills in order to manage bullying behaviours lacking in nursing. Conversely, the participant also acknowledged that conflict management is a complex skill to practise as indicated in the quotes:

“I think they [management] lack communication skills, conflict skills. Most people do not like to address conflict and that is a problem.” P2

“I think conflict management doesn’t come with a package. It’s also how you as a person handle conflict. We can tell everybody by the book what they must do but it’s not as easy in the real working environment.” P2

“I think we…we have to communicate, the guideline, the policy, conflict management…” P2

“I think professional nurses can handle conflict better or know how to address conflict. As the lower categories are not, because they are used to be the lower category … I’m not always sure they can handle the conflict or know how to address the conflict.” P2

These statements aligned with the information gained in the study by Baillien, Bollen, Euwema, and De Witte (2014:515) that indicated conflict management styles are the key components to managing workplace bullying. Adopting a conflict management approach assists in determining the emergence of conflict in a workplace and how these conflicts can be managed by the involved parties (Baillien et al., 2014:515). Additionally, the adoption of a conflict management approach provides conflict resolution in the case of bullying in the work environment. The participants’ voiced experiences were consistent with the theory of Kurt Lewin’s change approach (Burnes, 2004:309) which indicates that implementing conflict management as the proposed changed in the organisation enables the employees to understand and restructure their views to achieve change management in their work environments (Cummings, Bridgman & Brown, 2016:34).

5.3.2.4 Sub-theme 4: Change staff in units

The participants said rotating or changing staff in the units might lead to the establishment of a more positive work environment where nurse-to-nurse bullying is reduced as the quotes indicate:

“I also think, I’ve said it for a long time, that there needs to be a big shake up. … Different people working, so changing the shifts and you don’t always work with this person … we going to change … some people so you going to have the opportunity to work in high care, you go from that surgical ward to that surgical ward just creating movement and a bit of dynamics rather than a fresh input …” P4

“Because people have been working in units for a long time, just to … upset the apple cart a bit, somebody new, familiar still with the hospital and the set-up but somebody new to the unit. Just to break that chain of, we can do what we want.” P6
The nature of bullying in hospitals differs from other industries. Whereas management is responsible for 75% of bullying in other industries, peer-to-peer and top-down bullying is rife among nurse colleagues (Kaminski & Sincox, 2012:2).

In the literature, rotating nurses in their work environment was found to be useful in the management of workplace bullying. Rotation in the workplace is addressed by Ha (2015:2495), who asserts that rotating clinical practitioners across departments reduces the risk of possible burnout which may be as a result of unacceptable behaviours from other staff members. By rotating nurses through other units, the risk for staff members to be exposed to workplace bullying such as verbal abuse, physical assaults and clique forming could be reduced (Cheung, Lee & Yip, 2017:888; Ha, 2015:2495). As indicated in the quotes, nurses tend to form groups in the hospital which is a problematic issue in terms of horizontal and vertical bullying:

“Umm I think also would help for you break up those cliques that, yes, and there have been some movements not at the management team but just changes in people’s offices there has been movement and that has created a new dynamic as well so it supports the theory that the nurses need to be, just shaken up break up the cliques yah”. P4

The same participant said:

“So it’s often easier to find other solutions to the problem, transferring somebody out, not dealing with the issue, so let’s just take this irritation away and put it somewhere else …” P4

However, in such a case the problematic issue is that the bullying behaviours are not addressed and often not reported. This defies the whole aim of changing the workplace culture from that of a bullying to a non-bullying culture. This indicates poor management styles, because managers need to be aware of the impact that bullying has on the staff, the patients and the organisation (PSHSA, 2010:4). Management needs to react by taking control of the situation and addressing a bullying situation immediately to remove the threat. It is of no use to transfer a bullying nurse to another unit where he/she can continue bullying “fresh blood” so to speak. Bullying in nursing is a glaring issue which needs immediate resolution for its elimination because “the delivery of care will become meaningless if the continued level of violence among and against the health care workforce is allowed to continue” (Fink-Samnick, 2015:173).
5.3.3 Theme 3: Nurse-related aspects

The third theme that was identified in relation to the management of workplace bullying was strategies nurses can employ to ensure effective management of bullying between nurses. Two sub-themes emerged, namely role-modelling of expected behaviour and skills needed, as shown in Table 5.5.

Table 5.5: Theme 3 - Nurse-related aspects

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5.3.3.1 Sub-theme 1: Role modelling of expected behaviour

Role-modelling was indicated by the participants as an essential and vital component of strategies used in nursing practice in hospitals to obviate bullying behaviours in the nurses’ work environments. The participants all agreed and emphasised that higher level nurses in senior or management positions with years of practical experience in the hospital domain needed to remember they served as role models for junior and/or novice inexperienced nurses. The verbatim quote substantiates:

“Don’t always think of what we say, it must be said and it must be done, but this is now where the older nurse becomes a role model because over time she learns how to communicate quickly, effectively, but respectfully. People were role models and they were more enthusiastic to teach, because nursing has teachable moments and you learn by observing what the registered nurse is doing in the situation.” P3

Supportive literature sources are Kemppainen, Tossavainen and Turunen (2013), Granstra (2015) and Houghton (2014). Kemppainen et al. (2013:499) assert that by being role models to other nurses in the workplace, nurse leaders need to take effective action to motivate the staff and advocate positive actions which must contribute to a harmonised working environment. Granstra (2015:255) and Houghton (2014:2376) also agree that management should act as role models for other nurses by promoting respect and trust in the working
environment. Building respect and trust in the workplace leads to teamwork and efficiency in solving workplace conflicts (Granstra, 2015:255).

Four categories emerged from the first sub-theme, namely effective communication, assertive behaviour, respectful questioning and learning from others.

5.3.3.1.1 Category 1: Effective communication

An important part of role-modelling, according to the participants, is effective communication. The participants were quite assertive when mentioning that nurses in healthcare needed to be able to communicate effectively and respectfully with their peers or colleagues. The participants revealed that nurses who demonstrated effective communication skills in the work environment are more likely to develop good relationships with other nurses in the same environment. The quotes support these perceptions:

“We as leaders, must start and socialise [mentor] the junior nurses, so that when they [are] the seniors, they have the changed behaviour and respectful for communication with one another that we need to role model to them." P2

“…we as older nurses should teach the younger nurses and teach them about being role models of. I know the pressure is on, I know things are happening, I know the heat is on but I can still speak to you in a respectful way although I keep it short and sweet because we have to work. So this is now where experience and self-control, self-discipline and body language becomes important. “ P3

“They said caring ethos, we're role models. … we should start developing a theory about communication to prevent bullying, for example. So, if we teach the soft skills such as caring and active listening then one of the other soft skills that we must teach is respectful communication." P4

“I actually had high hopes that this deputy nursing manager will break the mould, in the sense of communicate effectively, stop bullying the staff. Now, the old nurse manager, she resigned, she's now on pension and the deputy nursing manager is now the manager. She bullies her staff just like the old one did. So, somewhere between her being … you know becoming in a leadership position and having that nursing manager, old nursing manager as her role model changed her behaviour.: P6

“… then I also have to realise, how can I be a role model for allowing students to question and to challenge but without being disrespectful and that in itself is a skill …” P3

Nurses with effective communication skills have the ability to prevent workplace bullying, because they have conversation skills to interact with other nurses to develop plans and strategies to help reduce workplace bullying (Blando et al., 2015:4). Nurses in management positions are expected to be role models in communication techniques. As such, demonstrating effective, respectful and professional communication with their peers, as well as lower rank staff, the latter can learn from them and copy the same communication techniques.
Additionally, Papathanasiou, Kleisiaris, Fradelos, Kakou and Kourkouta (2014:408) explain that effective communication from nurse management results in greater motivation and empower other staff members to engage in decision-making processes to address social problems in the health facility. However, addressing bullying behaviours is a highly personal and often threatening process for managers and even more so for the nurses. Therefore, the best way to broach the bullying subject is to use “a no-blame, conciliatory approach” (PSHSA, 2010:25) to assist in reaching an appropriate outcome to the satisfaction of all parties involved. But, to achieve this outcome, the use of effective communication skills during disciplinary hearings or informal conversations is essential to ensure what is said is said correctly and is understood and what is heard, is heard correctly and is understood correctly.

5.3.3.1.2 Category 2: Assertive behaviour

The participants stated having assertive skills in the workplace would assist with the management of bullying behaviours. However, according to them, nurses lacked these skills, which rendered them powerless against bullies. They further explained that nurses should be assertive when handling issues in the work environment, but that assertiveness is a learned skill acquired with experience and exposure to hands-on practice. According to the participants, there was a great difference between lower category nurses’ and registered nurses’ assertiveness in the clinical practice. The quotes serve to verify the aforementioned:

“No, they’re [nurses are] not assertive enough, especially lower categories against the higher category.” P2

“I think nurses keep quiet about being bullied because they feel powerless to do something about it and the new ones are simply not self-assertive enough to stand up and say, but you are bullying me. So, that’s the why I said to you that self-assertive behaviour comes with time and how are we going to, or we as older nurses should teach the younger nurses and teach them by being role models.” P3

“… and that’s the other challenge, is that assertive persons, maybe as you grow older you become assertive and we expect [that of] young women, if you think of, a young registered nurse, if she starts studying directly after matric, then she’s what, about 22, 24, 23 when she finishes with her degree or her course and then you put that 23 year old in a ward full of patients, with anxious family members, with challenging nursing care decisions to make, difficult doctors, a challenging work load, and you say to her, be self-assertive. And then we add the older bullying nurses and then we say to her, okay, now be self-assertive, assert yourself. Who is going to support her in that self-assertive role, because I can think of myself, when I was in my twenties, I don’t think I was as self-assertive as I am now, but it’s 30 years later.” P3

“Maybe as you grow older you become assertive and we expect [that from] young women. State your point of view using the scientific facts, no screaming, no shouting but bringing across the message that this is the unacceptable nursing action or this script is wrong and I use my scientific knowledge.” P3
“I think for them [enrolled nurses] being assertive is doing the work well. That could be for them, assertiveness. I think they [registered nurses] are assertive because they’re now at a higher rank. So they can be more assertive due to their knowledge, training. That is why they can be more assertive on certain levels.” P2

Training nurses to behave assertively is very much needed for nurses employed in hospitals where a bullying culture is present. Assertive behaviour in the workplace aids in the management of workplace bullying, because it promotes effective communication by enhancing verbal and non-verbal communication (body language) skills (Bradley & Campbell, 2016:443; Vertino, 2014:4). However, consider the following statement by a participant:

“I do assertiveness training. It helps nothing … So yes, I think, nurses are not assertive. We have been trained into non-assertive people because in private industry such tendencies are not allowed.” P4

The question is raised whether additional training to develop an assertive attitude has any value for nurse employees entering or already working in an environment where, according to a participant, even during their years of training, they are taught to listen and not to ask questions:

“If I think of the curriculum, currently it’s not one of the soft skills that we teach nurses. We teach them to be caring. We teach them to listen to the patients and we teach them to be submissive, patient first, doctors second, nurse, third. So we teach them that their own needs are always following after somebody else's and therefore, if you’re not allowed to verbalise your own position or to stand on your own two feet, defend your own position of power, because you have to be subservient to something or somebody, then bullying is acceptable.” P3

Upon entering the private hospital work environment, newly graduated nurses find themselves part of a workforce for which they “have neither the practice expertise nor the confidence” as Duchscher (2008:441) states. It is posited that by considering this scenario, role-modelling by senior, experienced and the older nurse workforce would benefit junior nurses to become assertive, provided the former exhibit ethical values and neither approve, nor participate in bullying practices.

5.3.3.1.3 Category 3: Respectful questioning

The participants mentioned that nurses should be role models with the capacity to moderate other nurses, thereby cultivating a culture of respectful questioning. Some junior nurse participants stated senior nurses did not like being asked questions – even if the intention of the juniors was to learn more by asking questions, some senior nurses seemed to experience it as a threat to their own knowledge and professionalism. The quotes illustrate:

“I can try to change that by being the role model encouraging my students to question.” P2
“... when do you allow junior nurses to question behaviour so that they first of all, they can understand why you decided on what you’ve decided and that you allow them to question you. We [experienced nurses] allow them much more leniency when it comes to questioning orders, to a certain extent, he, as long as it does not threaten us in our position and our knowledge but the moment they push the boundaries beyond our comfort levels, that's when we start bullying.”

“Until we have a nurse manager who is willing to listen and to say but listen this is not acceptable, the nurse has got the right to ask, the nurse has got the right to voice an opinion and you should respect that.”

Granstra (2015:255) asserts that part of role modelling is for nurse managers to educate and train juniors for the latter to get accustomed with the practical side of nursing. Responding to questions should not be on a personal level; responses need to be respectful and treated as empowering juniors with knowledge to facilitate better patient care, to learn more on a practical level and to facilitate better teamwork. However, Ganstra (2015:255) further states respectful questioning works two ways – the questions should be asked and responded to in a civilised and respectful way, as it is associated with improving discipline and work relationships, as well as to determine a collective destiny for the nurse team. Respectful questioning should be seen as a way to honour the wishes reflected by junior staff members, because it enables senior nurses and management to identify areas/aspects of learning opportunities. In fact, Adams and Iseler (2014:174) posit during human interactions (e.g. respectful questioning and responsive answering) emotional intelligence (EI) that helps to indicate efficiency and accomplishment can be effectively used to influence a positive learning outcome for both the learner (junior nurse who learns something new), as well as a the “educator” (senior nurse as a role model who is satisfied that he/she has achieved something). The quote verify this:

“... it’s easy in your training to learn how to manage a unit, but to do the emotional part of it, to look at people differently and not necessarily as a manager because although you are the manager, I think, in a sense you should also be a friend to the people there which might assist them to come to you when there is really a problem. I’m not a friend that’s doing you favours. They need to see you as an open person to come and discuss these problems with.”

When questioned what kind of life coaching course the same participant would propose for unit managers to understand junior nurses are not necessarily a threat, but they as seniors could also learn from the juniors, the participant immediately said:

“Topics on both emotional intelligence and ... IQ. Emotional intelligence, coping mechanisms, something that allows you to reflect ... It might be coaching, mentoring ...”
Mutual respect, trust and confidentiality between colleagues are among the values required to
develop an ethical work environment which will contribute to the reduction of bullying incidents.
Respect in the hospital group facilitates mutual understanding among members. Change of
behaviour is influenced by leaders through acting as examples to the workforce in the
organisational setting. Smith and Kelloway (2016:398) state that dealing with workplace
bullying is enhanced by employees controlling the impact of their social behaviours on others.
Hence, nurses are required to develop deep supportive interactions with their colleagues
which are only achieved through respect. Respect in the nursing workplace is earned by team
leaders coaching other nurses to develop self-respect, as well as respect for each other, the
patient and the employer (hospital) (Smith & Kelloway, 2016:398-399).

5.3.3.1.4 Category 4: Category - Learn from others

According to the participants, an ongoing learning process is an effective way of interacting
with other nurses. However, bullying might hinder the process of self-learning. The participants
mentioned that self-knowledge in a workplace can be achieved through acknowledging one’s
limitations:

“… and that for me … is something that I had to realise, is that if students ask something that I
did not know, I should be adult enough to say, ‘I did not know, that you taught me something’
because if you’re willing to acknowledge that the students taught you something and you
Teaching the students, then it becomes a mutual, respectful relationship where they’re willing to
share but then they’re also willing to listen.” P3

“… then I also have to realise, how can I be a role model for allowing students to question and
to challenge but without being disrespectful and that in itself is a skill …” P3

“The fact that, maybe, we as seniors must learn that we should show respect to the juniors
because bullying, I think occurs from a place of disrespect … It’s a reflection and it starts with
us as leaders, again, not as juniors. The juniors express what they learn from us. So, the leader
and the leadership style will determine how she solves the bullying or how she contributes to
the bullying in the hospital.” P4

This supports the information given by Sutton (2016:646) that self-knowledge in the workplace
promotes the psychological well-being of employees. According to Sutton (2016:646), it
promotes awareness and assists employees to evaluate their behaviours and adopt goal-
directed behaviours to promote their psychological well-being. Nurses must continue learning
on both a personal and professional level – the repercussions of “shutting down” or
disengaging and failing to take action include wasted talents with wisdom, knowledge, and
values not being shared “to positively influence care and support the development of new
nurse graduates and other colleagues through courageous role-modelling” (Dobos, 2015).
Jobe (2014:307) advocates for nurses and nurses in management positions to pay more attention to the "similarities the generations share" rather than focusing on the differences. By focusing on the similarities, in learning this would imply consciously striving to ask the question, “What can I learn?” instead of following the deeply ingrained rankism issue of, “she/he is a junior … What can he/she teach me?”. This approach can help all nurses “begin to improve group cohesion and limit generational conflict” (Jobe, 2014:307).

5.3.3.2 Sub-theme 2: Skills needed

The participants stated the need for the identification and management of workplace bullying among nurses. The elimination of bullying might only occur when both the perpetrators and targets develop the described sets of skills.

Three categories of the required skills emerged, namely stress management, anger management and conflict management. The key enforcers of these skills are registered and senior nurses.

5.3.3.2.1 Category 1: Stress management

Regarding stress management, the participants reported it would benefit nurses to be competent in managing workplace stress. The participants agreed stress management skills would assist them as individuals and as a team to respond appropriately to normal workplace stress aggravated by bullying behaviours. This is evident in the responses from participants’ verbatim statements:

“I think understanding, awareness. We work in a high-stress environment so people must be aware of that, also awareness and help people manage their stress, management can do something like that.” P1

“… the level of maturity that you expect of a young nurse is really very specific to the profession. You won’t expect that level of maturity from a bank teller that just now started her career or a young lawyer. … It’s just the pressure is so much … how many young professionals stand in the middle of the passage and get responsibility of 30 to 40 people, plus family, plus doctors and physio [physiotherapist], the multidisciplinary team. … they are really stressed. I think there is a lot of burn-out and stress and as I say, especially, I think, if you become stressed you cope less with pressure …” P3

“I mean, I've been stressed in my life and I've said things to juniors that should not have been said or I should have said it differently but the space, the emotional space that I found myself in at that moment was just, I could not think of a positive way to say this and I exploded because it was just too much and I think other senior nurses experienced the same and that's bullying, actually, hey?” P3
The statement is supported in the literature by Nowrouzi, Lightfoot, Larivière, Carter, Rukholm, Schinke and Belanger-Gardner (2015:308), who explain that stress management skills in the workplace promote a healthy work environment. Stress management assists in minimising occupational stress in order to promote the sustainability of health systems and increases productivity among employees. Also, Quinlan, Robertson, Miller and Robertson-Boersma (2014:37) assert nurses who have stress management competencies aid in minimising the levels of workplace bullying. Wright and Khatri (2015:140) are of the opinion that stress management skills also help nurses to adopt good behaviours that value the well-being of other staff members.

In the nursing domain, nurses already deal with extreme daily pressures, i.e. safe patient care, emergency situations, nurse shortages, long hours and so forth which cause “normal” stress. If bullying additionally occurs, “trust and respect among team members are now hampered, with fragmentation replacing cohesion” (Fink-Samnick, 2015:167), while the psychological impact on team members can make them “feel perpetually incompetent, inadequate, exhausted, disappointed, devalued, frustrated, and powerless” with no control over their work or lives (Duchscher, 2008:446).

5.3.3.2.2 Category 2: Anger management

The participants highlighted the need for management and colleagues to have the skills to reduce anger among nurses in the workplace. The participants emphasised that anger experienced by nurses and doctors contributes to bullying behaviours. As such, being skilled in anger management skills is essential, as evidenced by the quotes:

“… an extra duty for instance, so that they can be aware of it. My duty is to check the emergency trolley today now I don’t do it because I’m angry at somebody …” P6

“When they [bullies are] not happy with the way something is being done, they send messages to the doctors to complain and then the doctors come in angry about something.” P4

“… people mustn’t attack you personally if something is wrong, they need to talk to you about what is wrong, the task you are doing, not attack you personally.” P1

“The nurse waited … with a friend of hers after work and physically molested the person she was angry with as she got off the taxi after a shift in the evening.” P4

A study by Shahsavarani, Noohi, Heyrati, Mohammadi, Mohammadi and Sattari (2016:356) confirms anger management skills in the workplace help to reduce violence and other related bullying behaviours. Nurses with anger management skills should control their anger in the workplace for effective cooperation and productivity. Anger management needs to be used frequently in the workplace to reduce bullying behaviours towards all employees (Cassum,
When nurse relationships become strained, especially if higher stress levels are involved during critical situations as discussed in section 5.3.3.1, nurses have an obligation towards the patients and colleagues to address the situation with dignity, professionalism and in the least possible emotional way. The Joint Commission (2016:2) reflects on the words of Alan Rosenstein, an expert in unprofessional behaviour, that the primary goal should be to “improve care relationships by increasing understanding and responsiveness to individual (physician, staff, patient) needs” by providing training in, amongst others, “stress, anger, and conflict management” to enhance “an organisational culture that respects and supports physicians, staff, and patient-centered care.”

5.3.3.2.3 Category 3: Conflict management

The participants emphasised the need for this skill in the workplace. They said having conflict management skills would aid in addressing workplace bullying, as well as improve work relationships. However, according to them, experienced nurses tended to avoid handling conflict. They stated this skill needed to be better developed in the higher nursing categories. The participants proposed that a positive attitude and positive feedback for good work should be utilised to lessen conflict, as illustrated:

“I think professional nurses can handle conflict better or know how to address conflict.” P5

“Because you don’t want to address the conflict then the best other way is ignoring one another.” P1

“Yes, because I think if you’ve got a positive attitude, you’re willing to learn, you’re willing to abide by rules, you’re willing to ask, you’re willing to communicate and that will help in managing conflict.” P2

“And the positive feedback, if the higher category gives some positive feedback to what they do then there will be less conflict.” P4

This aligns with the study by Hopkins and Yonker (2015:227), who found that conflict management skills aided in reducing task conflicts among employees and also prevented destructive reactions to bullying behaviours. Additionally, Leon-Perez, Notelaers and Leon-Rubio (2016:1) assert that conflict management skills through training of employees enhance the effectiveness of employees to manage their workplace conflicts. Resolving conflicts in a mature way and with the assistance and support of management is considered as a way of managing workplace bullying. Conflict resolution in the organisation requires the active involvement of the management. Therefore, management has the responsibility of ensuring that the employees are trained and equipped with conflict resolution techniques. Ideally, the skills should focus on dealing with tendencies such as bullying in the organisation.
5.3.4 Theme 4: Work environment improvements

The fourth theme that was identified in relation to the management of workplace bullying was work environment improvements. A typical healthcare work environment comprises of professionals from diverse educational backgrounds and with different skills. The participants highlighted different elements within the work environment with a focus on the aspects of support and teamwork.

Two sub-themes emerged, namely improving teamwork and providing support and support systems as shown in Table 5.6.

Table 5.6: Theme 4 - Work environment

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5.3.4.1 Sub-theme 1: Improve teamwork

The participants agreed that improved teamwork was a key component in the management – and hopefully eradication – of workplace bullying among nurses. The participants mentioned that teamwork in units assured an effective workforce and the improvement of patient safety. Bullies tend to focus on new, inexperienced nurses or outsiders as targets for their bullying behaviours. Teamwork can therefore assist in addressing bullying by including all levels of nurse employees to work towards a common goal:

“In a team they will work well together and there will be less conflict because they know what to do and what is expected of them. I think a team is everybody in the ward, in the unit. We need one another in nursing for teamwork.” P2

“Agency or no agency, we’re nurses, professional nurses, it doesn’t matter what category. We’re there for the patient and then we need to work in a team, that’s the most important thing. Support, assisting one another. If you work as a team and the work is done, there will not be any need to bully one another.” P2
“Older nurses must take the new people or the new appointees in the department so that they can be part of our team.” P5

“Umm because you’ve got to start dealing with the people who are not playing as a member of the team.” P4

According to Blackstock, Harlos, Macleod and Hardy (2015:1106), the complexity of the functions that take place within the hospital context dictates that all the staff unite towards enhancing a healthy and safe working environment which is beneficial for both the patient and the medical staff. According to Sohmen (2013:4), leaders should focus on the development of strong teams in the workplace in order to achieve organisational goals. Successful leaders motivate employees to work as a team and to have a shared and common vision (Sohmen, 2013:5). In the current study, the prevention of bullying behaviours in terms of workplace conflicts and harassment depends on good leadership and teamwork.

Under Sub-theme 1, improved teamwork, two categories emerged: improved trust and respect among colleagues; and positive feedback.

5.3.4.1.1 Category 1: Improve trust and respect among colleagues

It was highlighted by the participants that improving trust increases teamwork in the workplace and reduces top-down vertical bullying (senior to junior nurses) in the hospital units. Unfortunately, as the participants shared their experiences, the bully was often a member of the team they were supposed to trust. Trust and respect were viewed by the participants as complementary values as indicated:

“…there is no trust, none whatsoever. Everybody is watching their back at the moment including the unit management group. So that tells you immediately that there is not trust.” P4

“The bully is the person in whom you must actually trust and look up to, that’s usually the bullying.” P3

“I think with this comes trust, you need to trust one another. Because if you trust one another you will be able to do the work and do not find the need to bully somebody.” P2

“I think people must trust one another. I know how to do my work. They must trust me to do it.” P1

“… people are set in their ways but I think the big thing is to build a trust relationship that they can see, they can come to you with a problem.” P6

“I think it also goes for trust. We must trust one another and have respect for one another. If you have respect for one another, you will treat one another, the way that they deserved to be treated.” P2

“We must trust one another and have respect for one another. Yes we got trust and respect for one another, then people will not, we will not allow bullying, people will not be able to bully us.” P5
"But it's about respect and it's not junior must respect senior, that's enough of that and actually they fear the seniors. It's about the seniors respecting the juniors as human beings and novice nurses who are still trying to get used to this environment. ... you should earn her respect by respecting her." P2

Trust is a key element of teamwork. Trust helps to ensure effective sharing of responsibilities and minimising workload among employees (Purpora & Blegen, 2015:2293). In South Africa, the culture of ubuntu needs to be harnessed within the nurses' workplace. Ubuntu, which means “human kindness”, is a cultural philosophy that promotes the striving for the good of humanity before the good of oneself (Mulaudzi & Peu, 2013:1-7). Nursing teams should adopt the ubuntu culture in order to encourage teamwork and collective achievement of goals; the ubuntu culture fosters humanitarian relationships and could minimise occurrences of bullying in the workplace (Metz, 2011:532).

5.3.4.1.2 Category 2: Positive feedback

It was stated by the participants that positive feedback makes nurses want to work in teams, thereby reducing the occurrence of bullying incidents. However, they claimed the work environment makes it challenging at times to provide positive feedback, as illustrated:

“Because positive feedback, competencies, all that stuff get to make you work better in a team because if everybody has got good competencies, they get positive feedback, in a team they will work well together and there will be less conflict because they know what to do and what is expected of them”. P2

“I think the big thing is give them the necessary credit and try and boost some of ... their self-confidence”. P6

“and I've said things to juniors that should not have been said or I should have said it differently but the space, the emotional space that I found myself in at that moment was just, I could not think of a positive way to say this and I exploded because it was just too much and I think other senior nurses experienced the same and that's bullying.” P3

A positive work environment encourages empowering employees through counselling, professional development and positive feedback. This ideal working environment encourages mentorship and free interaction among staff members (Granstra, 2015:255). The statement is evidently supported by Almost et al. (2015:2), who mention that good behaviour demonstrated by nurse leaders and medical professionals promote effective management and prevention of negative behaviours like bullying. Furthermore, good behaviour also increases a collaborative work environment in the healthcare setting.
5.3.4.2 Sub-theme 2: Provide support and support systems

Support is important in the work environment to curb bullying. The support required does not necessarily only come from colleagues, but also from other sources such as groups, forums, alternative communication and outsiders.

“But I think the most important thing is that there must be a support system in place … because if I’m being bullied I need to know, to whom can I communicate this. What support am I going to get? And support doesn’t necessarily mean it must be somebody from the hospital.” P2

According to Purpora and Blegen (2015:2297), there is less likelihood of bullying occurring in an environment with excellent management support, since support ensures effective teamwork and a reduction of the workload.

Under Sub-theme 2, four categories emerged, namely mediating as a support tool, employee assistance programmes, forums and discussion groups, and electronic communication.

5.3.4.2.1 Category 1: Mediating as support tool

In association with mediating as support tool, participants expressed that mediation is an excellent tool that could be applied in addressing bullying within the workplace due to the independence of the mediator.

“We made use of it [mediation] especially. Ummm. We kind of made use of it, person to mediate or facilitate a situation because if you make use of an independent person both parties feel like it’s somebody listening to them and share.” P2

A study by Oriol, Miranda, Amutio, Acosta, Mendoza and Torres-Vallejos (2017:1) showed that mediation practices assist in resolving violent relationships in the workplace by ensuring that bullying is reduced at social levels.

5.3.4.2.2 Category 2: Employee assistance programmes

Concerning employee assistance programmes (EAPs), the perceptions from the participants showed that adopting EAPs aid in promoting the health and wellness of all employees in the workplace. The programmes assist in presenting specific avenues where staff can report their concerns. EAPs could provide avenues for reporting incidents of bullying. The work environment would thrive when such programmes exist, as they would deter bullies from bullying their targets. The following information was collected from a participant:

“We’ve got an EAP, employee assistance programme, and we’ve got a social worker working with them. So you can make an appointment, independently or we can make you an appointment and you can discuss it with her.” P2
The adoption of EAPs ensures effective mentoring and counselling, as well as the option of long-term referrals to reduce behavioural issues in the workplace. The programmes can also help to address unacceptable behaviour among employees and ensure worksite problems are thoroughly addressed (Osilla, dela Cruz, Miles, Zellmer, Watkins, Larimer & Marlatt, 2009:194).

5.3.4.2.3 Category 3: Forums and discussion groups

With respect to forums and discussion groups, participants mentioned that the adoption of forums and discussion groups inside and outside of the workplace can assist in addressing bullying issues if they are managed correctly. Confidentiality seems to be a challenge to address actual incidents.

“If I think of the Forum for Professional Nurse Leaders, it is where all the nurse managers together. If they themselves sit together and say let's recognise bullying, let's develop a pliable strategy with principles and ideas that I can take to my hospital.” P3

“We just had an EE committee [employment equity] meeting this week and I was listening to the complaints and I know what is happening in the wards … and they were operational issues and one of the operational issues, they wanted to address in general. I said 'you can't do that … because you've got to start dealing with the people who are not playing as a member of the team' … People are reluctant to name names to address issues so how do you fix it? I know that's an operational issue but behind it is oh I don't want to name a name …” P4

According to Brush, Kirk, Gultekin and Baiardi (2011:160), organisations need to provide workplace forums where employees can voice their health and wellness issues, as well as other concerns. The development of forums enables the targets to report bullying cases to management, who can then engage in developing measures to help reduce the bullying behaviours in the workplace (Brush et al., 2011:160).

5.3.4.2.4 Category 4: Electronic communication

In relation to the last category, electronic communication, participants expressed a need for the use of electronic communication. Regarding the relevance of support in the management of bullying, the participants supported the inclusion or use of electronic communication as an alternative support system:

“Written communication is a challenge with us because nobody reads the communication book so it has been discontinued. It's a waste of paper but we have a WhatsApp group in the unit and we try to share important information, at least on that, however, not everyone is reading. That's the way that I try to communicate and then I do allow staff to send me an email if there's something, so most of them have got my email. If they don't want to necessarily want to come and talk to you. All of them have my cell phone number so they sometimes send me a WhatsApp as well, a private one. You at least have that.” P6
Hamblin, Essenmacher, Ager, Upfal, Luborsky, Russell and Arnetz (2016:53) explain that electronic reporting systems assist the employees to report their behavioural concerns like violence in the workplace using hospital system computers. This enables the management to understand the existence of workplace violence such as abuse, intimidation and harassment.

5.4 CHAPTER SUMMARY

In this chapter, the analysis, presentation and discussions of the qualitative data were presented. The data focused on the perceptions of healthcare professionals (nurses) on the management of workplace bullying. The participants’ experiences of factors that influenced workplace bullying and management strategies were presented in four themes, each with its own sub-themes and categories. The four themes included contributing factors, the work environment, nurses and management, and organisational actions.
CHAPTER 6 – INTEGRATION OF MAIN FINDINGS

6.1 INTRODUCTION

This chapter summarises and interprets the findings of the quantitative and qualitative data that formed Phases 1 and 2 of the study in relation to the research questions. Three key perspectives have been discussed in order to inform the development of a model for managing bullying in the nursing workplace, namely 1) trends arising from bullying acts in the nursing workplace; 2) recommendations for the prevention of bullying; and 3) motivators for behaviour change.

6.2 PHASE 1 (QUANTITATIVE) AND PHASE 2 (QUALITATIVE) FINDINGS

In a sequential explanatory mixed methods study, the first phase precedes the second phase. In this study, the quantitative phase preceded the qualitative phase where results were investigated in more detail (Moseholm & Fetters, 2017:2). The quantitative phase was the main phase of the study and the qualitative phase served as support (QUAN→qual).

Integration occurs when the data from the various phases are intentionally combined to provide a sense of clarity (Moseholm & Fetters, 2017:1). Integration at the interpretation phase and reporting can occur through “data transformation, narrative and joint display” (Fetters et al., 2013:2142). Data transformation was considered where the qualitative data was translated to quantitative data, but the study was not planned for this type of integration (Fetters et al., 2013:2142). For this study, the weaving narrative approach was used that involves the description of findings to provide an integrated presentation on a theme-by-theme basis. (Fetters et al., 2013:2143). The qualitative findings (Phase 2) supported, explained and provided depth to the quantitative results of Phase 1 (Moseholm & Fetters, 2017:5).

6.3 OVERVIEW OF DEMOGRAPHIC DATA

Demographic factors such as age, gender and experience were the most significant factors that were found to be contributors to nursing bullying from both the quantitative and qualitative studies. The findings from the quantitative data collection showed that 90.7% of the respondents were female nurses, while 83.3% of nurses that participated in the qualitative study were females. The findings correspond with the study conducted by El-Houfey et al. (2015:7), who indicated that the larger setting of the nursing working environment is made up of mainly female nurses. The results show that 63.3% (quantitative phase) were nurses aged 18-39, while 66.6% were above 40 years. Nurses with nursing experience of more than six
years (64.2%) from the quantitative study were more exposed to workplace bullying as compared to nurses with less than six years’ experience. In addition, the majority of the nurse respondents had worked in the medical or surgical wards at the time of the study.

Bullying occurs between nurses of the private hospital group. Some of the nurses feel powerful to overrule other nurses, resulting in bullying behaviours (Escartín et al., 2010:8). Bullying in nursing can occur in any dimension, which is a key issue to be addressed. Negative acts of bullying behaviours contribute to physical, psychological and emotional distress among the affected nurses. This is what motivated the researcher to investigate the state of bullying at the hospital to prescribe the best model for managing the situation.

6.3.1 Contributing trends with bullying behaviour at the nursing workplace

Research question 1 was to examine current trends with the acts/behaviours of bullying that occur in the nursing workplace setting. The research findings from both Phase 1 and 2 of the study indicate that bullying is prevalent in the nursing workplace and that several bullying acts were reported to occur very often. What this means is that, apart from the fact that most nurses are subjected to bullying, they are not subjected to the same forms of bullying. Instead, different forms of bullying are meted out against them. Confirmation of this finding was in the quantitative study, where results show that the negative acts that seldom occur among the nurses working in the private hospital group were pushing or shoving (11%), blocking the way (12%), hinting and signalling to someone that they should resign (13%), as well as pressuring someone not to claim a benefit they are entitled to (15%). Apart from these, most other bullying acts were found to be common among several nurses.

Both the quantitative and qualitative results confirmed that the bullying acts could be categorised into two broad types, namely physical and psychological. Although incidents of physical bullying were reported to have occurred, the negative bullying behaviours reported were mostly psychological in nature. On a weekly basis, the following were the most frequent forms of bullying acts suffered: gossip (54%), being ignoring (38%), criticising (37%), and social exclusion (36%). The qualitative data in Phase 2 confirmed this in the category of verbal bullying with the way people talk to each other, tone of voice and what is said, gossiping and shouting. The nurses also mentioned being ignored in the category non-verbal bullying behaviours. This shows consistency in the results from the mixed research design. On the other hand, results from the quantitative study reflect that nurses experience fewer personal attack forms of bullying, including isolation, exclusion, being ignored, intimidation, threats, belittlement, as well as humiliation.
Researchers have attempted to explain the reason for the trend that nurses suffer psychological abuse. According to Hutchinson, Vickers, Jackson and Wilkes (2010:173), the most frequent forms of bullying acts need to be understood in relation to the operations of power within an organisation. They suggest that nursing management structures perpetuate these behaviours over time through either disregarding or participating in the culture of bullying (Hutchinson et al., 2010:173). Because of the hierarchical nursing structure, nurses in a powerless position start to experience bullying when those in higher positions begin to exert authority and power. It was indicated by Purpora and Blegen (2012:2) that hierarchical power leaves targets with the feeling that they cannot defend themselves. Nursing’s hierarchical structure and rules have contributed to opportunities for bullying that have led to a culture of bullying (Granstra, 2015:252).

Age was also found to be a demographic factor that predicts the trend of bullying acts in the nursing work setting. The findings from this study revealed that different negative acts were more prevalent in different age groups. From the quantitative study, it was found that the act of withholding information was more prevalent for older or more experienced nurses. The qualitative study helped in understanding why this situation exists, as the findings revealed that this is indicative of older nurses trying to maintain authority over younger nurses. This was also confirmed in the qualitative data with a statement:

“…especially older nurses, don't always keep up with the theory and the science so the younger nurses, especially like the student nurses, …because they [older nurses] feel threatened then they revert to bullying … I gave you instructions, I know better than you. We've done it like this for 20 years, so who are you now to tell me. That's bullying.”

Delobelle et al. (2010:371) explain why older nurses behave in the manner described above, suggesting that they feel intimidated by the new knowledge of younger nurses. In other words, older nurses often feel their knowledge and experience are disregarded. Mitchell et al. (2014:147-148) indicate that bullying among nurses is increasing and verbal bullying is the most common form of bullying in the workplace.

Findings from the mixed methods design pointed to the role of a high work load and stress, as well as nurses performing duties outside their scope of practice or expertise as factors contributing to incidents of bullying. For example, 24.8% of the nurses in the quantitative study reported that role demands trigger workplace bullying behaviour among their colleagues. According to Riahi (2011:731) having clearly defined roles and responsibilities defined within the scope of practice of each nursing level may alleviate some of the areas where miscommunication and mismanagement exists. Almost et al. (2015:1) and Çalışkan and Ünlübay (2016:46) confirm coping with stress in the work environment is a way of managing workplace bullying behaviours. In the qualitative study, the nurses indicated that stress needs
to be controlled so that it would not be used as a reason for bullying. Stress in the work environment can be managed and handled by the management through debriefing discussions and counselling (Almost et al., 2015:1).

6.3.2 Perceptions of recommendations for the prevention and management of bullying

A number of strategies emerged across both quantitative and qualitative findings as recommendations for the prevention of bullying. About 38.3% of the respondents mentioned the use of a code of conduct to be an effective means of preventing bullying. There were also 40.7% who wanted to see reporting procedures implemented, while 31% of the participants wanted to see management actively investigating allegations as a measure to prevent bullying. Other strategies identified included improving interpersonal relationships and communication skills (59.9%), creating a positive organisational culture and climate (53.6%), motivating nurses to adopt ethical behaviour (49%), adopting a culture of team work (37.8%), and using coaching and modelling in leadership positions (49.1%).

6.3.2.1 Reporting of bullying

Findings from the quantitative study showed that 42.6% of respondents stated that when they experience bullying, they report the incident to a manager/shift leader. Employees took this step, because management has the responsibility to detect bullying behaviours among their employees by observing changes in their behaviour and deploying management strategies at departmental units (PSHSA, 2010:25; Royles, 2011). Apart from verbal reports, results showed nurses also consider writing incident reports (37.6%) to the nursing management team. A contradictory finding was that when they were the bully, nurses preferred face-to-face interaction (73.1%). The reason behind taking the step of reporting bullying was further confirmed in the qualitative study, as respondents emphasised that they speak out in order to obtain solutions. However, the qualitative data also showed that they do not have the self-confidence (5.03%) or the know-how (10.98%) to address the issue of bullying behaviours.

6.3.2.2 Acting on bullying incidents

While some nurses preferred speaking up about bullying as the best approach to controlling it, 37.5% of the respondents tended to keep quiet or ignore bullying incidents. The main reasons for keeping quiet were fear, embarrassment, or worsening the bullying experience (Mitchell et al., 2014:148; Granstra, 2015:251). Indeed, this finding from the literature was
confirmed in the qualitative data where respondents requested a need for support and safety: “I think they must protect us against people bullying us because reporting exposes us even more”.

Some respondents expressed the feeling that apart from the fear of being bullied more, they also had no faith in management to act on the reports they submitted, hence the decision not to report at all. This was echoed in the qualitative data where one respondent stated, “I reported it to management with her permission, and management did nothing”. The effect of such inactivity from management was that a number of nurse respondents (36%) confronted the perpetrator of the act. The findings align with Gaffney et al. (2012:6), who state that nurses who have experienced bullying take actions by themselves against their colleagues and peers.

6.3.2.3 Implementing of policies in management of bullying

Evidence from the quantitative results suggests reporting the bullying incident may be the most prominent response to bullying, but its effectiveness depends on the set policies and rules against bullying and how they are executed (Rocker, 2012:6). This was confirmed in the qualitative interviews, where nurses reported bullying behaviours according to their workplace policy’s description of what are considered bullying behaviours, as well as how management should react and implement strategies to address bullying behaviours. This means that the hospital policy goes a long way to influence the steps targets can take to seek redress.

Unfortunately, the quantitative results did not back the qualitative results in using policies to manage bullying. During the interviews, nurses described that there must be policies and ground rules for the departments that include not only what constitutes bullying, but also procedures for addressing the situation.

6.3.2.4 Open negotiations and counselling

Results of the study support the idea that workplace bullying behaviours are managed by encouraging open negotiations between management, bullies and the targets. In the qualitative study, respondents asserted that negotiations in the workplace ensure mutual understanding between any two parties involved in bullying behaviours. Harmony prevails in the workplace when negotiations advocate for changes in behaviours (Bradley & Campbell, 2016:445). In addition, the quantitative study found that counselling (37.2%) helps by giving nurses the knowledge, courage and skills to deal with workplace bullying behaviours. Counselling is one way in which management can provide support in the workplace environment to manage workplace bullying behaviours (McKay & Fratzl, 2011:13-14). Counselling is a measure of understanding the behaviour and offers a supportive remedy.
Moreover, counselling reduces work-related stress (Nyasha, Tendai, Makaita, Tasiyana, Pension, Edward, Farirepi, Vhuramayi & Bigboy, 2013:74).

6.3.2.5 Creating awareness

There was very high level of endorsement (64.91%) for the use of creating awareness as a preferred strategy for dealing with workplace bullying. In the qualitative study, it was revealed that the nurses perceived raised awareness as an option only when investigative measures are instituted. This is because when formal and informal investigative methods are initiated by management, it helps them to identify negative behaviours contributing to workplace bullying. This subsequently helps them to know which specific areas need raised awareness. Investigative measures have been observed as one of the strategies for dealing with bullying incidents in the workplace (Branch et al., 2013:290). Conducting research on workplace bullying has increased the opportunities for raised awareness about the issue and the negative impact thereof (Cleary, Hunt & Horsfall, 2010:331). Meanwhile, McKay and Fratzl (2011:17) indicate that the majority of management are not trained to handle bullied targets. Moreover, targets are unaware of which measures to take, or how to respond to workplace bullying incidents. The targets are also not aware what workplace bullying entails. These claims confirm the need for raised awareness about workplace bullying in hospitals.

Based on the interview findings, it is recommended that once management knows which areas need raised awareness, programmes should be launched to educate nurses about bullying behaviours and their prevention. Leaders in organisations should equip themselves with awareness about workplace bullying to provide a safe and healthy working environment (Georgakopoulos et al., 2011:1). The majority of employees believe that workplace bullying is minimised by organisational awareness and training. Moreover, raising awareness about the presence and impacts of workforce bullying in conjunction with conflict resolution strategies help in increasing nursing retention (Ceravolo, Schwartz, Foltz-Ramos & Castner, 2012: 600).

6.3.2.6 Leadership and management style

Results from the two methods in the mixed design confirmed that a change in leadership and management style can be used as an approach to manage bullying behaviours. Particularly in the quantitative study, it emerged that 35.99% of the participants perceived leadership and the management style to be a strategy for overcoming bullying of nurses in workplace environments. Several researchers found leadership and management styles contribute to dealing with workplace bullying behaviours (Cummings & Grau, 2014:5; Laschinger, Wong & Grau, 2012:1267-1268; Fernet, Lavigne & Austin, 2016:583, Shahbazi, Naami &
Aligholizadeh, 2013:1815). These researchers have identified authentic, transformation, laissez-fair and democratic leadership styles to be positive in managing workplace bullying behaviours. Laschinger et al. (2012:1267) indicated that nurse units’ leaders using authentic leadership can reduce the probability of newly trained nurses experiencing bullying within the first two years and can increase nurse retention rates in the workplace.

From the qualitative study, the nurses pointed out that they need to experience support from management and leaders while conducting their daily operations. The respondents wanted the leaders to support nurses by providing feedback and guidance, as well as employing good leadership skills in handling problems within the nursing environment. Wing, Regan and Laschinger (2015:633) assert that good leadership traits to manage bullying should include providing positive feedback to the nurses in the working environment. Moreover, peers and the management should provide emotional support and guidance to those affected by bullying behaviours. It is expected that leadership and management styles can be interventions for managing bullying, because good leadership skills and styles encourage learning processes, performance and growth (Korbi, 2015:2-3).

During the interviews, the nurses suggested that managers and leaders should act as role models with zero tolerance of workplace bullying behaviours. By being role models, nurses indicated that nurse leaders should take action by motivating them to do what is right and advocating positive actions that contribute to a harmonised working environment. The basis for this claim is that management is required to provide emotional support, professional development and encouragement to help nurses solve problems positively (Berry et al., 2016; Gaffney et al., 2012:2). In addition, participants in Phase 2 indicated that leaders who are ethical role models will help to manage bullying behaviours.

The findings from Phase 2 indicated that nurses believed management should be approachable and responsive in handling workplace bullying behaviours. The nurses also expressed that they thought changing bullying behaviour entails being transparent and open to friendship, as well as restraining from favouritism. Nurses indicated that leaders are not expected to use existing power in handling workplace bullying behaviours. Confirming this in the literature, Laschinger et al. (2014:7-8) noted that through the use of resonant, democratic and authentic leadership styles, anxiety in the workplace is reduced, the working environment improved, and self-awareness and responses to workplace bullying behaviours improved. Ideal workplace environments with bully-free behaviour are due to the presence of empathetic, approachable and friendly leaders capable of dealing with bullying behaviours (Sebok & Rudolph, 2010:25).
In addition, results confirmed that approachable leaders are needed to deal with workplace bullying behaviours. The nurse respondents wanted leaders who can take action once incidents of workplace bullying are presented to them. In addition, the participants wanted the leaders to address workplace bullying behaviours using peaceful conflict resolution and mediation between the two parties. Sebok and Rudolph (2010:25) indicate that leaders who are expected to deal with bullying behaviours exercise openness by listening to the status quo. The leaders should be approachable, fair, respectful and empathetic in order to deal with bullying behaviours (Sebok & Rudolph, 2010:25). Through empowerment, the leaders are able to influence change behaviour among the other employees (Curtis, Vries & Sheeren, 2011:308).

6.3.2.7 The need for support

Findings from the study revealed that management support (66.4%) plays a crucial role in maintaining a positive workplace environment and organisational climate. The support entails providing better working environments, retaining talent, as well as punishing people who exhibit bullying behaviour (Branch et al., 2013:289). Management gains the trust and respect of the workforce by handling bullying incidents (Hershcovis et al., 2015:13). Employees perceive management to constructively resolve workplace bullying by ensuring role clarity and ensuring reasonable workloads are given (Hershcovis et al., 2015:13).

6.3.2.8 Communication skills

Findings from the questionnaire indicated that 54.9% of the nurses believed that improved communication and interpersonal relationships are useful in dealing with workplace bullying. Findings from the interview corroborate the questionnaire data, since nurses described communication as a key component in causing and managing workplace bullying behaviours. It was evident the interview findings that the inappropriate verbal communication contributes to bullying through changes in the tone of voice (e.g. shouting). Consequently, communication is considered as an important strategy in managing workplace bullying behaviours.

In addition to verbal communication, good listening skills are also imperative in facilitating the management of bullying behaviours. Listening skills enable the leader to discover more about individuals and develop a strong relationship with them (Prewitt, Weil & McClure, 2011:17). Effective listening skills are considered key constructs in resolving conflict (Bao et al., 2016:543).
The respondents expected leaders at the private hospital group to listen and understand in order to change behaviour. One of the nurses indicated; “... have the openness to go to your supervisor”; “Trust, openness, coaching each other”. Nursing leaders are expected to be relationship-oriented by exercising openness (Curtis et al., 2011:308). Prewitt et al. (2011:17) indicate that competent leaders who aim to change behaviours must have the attributes of relationship competence.

In addition, leaders who are open to communication develop a relationship with their employees by encouraging respect and trust among the nurses. Moreover, change-oriented leaders are expected to be communicative (Derue, Nahrang, Wellman & Humphrey, 2011:17). The nurses also pointed out the necessity of non-verbal communication in managing workplace bullying. Non-verbal communication signals the intended conveyed message through body language. Verbal and non-verbal communication ensure the intended message is conveyed, encourage creativity and ensure efficient problem-solving (Bradley & Campbell, 2016:443).

### 6.3.2.9 Skills and training

Awareness should push management to support anti-bullying behaviours through taking adequate actions to support the targeted victims (Francis, 2014:1). In addition, nurse employees should receive the necessary skills and coping resources for dealing with bullying from management through training and workshops (Hershcovis et al., 2015: 13; Branch et al., 2013: 290). Part of the skills and training given to employees must focus on problem-solving and conflict management at the nurses’ level. That is, the nurses need to be trained on how to action first-hand interpersonal solutions to handle conflict or bullying. These skills will be useful against any bullying and will make it unnecessary for most of the cases to even rise to management levels (Francis, 2014:1).

### 6.3.2.10 Create a positive work environment

A positive work environment that is free of workplace bullying behaviours is encouraged. The nurses perceived improvements done to the work environment safety as a strategy for managing workplace bullying behaviours as indicated by findings from Phase 1 of the study. Georgakopoulos et al. (2011:1) point out management should provide a safe working environment. In addition, a positive organisational culture and climate (53.6%) from the quantitative findings contributes to a safe working environment. Nurse leaders can engage in enhancing ethical considerations by providing a safe environment and by reporting every bullying incident that emerges (Ditmer, 2010:11).
The nurses strongly believed that management and senior staff members are required to make interventions to prevent and manage workplace bullying. Support in the working environment contributes to the management of workplace bullying. In addition, several studies have evaluated the relevance of the working environment in managing workplace bullying behaviours. The study conducted by Wing et al. (2015:633) indicates that negative working environments, described by negative peer relationships, contributes to bullying behaviours in the workplace environment. A positive work environment is described as an environment that encourages the empowerment of employees through counselling, professional development and positive feedback (Wing et al., 2015:633). Granstra (2015:255) describes an ideal working environment as one that encourages mentorship and free interaction among staff members. In addition, a working environment that encourages workers' professional development has minimal chances for the occurrences of bullying behaviour. Ceravolo et al. (2012:601) indicate that communication and team building skills contribute to a safe working environment where the communication of rules and policies effectively contribute to the reduction of bullying behaviours. Ng (2014:13) and Berry et al. (2016:32) state that in safe environments, senior leadership encourages respect among nurses. The leaders encourage commitment to the organisation and adherence to rules. Respect also encourages teamwork among members.

6.3.2.11 Encourage teamwork

Teamwork as described by the participants (Phase 2) depicts that the employees must acknowledge their colleagues' efforts and accommodate one another despite small differences between the two parties. The nurses are not expected to exercise bullying in the workplace which negatively affects the targets who consider quitting or are affected by stress. Through encouraging motivation and success in achieving mutual goals as a team, a feeling of belonging is created among the nurses. In addition, this sense of belonging and connectedness is likely to discourage negative groups and gangs (Roffey, 2011:16-17). Socialisation plays a significant role in encouraging employee job satisfaction, as well as a sense of belonging. Socialisation encourages employees such as students to adopt the behaviour and ethos that fit in the organisational culture (Houghton, 2014:2370).

Communication goes hand-in-hand with teamwork and respect for others in order to alleviate bullying behaviours in workplace. In the quantitative study, it emerged that teamwork achieved through good communication contributes to the achievement of goals, improved relationships and safe working environments. Likewise, in the qualitative findings, it was found that communication, teamwork, respect and acting ethically reduce occurrences of bullying behaviours. One nurse stressed that; “To have a positive attitude when it comes to work things, always have a team member spirit”. Nurses are required to adhere to the principle of respect for
persons with whom they interact (Lachman, 2015:40). Moreover, collaboration is essential and requires trust, respect and decision-making skills in a healthcare team. Teamwork and communication work in the frontline to reduce workplace bullying behaviours (Koh, 2016:219).

6.3.3 Motivators for changes in behaviour

Motivators for behaviour changes identified by the participants related to people and the social environment of the workplace. Nurses wanted leaders who are approachable, an environment where they felt a sense of belonging and a caring ethos. They also wanted to be kept informed and receive feedback when actions or interventions against bullying are taken. Research by Avey, Wernsing and Palanski (2012:21) showed positive links between a sense of belonging and ownership to positive organisations, employee attitudes and work behaviours. The results from this study show that nurses want to receive support from the hospital, since the workplace was the origin of negative behaviours and conflicts. From the quantitative study, the participants indicated that they preferred support from nursing management leaders (66,4%) and from their colleagues (24.9%).

The nurses further indicated that respect among nurses was a major motivator for them in exhibiting changed behaviours, because it contributes to a reduction of workplace bullying behaviours. This respect could be fostered through efficient communication among the nurses. Nurses in the hospital setting must show respect by caring for themselves and caring for one another through engaging in constant communication. Closely related to respect were the issues of trust and fairness, which the qualitative research findings from this study identified as necessary elements for motivating nurses to put up anti-bullying behaviours. In addition, characteristics such as calmness in nurses enable them to manage stressful settings. Calmness also enables nurses to recognise their innate dignity and contributes towards caring for themselves and others with compassion and kindness. Calmness can make a substantial difference when dealing with bullying incidents among nurses (Meehan, 2012: 2913).

Because the motivators relate to people in the workplace environment, the literature shows that they are better harnessed through effective leadership. Leadership styles are observed to influence and alter the behaviours of the employees (Lunenburg, 2010:2). Effective leadership styles contribute to positive behaviours, while abusive leadership styles contribute to negative behaviours in the workplace. Leaders as change agents can influence decision-making in an organisation (Korbi, 2015:2). Management that involves itself in conducting change in an organisation often conducts the activities of organisational development change processes. Change agents conduct the roles of initiating interrelationship groups, teamwork, and survey feedback (Lunenburg, 2010:2-3). The change agents conduct training and
research to ensure successful change. Harnessing leadership in implementing change in an organisation requires organisational commitment.

The leaders influence interpersonal changes through communication processes, problem resolution, task control and recruitment (Korbi, 2015:2-3). Leadership styles are implemented to encourage learning processes, performance and growth. Resistance to change may be brought about by low self-esteem (Korbi, 2015:3). However, management can use strategies such as participation, commitment, negotiation, agreement, support and coercion (Korbi, 2015:10). A charismatic leadership style is associated with successful change. Charismatic leadership entails the integration of vision, empowerment, as well as inspiration. The leader using a charismatic leadership style is driven by confidence and the ability to influence moral behaviour. Transactional leadership entails employee motivation and a reward system associated with change management (Korbi, 2015:16-19). Based on the research study, leadership, management and leadership style were considered as change agents. The leadership styles contribute to the change of behaviours through the provision of a safe and suitable workplace environment. In addition, management of bullying behaviours is encouraged by conducting training, coaching, counselling and mentoring programmes (Lunenburg, 2010:2).

6.4 SIGNIFICANCE OF FINDINGS

Findings of the current study indicate that the responses to workplace bullying are varied and that there is no common response or reaction. The prevalence of those who reported bullying, those who remained silent, those who confronted the bully and those who sought help from peers is roughly similar, although using peers as a source of support was slightly less widespread. This may be explained by the inherently informal alliances in a workplace. The informal alliances, peer groups or power balance schemes have been proposed as the mechanism through which groups may act as bullies or facilitate bullying (Hutchinson et al., 2010:173). Unlike harassment, in which the two sides are in different positions vis-a-vis actual or perceived power, bullying can be done by anyone to anyone. To this extent, it may occur among same-ranking peers, or even upward bullying in which a higher-ranking staff member is bullied by a lower-ranking one (Vessey, DeMarco & DiFazio, 2010:133).

Results and findings depict the existence of bullying behaviours. Evidently, bullying behaviours exist in stressful workplace environments with autocratic and destructive leadership styles, lack of formal policies, power imbalances and bureaucracy. Interventions for bullying behaviours are facilitated by conducting awareness of the issue, encouraging the development of interpersonal skills, educating individual nurses, as well as legal measures
and policies to diminish bullying behaviours and incivility. The findings demonstrate the importance of raising awareness about bullying behaviours in the workplace and the need to take steps to prevent the practice once the awareness is created.

Branch et al. (2013:289) indicate that awareness in Sweden contributed to reduction of bullying behaviours which was achieved by the development of formal policies and legislation. The nurse leaders need to be in the frontline of creating awareness to minimise bullying behaviours. The findings can be used to teach nurses strategies to deal with workplace challenges and conflicts. Moreover, the findings will be of importance to hospitals, especially nursing managers, to understand the types of bullying behaviours and their consequences. The findings also provide insights on creating a healthy environment by implementing strategies for dealing with workplace conflicts. As a result, organisational and personal goals will be achieved through reduced bullying and the creation of a harmonious working environment.

The results have been useful in paving the way to design a model that focuses on the successful and systematic changes of behaviour influenced by effective strategies and tools to stop bullying. From the study, it has emerged that the nursing leaders and managers are the key stakeholders in facilitating change, in contrast to the researcher’s initial prediction that change would emanate from nurses. The nurse leaders need to use tools such as training, coaching, leadership styles and leadership traits to facilitate behaviour changes. In addition, strategies and skills include teamwork, values, individual skills such as respect, trust and professionalism, incentives, and a positive work environment. The expected results of behaviour changes are a bully-free environment with lowered stress, an increased sense of belonging, career progression, employee retention, a harmonised work environment, as well as professional development.
CHAPTER 7 – CONCEPT ANALYSIS AND MODEL DEVELOPMENT

7.1 INTRODUCTION

The aim of this study was to develop a model for the management of workplace bullying between nurses in a private hospital group context. A research method based on the theory development process described by Walker and Avant (2011:157-175) and Chinn and Kramer (2008:220-235) was followed. Concept analysis and the data interpretation recorded in Chapter 6 were used to develop a workplace bullying management model. The constructed model is described in this chapter. The chapter describes the development of the model, its purpose and goals as well as the components of the model. Also described is the evaluation of the model that lead to finalised description of the model.

7.2 DEVELOPMENT OF THE WORKPLACE BULLYING MODEL

The model was developed and described by shaping and contextualising theory (Chinn & Kramer 2008:300). The description of the model includes the following (Chinn & Kramer, 2008:220-235; Walker & Avant, 2011:157-175):

- Purpose of the model
- Goals of the model
- Concepts of the model
- Assumptions of the model
- Evaluation of the model
- Description of the model
- Definition of workplace bullying management

7.2.1 Purpose of the model

The model developed by the researcher should be implemented in nurses’ working environment in a private hospital group to reduce bullying behaviours among the nurses for the following reasons:

- The model will serve the purpose of giving strategies for managing workplace bullying behaviours, as well as giving the best strategies to be adopted by management and nurse employees in handling workplace conflict and bullying behaviours.
• The model will serve as a motivator for behaviour change.
• The model will serve the purpose of creating awareness, educating and improving nurses' knowledge of workplace bullying behaviours and its management.
• The model will serve as guidance for nurse leaders in management roles when they are developing workplace bullying management policies and codes of conduct.
• The nurse leaders, as well as individual nurses will have an opportunity to identify the types and causes of various workplace bullying behaviours.
• The model also adds to the literature and the body of knowledge in the research field. Although the context of this research was private healthcare, the model is not restricted to the nurse management field only but can also influence various fields that encounter workplace bullying (research transferability). Researchers interested in studying workplace bullying behaviours in other research fields will have the opportunity to access literature to advance their knowledge of the management of workplace bullying behaviours.
• The model depicts the implementation of organisational and personal actions in solving a real-life issue. A skill such as effective communication is essential in solving the problem of workplace bullying.

7.2.2 Goals of the model

The need for a model with which to address the management of workplace bullying in a private hospital group in South Africa arose from the researcher's personal experiences as a nursing manager. The researcher witnessed interactions between nurses and had moreover witnessed (and experienced) the effect of bullying on the target, the organisation, the day-to-day activities of nursing care and the nursing profession. The findings of this study described in Chapters 4 to 6 serves to confirm the assumption that workplace bullying is extremely complex and it contains many elements that should be addressed to facilitate change in the current negative culture.

The objective of Phase 3 of this study was to develop a model that would assist nurses in the management of workplace bullying. The model further serves to guide managers and leaders through the actions to take when addressing the phenomenon. It can lead to a change in negative behaviour and ensure a positive workplace environment. The model will further help individual nurses and managers to understand how their contribution can improve the nature of the nursing environment. Clarification of the concepts in the model will lead to an operational definition of workplace bullying management that add to the existing nursing theory.
The goal of developing the model was to identify strategies for managing workplace bullying in a private healthcare group in South Africa. The development of the model serves to:

- Enable nurses to change their behaviour and reduce occurrences of bullying.
- Advocate for a suitable working environment which encourages positive relationships between nurses as professional colleagues and management. The model was developed to raise awareness of the need to create a bully-free working environment in the nursing profession.
- Achieve the lessening of bullying through raising awareness, the implementation of anti-bullying policies in the workplace, using supportive leadership styles, improving communication skills, negotiation and counselling, and encouraging active management of workplace bullying.
- Encourage cohesion and positive interpersonal relationships within the organisation.
- Create awareness of bullying behaviour and how to address the issue.
- Introduce methods of reporting bullying behaviour and coping with the effects of bullying.
- Familiarise nurses with different methods of responding: by reporting bullying behaviour to the management or dealing with the behaviour in a professional manner.
- Enable leadership to understand their role in managing workplace behaviours, to be change agents in ensuring bullying behaviour is eradicated from the workplace environment.
- Enable leadership to measure behaviour change by using the motivators.
- Encourage a framework of learning positive behaviour in nurses’ working environment.

7.2.3 Concepts of the model

Concepts are the building blocks that provide the emphasis and meaning of a model (Chinn & Kramer 2008:178). The concepts of the model were formed during the integration of phases 1 and 2 of the research findings (note Chapter 6).

The main concept of the study was workplace bullying management and it will be defined as an empirical referent after the development of the model; as the last step of model description (note section 7.2.6.4).
7.2.3.1 The hospital workplace

A hospital is defined in the Concise Oxford English Dictionary (2006) as an “institution providing medical and surgical treatment and nursing care for sick or injured”.

A hospital consists of various departments that perform different functions such as nursing. It can be divided into three large components in the South African context namely, clinical care areas, administrative areas and education and training. Nurses spend considerable time during a week between the walls of a hospital. During this time nurses interact on numerous occasions with each other and various interdisciplinary team members to coordinate patient care and to perform nursing tasks. The nurses should feel comfortable to perform the tasks at hand.

For the purpose of this study, a hospital is viewed as the structure wherein nurses provide patient care. It is therefore the workplace of nurses regardless of the department the type of nursing care that is performed. Figure 7.1 depicts the hospital workplace as a concept of the model.

Figure 7.1: The hospital workplace
7.2.3.2 Bully and target

Caponecchia and Wyatt (2011:53) define a bully as a person using bullying behaviours - with a power gradient evident between peers, upwards to a senior or downwards to a junior in the organisation. A bully can be categorised according to the behaviour displayed e.g. gossiping or the personality traits of the individual such as competitive or power hunger (Leighton, 2001:99). For the purpose of this study a bully is the person that performs actions that is negative in nature and that can be interpreted as hurtful by another person or target.

A target is also defined as a ‘victim’ “who has been harmed through some form of injustice” and who is vulnerable (Davis & Snyman, 2012:213, 353). A target is further defined as the recipient of bullying behaviour.

There is an interrelationship between bully and target. A bully needs a target to bully and a target can only be bullied by one or more bullies. However, a person (nurse) can be a bully in a given situation with another nurse, but can also be a target of bullying from another individual (nurse). Figure 7.2 represents the bully and target as a concept of the model.

![Figure 7.2: The interrelationship between bully and target](image)

7.2.3.3 Trends in bullying

Becher (2012:210) indicates that workplace bullying is understood as privately or publicly demeaning another person. Kassem (2015:25) indicates that workplace bullying is understood as causing harm or injury towards an individual. In a nursing context, it is understood as the act of causing aggression or harm towards a nurse in the nursing working environment.
The behaviours associated with the act of bullying are intentional or unintentional with an aim of causing harm, physical damage or emotional and psychological distress to the target (Cunniff & Mostert, 2012:3). The bullies may be encouraged by other people or managers who condone bullying behaviour: it portrays the message that such behaviour is acceptable and therefore contributes to the rise in bullying activities. The people that support bullying behaviours isolate the targets which gives the bully an opportunity to extend or operate his/her influence. Figure 7.3 represents identified trends that need to be addressed to curb workplace bullying.

Figure 7.3: Trends in bullying

7.2.3.3.1 Senior colleagues as bullies

Workplace bullying can occur between peers, colleagues, management or lower nursing categories. Workplace bullying is defined in several contexts of incivility, horizontal violence, harassment, mobbing, relational aggression as well as interpersonal conflict (Kassem 2015:25). Bullying is also identified as the existences of differences in power or conflict. Figure 7.3 represents the main trends of workplace bullying identified in this study.

Senior employees (higher ranking or extended employment) “formulate and articulate an organisational vision and organisational values, which influence the behaviour and feelings of the organisation’s members…” (Bergh & Theron, 2019:212). If senior colleagues act as the bullies through their “values, beliefs and habits” as shown in the trends identified in the research data (section 6.4.1) it will lead to the continuation of a bullying culture in nursing (Bergh & Theron, 2019:200).
7.2.3.3.2 Psychological bullying as common form

Psychological bullying behaviour leads to emotional trauma in the target (Meyer & Kirsten, 2014:1). Bullying is a form of hurtful behaviour towards a colleague regardless of the direction of bullying (horizontal or lateral) through attitudes, actions and words (Becher 2012:210). Nurses reported several cases of workplace bullying causing distress that contain fear, increased stress levels, anxiety, depression, hurt as well as low self-esteem (section 6.4.1). The workplace bullying behaviours reported on in the study included gossiping, eye rolling, isolating or ignoring another person, unreasonable silence, public humiliation as well as undermining efforts (Becher 2012:210). For this study bullying is understood as showing and directing harmful behaviours from nurse to nurse and psychological bullying was seen as any negative behaviour that cause emotional distress or bodily symptoms of distress.

7.2.3.3.3 Stress as cause of bullying

Merriam-Webster’s Learner’s Dictionary (2016:sv “stress”) define stress as a “physical, chemical, or emotional factor that causes bodily or mental tension”. Stress is seen as the consequence of the difference between a nurse’s expectation of the job and the actual job role due to a lack of job control that can lead to bullying and burnout (Chang & Hancock, 2003:155).

Stress is the reaction towards bullying, in this study stress was the result of bullying behaviour such as gossip, work load and the delegation of duties outside the nurse’s scope of practice (section 4.6.1). These are uncaring behaviour and against the job expectations of many nurses. Stress can also originate outside the work environment, such as at home or in society, and brought into the work environment.

The relationship between nursing employees is affected and alters when stress is present. Since bullying is also a source of stress it will further increase bullying in the workplace. In addition, stress is attributed to an unsuitable working environment. Stress is among the factors that contribute to low work performance, as well as engagement in unethical behaviours such as bullying. El Rahman (2014:16) indicates that stress in the workplace is caused by work pressure.
7.2.3.4 Managing bullying

Management is the process of managing people according to the *Concise Oxford English Dictionary* (2006). Managing bullying is the activities performed by managers or leaders to reduce bullying behaviour and the consequences of bullying. Management of bullying is seen as the foundational actions that should take place in the hospital environment. Figure 7.4 represents the management of workplace bullying actions needed to ensure a change in bullying behaviour.

![Managing Bullying Strategies](image)

**Figure 7.4: Managing bullying strategies**

7.2.3.4.1 Reporting of bullies

Reporting is to give a “spoken or written account of something” as defined in the *Concise Oxford English Dictionary* (2006). Formal reporting is the writing of incident reports however, bullying is an experience of behaviour that the target is subjected to and it is at times difficult to put in writing. Informal reporting should also be considered and acted upon. Incidents that are reported should be kept on record to identify trends and to adjust management actions.

Reporting is also a form of communication between the target and another person or a bystander (witness to bullying behaviour). Reporting should be taken seriously and should lead to an investigation of the allegation. In this study the nurses indicated that they do not report bullying because “nothing gets done”. This demotivate them to report bullying behaviour in future and the scope of the problem can therefore be underestimated in the hospital environment.
7.2.3.4.2 Bullying management policies

Branch et al. (2013:289) indicates that management’s role is creating a bully free environment by developing policies and rules.

A policy is a guide that indicates the whom, what, where, when and how to address bullying in the workplace. The nurses were clear that there is a need for policies but that the policy should be used as a reference tool to address the full spectrum of bullying. This should be the identification of bullying behaviour, the creating of awareness to colleagues, ways to report it and options to address it.

7.2.3.4.3 Actions against bullying

Action mean to do something. After witnessing or receiving a report of bullying action should be taken to investigate and address the issue. Feedback should be given to the reporter on the process and progress. This will ensure that the reporter knows what action was taken and learns from the situation but also feel that is was “worth it” to report it. However, previous research has shown that ignoring bullies is an act of cowardice which condones the bullying behaviour and so it is not recommended (Etienne, 2014:10).

Actions against bullying would include any activity performed to protect targets and potential targets as well as the immediate reaction to the bullying behaviour. Action against bullying is not only the responsibility of the managers but every individual nurse must do introspection on his/her own behaviour. Witnesses to bullying behaviour must address the bully and/or to report the behaviour.

7.2.3.4.4 Leadership style

Leadership as understood by Ali (2012:73-74) and Sharma and Jain (2013:310) is the ability to influence a group towards the realisation of defined objectives. Leadership entails guiding and directing a group of people. It depicts the ability of an individual to lead and control. In addition, leaders guide or rule other people. Leaders facilitate growth and learning. Leadership entails knowledge and skills and entails; followers, communication, leaders and situations. In addition, leadership is employed in the hospital environment to create harmony and improve the behaviours of nurses. Leadership has been extensively used in the study to describe its effectiveness in handling bullying behaviours.

Moreover, leadership styles are types of leaderships employed to influence performance and change in different situations (Sthuraman & Suresh, 2014). Leadership styles affect employee performance, working environment and individual worker behaviour. Leadership style is the
tool used by leaders to influence change or improvement. Certain leadership styles are associated with improved abilities to reduce bullying behaviours. Authentic, supportive, transformational and democratic leadership styles encourage teamwork, positive workplace environments and integrity in handling workplace bullying behaviours.

On the other hand, an autocratic leadership style (Shahbazi et al., 2013:1815) and disruptive leadership styles (Lavoie-Trembaly et al., 2016:584) are associated with increased bullying behaviours in nurses’ working environments. Disruptive leadership is associated with narcissism characteristics. Moreover, Krasikova, Green and LeBreton (2013:1311) describes destructive leadership style associated with abusive leadership as abuse of power, which contributes to harmful behaviours such as bullying. Leader and management support are considered as a transformative element which encourages management of bullying behaviours. Leadership styles are considered as change agents in encouraging management of workplace bullying behaviours. The leadership styles and support from management enables the nurses to change their behaviours.

From the research study, leaders were considered as the change agents of various behaviours. Leaders contribute greatly to the development of safe, positive and encouraging work environment. The leaders empower the employees of an organisation by guiding, mentoring, coaching and counselling the nurses. More importantly, the leaders and management create awareness in managing workplace bullying behaviours and role modelling the appropriate behaviour.

7.2.3.4.5 Negotiation and counselling

Negotiation is to create win-win situations between two or more parties. In this study the manager should be the mediator in the negotiation discussions between the bully and the target with the aim to address the bullying behaviour and the target’s expectation. Never in this process should the bully think that the bullying behaviour will be overlooked. Usually before negotiation happens, an investigation should be conducted but since it is difficult to conduct the investigation without the two parties knowing about it, the negotiation should be part of the investigative process.

Counselling should be offered to both the target and the bully. The bully needs to find ways to change behaviour and/or the causing factors of the bullying (such as stress). Nyasha et al. (2013:74) indicate that stress is managed through counselling. Targets need counselling to learn skills of assertiveness, crucial confrontation techniques as well as coping strategies with
the after effects of the bullying. It is known that targets can suffer from symptoms similar to post traumatic stress syndrome.

7.2.3.4.6 Awareness creation

Georgakopoulos (2011:1) and Nyasha et al. (2013:74) indicate that a healthy working environment is constituted of counselling and awareness. The management raises awareness against bullying behaviours in working environment. Awareness is to create mindfulness to facts or situations. The nurses in the study indicate that they need to know what is considered bullying and what is not, when and how to report it and what will be the consequences of bullying behaviour to themselves and the bully. Awareness and the anti-bullying policy and code of conduct should support each other. Awareness should not be seen as a stand alone action but as actions that are followed through by all parties to have a positive outcome.

7.2.3.4.7 Communication skills

Poor communication contributes to conflict and workplace bullying behaviours (Kim, Nicotera & McNulty, 2015:2075). On the other hand, efficient communication contributes to the sharing of information between management and the nursing workforce.

Communication as a concept during the model development processes constituted the effectiveness of reporting workplace bullying behaviours, responses to bullying and feedback from supervisors and management. Communication consists of verbal and non-verbal methods that includes listening skills. The verbal and non-verbal communication played a vital role in managing of workplace bullying behaviours by ensuring that there is positive interaction between supervisors and nurses. The study shows that effective dealing with bullying behaviours through confrontation, negotiation and mutual understanding is facilitated through communication. Communication was used in every aspect of the model to influence behaviour change. The process of ensuring correct information is conveyed, easy decision-making processes and effective dealing with conflict is facilitated by effective use of communication. Poor communication contributes to workplace bullying behaviours (Omiseore & Abiodun, 2014:119). Communication contributes to both prevalence and management of workplace bullying (El-Houfey et al., 2015:7). Effective communication through positive feedback constitutes to management of workplace bullying behaviours (Clarke, 2012:275).
Measuring prevalence

Measuring means determining the “size, amount or degree of something by comparison with a standard unit” according to the *Concise Oxford English Dictionary* (2006). Prevalence is the frequency at which workplace bullying is occurring. Measurement of workplace bullying behaviour would need an instrument to standardise measurements that can inform the managers if management actions were successful. According to The Institute for Health Improvement (2016), all changes lead to improvement and all improvement requires change. To improve something, you need to know what the current situation is, to make a change and to measure the effect and adjust. The plan-do-change-act cycle promoted by the Institute for Health Improvement (2016) advocate regular measuring to assist in changing workplace bullying prevalence. Measurement will inform success or failure in improvement and will trigger another change a cycle for improvement. Measuring prevalence is therefore a vital step in the management of workplace bullying.

7.2.3.5 Behaviour change

Behaviour change is the expected outcome of this model. The workplace environment should change from a negative bullying environment to a positive bully free environment. In line with the Influencer Model (Patterson *et.al.*, 2008) that require that at least six of the sources of influence should be utilise to set change in motion and to make the change sustainable, it is suggested that four of the six sources of influence should be addressed. The six sources were divided into abilities and motivation. Under each of these two categories there are three categories namely individual, team and organisation. The six sources need a strong drive to succeed and that will need a core set of values (section 7.2.3.5.1) acceptable to the group to change their behaviour. To make the change sustainable the behaviour change should be measured as were discussed in section 7.2.3.4.8. measuring prevalence.

The set of values discussed below is therefore a precursor of the actions that should be taken to ensure change. Teamwork, suitable workplace environment, support and implementation of leadership styles is facilitated through efficient application of communication. Figure 7.5 represents the constructs that will enable the behaviour change.
Figure 7.5: Behaviour change motivators

7.2.3.5.1 Values

The values are morals and ethics that depict the occurrence of certain behaviours. Values were considered a significant element in the model. Understanding the value concept is important to help understand codes of ethics that guide management of workplace bullying behaviours. Values contribute to creating a safe working environment. The nurses identified values relevant to nurses in managing bullying behaviours such as respect and trust among nurses and team members.

Respect was considered as the main ethical value needed in managing workplace bullying behaviours. Respect was considered as due regard for other people’s opinions and feelings and treating people accordingly. Nurses are required to respect other people’s feelings. In addition, self-respect contributes to respect of other people. Respect according to the hierarchy in the nursing environment is important in managing of workplace bullying behaviours. Respecting other people’s privacy and confidentiality of information which promotes harmony significantly manages bullying. Cooper et al. (2011:14) observed that respect and caring values greatly contribute to the management of workplace bullying. Respect is also enhanced by the presence of policies employees can adhere to. Respect between senior leaders and nurses in a working environment enhance effective prevention of
workplace bullying behaviours (Ling et al., 2014:13). Respect in teams contributes to collaboration among nurses leading to achievement of desirable results (Lachman, 2015:40).

Trust enables nurses to unite in achieving desirable results (Lachman 2015:40). The nurses described trust in working environment to be important in managing bullying behaviours. Trust entails the dependability, reliability, worthiness and effectiveness of a person. Trust contributes to finding solutions in the workplace as people are able to engage in negotiations and coach each other accordingly. Trust indicates the approachability of an individual where problems and ideas are shared among members. Openness, open mindedness and friendliness as elements of trust contribute to efficiency in solving problems. Accommodating individuals are less likely to practice bullying behaviours. Granstra (2015:255) observed that trust encourages problem solving behaviours. Nurse leaders must show trusting behaviours in order to enhance suitable environment for managing workplace bullying behaviours.

The research study pointed out the relevance of trust and respect in managing workplace bullying behaviours. The positive behaviours in the workplace environment arise from the aspects of exercising trust and respect where individuals were expected to have self-respect, respect for one another and respecting their superiors. The research study indicated trust resulted from openness and that trusting of an individual contributed to respect. A positive environment comprised of honesty, openness and addressing issues in a friendly manner; which illustrates the importance of trust. Trust and respect as values in the workplace contributes to teamwork as a strategy of addressing workplace challenges. Mutual respect among seniors and juniors contributed to harmony and a safe working environment. Confidentiality and respect for other people’s privacy encouraged mutual trust. Ethical behaviours such as trust and respect contribute positively to collaboration and decision making and result in positive outcomes (Lachman 2015:40).

Trust and respect are evident in codes of ethics in organisations and define relationship building and guide harmonized working environments. The purposes of trust and respect as pointed out by the research study is to enhance mutual understanding, collaboration in the workplace and to create a safe working environment free of bullying. Strong relationships between management and staff members as well as among nurses themselves were contributed to the existence of trust and respect. The nurses are able to maintain confidentiality of colleagues’ information as result of integrating trust and respect. The nursing management supports and respect within the work environment by coaching and providing codes of conduct that prompt the nurses to respect and trust one another (Smith & Kelloway, 2016:398-399). Respect and trust as ethical behaviours aid the decision-making process in dealing with workplace bullying behaviours (Lachman, 2015:40).
Trust and respect are often influenced by the presence of policies and codes of ethic. The management acts as a role model to the other nurses by enhancing respect and trust in the workplace. The nurses follow the example of the management by engaging in respectful and positive behaviours that contributes to the management of workplace bullying behaviours. Experiences associated with trust and respect influence the working relationships and working ethics created to guide discipline in the workplace. The research study showed positive behaviours and understanding contributes to trust and respect. The consequences of trust and respect are increased harmonised working environments, teamwork in the decision-making process and positive relationships. Trust between individuals and group of people contributes to efficiency problem solving (Granstra, 2015:255). Harmonised and safe working environment were as result of increased respect in the workplace environment (Cooper et al., 2011:14).

7.2.3.5.2 Skills

The first source of influence refers to the individual's abilities. According to Berry, Gillespie, Gates and Schafer (2012:81), the target of workplace bullying "has difficulty defending against the negative acts of workplace bullying, which creates a power imbalance between the target and bully. Nurses are in a unique, powerless position. They are unprepared to respond to workplace bullying, increasing an already stressful situation. Berry and colleagues (2012:81), point out that one specifically vulnerable population, novice nurses, may be at a higher risk of becoming targets of workplace bullying. Being newcomers and novices make them highly dependent upon senior nurses to mentor and integrate them into the workplace, while also rendering them an easy target for lashing out and expressing frustration. Thus, one action point could be to provide novice nurses with interpersonal skills that will help them prevent new bullying or cope with and mitigate existing bullying.

This study discovered that other than work environment and management intervention, individuals also play a significant role in helping to manage workplace bullying. Individual skills are considered as a key element in the model development to encourage management of workplace bullying. Individual nurses are the main contributors to workplace bullying due to the different levels of interactions that exists between them and their colleagues as well as the leaders. The qualitative study conducted provides numerous insights into the imperative skills needed to encourage prevention of workplace bullying. The skills identified include communication skills, problem solving skills, conflict management skills, professionalism and emotional maturity.
Nurses are required to have problem solving skills and should not depend on the managers to help them deal with conflict. Managing conflict individually is a key step in preventing workplace bullying. Granstra (2015:255) believe that managers are responsible for educating employees about problem solving through mentorship programs. Problem solving contributes to a safe environment and the results are reduced bullying behaviours. Nurses are also required to have emotional maturity in order to handle workplace bullying behaviours. Nurses in the study indicated that emotional maturity is related to the emotional intelligence of the individual. Laschinger et al. (2014:5) observed that nurses must have emotional intelligence to have the capability of handling workplace bullying behaviours. Danarson et al., (2014:168) illustrated emotional intelligence as a peaceful methodology for handling conflict. Acting professionally by demonstrating integrity and professional judgement when handling conflict contributes to handling workplace bullying behaviours. Killoren (2014:8) indicates that nurses act professionally by giving recommendations on what can be done.

7.2.3.5.3 Support

Within the social motivation realm, support for bullying in the workplace can be either explicit or implicit. Some workers may share the bully's sentiments, while others remain witnesses and contribute to the bullying through silence. By refraining from intervention on behalf of the target, other staff members contribute to the bullying and in fact support it, even if not actively (Parzefall, & Salin, 2010:761). Thus, a model combating workplace bullying must influence peers, other staff members and managers, encouraging them to prevent and intervene in workplace bullying when they see it.

Support requires managerial intervention to encourage nurses in an organisation to perform activities diligently. Managers provide support to nurses through professional development, training, coaching and counselling programs. Support has been considered as a motivator to encourage nurses to solve their problems in an efficient manner. Support through positive feedback encourages nurses. Support entails guidance from the management as the majority of nurses are unsure of the correct methods to solve bullying behaviours. Newly employed and novice nurses are required to be provided with support and guidance from both the management and their peers which enables them deal with workplace bullying behaviours (Wing et al. 2015:633).

Support in the work environment involves the provision of emotional support and professional development support which is enhanced by both the management and colleagues (Granstra 2015:255; Gaffney 2012:2). Educational support, provision of coping skills, management of stress as well as an increase of morale encourages the management of workplace bullying
Support in the management of workplace bullying is associated with the leadership style used. Supportive leadership styles such as authentic, democratic and transformational leadership focus on the welfare of employees and involve engagement of employees' activities. Moreover, support is evident from encouraging and motivating employees towards a shared vision and a common goal evident from the supportive leadership styles (Shahbazi et al., 2013:1815).

Support is extensively used in the study to show its effectiveness in managing workplace bullying behaviours. The concept of support is imperative in the model development as it is emphasized greatly in the study. Support has been understood as providing professional development to nurses as well as helping nurses deal with workplace challenges such as conflict and bullying. The study's nurses observe support as protecting novice nurses in the work environment from exploitation by senior nurses and nurse leaders due to the existence of rankism and power expatriation. Support consists of conducting activities such as coaching, training and mentoring to empower nurses. The study's nurses perceive support to be provided by the management who plays the biggest role in this regard. However, support has been defined as giving encouragement to people or something. In addition, support entails giving emotional support. Support is given to individuals in order to enhance success of the change being carried out.

According to Lesakova (2012:86), support is identified as providing help or assistance to something or someone with the purpose of encouraging success. Support in a leadership context has been understood as engaging nurses in professional development through educating the nurses as well as increasing their level of education. In addition, support has been understood as ensuring nurses have engaged in moral behaviours as well as peaceful interactions with clinicians within the nursing environment (Henderson, Briggs, Schoonbeek & Patterson, 2011). It is important to support nurses in order to prepare them to enhance peaceful interaction with other nurses in the clinical setting. Support is understood to be crucial in enabling nurses to engage in ethical nursing care as well as enabling nurses to maintain strong relationships as well as engage in teamwork.

The attributes associated with support include the work environment. The work environment provides support to nurses, who in turn provide better patient healthcare. A supporting work environment is constituted to entail training, mentoring and coaching of nurses. In addition, study respondents indicated that a supportive work environment should be free from noises in order to practise better and competent healthcare. Berry et al. (2016) indicated that support for nurses is provided in terms of coaching and counselling of nurses. The nurses are counselled to maintain respectable workplace behaviours. Coaching of nurses is conducted.
to enable nurses improve their communication skills. Increased communication skills contribute to dissemination of information and minimize occurrences of conflicts. Schoonbeek and Handerson (2011:44) indicate that support encourages most nurses to engage in teamwork. Team cohesion which is facilitated by a safe work environment facilitates sharing of information as well as learning. Nurses use teamwork strategies to teach one another about efficient strategies of maintaining harmony. As a result, manageable workplace behaviours are encouraged. Support is also based on the skills and attitude of management. The management is the key factor in providing support. The management provides support to the nurse workforce in a number of ways including; professional development, protection against bullying as well as mentoring strategies of dealing with conflicts. The management supports nurse welfare by providing policies that favour their freedom. Nurse management provides anti-bully policies which contribute to a work environment free of unethical conducts (Purpora & Blegen, 2012:2). The anti-bullying policies should favour especially the newcomers. Newcomers are exposed to bullying due to their inexperience in the working environment or hospital setting. Providing nurses with stress management skills will enable them to concentrate on their tasks. In addition, stress relieving will increase nurses’ sense of belonging. Stress management through the creation of a suitable working environment contributes to the management of conflict. In addition, it contributes to handling of bullying behaviours (Schoonbeek & Handerson, 2011:45-46).

The antecedents associated with support include the existence of conflict, unethical behaviour as well as stress. Existence of conflict requires problem solving strategies which are provided in the form of mentoring. Conflict in organisations arises due to ranks, power distance and educational differences. Granstra (2015:252) and Stelmaschuk (2010) indicate that conflict and unethical behaviour arise due to the presence of hierarchy systems in working environments. Nurses at high ranking levels exploit nurses at low ranking levels due to their positions of superiority and authority (Stelmaschuk, 2010). In addition, nurses with low ranking levels are associated with having low levels of self-esteem and poor group identity (Stelmaschuk, 2010). The most disadvantaged nurses are new nurses who enrol in work environments. Due to their levels of inexperience, they are bullied extensively. In addition, nurses of young age are often bullied. Conflict arise due to poor communication. Poor communication contributes to the misinterpretation of information. According to Omisore and Abiodun (2014:119), poor communication results in conflict. Conflict in the workplace are inevitable. Conflict require the best strategy to help overcome it. However, poor communication contributes to destructive conflict. Destructive conflict is characterised by competing individual interests (Omisore & Abiodun 2014:124). Conflicts in organisations are caused due to scarce resources. Everyone strives to acquire the resources in order to achieve
their own goals which contribute to conflict. In addition, goal differences among employees as well as organisational departments contribute to conflict. Authority relationships the majority of which are associated with managerial employee relationships contributes to conflict (Omisore & Abiodun 2014:127).

The consequences associated with support are the existence of healthy relationships among nurses. In addition, support results in an improved working environment, a stress free working environment, reduced conflict and the achievement of organisational and personal goals. Support provided by management contributes to improved nurse retention in the workplace. Francis (2014:7) indicates that support in the workplace contributes to reduced workplace bullying behaviours. Support offered through training and mentoring results in reduced conflict. Moreover, nurses are equipped with problem solving and management strategies.

Georgakopoulos et al. (2011:6) indicated that support in any organisation environment ensures that the needs of every employee are addressed. Shahbazi et al. (2013:1815) indicated that support originating from the employed leadership style contributes to positive organisational outcomes, organisational commitment and employee well-being. Supportive leadership results in improved nurse’s self-awareness, skills, knowledge and competence. The nurses also added that support contributes to career development and professional learning. Support results in reduced nurse turnover. Moreover, new nurses are able to interact freely with other experienced nurses (Wing et al. 2015:633).

7.2.3.5.4 Work environment

The working environment was considered an organisational change that is needed to manage workplace bullying behaviours. Working environment contributes greatly in the management of workplace bullying as indicated by the study’s nurses and information retrieved from literature sources (Berry et al., 2016; Kelloway, 2016:398; Wing et al., 2015:633). The nurses described the changes required in the work environment to prevent workplace bullying. The work environment had elements such as rankism and power challenges which contributed to the spread of bullying behaviours; the need for changing management and leadership style and the interventions required on changing workplace behaviour. Nurses stated that rankism, hierarchy and power contribute to workplace bullying when misused. Power misuse in the work environment constitutes of the seniors oppressing their juniors (Granstra, 2015:252). Seniors misuse rules and processes. In addition, treating workers unfairly is considered as power misuse which contributes to workplace bullying. In addition, the nurses face bullying in the work environment where the nurses are ordered to conduct duties not in their scope of practice. Interventions developed to create a healthy working environment and to manage
workplace bullying behaviours were described by the study’s nurses. Healthy working environments characterised by calmness and quietness facilitate the management of workplace bullying. The ideal working environment has rules, policies, procedures, fun and fairness. The working environment as described by nurses consist of people, an organisational atmosphere and has organisational rules. The team development consists of the working environment and the behaviours adopted by every member which in the working environment affects the operations of the organisation. Management of workplace bullying was facilitated by the existence of a stress-free environment, policies protecting employee rights, counselling and counselling, training as well as management intervention.

The nurses in the study strongly believed that management and senior staff members are required to make interventions to prevent workplace bullying. Support in the working environment contributes to management of workplace bullying. In addition, several studies evaluated the relevance of the working environment in managing workplace bullying behaviours. The study conducted by Wing et al. (2015:633) indicates that negative working environments described by negative peer relationships contributes to bullying behaviours in the workplace environment. Positive work environment was described as an environment that encourages empowering of employees through counselling, professional development and positive feedback. Granstra (2015:255) described an ideal working environment that encourages mentorship and free interaction among staff members. In addition, a working environment that encourages workers’ professional development has minimal chances of occurrences of bullying behaviours. Ceravolo et al. (2012:601) indicates that communication and team building skills creates a safe working environment whereby the communication of rules and policies effectively contributes to the reduction of bullying behaviours. Ling (2014:13) and Berry et al. (2016) indicates safe environment constituted of respect among nurses that is encourage by senior leadership. The leaders encourage organisational commitment and adherence to rules. Respect also encourages teamwork among members. It is important to change the negative hospital work environment to a positive work environment by means of behavioural change.
Motivation

Bullying is the result of many factors, one of them is the bully's motivation for engaging in bullying. Some bullies are well aware of their aggression towards the target, while others are unaware and perhaps do not even have the intention to harm another. One of the most prominent examples of unintentional bullying is between managers and their subordinates (Hutchinson & Jackson, 2013:11).

The reinforcement of positive behaviour as identified in the study, entailed the organisation motivation accrued with increased motivation to manage workplace bullying behaviours. Motivation in the workplace is facilitated by the leader’s approachability, openness in the working environment as well as the employee’s sense of belonging. The feeling of belonging to a team or a group motivates nurses to deal with workplace bullying behaviours. There is a positive relationship between a sense of belonging and ownership with positive attitudes and workplace behaviours (Avey et al., 2012:21). Houghton (2014:2370) indicates that socialising arising from a sense of belonging through mentorship, coaching and training contributes to a positive work environment that encourages a reduction in bullying behaviours.

In addition, Sebok and Rudolph (2010:25) indicate that emphatic, approachable and friendly leaders are able to deal with bullying behaviours. Prewitt et al. (2011:17) indicate that approachable and friendly leaders are observed to be good listeners who develop strong and good relationships with employees. This gives them the opportunity to deal with workplace bullying behaviours (Derue et al., 2011:17). Accurate and timely feedback helps in times of appraisal crisis where supervisors are able to deal with challenges. Approachable leaders emphasize an organisational culture and environment that encourages change and innovation (Katsaros et al., 2014:37). Motivators to behavioural change are considered as modifiers of change behaviour in the work environment. The motivators illustrate extra values and skills required in nurses in order to have respectable behaviours.

Leadership is defined as influencing a group of people towards the accomplishment of objectives and ensures that operations in an organisation run smoothly. The leader influences other people to achieve a common goal. Leadership entails the implementation of knowledge and skills to influence behaviours in a group of people (Sharma & Jain 2013:310). Prewitt et al. (2011:13) defined leadership as the process of influencing others by setting an example. Setting an example towards a group of people motivates them to pursue goals that benefit an organisation. Leadership takes the responsibility of defining the vision of an organisation, identifying strategies to achieve the vision as well as implementation that entail communication of the vision. Leaders are required to possess different skills, knowledge, talent and abilities.
Leadership is applicable in different fields such as business, academics, politics and it depicts a person’s ability. Leadership entails the process of empowering and inspiring staff members in an organisation to achieve common goals. Leadership focuses on addressing employee needs as well staff growth and development (Obiwuru, Okwu, Akpa & Nwankwere 2011:101) that in turn motivate nurses.

7.2.3.5.6 Teamwork

Teamwork refers to the entire staff’s ability to work together in preventing bullying and dealing with the bully (Hogh, Mikkelsen & Hansen, 2011:107). An action point in this context would include team-building activities, empowering staff to work together and appreciate one another.

Teamwork was considered an essential and key element in encouraging management of bullying behaviours in work place environment. The building block of communication between a nurse and colleagues as well communication with the management was strongly facilitated through teamwork. The crucial element in behavioural change is teamwork as it enables the development of the social ability for overcoming the necessary negative behaviours within the work environment. It also facilitates peer pressure to change behaviour. The information obtained from the study’s nurses was used to depict the relevance of teamwork in managing workplace bullying behaviours. The model development process considered teamwork as a change behaviour implemented by both the nurses and nurse leaders to manage workplace bullying behaviours. Information extracted from the nurses revealed that teamwork was not related to the management’s responsibilities in handling workplace bullying. However, the information extracted from participants’ responses described teamwork as a crucial element in management of workplace bullying. Information revealed that teamwork is created in the nursing environment to assist in dealing with challenges rather than criticising one another. The nurses described effective teamwork to be facilitated by effective communication among the members. In addition, teamwork was essential to provide the best patient care. The members in the team are expected to show trust and respect.

Most studies reported that nurse managers and nurse leaders are in the frontline of initiating teambuilding and teamwork to enhance management of workplace bullying. Desirable behaviours are achieved in the nurse workplace environment when equality and fairness is exercised in teams. Nurses indicated that every individual in a team has the right to provide opinions and the members should respect each and every member’s opinion. Teamwork contributes to healthy working relationships whereby managers are required to initiate teamwork strategies. Wing et al. (2015:633) indicated that the management responsibly
fosters team building strategies to deal with workplace bullying behaviours. The management creates an opportunity for the workers to interact with one another. Ceravolo et al. (2012:600) also described the importance of teamwork in managing workplace bullying behaviours. Ling et al. (2014:13) indicated that teamwork is essential in organisational culture. Moreover, it is through teamwork that most of the nurses in the industry earn their respect due to improved practice of care. Schoonbeek and Handerson (2011:44) and Berry et al. (2016) pointed out the relevance of teamwork in nursing working environment in facilitating learning and fostering freedom of sharing information for the wellbeing of the surrounding environment. However, leadership is expected to be integrated in teamwork to encourage creativity.

Kelloway (2016:398) indicated that team leaders are considered as change agents by empowering and educating other nurses to manage workplace bullying behaviours.

7.2.4 Assumptions of the model

Assumptions are the basic underlying premises from which and within which theoretical reasoning proceeds. Assumptions are the value statements of this study (Chinn & Kramer, 2011:208-211, 293). The model in this study is based on the assumptions that:

- The context of the model or context that formed the defining attributes of the concept of workplace bullying management are based on data that emerged from Phases 1 and 2 of the research. In other words, this was an inductive study where the theory or model was developed from the availability of data collected through the research process (Ormston, Spencer, Barnard & Snape, 2014:53). It was not a deductive approach where a theory or model was tested by using findings to fit into it.
- To contribute to the achievement of positive results the concept should be linked with the motivators which include values, skills, support, the workplace environment, incentives, and teamwork.
- The motivators are related to the principle of behavioural change. The motivation is based on the rewarding of positive non-bullying behaviours in order to influence behaviour changes. Motivation drives employees towards the achievement of goals and objectives. The employees in an organisation work harder due to the knowledge that effort contributes to higher rewards (Lunenburg, 2011:1).
- Offering motivation is related to the assumption of operational conditioning, which indicates that incentives are needed to relate an unconditional response with another one. Lineros and Hinojosa (2012:3) and Patterson et al., (2008:194) is of opinion that the identification of behaviour either contributes to reward or punishment. Ahmad,
Jehanzeb and Alkelabi (2012:182) indicate that operational conditioning is considered a function of positive behaviour.

- Operant conditioning entails systematic rewards and punishments in order to attain the desired behaviours. Dartey-Baah and Amponsah-Tawiah (2011:14) indicate that operant conditioning contributes to human learning and organisational learning. In certain cases, reinforcement is employed to change bullying behaviours in a specific situation or environment. Operant conditioning focuses on punishing to reduce the occurrence of negative behaviours such as bullying in future, whereas reinforcement increases the occurrence of positive behaviours such as not bullying or supporting the target. However, negative reinforcement contributes to a bullying culture. Reinforcement of negative behaviour explains the workplace relationships, e.g. absenteeism, as well as motivation better (Ahmad et al., 2012:183). Positive behaviour motivation increases the chances of repeating good actions in future (Goodboy, Martin, Knight & Long, 2017:245).

- The motivator of support is also related to the assumption of leader and bystander intervention in dealing with bullying behaviours. Leaders and bystanders are required to intervene regarding the bullying behaviours and the perception that employees perform best when supplied with the needed skills (Astrauskaite, Notelaers, Medisauskaite & Kern, 2015:124). The skills are enhanced through continuous training, provision of resources, responding to employees reporting bullying, intervening by solving problems affecting employee performance and with feedback to the reporters about the actions taken to address the bullying behaviours. Coaching will further increase the competency of an employee, which enables them to address bullying behaviours on their own (Astrauskaite et al., 2015:130). Rewarding employees motivates them to input more effort in the change of behaviours. Based on the research study, employee behaviours require effort from the managers. The managers intervene in employees’ welfare through providing professional development, training, mentoring, counselling (Goodboy et al., 2017:246), as well as role modelling non-bullying behaviours and how appropriate action should be taken against bullies. Nurses will be motivated to focus on important tasks within an organisation, rather than engaging in unethical behaviours. In addition, efforts such as the provision of the right skills (such as communication and teamwork to hold bullies accountable), will encourage the nurses to abandon bullying behaviours. The nurse managers and leaders are the change agents who can motivate nurses to adopt respectable behaviour.
• Elimination of negative behaviour reduces the chances of the behaviour reappearing in future (Erkutlu & Chafra, 2014:56). This shows that the motivator of the work environment is related to the principle of eliminating disruptive behaviours. Francioli, Conway, Hansen, Holten, Grynderup, Persson, Mikkelsen, Costa and Hogh (2018:889) assert that using the right strategies in instilling moral behaviour in an organisation contributes to positive outcomes. Operant conditioning facilitates employees to respond to positive stimuli. The management and leaders intervene by maintaining ethical behaviour in an organisation and by providing coaching, manageable workloads, addressing stressors in the workplace and rewarding programmes such as training and mentoring. In addition, early management of bullying behaviour reduces the chances of observing bullying behaviour in future. Through operant conditioning, policies restricting bullying reduce the occurrence of bullying behaviours.

7.2.5 Evaluation of the model

Chinn & Kramer (2008:234) requires critical reflection of a tentative model, to determine how well the theory is developed or whether it is a fit. The model was submitted for evaluation to experts knowledgeable in nursing education, nursing management, model development and nurses with private hospital experience. These experts were chosen by purposive sampling. The experts were provided with an electronic copy of the description and graphic design of the tentative model (Annexure K) and an evaluation form (Annexure L). They familiarised themselves with the model, clarified uncertainties with the researcher, evaluated the model and then gave written and verbal feedback.

Twelve purposively selected persons were invited to participate and most were experts in more than one relevant field. One person was unable to assist in the evaluation of the model. Nine provided electronic feedback while one bullying expert and one model development expert engaged the researcher in academic discussion. Of the eleven that assisted with the evaluation of the tentative model three completed a masters degree while eight obtained doctoral degrees. All the experts have approximately 20 years of experience in their chosen fields. Nine has an educational background, six are experienced in private hospital management, one has a military hospital background, three are experts in bullying and three are experts in model development. One expert has a human resource and change management background while another has health systems strengthening and policy development as additional fields of expertise. Table 7.1 indicates the fields of expertise, years of experience and highest qualification.
Table 7.1 Biographical profile of expert evaluators

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A combination of six reflective questions proposed by Chinn and Kramer’s (2008:197-205) evaluative criteria was used for the evaluation tool and was in the form of a five-point Likert scale that included the following criteria: Totally agree, agree, unsure, disagree and totally disagree. The evaluators were provided with an option to make suggestions. Table 7.2 depicts the electronic feedback received from the expert evaluators.

Evaluation criteria for the model were (Chinn & Kramer 2008:197-205; Walker & Avant, 2011:195-210):

- Logic
- Clarity, simplicity and consistency
- Level of developments, comprehensiveness
- Adequacy, comprehensiveness
- Applicability, usefulness and practicality
- Importance for research and practice
Table 7.2 Feedback on tentative model received

<table>
<thead>
<tr>
<th>Logical development</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
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<tr>
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<tr>
<td>The stages of model development are explicit</td>
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<td>1</td>
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</thead>
<tbody>
<tr>
<td>The model is easy to understand</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td></td>
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</tr>
<tr>
<td>The definition of the concept is clear</td>
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<tr>
<td>The concepts are used consistently in the description of the model</td>
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<td>Relationship statements are described with clearly supported arguments</td>
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<tr>
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The model create understanding that is important for nursing  

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<tr>
<th></th>
<th>Score</th>
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<tbody>
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<td>The model add value to research in nursing</td>
<td>5</td>
</tr>
<tr>
<td>The model add value to nursing education</td>
<td>6</td>
</tr>
</tbody>
</table>

**Suggestions to improve the model**

Add the context as a background

The diagram of the model is not cluttered – so concepts are easy to find and understand. I made some suggestions re the blue line and the characteristics.

What is the name / title of your model? I think it deserves a unique (descriptive) title.

The model is easy to understand

Suggest more colour to let the concepts stand out

Consider the use of directional arrows that links the motivators for behavioural change to trends in bullying and managing bullying for clarification purposes.

More definite line between motivators and the Managing Bullying “cell”

It is recommended that the heading “Managing Bullying” is moved to the top of the managing cells to improve the understanding of the model

Add directional arrows to guide the flow of the model

The weight of the lines must be increased, very faint and is therefore not clear

The “Managing Bullying” cells arrange to a more practical sequence –

- Awareness
- Management policies
- Action against bullies
- Negotiation and counselling
- Leadership style
- Communication skills

Thank you for digging into this very important and relevant topic. I hope the implementation of this model would really create new awareness of the existence of bullying and that a method for its management will be a turnaround point in nursing and nursing education.

I can relate to the challenges in presenting a model for evaluation. It is very difficult for the reader to conceptualise the content of the model without the background as to the data and how the model originated.
It seems as if the concepts in par 7.2.3.1-7.2.3.6 are main categories or themes? If so, it is suggested that they feature more prominently in the model and as stand-alone “graphics”

You said “Each of the motivators must be linked to the trends in bullying, which is why there is a line connecting the trends in bullying with the motivators”. Graphically this is not very clear.

Under relationship of statements you only address the relationship between leadership and teamwork. What about the rest?

In the beginning of the chapter you described the concepts under motivators ie values, skills etc but not the other concepts under management of bullying and trends in bullying. Is there a reason for this or is it maybe somewhere in another chapter? I suggest, as they form part of the model, that you also describe these concepts.

I see the above in par 7.4 but find it a bit confusing as the concepts and description of the related cases do not correlate with those in the model. I.e. Training and development is discussed but does not feature in the model, whereas policies do feature but are discussed under training and development. It is suggested that, for the sake of the reader, you maintain consistency in your description of the model and what is actually seen in the model.

It is suggested that you make the antecedents and consequences graphically visible in your model.

In Par 7.2.3.1 you refer to workplace skills. Before reading further I immediately thought of technical skills, then you mentioned interpersonal and individual skills. Further on you only refer to “skills”. It is suggested that you remain consistent in the use of the name of the concept and maybe just elaborate on the different skills you refer to.

Nowhere do you refer to the transferability of the model to other contexts.

Lastly, it is suggested that you approach a graphic designer to assist with the layout and detail of the model.

Thank you for the opportunity to evaluate your work. Good luck with the remainder of your studies!

The model easy to understand after reading the details as provided in the chapter.

The evaluation is very subjective and narrow. What could have assisted was to include the Methodology chapter to get a broader picture of the origin of the concept so as to understand the developed model. The diagram could perhaps be improved to show relationships between concepts/statements.
7.2.5.1 Adjustments made to the tentative model

Feedback from these experts was incorporated into the model discussed. Comments included positive responses as well as suggestions for changes. Some expert reviewers referred to the content of the model explanation as well as the schematic representation of the model. In Addendum K is the first model that was send to the experts. The feedback about the evaluation and recommendations for amendments to refine the model was actioned and implemented in the model presented.

7.2.6 Description of the model on management of workplace bullying between nurses of a private hospital group in South Africa

A model consists of organisational components that include concepts, assumptions and relational statements to indicate the association between concepts as well as functional components that refer to descriptions of how to interpret the model (Gray et al., 2016:139) to provide meaning to the concepts (Brink et al., 2012:26).

According to Chinn and Kramer (2008:179), structuring and contextualising the model involve systematic linkages between and among the concepts. In this study, the management of workplace bullying model was constructed, giving form to the relationships among the concepts in the theory using visual shapes, colours, arrows and connecting lines. Figure 7.6 represents trends identified that needs to be addressed to curb workplace bullying.
Figure 7.6: Model for managing workplace bullying
7.2.6.1 Context of the model

The context describes the circumstances or situations in which the theoretical relationships of the model are expected to be empirically relevant and important in terms of implementing the model (Chinn & Kramer 2008:181-182). The use of the model is not restricted to the private hospital group and nurses alone but can be applied to all workplaces that experience workplace bullying. This model is thus transferrable to a wide range of contexts.

7.2.6.2 Structural description of the model

The model consists of the main categories identified during the research study to determine strategies and motivators to change workplace bullying behaviour. The frame surrounding the model represent the hospital workplace as context. The two parties involved in the workplace bullying is the bully and the target. This was represented by a circle and has an adapted “target” appearance. The trends are the inner circles of the “target” and are connected at the bottom to show the link to the bully and target but also their interconnectedness. The arrow indicate that the bully, target and trends will dictate the management of bullying action that should take place. The management of bullying is indicated at the bottom of the model and have the appearance of a “foundation”. The management of bullying are not stand-alone actions and are on the same level to indicate that no weight is given to any one specific managing action. There is also no specific order to the management actions because the bully, target and trends will dictate what actions should happen in each situation. Although management of bullying is the foundational actions it is enabled by the six behaviour change motivators. The arrows leading from the “managing bullying” section is linked to all the “columns” that support the bridge. The columns have open and not solid lines as it spills over into the work environment and is also grounded in the foundation of managing bullying. The arrows between the columns indicate interrelatedness between each behaviour change. The bridge is the outcome of the model and is therefore a strong structure. The arch of a bridge is known to strengthen the structure. The symbolism of the bridge is the crossover of behaviour change from a bullying environment/behaviour to a positive environment/behaviour.

7.2.6.3 Relationship between concepts

Statements link concepts in a relational manner to indicate a relationship between concepts (Walker & Avant, 2011:60). Relationship statements are used to describe the nature of the interactions between two or more concepts of the model (Chinn & Kramer 2008:182; Walker & Avant 2011:183).
The concepts identified in the model are interlinked, therefore certain concepts influence the occurrence of other concepts. The leadership styles as identified in the model are related to teamwork. Leadership influences the formation of teams through training, coaching, mentoring and role modelling. Training and coaching mediate the relationship between leadership styles and teamwork. Leadership and teamwork depend on each other for the success of organisations and situations. Leaders emphasise the formation of teams in handling situations, problems and conflict. Through teamwork, leaders emphasise the achievement of organisational goals. Successful leaders build strong teams with goal-oriented effort (Sohmen 2013:4). In addition, leaders motivate teams and obtain outcomes by a created shared vision that is clearly communicated to the team.

The leaders identify challenges, whereas the team solves the challenges associated with a certain phenomenon such as workplace bullying. The type of leadership style adopted by leaders influences the team effectiveness of problem-solving. Moreover, team success depends greatly on the effectiveness of the leadership style employed (Sohmen 2013:5). Teamwork leads to support and strength in numbers and it enables sharing information, whereby leadership can integrate and co-ordinate various processes within the team. Leadership contributes to effective and successful teams through role modelling appropriate behaviour and conducting training. Training that is provided by leaders contributes to cross-disciplinary aspects in teamwork such as teambuilding and human resource management. Moreover, leaders provide an appropriate environment, collaboration and communication which are required for building a successful team (Adams, Cain, Giraud & Stedman, 2012:179,184).

Similarly, leadership is constantly related to the work environment and motivation (Francioli et al., 2018:890). Leaders are responsible to provide a safe and suitable environment for carrying out activities. Leaders intervene by addressing stressors in the environment, as well as creating a harmonious environment. The leaders ensure that unethical behaviours in an organisation are addressed. The leadership provides a suitable working environment which motivates employees to improve their behaviour and performance. Leaders also motivate employees to practise competent healthcare in hospital settings through constant rewards and providing an encouraging and positive working environment. Chandra and Priyono (2016:131) indicate that insecure work environments contribute to increased chances of job insecurity. Participation and motivation will make nurses committed to their work to improve behaviour and performance. Efficient leadership involvement features high morality, self-assurance and increased levels of that would attract more people to the nursing profession and that could alleviate the workload in future. Workload is a stress factor that increase bullying behaviour.
Leaders make use of work environments to realise goals and successes. The leaders provide a suitable working environment which motivates staff to perform better (Chandra & Priyono 2016:132-133). Moreover, Men (2010:3) indicates that participative leadership styles which encourage a participative organisational culture, communication, equality and hospitable environments provided by leaders, contribute to employee empowerment and result in increased performance. The leaders motivate the nurses to manage and deal with bullying behaviours by addressing bullying in the workplace. Leadership styles used by leaders in hospital settings dictate the occurrence of either unethical or ethical behaviours.

7.2.6.4 Definition of workplace bullying management

The last step in the model development is the definition of an empirical referent. Walker and Avant (2011:72) note that the empirical referent is not a measuring tool, but can be developed into a tool to measure the concept. Walker and Avant requires that an operational definition be developed from the concept analysis. The empirical referent can best be defined in a way that gives an operational definition about workplace bullying management with indications of how to measure change in the management of the concept. The operational definition emerged from the model created, as well as all the different aspects of the concept analysis from the first to final step in the concept analysis method selected.

Referring to the model, the operational definition assigned to workplace bullying management by the researcher is:

The ethical values and actions taken towards practice of psychological mistreatment, often meted out by older workers on younger ones as a way of expressing their stress from work overload. Evidence of management of workplace bullying can be observed when the right working environment is created to eliminate occurrences of the concept or when the current prevalent levels are reduced significantly. Management of workplace bullying include the reporting of bullying, actions taken against the bully, development and implementation of anti-bullying policies, implementation of supportive management styles, supporting the target with negotiation and counselling, creating awareness of bullying behaviours and actions to be taken, improved communication skills by all nurses and the measurement of resolving a highly prevalent phenomenon. This will be reinforced by the values: respect and trust, skills, support, a positive work environment, motivation and teamwork.
7.3 CHAPTER SUMMARY

A model was developed for the management of bullying in the nursing workplace which can be used to guide nursing management to create a nurturing environment that minimises bullying incidents, but that is also able to effectively address these incidents when they do occur. Effective bullying management or the eradication of these negative behaviours will not occur overnight. However, focussing on each individual component of the model will provide nurses with a systematic yet intuitive approach to start making the changes needed. And while the model was developed specifically with the nursing workplace in mind, the general principles are universal to most other environments. The research findings are therefore transferrable.

In addition, the chapter focused on conceptualising the model. The main concepts of the model identified are leadership style, support, teamwork, work environment, skills and values, response strategies, as well as motivators. The concepts were developed using different interconnected attributes to enable change and lead to positive outcomes. The main concept that influences change is leadership. Leadership contributes to skill development, professional development, the provision of a positive workplace environment, support, increased motivation, as well as the building of teamwork. The researcher’s developed model aims to contribute to nurse retention and providing a bully-free work environment. The goal of the model is to minimise the occurrences of workplace bullying behaviours. The implementation of the model will help nurses who are bullying targets. The model is applicable in the nursing setting to help build positive relationships among the nurses and contribute to trust relationships between nurse leaders and nursing staff. The model is based on the principle of behavioural motivation with the main purpose of behaviour change. Moreover, the workplace bullying management model can improve managers’ and nurses’ knowledge of workplace bullying behaviours and assist in addressing such behaviours once detected.
8.1 INTRODUCTION

In this chapter, the main findings and conclusions are discussed. The quantitative and qualitative data and the model concepts are summarised with regard to workplace bullying management. Recommendations are given regarding further management. The purpose of the study was to investigate workplace bullying management between nurses in a private hospital group to develop a model for the management of the practice. A three-phase sequential explanatory mixed method design was used to answer the research objectives.

8.2 PURPOSE OF THE STUDY

The purpose of the study was to investigate workplace bullying management between nurses in a private hospital group to develop a model for the management of the practice.

8.3 RESEARCH DESIGN AND METHODS

This study used a three-phase sequential explanatory mixed method design to answer the research objectives, namely:

• Determine the perceptions of nurses regarding the contributing factors towards workplace bullying between nurses in a private hospital group in RSA.
• Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
• Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
• Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.
• Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.
Integration was achieved through the blending of quantitative and qualitative methods to better understand workplace bullying management strategies and motivators. The quantitative and qualitative approaches supplemented each other and were beneficial, because the research problem was analysed from diverse perspectives to find solutions to workplace bullying between nurses. The disadvantage was that the complex design was laborious. Regardless of the challenges, rigour was maintained throughout the study.

8.3.1 Phase 1

The first phase was the qualitative investigation with a questionnaire on workplace bullying management practices. The questionnaire covered:

- the frequency and type of workplace bullying (NAQ-R),
- factors contributing to workplace bullying,
- responses to bullying,
- current management of bullying and its effectiveness, as well as
- proposed management of workplace bullying.

The data was from a population of 664 nurses including registered nurses, enrolled nurses, enrolled nurse auxiliaries, nursing managers and nurse educators in eight of the nine provinces in South-Africa where the private hospital group is active. The data was analysed with the support of a statistician using SPSS and was displayed in tables and graphs. Validity was established by addressing design and instrument validity techniques. Reliability was established through piloting the questionnaire and the NAQ-R Cronbach’s alpha test application. On completion of Phase 1, the first three objectives were met, but to explain the findings, Phase 2 of the study was initiated.

8.3.2 Phase 2

Phase 2 consisted of a qualitative face-to-face interview component in which data was collected from a purposive sample of an enrolled nurse, registered nurse, two nurse educators, a unit manager and a human resource manager. The interview questions were:

- Tell me what you and other nurses can do to change bullying at work.
- What changes do you think should happen in the work environment to manage bullying behaviours?
- Tell me what you think management should do in order to address the problem of bullying at work.
The interviews were transcribed and supported with field notes. Tesch’s method of data analysis was employed to analyse the qualitative data and four themes emerged:

- perceptions of contributing factors to workplace bullying,
- management and organisational actions,
- nurse-related aspects, and
- work environment improvements.

Trustworthiness was ensured in the qualitative strand by using the criteria of credibility, confirmability, dependability, transferability and authenticity.

8.3.3 Phase 3

The quantitative and qualitative data were integrated to answer the last objective of the study, namely to develop a workplace bullying management model. The model originated from the integrated data grouped together in themes and categories. Professional nurses, educators and model experts validated the model that was the product of the sequential explanatory mixed methods design. The model was presented in Chapter 7.

8.4 SUMMARY AND CONCLUSION

The research study focused on addressing the management of workplace bullying behaviours in the nursing environment. More importantly, the research study focused on developing a model for the management of workplace bullying behaviours. In order to do this effectively, three main areas were set for data collection purposes. The areas were related to the research questions and specific objectives. In the following section, the summary of major findings that answer the research questions and address the themes of the study are presented.

8.4.1 Trends associated with workplace bullying

The first theme was the current trends associated with workplace bullying in the private hospital group. Based on the primary data collected, it was found that workplace bullying behaviours are prevalent in the nursing environment. Workplace bullying behaviours were identified to be any form of harassment, mobbing, horizontal violence, physical attack, as well as behaviours such as eye-rolling and gossiping.

Regarding the first theme, the data revealed that the bullying behaviours have negative consequences for victims/targets, bystanders and the organisation as a whole. To the victim, bullying behaviours cause work distress, stress, job turnover, damaged relationships and low
performance. In addition, bullying behaviours have negative effects on the organisation, which contributes to an unsafe working environment, low organisational performance, as well as incompetent patient care. Moreover, conflict can arise among bystanders and perpetrators can be subjected to punishment by the organisation or face legal action.

8.4.2 Strategies to manage workplace bullying

Based on the second theme and research question, the researcher set out to examine ways of managing workplace bullying. Data collected confirmed that workplace bullying behaviours are manageable when the right strategies are used. Appropriate responses to workplace bullying are achieved through reporting directly to the management, conducting peer-to-peer negotiations, direct confrontations, as well as the use of informal platforms such as writing letters and anonymous notifications. However, direct confrontations contribute to increased conflict. The study indicated that new nurses are mostly targeted due to their inexperience. Moreover, the majority of nurse bullying behaviours arise from senior to junior nurse relationships. The management of workplace bullying behaviours depends on a number of factors. Leadership was one of the main factors that emerged from the primary data, the literature and the developed model to effectively manage workplace conflict.

Leadership was identified as a change agent for behaviour management. Moreover, skills such as communication are important in managing workplace bullying behaviours. Values such as professionalism contribute to dealing with workplace bullying behaviours in a mature way to reduce the emergence of conflict. The work environment influences behaviour changes and a safe environment minimises conflict. Teamwork as indicated by the study participants encourages the sharing of information, decision-making, problem-solving and learning. Teamwork is encouraged by the management through the provision of resources for team building and encouraging team spirit. Training, coaching and mentoring improve nurse learning processes. Training increases nurses’ knowledge about handling bullying behaviours.

8.4.3 Motivators to change bullying behaviours

The last theme was the motivators or defining attributes to manage workplace bullying based on the factors identified above. Motivators such as approachable leaders raise nurses’ motivation to report challenges in the workplace. Other motivators include values, skills, support, the work environment, incentives and teamwork. In addition, employees’ sense of belonging raise their motivation. The research study developed a model to help the management of workplace bullying behaviours. The Influence model makes use of the concepts leadership, work environment and support in addressing workplace bullying
behaviours. Based on the influence of the motivators, it can be concluded that motivators for behaviour change contribute greatly to the management of workplace bullying behaviours.

The final aspect of the study was to develop a model that would serve as a guide for leaders and managers of hospitals to deal with workplace bullying. The model was developed with the aim of managing workplace bullying behaviours. The model was developed to educate both nurses and management in choosing the best strategies for managing workplace bullying behaviours. Moreover, the model was applied to facilitate the acquisition of skills necessary to promote harmony within the nursing working environment. As a result, the model based its functions on contributing to behaviour change in any organisational work environment. With this outcome, it can be concluded that workplace bullying is a reality, but can be managed. In order to effectively manage workplace bullying, there is a need to institute a holistic behaviour change based on the factors and motivators identified from the data collected and the model.

8.5 RECOMMENDATIONS FOR MANAGEMENT

With reference to the summary and conclusions given above, a number of recommendations will be made particularly to hospital management on how to achieve behaviour change towards the elimination of workplace bullying. Workplace bullying behaviours have negative and damaging consequences for employee relationships. Specifically, bullying causes emotional distress to the targeted victims, especially new and inexperienced nurses. Bullying behaviours are caused by superiority, educational level and rankism.

8.5.1 Support

The first recommendation is for management to address workplace bullying behaviours by offering managerial support. Management should offer support by intervening through the provision of anti-bullying policies that protect nurses from bullying and harassment. It is also recommended that management should offer support to employees by prioritising their personal development. This is because training and coaching contribute to knowledge imperative for curbing incivil behaviours (Goodboy et al., 2017:254).

The work environment contributes substantially to the existence of workplace bullying behaviours. Work environments characterised by work overload and stress contribute to increases in conflict and harassment. Participants indicated that their work environment was characterised by low managerial support. Francioli et al. (2018:892) indicate that employee preferences correspond with job characteristics which results in perceived wellbeing. With this in mind, it is also recommended for management to create the right working environment that motivates employees to focus on their personal and professional development, rather than
suppressing the gains of others through bullying. The work environment predicts employees’ motivation. The results of this study have shown that stress in a work environment is related to health outcomes and is caused by work overload, as well as lowered job satisfaction. Work-related stress contributes to low self-esteem. It is therefore recommended that management should take the initiative of providing a stress-free environment. This is enhanced by clearly communicating goals and the vision. In addition, work overload should be minimised to ensure employee satisfaction. A stress-free working environment contributes to reduced unethical behaviours and lowered chances of conflict emergence.

8.5.2 Communication

Based on the findings, participants indicated that they lack efficient communication skills necessary for dealing with workplace bullying behaviours. Therefore it is recommended that leaders of the hospitals should use the right communication skills and train employees to also adopt good communication skills. Communication skills enable the efficient handling of conflict and promote the dissemination of information. It is recommended that management should provide communication skills through education and mentoring programmes. Overton and Lowry (2013:86) observe that communication processes help to manage conflict. Communication reduces the occurrences of confronting issues, as well as contributes to employee motivation in handling issues. In addition, effective communication skills enhance the effective spread of information. Good leadership is defined by the presence of both verbal and non-verbal communication skills (Chuang, 2013:13). Management should therefore intervene to ensure education is provided to nurses to improve their communication skills.

8.5.3 Team development

The study participants indicated that they lack teamwork skills due to a lack of interpersonal skills and managerial support. The participants indicated that they should improve their teamwork skills in order to help challenge bullying behaviours. Moreover, they required teamwork skills to manage existing challenges. The third recommendation is for management to intervene by using team formation and coordination in the teams. Once the teams have been formed, it is strongly recommended that leaders should offer mentoring and coaching to ensure there are sufficient harmony and team management skills among the nurses. Sohmen (2013:4) indicates that leadership goes hand-in-hand with teamwork, as they are interdependent factors.
Effective leadership is required to facilitate problem-solving, opportunity seeking and professional development in teamwork. Management provides a work environment where a team flourish. Management should take the responsibility of conducting employee professional development to encourage teamwork which focuses on decision-making and problem-solving in an organisation.

8.5.4 Ethical work environment

Also, participants indicated that a lack of values such as respect and fairness contributed to bullying in the workplace. In addition, misuse of power within the work environment contributes to the bullying of lower-ranked nurses. Another recommendation for management is that they should aim to create an ethical work environment that is guided by a clearly documented code of ethics and code of conduct. These codes must also be enforced to the letter by ensuring that culprits are punished to serve as deterrents to others. The ethical standards provided by management should spell out rules and policies that need adherence. Strict follow-up of the rules of conduct is ensured by punishing staff who violate such rules. According to Zahedi, Sanjari, Aala, Peymani, Aramesh, Parsapour, Maddah, Cheraghi, Mirzabeigi, Larijani and Dastgerdi (2013), nurses are required to adhere to the code of ethics prepared by the International Council of Nurses. Nurses are required to practise professionalism in the workplace. The code of ethics supports nurses in the nursing practice and reduces their moral distress. McKay and Narasimhan (2012:53) mention that nurses are less respected compared to doctors due to their type of jobs. Elimination of such stereotypes will encourage a healthy working relationship. The management should provide a code of ethics that favours all nurses, irrespective of authority. Punishment strategies should be recommended to reduce harassment, especially for nurses who misuse power by exploiting other nurses. In addition, the code of ethics should encourage respect and fairness in an organisation to reduce conflict.

8.5.5 Professional development

Finally, it is recommended that management should prioritise the professional development of nurses by creating a learning culture. This can be done when management acts as a frontline in harnessing education by undertaking periodic and regular formal training programmes for nurses. Professional development should be provided through training, workshops, mentoring and coaching. Professional development ensures that the nurses practise competent patient healthcare. Short courses that deal with handling emotional challenges and relationship development should be provided in the workplace. The improved education will enable the nurses handle conflict maturely. According to Brekelmans, Poell and Wijk (2012:314), the main
reason for nurses engaging in continuous professional development is to ensure that the nurses work within the legal requirements. Professional development is concerned with encouraging skills development which most employers seek in employees to provide competent patient care. In addition, inadequate support from the management contributes to challenges in ensuring professional development. The employers therefore intervene by providing necessary conditions such as resources and a learning environment (Brekelmans et al., 2012:315). Management should intervene by providing professional development so that nurses can equip themselves with the required skills to provide competent healthcare. In addition, problem-solving skills are important in the nursing environment. Mentoring and coaching programmes should be provided on a regular basis.

Below, a summary of the recommendations that can be applied to other stakeholders responsible for nursing practice has been presented.

8.6 RECOMMENDATIONS FOR NURSES

- Nurses must self-educate to gain awareness of their own and others’ actions that could be interpreted as bullying.
- Nurses must familiarise themselves with policies and codes of conduct and must resolve to follow them.
- Nurses should prioritise improving their communication skills to create healthy working relationships with other people.
- It is important for nurses to be aware of stressors and their management.

8.7 RECOMMENDATIONS FOR FURTHER RESEARCH

- It is recommended that future researchers test the model that was created in this study.
- It is recommended that future researchers expand the model into other fields outside the private healthcare industry, e.g. the public sector.

8.8 RECOMMENDATIONS FOR IMPLEMENTATION OF THE MODEL

It is recommended that model implementation should first entail the identification of the types of bullying behaviours at the workplace, as well as the causes of these behaviours. Identification of the behaviours will help in defining the strategies for mitigating occurrences of the incivil behaviours. As indicated by Fischer, Greiff and Funke (2014:24-25), human problem-solving entails the processes of constructing an internal representation of the external
problem where goals on addressing the problem are developed. Managers of hospitals should also put in efforts to ensure that methods for attaining organisational goals are identified and linked with strategies of solving the problem of workplace bullying. New solutions should be sought based on unique trends. To ensure successful implementation, it is important that the strategies and skills required in managing workplace bullying behaviours are identified and explained in the context of each hospital.

Strategies for managing bullying behaviours must include direct reporting, negotiations and developing policies. In addition, the skills that facilitate the implementation of the strategies must be provided. What is more, it is recommended that measures such as training and mentoring are introduced to improve the knowledge of the best strategies in dealing with workplace bullying behaviours. Management should provide support to staff to develop their skills. The model will be implemented by solving real-life challenges and conflicts. Teamwork needs to be built to improve decision-making and problem-solving. In addition, policies should be employed in the work environment to minimise bullying behaviours. Management should provide support by implementing the policies and providing positive feedback to nurse queries. Management should also provide a safe and suitable working environment to encourage the implementation of the model.

8.9 CHAPTER SUMMARY

Chapter 8 gave an overall summary of the study and include the mine findings of the study namely trends associated with workplace bullying, strategies to manage workplace bullying and motivators to change bullying behaviour. Recommendations from the study were also made for management, nurses, future research and the implementation of the management of workplace bullying model.
REFERENCE LIST


Bartholomew, K. 2006. Ending nurse-to-nurse hostility: Why nurses eat their young and each other, Marblehead: HCPro Inc.


252


Oliver, P. 2010. Understanding the research process. Los Angeles: SAGE.


ADDENDUM A: MEDUNSA RESEARCH & ETHICS COMMITTEE CLEARANCE CERTIFICATE

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE
CLEARANCE CERTIFICATE

MEETING: 09/2013

PROJECT NUMBER: MRECCH/296/2013: PG

PROJECT:
Title: A model to manage workplace bullying between nurses at a private hospital group in South Africa

Researcher: Ms S Goosen
Supervisor: Dr. JD Makoena
Co-supervisor: Prof S Lekalakala-Molgale
Department: Nursing Sciences
School: Health Care Sciences
Degree: PhD

DECISION OF THE COMMITTEE:
MREC approved the project.

DATE: 07 November 2013

PROPAGA OGUNBANJO
CHAIRPERSON MREC

The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an Institutional Review Board (IRB00005102); and functions under a Federal Wide Assurance (FWA00004419). Expiry date: 11 October 2016

Note:
1) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
2) The budget for the research will be considered separately from the protocol.

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Finding Solutions for Africa
ADDENDUM B: PERMISSION TO USE NAQ-R

To whom it may concern,

If you are interested in using the Negative Acts Questionnaire in your research, you are welcome to use this scale in your research as long as you agree with the following terms:

1. That you give us a short description of your research project, and some information about yourself (workplace/institution, education/title). Please provide the following information:

   **Dissertation title/working title:**

   A model to manage workplace bullying between nurses in a private hospital group in South Africa

   **Purpose:**

   The purpose of the proposed research is to develop a model for managing workplace bullying at a private hospital group.

   The objectives of this research are to:

   1. Determine and explore the perceptions of nurses regarding the contributing factors towards the management of workplace bullying between nurses in a private hospital group in RSA.
   2. Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
   3. Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
   4. Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.
   5. Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.

   **Personal information:**

   Suseth Goosen

   [Redacted]

   suseth.goosen@gmail.com

   **University information:**
Sefako Makgato University (previously known as Medunsa)

Supervisor information and contact details:

Dr J Mokoena                joyce.mokoena@smu.ac.za
Prof S Lekalkalaka-Mokgele  sebi.lekalakala@smu.ac.za

2. That you provide us with the NAQ data (only the NAQ data, not any other data you collect) after you have finished your study, including demographic data and response rate. The data must be compatible with SPSS. Please state:

I will attach this requested information.

3. That the use of the NAQ is for research purposes only (non-profit).

The data collected is intended to complete my PhD studies.

4. That each permission is for one project only.

This data will only be used for this study and additional permission will be obtained for future research.

5. That you provide us with any translation of the questionnaire you may do, and that such translation must be done in a professional sound manner with back translation.

No translation was needed as the English version was used.
STATEMENT CONCERNING PARTICIPATION IN THE RESEARCH PROJECT TITLED:

“A MODEL TO MANAGE WORKPLACE BULLYING BETWEEN NURSES AT A PRIVATE HOSPITAL GROUP IN SOUTH AFRICA”

1. I have been apprised of the aims and objectives of the study, afforded the opportunity to ask questions, and given adequate time to consider the matter. The aims and objectives of the study are clear to me and I have not been pressurised in any way to participate.

2. I understand that I will be required to complete a questionnaire. I am aware that this material may be used in scientific publications which will be available in electronic format worldwide. I consent to this provided that my name and other personal details are not disclosed.

3. I understand that participation in this research project is completely voluntary and that I may withdraw from it at any time without furnishing any reasons whatsoever.

4. I know that this research project has been approved by the Medunsa Research Ethics Committee (MREC) of the University of Limpopo (Medunsa Campus). I am fully aware that the results of this research project will be used for scientific purposes and may be published.

5. I agree to this provided that the confidentiality of my responses and my privacy are guaranteed.

I hereby consent to participating in this research project.

________________________________________  _________________________________________
Name of Participant                        Signature of Participant

________________________________________  _________________________________________
Place                                     Date                                     Witness
Statement by the Researcher

1. I have provided detailed verbal information regarding this research project to all parties concerned.
2. I agree to answer any future questions concerning the research project fully and to the best of my knowledge and ability.
3. I undertake to adhere to the approved protocol scrupulously.

<table>
<thead>
<tr>
<th>Suseth Goosen</th>
<th>Signature of Researcher</th>
<th>Date</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Researcher</td>
<td>Signature of Researcher</td>
<td>Date</td>
<td>Place</td>
</tr>
</tbody>
</table>
17 December 2013

Ms S Goosen
202 Mont Toulouse
Catharina Street
LA MONTAGNE
0184

Dear Suseth

PERMISSION TO CONDUCT RESEARCH AT VARIOUS MEDICLINIC HOSPITALS

Your research proposal entitled "A model to manage workplace bullying between nurses at a private hospital group in South Africa" refers.

It is in order for you to conduct your research at various Mediclinic hospitals, and I wish you success with this project.

Yours sincerely

[Signature]

ESTELLE JORDAAN
Nursing Executive
11 March 2014

Suseth Goosen

Dear Suseth,

I am pleased to be able to confirm that the MediClinic ET3CO has approved your request to do research on Workplace Bullying.

I wish you all the best with your research work, and request that you supply us with some feedback on your findings.

Regards

Avril Stroh
(General Manager Training)
ADDENDUM E: LETTER TO HOSPITALS ACCOMPANYING THE QUESTIONNAIRE

Dear Colleague

Thank you for helping me to collect the data for my research.

Some pointers for the data collection:

1. I suggest that you hand it out at a training session, e.g. BLS, and collect it after completion. This will hopefully increase the return rate on the questionnaires, since I need at least 500 completed questionnaires for the analysis to have a statistically significant sample.
2. The completion of the questionnaire should take around 15 minutes as it is mostly multiple-choice types of questions.
3. I am looking for a mix of Registered Nurses, Enrolled Nurses, Enrolled Nursing Assistants, as well as Nursing Management and Trainers.
4. At the end of this document an explanation of the research project’s purpose and objectives is provided. You can recite this to the employees before handing out the consent forms and questionnaires.
5. Please collect the consent forms in isolation from the questionnaires to maintain the required anonymity.
6. Enclosed you will find A6 envelopes for the completed questionnaires. The participants can insert and seal the questionnaires before handing them to you. This will also increase anonymity and truthful answers. Hopefully this measure will also increase the return rate on the questionnaires.
7. You can then send me the sealed A6 enveloped with the questionnaires and the consent forms in the addressed large enclosed envelope.

Questions you can expect from the participants:

- Do I need to answer all the questions?
  Yes please, this will help with the quality of the data collection and development of a comprehensive management plan on workplace bullying between nurses.

- How many options can I exercise per question?
  Most questions indicate the number of options preferred. All other questions are for the participant’s discretion.

- Why is there a number at the back of my envelope?
  The number is for the researcher to keep track of the number of questionnaires sent out for completion. The number is not linked to a person and your privacy and the confidentiality of the information will not be influenced.
Dear Nurses

I am currently a PhD student with the University of Limpopo. The purpose of the research is to develop a model for managing workplace bullying between nurses in the private hospital groups in South Africa. I foresee that the research findings will contribute to improving the working environment of nurses within the private hospital group and lead to significant improvements in patient safety.

The objectives of the research are the following:

1. Determine and explore the perceptions of nurses regarding the contributing factors towards the management of workplace bullying between nurses in a private hospital group in RSA.
2. Determine the perceptions of nurses in a private hospital group in RSA regarding the management of workplace bullying between nurses.
3. Identify the strategies used by nurses in a private hospital group to manage workplace bullying between nurses.
4. Determine the motivators needed to change the bullying behaviour of nurses in order to manage workplace bullying between nurses.
5. Develop a model for managing workplace bullying between nurses at a private hospital group in RSA.

Please be ensured that I – the researcher – will treat your answers in the strictest of confidence and maintain your privacy. The completion of this questionnaire must be a voluntary decision. I would however appreciate it if you can take the time to answer the questions. It will only take about 15 minutes of your time to express your opinion as to how workplace bullying must be managed. All, with the exception of one question, are multiple choice questions.

Thank you for completing the questionnaire.

Kind regards

Suseth Goosen
Researcher
Cell: 083 365 5277
Email: suseth.goosen@gmail.com
ADDENDUM F: QUESTIONNAIRE

Dear Respondent

The purpose of the following questionnaire is to obtain information on the nature, extent and management of workplace bullying that you are familiar with within your field of employment.

Please complete the questionnaire as objectively as possible by placing a tick (✓) next to your choice, or by completing the empty space in each case. Your responses will be treated in the strictest confidence and the anonymity of the information you provide will be assured.

<table>
<thead>
<tr>
<th>Province</th>
<th>Gauteng</th>
<th>Limpopo</th>
<th>Mpumalanga</th>
<th>North West</th>
<th>Northern Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>KwaZulu-Natal</td>
<td>Free State</td>
<td>Western Cape</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current nursing area (speciality)</th>
<th>Midwifery</th>
<th>Critical care</th>
<th>Neonatology</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health/clinic</td>
<td>Operating theatre</td>
<td>Surgical</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Paediatrics</td>
<td>Medical</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing experience</th>
<th>7–12 months</th>
<th>1–5 years</th>
<th>6–10 years</th>
<th>11+ years</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Shift</th>
<th>Day</th>
<th>Night</th>
<th>Mixed (day and night)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Enrolled Nurse</th>
<th>Registered Nurse</th>
<th>Unit Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Manager</td>
<td>Nursing Educator</td>
<td>Registered Nurse</td>
<td>Unit Manager</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>18–29</th>
<th>30–39</th>
<th>40–49</th>
<th>50–59</th>
<th>60+</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
</table>

We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We will not refer to a once-off incident as bullying.
### Question 1

Place a tick (✓) next to all the incidents of workplace bullying that you have experienced or observed between nurses in your hospital:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Withholding information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Finger-pointing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Invasion of personal space</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Pushing/shoving</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Blocking the way</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 Giving someone task(s) with unreasonable/impossible targets or deadlines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7 Subjecting someone to excessive monitoring of his/her work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.8 Pressurising someone not to claim a benefit the person is entitled to (e.g. leave)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9 Exposing someone to excessive teasing and sarcasm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.10 Ordering someone to work below his/her level of competence/qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.11 Ordering someone to work above his/her level of competence/qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.12 Spreading gossip and rumours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.13 Ignoring, excluding or isolating someone from a/the group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.14 Shouting at someone or making him/her the target of spontaneous anger</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.15 Hinting or signalling that someone should resign</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.16 Repeatedly reminding someone of his/her errors or mistakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.17 Constantly criticising someone's work and effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.18 Ignoring someone's opinions and views</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.19 Playing practical jokes on someone the person does not get along with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Question 2: Factors contributing to workplace bullying**

Which of the following contribute to bullying in your workplace area?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Changes in the work environment</td>
</tr>
<tr>
<td>2.2</td>
<td>Poor communication</td>
</tr>
<tr>
<td>2.3</td>
<td>Organisational politics/culture</td>
</tr>
<tr>
<td>2.4</td>
<td>Job insecurity/Lack of job control/autonomy</td>
</tr>
<tr>
<td>2.5</td>
<td>Role demands</td>
</tr>
<tr>
<td>2.6</td>
<td>Leadership behaviours</td>
</tr>
<tr>
<td>2.10</td>
<td>Poor conflict management</td>
</tr>
<tr>
<td>2.11</td>
<td>Shift work</td>
</tr>
</tbody>
</table>

**Question 3: Response to bullying**

a) Indicate how you respond when you observe or experience bullying?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Keep quiet/ignore it</td>
</tr>
<tr>
<td>3.2</td>
<td>Confront them</td>
</tr>
<tr>
<td>3.3</td>
<td>Report the incident to a manager/shift leader</td>
</tr>
<tr>
<td>3.4</td>
<td>Avoid the person(s) participating in the behaviour</td>
</tr>
<tr>
<td>3.6</td>
<td>Insult the person participating</td>
</tr>
<tr>
<td>3.7</td>
<td>Document the incident</td>
</tr>
<tr>
<td>3.8</td>
<td>Resign</td>
</tr>
<tr>
<td>3.9</td>
<td>I express my feelings and rights to others</td>
</tr>
<tr>
<td>3.10</td>
<td>I withdraw from the team</td>
</tr>
<tr>
<td>3.11</td>
<td>I ask to be transferred to another unit</td>
</tr>
</tbody>
</table>

b) Do you think you act correctly in the above situation?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.12</td>
<td>Yes</td>
<td>3.13</td>
</tr>
</tbody>
</table>

c) I acted the way I do because:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.14</td>
<td>I am afraid of confrontation.</td>
</tr>
<tr>
<td>3.15</td>
<td>I do not want to become involved.</td>
</tr>
<tr>
<td>3.16</td>
<td>I do not tolerate such behaviour.</td>
</tr>
<tr>
<td>3.17</td>
<td>I am unsure how to handle these situations.</td>
</tr>
<tr>
<td>3.18</td>
<td>I do not have the self-confidence to act differently.</td>
</tr>
<tr>
<td>3.19</td>
<td>All the other nurses act this way.</td>
</tr>
</tbody>
</table>
**Question 4: Current management of bullying**

a) Which measures are used for preventing workplace bullying in your hospital?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Bullying policies</td>
</tr>
<tr>
<td>4.2</td>
<td>Reporting procedures</td>
</tr>
<tr>
<td>4.3</td>
<td>Investigation of allegations</td>
</tr>
<tr>
<td>4.4</td>
<td>Use of code of conduct</td>
</tr>
<tr>
<td>4.5</td>
<td>Nothing is done</td>
</tr>
<tr>
<td>4.6</td>
<td>Other (specify) __________________________</td>
</tr>
</tbody>
</table>

b) How is bullying managed in your work environment? Indicate all in your environment:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7</td>
<td>Tolerate bullying</td>
</tr>
<tr>
<td>4.8</td>
<td>Management sides with the perpetrator</td>
</tr>
<tr>
<td>4.9</td>
<td>Discourage reporting</td>
</tr>
<tr>
<td>4.10</td>
<td>Counselling</td>
</tr>
<tr>
<td>4.11</td>
<td>Adoption of problem-solving behaviours</td>
</tr>
<tr>
<td>4.12</td>
<td>Encouraging compromise</td>
</tr>
<tr>
<td>4.13</td>
<td>Open negotiations</td>
</tr>
</tbody>
</table>

c) How effective are the currently adopted measures for managing bullying?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.14</td>
<td>Highly ineffective</td>
</tr>
<tr>
<td>4.15</td>
<td>Ineffective</td>
</tr>
<tr>
<td>4.16</td>
<td>Effective</td>
</tr>
<tr>
<td>4.17</td>
<td>Highly effective</td>
</tr>
</tbody>
</table>
Question 5: Managing workplace bullying

a) In your opinion, which among the following strategies should nurse managers and leaders use to deal with workplace bullying?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Creating awareness of workplace bullying</td>
</tr>
<tr>
<td>5.2</td>
<td>Motivating to adopt ethical behaviour</td>
</tr>
<tr>
<td>5.3</td>
<td>Creating a positive organisational culture and climate</td>
</tr>
<tr>
<td>5.4</td>
<td>Adopting specific anti-bullying policies</td>
</tr>
<tr>
<td>5.5</td>
<td>Instilling reporting procedures</td>
</tr>
<tr>
<td>5.6</td>
<td>Mediating workplace conflicts</td>
</tr>
<tr>
<td>5.7</td>
<td>Coaching and counselling employees</td>
</tr>
<tr>
<td>5.8</td>
<td>Changing leadership and management styles</td>
</tr>
<tr>
<td>5.9</td>
<td>Improving interpersonal relationships and communication</td>
</tr>
<tr>
<td>5.10</td>
<td>Emphasising legal measures for extensive bullying</td>
</tr>
</tbody>
</table>

b) Which among the following values and skills should nurses have to minimise bullying?

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<tbody>
<tr>
<td>5.11</td>
<td>Fairness</td>
</tr>
<tr>
<td>5.12</td>
<td>Honesty</td>
</tr>
<tr>
<td>5.13</td>
<td>Acting as a team player</td>
</tr>
<tr>
<td>5.14</td>
<td>Patience</td>
</tr>
<tr>
<td>5.15</td>
<td>Objectivity/Impartiality</td>
</tr>
<tr>
<td>5.16</td>
<td>Sincerity</td>
</tr>
<tr>
<td>5.17</td>
<td>Positive mindset</td>
</tr>
<tr>
<td>5.18</td>
<td>Constructive feedback</td>
</tr>
<tr>
<td>5.19</td>
<td>Willingness to assist</td>
</tr>
<tr>
<td>5.20</td>
<td>Good communication skills</td>
</tr>
<tr>
<td>5.21</td>
<td>Human dignity/respect for others</td>
</tr>
</tbody>
</table>

C) Whose help/support do you need to change bullying behaviours?

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5.22</td>
<td>Nursing management</td>
</tr>
<tr>
<td>5.23</td>
<td>Trainers, facilitators and educators</td>
</tr>
<tr>
<td>5.24</td>
<td>Shift leaders</td>
</tr>
<tr>
<td>5.25</td>
<td>Family</td>
</tr>
<tr>
<td>5.26</td>
<td>Colleagues</td>
</tr>
<tr>
<td>5.27</td>
<td>External mediators</td>
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</tbody>
</table>
d) Should my own behaviour be negative, I would like my colleagues to make me aware of this by:

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>5.28</td>
<td>Telling me face-to-face</td>
</tr>
<tr>
<td>5.29</td>
<td>Sending me an anonymous letter</td>
</tr>
<tr>
<td>5.30</td>
<td>Having the unit manager inform me</td>
</tr>
<tr>
<td>5.31</td>
<td>Asking a friend to tell me</td>
</tr>
<tr>
<td>5.32</td>
<td>Using an outsider to inform me e.g. Human Resources</td>
</tr>
</tbody>
</table>

e) Which bullying reporting procedures would you recommend?

<p>| | |</p>
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<thead>
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</thead>
<tbody>
<tr>
<td>5.33</td>
<td>Verbally informing the unit manager</td>
</tr>
<tr>
<td>5.34</td>
<td>Completing an event report</td>
</tr>
<tr>
<td>5.35</td>
<td>Asking a friend/colleague to report</td>
</tr>
<tr>
<td>5.36</td>
<td>Writing an anonymous letter and posting it from a box outside the unit</td>
</tr>
</tbody>
</table>

*THANK YOU*
ADDENDUM G: CONSENT FORM FOR PARTICIPANTS

STATEMENT CONCERNING PARTICIPATION IN THE RESEARCH PROJECT ENTITLED:

“A MODEL TO MANAGE WORKPLACE BULLYING BETWEEN NURSES AT A PRIVATE HOSPITAL GROUP IN SOUTH AFRICA”

1. I have been apprised of the aims and objectives of the proposed study, afforded the opportunity to ask questions, and given adequate time to consider the matter. The aims and objectives of the study are clear to me and I have not been pressurised in any way to participate.

2. I understand that my oral statements will be electronically sound recorded. I am aware that this material could be used in scientific publications which will be available in electronic format worldwide. I consent to this provided that my name and other personal details are not disclosed. If, however, I elect to be given credit for my contribution, I have been given the assurance that it will be done.

3. I understand that participation in this research project is completely voluntary and that I may withdraw from it at any time without furnishing any reasons whatsoever.

4. I know that this research project has been approved by the Medunsa Research Ethics Committee (MREC) of the University of Limpopo (Medunsa Campus). I am fully aware that the results of this research project will be used for scientific purposes and may be published. I agree to this provided that the confidentiality of my responses and my privacy are guaranteed.

I hereby consent to participating in this research project.

________________________________________  ______________________________________
Name of Participant                                 Signature of Participant

__________________   ______________________
Place                                           Date

Witness
Statement by the Researcher

1. I have provided detailed verbal and written information regarding this research project to all parties concerned.
2. I agree to answer any future questions concerning the research project fully and to the best of my knowledge and ability.
3. I undertake to adhere to the approved protocol scrupulously.

Suseth Goosen _____________________ _____________________ _____________________
Name of Researcher Signature of Researcher Date Place
ADDENDUM H: INTERVIEW GUIDE

Introduce
- Self
- Topic

Purpose of study
Consent confirmation/sign consent and clarify questions

Tell me about yourself?
- Work
- Age
- Position

Research questions
1. Please tell me what can you and other nurses do to change bullying at work?
   - Motivate /encourage you?
   - Skills needed.
   - Reporting?

2. What changes do you think should happen in the work environment to manage bullying behaviour?
   - Physical
   - Social

3. Please tell me what do you think management should do in order to address the problem of bullying at work?
   - People
   - Place
   - Programmes

How do you feel?

Thank you.
ADDENDUM I: EXCERPT FROM AN INTERVIEW

INT: How are you going to change this?

R: I think, it's really something as I said, I have to realize, how do I contribute to the bullying and stop that behaviour, if I do it and then I also have to realize, how can I be a role model for allowing students to question and to challenge but without being disrespectful and that in itself is a skill. Are we going to change it overnight? I don't know. I don't think so. It's so ingrained into us as nurses and I think the hospital environment contributes to that because even if you as a nurse try to change that, you are faced with the doctor that's now upset because the nurse is asking him about medication. She's got the right to ask because she needs to know what she's giving. She needs to recognize the dose might be wrong so she should be able to question the doctors but they don't. They don't at all accept that so now they bully, especially private hospital care. If the doctor feels unhappy about the nurses attitude then he goes to the nursing management and unfortunately, currently the nurses perceive the management as being supportive of the doctors' view not the nurses' view. So the bullying on the ground floor level as an educator, I can try to change that by being the role model encouraging my students to question but I'm constantly faced with the management and the doctor's power that's more than that of a nurse. Until we have a nurse manager who is willing to listen and to say but listen this is not acceptable, the nurse has got the right to ask, the nurse has got the right to voice an opinion and you should respect that we not going to get anywhere because education, the educator are in a consultative role not in a direct organisational line. So we consult and we support and we encourage but I do not have the power to walk in and say to the doctor, this is unacceptable behaviour or to the nurse manager because unfortunately the nurse managers themselves also bully.
ADDENDUM J: DECLARATION FROM CO-CODER

Confirmation : Co-coder

Fri, Dec 28, 2018, 10:52 AM

Lily van Rhyn

To whom it may concern

Hereby I confirm that I acted as co-coder of the data in Suseth Goosen’s study

Dr Lily van Rhyn

+ 27 (0) 82 873 5837
ADDENDUM K: TENTATIVE MODEL FOR WORKPLACE BULLYING

Figure 7.1: Tentative model for managing workplace bullying
# ADDENDUM L: MODEL EVALUATION FORM

Evaluation of the tentative model by experts

<table>
<thead>
<tr>
<th>Name and Surname</th>
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<tbody>
<tr>
<td>Current place of employment</td>
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<tr>
<td>Qualification</td>
<td></td>
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<tr>
<td>Areas of expertise</td>
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<tr>
<td>Years of experience in your field</td>
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<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly agree</th>
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<tbody>
<tr>
<td><strong>1. INTERNAL STRUCTURE</strong></td>
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<tr>
<td>This applies to the description of the model itself.</td>
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<tr>
<td><strong>1.1 Logical development</strong></td>
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<tr>
<td>1.1.1 The process of model development is logical</td>
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<td>1.1.2 The stages of model development are explicit</td>
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<tr>
<td><strong>1.2 Clarity</strong></td>
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<td>1.2.1 The model is easy to understand</td>
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<td>1.2.2 The definition of concepts is clear</td>
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<td>1.2.3 The definition is described in a way that indicate the relevancy of the model</td>
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<td>1.2.4 The concepts are used consistently in the description of the model</td>
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<tr>
<td>1.2.5 The diagram representing the model is self-explanatory</td>
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<tr>
<td><strong>1.3 Level of development</strong></td>
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<td>1.3.1 The development of the model is based on supported statements</td>
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<tr>
<td>1.3.2 The model is systematically developed</td>
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<tr>
<td>1.3.3 Relationship statements are described with clearly supported arguments</td>
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<tr>
<td>1.3.4 The number of elements and concepts are minimal</td>
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<tr>
<td>1.3.5 Relational components are limited appropriately</td>
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<td><strong>1.4 Adequacy</strong></td>
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<tr>
<td>1.4.1 The model is adequate to guide nurses, managers and leaders</td>
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<tr>
<td>1.5  Applicability</td>
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<tr>
<td>1.5.1 The model can be used for managing nurse-to-nurse bullying in the workplace</td>
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</tr>
<tr>
<td>1.5.1 The purpose of the model can be attained</td>
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</tbody>
</table>

| 1.6  Importance |   |   |   |   |
|-----------------|---|---|---|
| 1.6.1 The purpose of the model applies to general and specific specialities |   |   |   |
| 1.6.2 The model create understanding that is important for nursing |   |   |   |
| 1.6.3 The model has practical value |   |   |   |
| 1.6.4 The model add value to research in nursing |   |   |   |
| 1.6.5 The model add value to nursing education |   |   |

| 1.6  Suggestions to improve the model |   |
|---------------------------------------|---|---|---|---|
|                                        |   |   |   |   |
ADDENDUM M: DECLARATION FROM LANGUAGE EDITOR

16 Bay View Ave
Tamboerskloof
Cape Town
8001
15 January 2019

LANGUAGE EDITING OF PHD

To whom it may concern,

This letter confirms that I, Lize Terblanche, edited and proofread Suseth Goosen’s PhD entitled ‘A model to manage nurse-to-nurse bullying in a private healthcare group in South Africa’.

The service included electronic language and grammar editing, corrections, professional layout and applying academic style. The service excluded checking for plagiarism and critical reading from an academic point of view (e.g. logical structure, sound arguments, research methodology, checking of statistics).

Electronic queries and recommendations were made using track changes for the client’s final approval.

Sincerely,

Lize Terblanche
Academic editor
lize.terblanche@gmail.com