HORIZONTAL VIOLENCE AMONG NURSES WORKING IN INTENSIVE CARE ENVIRONMENTS WITHIN THE PRIVATE HEALTHCARE SECTOR

by

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Declaration

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March 2018

Date

Abstract

Background: Nurses are three times more likely to become victims of abuse in the workplace than any other profession, with 65% of American nurses having reported being abused in the workplace in 2008. Horizontal violence has a detrimental effect on a victim's psychological and physical health and can lead to a decrease in the quality of care a patient receives when being cared for by a nurse who is a victim of horizontal violence.

Aim: The aim of the study was to investigate horizontal violence among nurses in order to quantify and describe this phenomenon as it occurs in intensive care environments.

Methods: This study applied a quantitative descriptive survey design. Control over the relevant research topic were over a period of five months from 2016 to 2017. A two-stage cluster sampling design was applied to include hospitals with intensive care environments in the private healthcare sector within the Cape Metropole (N = 13, n = 6) and participants who met the study inclusion criteria (N = 182, n = 118). The participants completed a self-administered questionnaire developed from relevant contemporary literature to quantify and describe the existence and effect of horizontal violence among nurses working in these environments. The data were analysed using the statistical package Stata version 14.2 for Windows. The data collected were organised by using frequency distribution in which the number of times each event occurs was counted.

Results: A response rate of 65% was obtained (N = 182, n = 118). The results showed that both covert and overt abusive behaviours occur among nurses working in intensive care units. The most common form of covert abusive behaviour was a person being ignored by his or her colleagues (n = 35, 32%) and that of overt abusive behaviour was colleagues complaining about one another in the workplace (n = 25, 21%). Both covert and overt abusive behaviours occur daily; however, more participants (n = 68, 60%) experienced some form of covert and/or overt abusive behaviour at least a few times a year. The participants reported having negative psychological effects and physical symptoms, such as negative internalised feelings about self and headaches, as an outcome of experiencing abusive behaviours. Quality of patient care is seen to be negatively affected by horizontal violence due to a person's fear of being victimised (n = 56, 46%). Further, horizontal violence is seen as a trigger to the victim making errors (n =

51, 46%) as well as choosing to engage in unsafe practices during patient care (n = 44, 36%), or to leave employment (n = 23, 16%). The participants identified that both colleagues and supervisors commit abusive behaviours.

Conclusion: Horizontal violence is experienced by all categories of nurses working at patients' bedside in intensive care environments in the private healthcare sector within the Cape Metropole. Nurses experienced both covert and overt abuse in the workplace and suffered from a variety of effects such a professional discouragement, internalised negative feelings and even physical symptoms such as headaches and abdominal pain. For some nurses, the only way to end this cycle of abuse was to resign from their current employment. The quality of patient care delivered by abused nurses was also reported to be affected in terms of unsafe practice, with nurses putting not only their patients but also themselves at risk.

Keywords: workplace violence, horizontal violence, bullying, abuse, nurses

Opsomming

Agtergrond: Die kanse vir verpleërs om slagoffers van mishandeling in die werkplek te wees, is drie keer dié van enige ander professie, met 65% van Amerikaanse verpleegpersoneel wat mishandeling in die werkplek gerapporteer het in 2008. Horisontale geweld het 'n nadelinge uitwerking op 'n slagoffer se sielkundige en fisiese gesondheid en kan lei tot 'n afname in die gehalte van versorging wat 'n pasiënt ontvang wanneer versorging gegee word deur verpleegpersoneel wat 'n slagoffer van horisontale geweld is.

Doel: Die doel van die studie was om horisontale geweld onder verpleegpersoneel te ondersoek ten einde hierdie verskynsel te kwantifiseer en te beskryf waar dit in intensiewesorg-omgewings voorkom.

Metodes: In hierdie studie is 'n kwantitatiewe beskrywende opname-ontwerp toegepas. Data is oor 'n tydperk van vyf maande in 2016 tot 2017 ingesamel. 'n Tweefase-trosstreekproefontwerp is toegepas om hospitale met intensiewesorg-omgewings in die privaat gesondheidsorgsektor in die Kaapse Metropool (N = 13, n = 6) en deelnemers wat aan die studie se insluitingskriteria voldoen het (N = 182, n = 118) in te sluit. Die deelnemers het 'n selftoegediende vraelys ingevul wat op grond van toepaslike onlangse literatuur ontwikkel is om die voorkoms en gevolge van horisontale geweld onder verpleërs wat in hierdie omgewings werk, te versyfer en te beskryf. Die data is met behulp van die statistiekpakket Stata, weergawe 14.2 vir Windows, ontleed. Die ingesamelde data is georden met behulp van frekwensieverspreiding waarvolgens die getal kere wat 'n gebeurtenis voorgekom het, getel is.

Resultate: 'n Responskoers van 65% is verkry (N = 182, n = 118). Die resultate het getoon dat sowel bedekte as openlike mishandelende gedrag onder verpleërs voorkom wat in intensiewesorg-eenhede werk. Die algemeenste vorm van bedekte mishandelende gedrag was dat 'n persoon deur sy of haar kollegas geïgnoreer word (n = 35, 32%) en dié van openlike mishandelende gedrag was kollegas wat oor mekaar in die werkplek kla (n = 25, 21%). Sowel bedekte as openlike mishandelende gedrag kom daagliks voor, maar meer deelnemers (n = 68, 60%) het egter een of ander vorm van bedekte en/of openlike mishandelende gedrag ten minste 'n paar keer per jaar ervaar. Die deelnemers het negatiewe sielkundige gevolge en fisiese simptome, soos negatiewe geïnternaliseerde gevoelens oor hulself en kopseer, as 'n uitkoms

van die ervaring van mishandelende gedrag gemeld. Dit blyk dat die gehalte van pasiëntesorg negatief deur horisontale geweld beïnvloed word weens vrees om geviktimiseer te word (n = 56, 46%). Voorts lei horisontale geweld tot slagoffers wat foute begaan (n = 51, 46%) en ook kies om onveilige praktyke tydens pasiëntesorg uit te voer (n = 44, 36%), of om te bedank (n = 23, 16%). Die deelnemers het gemeld dat sowel kollegas as toesighouers aan mishandelende gedrag skuldig is.

Gevolgtrekking: Horisontale geweld word deur alle kategorieë verpleërs ervaar wat pasiënte in intensiewesorg-omgewings in die privaat gesondheidsorgsektor in die Kaapse Metropool versorg. Verpleërs ervaar sowel bedekte as openlike mishandeling in die werkplek en ly onder verskeie gevolge, soos professionele ontmoediging, geïnternaliseerde negatiewe gevoelens en selfs fisiese simptome soos kopseer en maagpyn. Vir sommige verpleërs is die enigste manier om hierdie kringloop van mishandeling te beëindig om te bedank. Die gehalte van die pasiëntesorg wat deur mishandelde verpleërs gelewer word, word ook benadeel met betrekking tot onveilige praktyke, met verpleërs wat sodoende nie net hul pasiënte nie, maar ook hulself in gevaar stel.

Sleutelwoorde: werkplekgeweld, horisontale geweld, afknouery, mishandeling, verpleërs

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CHAPTER 1: FOUNDATION OF THE STUDY

1.1 Introduction

Workplace violence includes any form of violence, or the threat thereof, made against workers at their workplace. Violence that occurs outside of the workplace but occurs because of the employees' type of work is also considered as workplace violence. The violence can exist among employees, employers and society. Workplace violence has become a great concern for employers, as it places a threat on employees' safety and well-being. Over 2 million American workers are exposed to workplace violence each year. People working in healthcare and social services occupations are most at risk for becoming victims of workplace violence, as these employees have extensive contact with the public (US Department of Labour, 2002:1).

Workplace violence occurring between specific individuals or within groups, such as nurses, who function on the same hierarchical level, is classified as horizontal violence. Horizontal violence occurs when a nurse or nurses engage in interpersonal abuse that is projected on other nurses with whom they work (Wilson, Diedrich, Phelps & Choi, 2011:453). In South Korea, 82% of nurses indicated being exposed to some form of horizontal violence (Park, Cho & Hong, 2015:90), while in Cape Town, 44% of nurses working in public hospitals had experienced horizontal violence in their work environment (Khalil, 2009:210).

Being a target of horizontal violence can have detrimental effects on a person's psychological well-being and physical health. Victims of horizontal violence can present with psychological symptoms such as low self-esteem, anxiety and depression; in severe cases a person may develop post-traumatic stress disorder (PTSD) (Felblinger, 2008:237). Furthermore, the physical symptoms mentioned by nurses who have been victims of abuse in the workplace include fatigue, weight loss and headaches (McKenna, Smith, Poole & Coverdale, 2003:95). Horizontal violence may also influence the quality of patient care the abused nurses deliver to patients (Dumont, Meisinger, Withacre & Corbin, 2012:48). Studies have shown a positive correlation between horizontal violence and the incidence of patient falls and medication errors (Vessey, DeMarco & Difazio, 2010:146).

Intensive care environments are stressful due to the complex nature of nursing care required in the care of critically ill people. In combination with high work demands, it was found that the risk

of being exposed to horizontal violence in an intensive care environment is increased compared to a general ward (Camerino, Estryn-Behar, Conway, Van der Heiden & Hasselhorn, 2008:39; Campbell, Messing, Kub, Agnew, Fitzgerald *et al*., 2011:85; Park *et al*., 2015:93). With horizontal violence shown to be pervasive among nurses and damaging to patients, particularly in high-stress environments, the intention of this study was to investigate horizontal violence among nurses in intensive care environments in order to gain insight into this problem in this context.

1.2 Preliminary literature review

The International Council of Nurses determined that nurses are three times more likely to become victims of workplace violence than any other occupational group (International Council of Nurses, 2009:2). Studies conducted in various countries across the world have indicated that between 44 and 82% of nurses have reported being victims of workplace violence (Hader, 2008:16; Khalil, 2009:210; Park *et al*., 2015:90).

Horizontal violence is a form of workplace violence that occurs among peers (Wilson *et al*., 2011:453). Horizontal violence occurs when a nurse engages in abusive behaviour or behaviours towards another nurse colleague in a work environment. There are various types of horizontal violence that occur in the workplace; examples include covert, overt, psychological, physical and sexual abuse (Ditmer, 2010:9; Felblinger, 2008:234). Lateral violence and bullying are other forms of abuse recognised in the workplace. These differ from horizontal violence in that they occur between staff members of different levels in the hierarchy, for example when a nursing unit manager mistreats a staff member working in the unit he or she manages (Vessey *et al.*, 2010:136).

For the purpose of focusing this study, horizontal violence was examined, as this type of workplace violence occurs among nurses who engage in direct patient care, so-called bedside nurses, rather than across the different managerial hierarchy levels (Vessey *et al.*, 2010:136; Wilson *et al.,* 2011:453). Within the broader scoping of horizontal violence, the study considered abusive behaviours within the groupings of covert and overt abusive behaviours. Covert abuse is regarded as a more concealed form of horizontal violence, as it takes place ‘behind closed doors’ in subtle or secretive ways (Becher & Visovsky, 2012:210; Khalil, 2009:215; Walrafen, Brewer & Mulvenon, 2012:10). An example of covert abusive behaviour is gossip, sabotaging colleagues and ignoring colleagues when they ask for help. Thirty per cent of nurses who

participated in a local study indicated being victims of covert abuse in the workplace (Khalil, 2009:211). Overt abuse was reported at 26% among nurses working in public hospitals in Cape Town (Khalil, 2009:215). Overt abuse is a more public form of abuse in the workplace, where perpetrators publically humiliate their victims (Farrell, 1997:501; Wilson *et al.*, 2011:453), an example being passive aggressive behaviours such as making insinuations and threatening others.

A number of factors have been recognised as contributing to horizontal violence occurring between nurses. Poor communication has been identified as one of the biggest contributing factors (Khalil, 2009:214–215), with participants reporting in one study that poor communication led to a difficult day at work (Walrafen *et al*., 2012:10). A lack of respect for others is another contributing factor towards horizontal violence. Simmons (2008:52) reported that 24% of nurses indicated being ignored by colleagues every day and 13% indicated having been humiliated by their colleagues while on duty. Poor anger management skills can also contribute to horizontal violence, as inadequate anger management skills can lead to frustration and violent behaviour towards others (McKenna *et al.*, 2003:95).

An association between levels of experience and workplace violence has been established, where nurses with less than five years of experience have nine times higher odds of experiencing workplace violence than those with five or more years of experience (Fute, Mengesha, Wakgari & Tessema, 2015:3). Nurses who are relatively new to the profession are unsure of their roles and capabilities; this underpins low self-esteem, ultimately making them a target for abusers and experiencing horizontal violence (Johnston, Phanhtharath & Jackson, 2010:37). The reported occurrence of horizontal violence is concerning; however, studies have shown that this phenomenon is frequently unreported, as some nurses believe that others will perceive them as incompetent in their profession when reporting horizontal violence. Other nurses feel too embarrassed to report horizontal violence (Deans, 2004:34; Gates & Kroeger, 2003:27).

Horizontal violence can have detrimental effects on a person's psychological well-being and physical health, with serious consequences for the victim. The psychological effects can range from low self-esteem and anxiety to depression and PTSD (Felblinger, 2008:237). Thirty-eight per cent of Australian nurses suffered from work-related burnout after being victims of horizontal violence (Allen, Holland & Reynolds, 2015:386). Physical symptoms reported by nurses who

were subjected to horizontal violence included fatigue, weight loss and headaches (McKenna *et al.*, 2003:95). Horizontal violence can affect the retention of nurses in practice; nurses have indicated that they felt disillusioned with the nursing profession and considered leaving the profession (McKenna *et al*., 2003:95). The loss of nurses from the profession can lead to a decrease in effective patient care and a rise in adverse clinical outcomes (Felblinger, 2008:237). In one study, 40% of participants indicated that they strongly considered leaving the organisation due to horizontal violence (Wilson *et al.*, 2011:457).

Horizontal violence not only has a negative effect on the nurses, but may also influence the quality of patient care being delivered by nurses. Nurses have indicated that horizontal violence contributes to poor production in the workplace and compromises patients' safety (Dumont *et al.*, 2012:48). Australian nurses reported that aggression in the workplace frequently contributed to their making errors (Farrell, Bobrowski & Bobrowski, 2006:778). After examining the effect of horizontal violence on the quality of patient care being delivered, it was found that there was a positive correlation between horizontal violence and patient falls, as well as a positive correlation between workplace violence and medication errors (Vessey *et al*., 2010:146).

Intensive care units (ICUs) in hospitals are classified as high-risk units in which horizontal violence can occur (Camerino *et al*., 2008:39; Park *et al.,* 2015:90). The working environment is stressful due to the complexity of nursing needed in caring for patients and their families, as well as the complex demands of the environment itself. Stressful environments have been reported by nurses as contributing to them feeling powerless and demeaned, creating an environment for horizontal violence to occur (Dumont *et al.*, 2012:48). Physical violence was found the highest in ICUs at 48.5%, with patients being the main abusers, followed by physicians and patients' families (Park *et al.*, 2015:90).

Horizontal violence not only has detrimental effects on a person's well-being and ability to perform well as a nurse, but also on the quality of care delivered to patients. When nurses become victims of horizontal violence they are unable to fulfil the promise they made to deliver the best quality of care to their patients (South African Nursing Council, s.a.).

1.3 Significance of the problem

As discussed above, a person's experience of horizontal violence can have serious adverse effects not only on nurses, but also on the quality of care nurses provide to patients. Due to their physiological instability and related needs, critically ill patients require nurses who can provide constant, precise, good nursing care. When horizontal violence occurs in intensive care environments, nurses may be or become unable to provide safe, quality care to these patients and their significant others. In addition, nurses may leave their current employment to end the cycle of abuse they are exposed to at work, aggravating the current shortage of nurses in clinical practice and further negatively influencing the care provided to people in need.

1.4 Research problem

The discussion presented in the previous sections demonstrates that horizontal violence is a real and significant problem affecting nurses working in a hospital setting. Further, horizontal violence has been shown to have detrimental effects on nurses who are victims of these behaviours. Horizontal violence impacts on people's psychological and physical well-being, and affects nurses' ability to work effectively, ultimately influencing patient safety and nursing care.

An ICU or ICU/HCU is a stress-filled environment where critically ill patients require specialised and complex nursing care. In South Africa, nurses provide this care in an environment that is further stressed by personnel shortages, poor communication, a lack of respect among nurses and inadequate anger management training for nurses, all of which can contribute to creating an enabling environment for horizontal violence to occur among nurses working in ICU or ICU/HCU (Khalil, 2009:215).

Published South African research has established horizontal violence as a real problem between nurses in various public healthcare-delivery environments (Khalil, 2009:215–216). The effect this may have on nurses and the care they are able to deliver has been established (Dumont *et al*., 2012:48; Farrell *et al*., 2006:778; Vessey *et al*., 2010:146). However, there is no published research that has investigated the phenomenon of horizontal violence among nurses working in the private sector intensive care environment in South Africa.

For these reasons, it was necessary to investigate horizontal violence among nurses in the intensive care environment in order to gain insight into this phenomenon.

1.5 Research question

The following research question was posed: What is the extent and nature of horizontal violence among nurses working in the private healthcare sector intensive care environment?

1.6 Research aim

The aim of the study was to investigate horizontal violence among nurses in order to quantify and describe this phenomenon occurring in intensive care environments within the private healthcare sector.

1.7 Research objectives

The following research objectives were formulated:

Identify and describe the ways horizontal violence is experienced by nurses working in intensive care environments

Determine the frequency of horizontal violence as experienced by nurses working in intensive care environments

Describe the effects of horizontal violence as identified by nurses working in intensive care environments.

1.8 Conceptual model

A conceptual model is a structure that is applied to a concept being examined. This ensures that the study develops in a logical and meaningful manner, enabling the researcher to accurately connect the study findings with the existing research (Burns & Grove, 2011:238–239). For this study, the Ecological Model of Workplace Violence (Johnson, 2011:55–61) was used to frame this study. This model was considered to be relevant, as the focus of the study was the concept of horizontal violence as this occurs among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole.

Johnson's model (2011:55–61) of horizontal violence consists of four interrelated hierarchical systems. The model allowed the researcher to investigate horizontal violence among nurses working in ICU or ICU/HCU and the effect it has through the different hierarchical systems depicted in the model.

The conceptual model places the abusive act in the middle of the model, with the four interrelated hierarchical systems surrounding the abusive act. As the abusive act is the centre point of the model, any form of abuse taking place in the workplace has an effect on all of the hierarchical systems (Bronfenbrenner, 1977:514; Johnson, 2011:56–57). This conceptual model is explained further in the following chapter.

1.9 Research methodology

Research is a systematic investigation of a specific phenomenon in order to discover new knowledge, validate existing knowledge and establish new relationships among variables. Methodology is a scientific plan set out by the researcher in which the purpose, method of conducting the study, strategy for collecting the data and analysis thereof are discussed (De Vos, Strydom, Fouché & Delport, 2011:63; LoBiondo-Wood & Haber, 2010:6–7). A quantitative approach was chosen for this study to confirm the existence of horizontal violence among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole and to draw conclusions there from.

1.9.1 Research design

Within the broader quantitative approach, a descriptive design was used to gather more information about horizontal violence occurring among nurses working in an intensive care environment. A descriptive design supported the researcher in describing and quantifying the phenomenon of horizontal violence among nurses in an intensive care environment and in determining what, if any, relationships existed among specific study variables (Grove, Burns & Gray, 2013:215).

The variables that were described and quantified in this study included the manner, frequency and effects of horizontal violence on nurses.

1.9.2 Study setting

The study was carried out in private hospitals in the Cape Metropole. The Cape Metropole is part of the City of Cape Town Metropolitan District, and is situated in the southern peninsula of the Western Cape Province. The Cape Metropole district runs along the Atlantic Ocean coastline from Gordon’s Bay to Atlantis. The Swartland and West Coast districts are north of the Cape Metropole border, while the northeast border is adjacent to the Drakenstein, Cape Winelands

and Stellenbosch districts. The Theewaterskloof, Overberg and Overstrand districts are southeast of the Cape Metropole border (*Municipalities of South Africa*, Yes Media!).

A private hospital provides services to people who are able to self-fund healthcare services or people who fund their healthcare through a medical insurance scheme (*The Private Health Care Sector*, s.a.). Within these hospitals, the study was located in the intensive and high-care environments. Patients admitted into these environments require advanced respiratory support and/or support for one or more dysfunctional body system. The final setting of this work was across eleven ICU's or ICU/HCU's in six private hospitals within the Cape Metropole.

1.9.3 Population and sampling

A population is a particular group of individuals who have one or more characteristics in common. This group of individuals becomes the focus of the study (Grove *et al*., 2013:351).

A two-stage cluster sampling strategy was applied in order to randomly include eleven ICU's or ICU/HCU's from six private healthcare hospitals within the Cape Metropole. The population consisted of 484 nurses working in these intensive care environments. A convenience sampling strategy was used to include participants from this population who met the study inclusion criteria. The inclusion criteria were that a participant:

- must be a professional nurse, enrolled nurse or an enrolled nursing assistant as specified by the Nursing Act No. 33 of 2005 (South African Nursing Council, 2005:25–26); and
- must provide direct patient care to critically ill patients in an ICU or combined ICU/HCU (high-care unit) environment in a private hospital in the Cape Metropole

The final study sample consisted of 118 participants.

1.9.4 Data collection

Data collection comprises the gathering of data from the participants forming the study sample. Data can be collected through various methods, such as questioning, observing, recording or a combination of these methods (Grove *et al.,* 2013:523).

Data collection was done by means of a structured self-administered questionnaire. For this study, a 32-item self-administered questionnaire was developed by the researcher by combining items from three surveys previously used in other studies by experts in the field. Face and content validity were established through consulting with nursing experts in critical care and research as well as a pilot study. The research questionnaire for this study did not lend itself to reliability testing, as it made use of both nominal and ordinal levels of measurement, therefore not using one consistent level of measurement. In the research questionnaire the nominal level of measurement measured the participants' responses in true or false and yes or no answers. The ordinal level of measurement was assigned to categories of horizontal violence that can be ranked, such as age, professional category and the occurrence of horizontal violence (never, once, a few times, monthly, weekly and daily).

The 32-item questionnaire consisted of five sections. Each of the sections focused on a different aspect of horizontal violence that may occur among nurses working in ICU or ICU/HCU (see Appendix E). The five sections were demographic data, frequency and types of horizontal violence, effects of horizontal violence on victims, perpetrators and why horizontal violence is not reported.

The questionnaire was available in English. The researcher is fluent in English and Afrikaans and was available after the distribution of the questionnaire to assist participants should they had require assistance with the questionnaire. The questionnaire took approximately 20 minutes to complete.

1.9.5 Pilot test

A pilot test is a smaller version of the proposed study. The pilot test was conducted in a similar setting to that of the proposed study among five conveniently sampled participants who met the study inclusion criteria. The same data-collection tool and data-collection process were utilised with a group of participants who met the same inclusion and criteria as determined for the main study. The researcher used the information gathered from the pilot test to check the feasibility and appropriateness of the research questionnaire (Grove *et al.,* 2013:46). No changes were made to the data collection instrument, in example the questionnaire after the pilot test. The data gathered from this pilot test were not included in the final data set.

1.9.6 Data collection

Once ethical approval and access permission were granted, qualifying nurses were approached to participate within six private hospitals that offer intensive care services in the Cape Metropole. Each nurse consented in writing to participate in the study. The data-collection process took place at times that were convenient to each ICU and ICU/HCU over two to four days as well as nights. This allowed each nurse to have a fair chance of participating in the study. The data collection took place over a period of five months.

Questionnaires were completed at the convenience of the participants. The completed questionnaire was either handed back to the researcher by the participant or placed in a sealed container left in the unit, which was collected by the researcher.

Each consent form was paired with a questionnaire by means of a unique number. The researcher was thereby able to keep track of the number of questionnaires distributed. The completed questionnaires were kept separately from the consent forms. Both documents were kept in a locked file cabinet to which only the researcher had access. The completed questionnaires were reviewed by the researcher and the data entered into an Excel spreadsheet. This method allowed for the protection of the participants' identity as well as the identity of the private hospital groups.

1.9.7 Data analysis and interpretation

The purpose of data analysis is to reduce and organise the information gathered during data collection. The statistical office at the Faculty of Medicine and Health Sciences was consulted for data analysis. The statistical package Stata version 14.2 for Windows was used to analyse the study data. The data collected were organised into descriptive statistics by using frequency distribution, in which the number of times each event occurred was counted (LioBiondo-Wood & Haber, 2010:313). The frequency distribution included the types of horizontal violence that took place, how often it was experienced by nurses and the effects horizontal violence had on the nurses as well as the quality of patient care being delivered by the victimised nurses.

1.10 Ethical considerations

The study proposal and related documents were approved by the Health Research Ethics Committee at the Faculty of Medicine and Health Sciences, Stellenbosch University

(S16/06/098), and the ethics committees of the identified private hospital groups. Permission to access each private hospital was obtained from the appropriate person as identified by the ethics committee of each private hospital group; this included the research committee of each private hospital group, the hospital manager, nursing manager and the unit manager of the ICU or ICU/HCU.

During the study the ethical guidelines and principles of the International Declaration of Helsinki, Department of Health (DoH) and the Singapore Statement on Research Integrity were considered and respected (DoH, 2015; *Singapore Statement on Research Integrity*, s.a.; World Medical Association, s.a.). Three basic ethical principles that must be adhered to during a study to ensure that the human rights of the study participants are respected are respect for others, beneficence and justice (LoBiondo-Wood & Haber, 2010:250–251).

1.10.1 Respect for others

All nurses who were on duty on day of data collection were invited to attend the 10-minute information session that was held in the unit on the day of data collection. During this information session, all the nurses were informed of the purpose of the study, the inclusion criteria and what participation in the study would entail. Information was also given on the responsibilities of the participants as well as the researcher. It was made clear to all persons that participation in the study was voluntary and should they wish withdraw from the study at any point they would endure no consequences. At the end of the information session the researcher gave an opportunity to all nurses to ask questions.

It was made clear throughout the information session that all documents completed by the participants would be handled as private and confidential documents, with only the researcher having access to the documents. The participants' names only appeared on the consent form, which was handed back to the researcher after completion. The consent form was then removed from the study setting by the researcher and kept in a locked cabinet at the researcher's home. All information gathered throughout the study was handled as confidential and only the researcher had access to it.

Each consent form and questionnaire was labelled with a unique number. The questionnaire did not contain any personal details of the participants. The unique number on the documents

allowed the researcher to identify questionnaires that did not have consent forms, which were then excluded from the final data set.

On the day of data collection, the researcher approached each nurse individually to ask whether they would be willing to participate in the study. The nurses who showed interest in the study were given a consent form and a questionnaire. The participants were given the opportunity to complete the questionnaire in their own time. Those who wished to complete the questionnaire at home were able to do so. These questionnaires were placed in a sealed container in the unit that was accessible to the participants. The sealed container was collected by the researcher. The questionnaires and consent form were kept as separate documents.

1.10.2 Beneficence

The research study had a low risk of causing harm to the participants. However, if a participant became distressed or emotional and felt the need for debriefing or counselling, the researcher was available on site for one hour after the questionnaires were distributed. The researcher's contact details were made available on the participants' information leaflet and consent form should a participant have felt the need to contact the researcher for debriefing or counselling. The relevant private hospital and nursing agency trauma counsellor's contact details were also available on the information leaflet. Only the trauma counsellor's contact details of the specific hospital and the nursing agency contracted to work in that particular hospital were made available on the information leaflet handed out in that particular hospital. Permanent employees of the private hospitals would have been referred to a relevant person on site for debriefing and counselling. Participants who were employees of a nursing agency would have been referred to the counsellor of the relevant nursing agency.

All the nurses were informed about the study and what participation would entail. The researcher ensured that all participants understood the purpose of the study and allowed the participants time to ask questions after the information session. All participants signed an informed consent form in which they acknowledged that they understood the research study.

The data were collected in such a manner that the participants felt the least discomfort when talking about their possible experience with horizontal violence. The researcher approached each nurse individually to enquire whether they would be interested in participating. The

participants were given time to complete the questionnaire and should they have requested to complete the questionnaire at home they were allowed to do so. The researcher set up a date and time for collecting the completed questionnaire that were convenient for the participants and the researcher. This allowed for the participants to experience the least amount of discomfort throughout the collection of the study data.

1.10.3 Justice

The selection of participants for the study was fair, as all participants who met the inclusion criteria were invited to partake in the study. All participants were treated as equals and were given the same questionnaire. There were no incentives for participation in this study.

Data collection took place inside the ICU or ICU/HCU with the least amount of disruption to the participants' and patients' daily routine. Nurses were approached to participate; should they have wish to participate they were asked to complete a consent form. Each participant would have been given a research questionnaire and would have been allowed to take it home to complete in an environment in which they felt comfortable and safe.

All documentation was handled as strictly confidential, ensuring that the privacy and confidentiality of the participants were maintained. Only the researcher had access to the collected data. Once the study was completed, all data and related documents were kept in a locked filling cabinet at the researcher's home and will be kept there for five years, where after it will be destroyed.

1.11 Operational definitions

The following key terms and concepts are clarified below for the purpose of this study.

- Horizontal violence: A form of abuse that takes place inside the workplace. Colleagues exert certain behaviour traits that contribute to creating a hostile environment in the workplace. These behaviours include bullying, gossiping, ignoring others, shouting, rudeness and having no respect towards other colleagues (Ditmer, 2010:9, Felblinger, 2008:234). The terms 'horizontal violence' and 'horizontal hostility' were used interchangeably in research (Wilson *et al.,* 2011:453).

- Intensive care unit (ICU): Provides the highest level of care and treatment to extremely sick patients with potentially recoverable conditions. When admitted to ICUs, patients are continuously monitored while being given treatment to sustain optimal organ function. Patients who are admitted to an ICU require advanced respiratory support and/or support of two or more organ systems (Intensive Care Society, 1997:np). These environments may also be referred to as critical care units in South Africa.
- High-care unit (HCU): Provides higher levels of care than a general ward, but less intensive care than an ICU. Patients admitted to an HCU require support for only one dysfunctional body system and this does not include advanced respiratory support. Patients admitted to an HCU need close observation or monitoring for longer than a few hours without the need for intensive care (Intensive Care Society, 1997).
- Intensive and high-care combination unit (ICU/HCU): A hospital may have a combined intensive and high-care unit, depending on the needs of the patient population each individual hospital serves. Patients are either admitted for intensive care treatment or high-care treatment to these combination units. Patients' level of care may also be upgraded or downgraded according to their individual needs without transferring them to another unit. Nursing staff who work in ICUs and ICU/HCUs are usually the same personnel.
- Private healthcare sector: South Africa's healthcare consists of two sectors, namely the private healthcare sector and the state healthcare sector. Private companies manage the private healthcare sector, whereas the state healthcare sector is managed by the Department of Health. The private healthcare sector provides services to people who are able to self-fund healthcare services or people who fund their healthcare through a medical insurance scheme (*The Private Health Care Sector*, s.a.).
- Professional category: Nurses' professional category is determined by their registration category with the South African Nursing Council. All nurses who wish to practise in South Africa must be registered or enrolled with the South African Nursing Council after completing an accredited education programme, as specified by the Nursing Act No. 33 of 2005 (South African Nursing Council, 2005:25–26).
- Nurse specialist: A nurse specialist or a nursing specialty refers to a person who has obtained a postgraduate diploma or degree in a specific field of nursing and holds in-depth knowledge and expertise in their field of study. Once a nurse obtains a postgraduate degree or diploma in a specific field of nursing, such as intensive care, the

nurse must uphold a professional registration with the South African Nursing Council annually in order to practise as such (South African Nursing Council, s.a.).

1.12 Chapter outline

Chapter 1: Foundation of the study

Chapter 2: Literature review

Chapter 3: Research methodology

Chapter 4: Research findings

Chapter 5: Discussion, conclusions and recommendations

1.13 Conclusion

In this chapter, the researcher described the overview of the study as well as the study rationale, research problem and objectives. The ethical considerations undertaken to ensure that the study participants' human right were protected were discussed in this chapter. The next chapter provides an in-depth review of the literature regarding horizontal violence among nurses.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A literature review provides an overview of the research that has been done on a phenomenon and the existing knowledge thereof. The purpose of this literature review was to identify and discuss the current evidence base and knowledge related to horizontal violence among nurses working in a hospital setting held in national and international literature. This discussion will assist in establishing the boundaries of knowledge within which this study was contained and to which it can contribute.

2.2 Search strategy

The literature review was undertaken through focused critical reading of relevant sources in the form of books and journal articles. These sources were identified through applying a search strategy to identify studies relevant to the research topic. Keywords were derived from the research question in Chapter 1 and provided direction in the search strategy. These keywords were:

- Workplace violence
- Horizontal violence
- Bullying
- Abuse
- Nurses.

The above-mentioned keywords were entered singly and in combination into three electronic databases, namely PubMed, Cochrane and CINAHL. A total of 44 articles were included in the literature review after reviewing the abstracts of the returned search results to determine relevance and appropriateness to the study. In addition, relevant textbooks were used. To offer a structured overview of this topic, the following subheadings, mostly drawn from the conceptual framework (Johnson, 2011:55–61), are discussed:

- The difference between workplace violence and horizontal violence
- Background to the Ecological Model of Workplace Violence

- The abusive act
- The microsystem
- The mesosystem
- The exosystem
- The macrosystem

2.3 The difference between workplace violence and horizontal violence

Workplace violence is a general term used to describe abuse or harassment that occurs in the working environment. Abuse or harassment can occur among colleagues in the workplace in any occupation or profession within and across hierarchical structures, creating a hostile and negative environment among individuals (Wilson *et al.,* 2011:453). However, nurses are three times more likely to become victims of workplace violence than any other occupational group (International Council of Nurses, 2009:2; Johnson, 2009:34; Yildirim, 2009:509).

Workplace violence differs from simple workplace conflict (Johnson, 2009:35). Simple workplace conflict occurs as a once-off incident between people and does not have lingering negative effects on the work environment or the personnel. Simple workplace conflict can occur in a discreet or public manner, usually revolving around solving a problem or stating an argument, and does not include making personal attacks on other colleagues (Johnson, 2009:35). In contrast, workplace violence can have negative and lingering effects on both the victim and the work environment (Johnson, 2009:35). Workplace violence can occur in a very discreet and subtle manner, making it difficult to distinguish between workplace violence and simple workplace conflict (International Council of Nurses, 2009:2; Johnson, 2009:35). A South African study on the prevalence of workplace bullying of employees conducted across six work sectors found that 31.13% of the participants self-reported being victims of bullying by their supervisors and colleagues. Abusive behaviours that were reported as being experienced either often or always included negative personal remarks directed at the victim and rumours being spread about victims (Cunniff & Mostert, 2012:8). Some characteristics that are unique identifiers of workplace violence are that it occurs more frequently and over longer periods than simple workplace conflict. Victims of workplace violence often experience at least two or more negative acts in a week and during these negative acts, victims are unable to stand up for themselves, resulting in feelings of powerlessness against the abuser (Johnson, 2009:35).

Workplace violence as a term encompasses a number of different types/forms of violence between colleagues. These include bullying, physical abuse, psychological abuse and sexual abuse. International nursing literature makes use of various terms and definitions to describe workplace violence, lateral violence and vertical violence are two other forms of workplace violence. For the purpose of focusing this study, lateral and vertical violence are not discussed. Information on lateral and vertical violence can be found in the following studies: Ditmer (2010), Felblinger (2008) and Vessey *et al.* (2010:136).

The focus of this study was on horizontal violence, specifically the abuse that occurs among nurses who work on the same hierarchical level. This form of abuse is defined by a nurse displaying negative behaviour traits towards another nursing peer in the work environment. In this study, the hierarchical level was set as all those nurses who provide direct patient care, and the work environment was that of the ICU or ICU/HCU.

The extent to which horizontal violence occurs is concerning. Research conducted among newly graduated nurses in New Zealand identified that up to 41% of the participants were exposed to rude, abusive or humiliating comments in the workplace. Furthermore, in 2001 a survey among nurses in Britain indicated that 44% of nurses felt they were being bullied at work compared to the 35% of non-nursing personnel working in a hospital setting (Quine, 2001:77). A study in the USA revealed that 65% of nurses have reported being victims of workplace violence (Hader, 2008:16).

Limited research has been conducted on horizontal violence in South Africa. Research conducted by Khalil (2009:210) found that 54% of nurses working in state sector hospitals in Cape Town reported horizontal violence being present in nursing.

The discussion presented in the previous sections demonstrates that horizontal violence is a real and significant problem across many work environments. Workplace violence is a global concern that is also a significant problem in nursing, with horizontal violence prominent in the literature. The following discussion of the relevant literature was structured using Johnson's conceptual framework, the Ecological Model of Workplace Violence. A short explanation of the model's foundation and how it assists in explaining horizontal violence is presented first.

2.4 Background to the Ecological Model of Workplace Violence

To better understand horizontal violence among nurses and the impact it may have on the quality of patient care, the triggers and influencers of horizontal violence, as well as its impact on nurses, can be viewed through a conceptual model offered by Johnson, namely the Ecological Model of Workplace Violence. Johnson (2011:55–61) used Bronfenbrenner's ecology of human development theory to develop this model to offer a way of examining horizontal violence through four interrelated systems that can create an environment in which horizontal violence may be facilitated. Bronfenbrenner's theory states that in order to understand human development, it is necessary to examine how individuals and groups from different hierarchical systems interact with one another over time (Bronfenbrenner, 1977:514; Johnson, 2011:55–61).

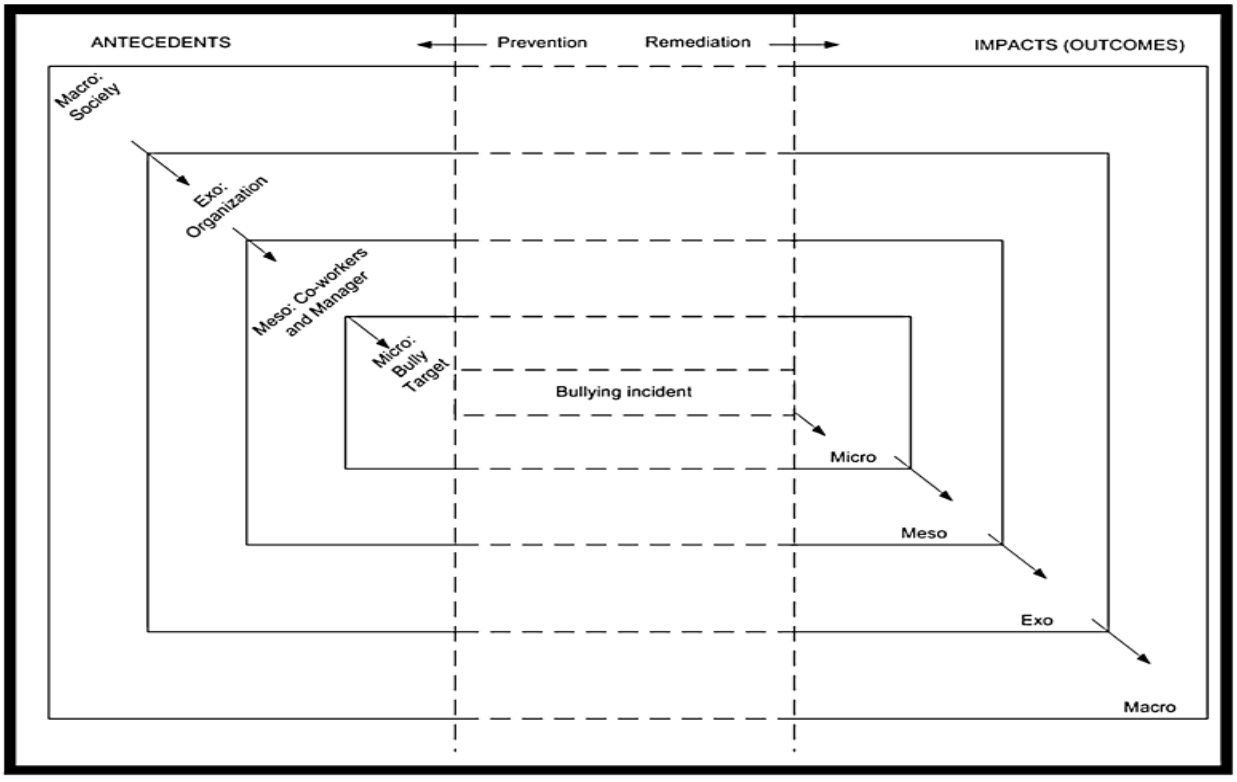


Figure 1: Ecological Model of Workplace Violence (Johnson, 2011:56)

This model situates the abusive act at its centre; the abusive act is marked as the event that occurs between the abuser and the victim. The term 'abuser' represents the person committing the act(s) of horizontal violence and the term 'victim' represents the person who is the target of the horizontal violence, as this is a form of interpersonal abuse. Surrounding the abusive act are four hierarchical systems. Each system represents a level within the organisation in which

nurses' work and builds around the previous system. The four hierarchical systems are named the microsystem, mesosystem, exosystem and macrosystem. Each hierarchical system has its own origin and impact (Bronfenbrenner, 1997:514; Johnson, 2011:56–57).

The microsystem represents the relationship between the victim, the abuser and their immediate environment at that moment in time. This relationship represents the role and activities the victim performs in the immediate environment as well as the victim's own interpersonal relationships. The origin of the microsystem will depend on the personal profile of the victim and the abuser, namely age, gender, race, culture and work experience. The impact horizontal violence has on the victim is dependent on the victim, as some might suffer from psychological systems and even physical symptoms. The mesosystem represents the relationships between the victim and abuser and their colleagues. The impact horizontal violence can have on the mesosystem can lead to poor productivity among nurses. The exosystem is the broader social systems that indirectly affect the victim and the abuser; these are their managers with whom they work and the organisations within which they work. Autocratic leadership styles and poor working conditions have been found in environments in which horizontal violence exists. In the macrosystem, horizontal violence can originate from the existing cultural and societal norms to which the victim and abuser adhere (Bronfenbrenner, 1997:515; Johnson, 2011:56–57).

Johnson (2011:55–63) uses the ecological model as a way of explaining horizontal violence in the workplace. All four of the hierarchical systems are interrelated and each system can have an impact on one or all of the other systems. If horizontal violence exists in one system, this creates an environment for horizontal violence to exist in in the next system (Johnson, 2011:57).

The relevant published literature related to horizontal violence is discussed and presented within each the four hierarchical systems of the ecological model.

2.5 The abusive act

Horizontal violence is a form of abuse that takes place in the workplace and occurs among colleagues who function on the same hierarchical level (Wilson *et al.,* 2011:453). Horizontal violence has been found to occur more commonly in the form of psychological abuse rather than physical abuse (Reynolds, Kelly & Singh-Carlson, 2014:24). Forty-five per cent of nurses working in a public hospital in Cape Town who participated in a study indicated being victims of

psychological abuse at work (Khalil, 2009:207). As such, the literature review is focused on the psychological abuse aspect of horizontal violence. The forms of psychological abuse are covert abuse, overt abuse and other forms of non-physical abuse occurring among nurses who engage in direct patient care.

2.5.1 Covert abuse

Covert abuse is defined as a concealed form of abuse and is often not recognised as abuse at all. Covert abuse includes gossip that undermines the victim, professional jealousy and manipulation. Covert abuse behaviours include sabotage, 'backstabbing' by ignoring colleagues when they ask for help and being inapproachable (Becher & Visovsky, 2012:210, Khalil, 2009:215; Walrafen *et al.*, 2012:10). Another form of non-physical negative behaviour towards colleagues that can cause discomfort to others is incivility. This occurs when a person treats another in a rude and intimidating manner (Felblinger, 2008:235).

Participants in various studies have reported that covert abuse takes the form of personal attacks made against them; being excluded from conversations, especially while on their tea break; being ignored by a specific nurse for extended periods; and having heard grunting sounds when the abuser was near (Hutchinson, Vickers, Wilkes & Jackson, 2010:2324–2325). More examples of covert abuse occurring in the workplace include nurses being unfairly denied their request for annual, sick or study leave or being continuously overlooked when opportunities arise to continue their professional education (Hutchinson *et al.*, 2010:2324–2325). A study done among newly graduated nurses in South Africa established that gossip by colleagues was a prominent covert abusive behaviour, as other colleagues' perceptions of the neophyte nurse were shaped by the gossip, leading to mistrust and unfair judgement (Yon, 2014:55–56).

Khalil (2009:211) found that 30% of nurses working in a public hospital in Cape Town indicated being victims of covert abuse in the workplace. Covert abuse occurs in ways such that there are no witnesses to the abusive behaviours and allows abusers to deny allegations made against them when confronted. Covert abuse allows the abusers to isolate their victims from their peers, preventing them from getting the support they need in order to report and cope with the horizontal violence. Victims feel alienated from supportive peers and incapable of asking for help, making victims more susceptible to the abuse (Hutchinson *et al.*, 2010:2321).

2.5.2 Overt abuse

Overt abuse is a visible form of abuse in which the abuser makes obvious attempts to abuse others. In the study by Khalil (2009:215), 26% of the participants reported that overt abuse occurred in their work environment. Abusers make use of abusive behaviours overtly to publicly humiliate victims and damage their professional reputation in order to keep them from professional growth (Farrell, 1997:501; Hutchinson *et al.,* 2010:2323; Wilson *et al.*, 2011:453). Abusers ask demeaning questions, such as "Why do they let you do that?" or "What do you know?" strategically in front of other colleagues in order to undermine the victim (Hutchinson *et al.,* 2010:2323–2324). Other humiliating behaviours include requiring victims to do menial tasks that are not part of the victim's work description, such as mopping the floor or running errands, which has a negative and belittling effect on the victims' confidence, causing victims to feel unsupported, alone and scared (Hutchinson *et al.,* 2010:2323–2324). The unfair allocation of duties is another form of overt abuse, an example of this being where a nurse was allocated to work seven days in a row, often being the sole provider of patient care; instead of receiving assistance and support from her colleagues, they accused her of making mistakes (Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012:5). Passive aggressive behaviours, shouting, making insinuations, threatening and avoiding contact with victims are some of the more common overt behaviours abusers display (Khalil, 2009:215; Wilson *et al.*, 2011:453).

Newly registered nurses easily fall prey to abusers, as they have little confidence, with these abusers often being their allocated preceptors. Abusive behaviours reported in a study by Gaffney *et al.* (2012:3–5) include the new nurses being shouted and sworn at and falsely accused of being incompetent and incapable of performing their duties. These newly registered nurses also felt that their only solution to ending the abuse was to leave their current employment (Gaffney *et al.,* 2012:3–5). Newly graduated professional nurses in South Africa reported being expected to do menial tasks such as collecting medication from the pharmacy or escorting patients to other facilities. The neophytes felt this impeded their professional development (Yon, 2014:49–51).

Horizontal violence can present in various forms, such a psychological or physical abuse. However, the most common form of horizontal violence is of a psychological nature, and it can occur in the form of covert or overt abuse, or any other non-physical negative behaviour towards

colleagues. The abuse act always occurs between the abuser and the victim in their working environment – this environment is part of the microsystem of the ecological model.

2.6 The microsystem

The microsystem represents the relationship between the victim and abuser in their immediate work environment. This relationship relates to the roles and activities of the victim and abuser in their working environment, as well as their relationship with each other. For example, for a registered nurse employed in an ICU or ICU/HC who provides direct patient care, his or her role is that of an employee, the activities are those necessary in delivering care to patients and the environment is the whole context of the ICU or ICU/HC within the hospital. In a situation of horizontal violence, both the abuser and the victim may have similar roles and responsibilities and they may share similar characteristics, as they function on the hierarchical level of direct patient care delivery. The victim and the abuser might have the same demographic characteristics such as age, gender, race or work experience.

Johnson (2011:57) asserts that to date, no consistent association has been established between the demographic characteristics of nurses who experience horizontal violence. However, other studies note that female nurses are more likely to become victims of horizontal violence and are twice as likely to experience horizontal violence when compared to male nurse colleagues (Campbell *et al.,* 2011:82–83, Fute *et al.*, 2015:3). Furthermore, in South Africa, it was found that race and cultural differences appear to aggravate horizontal violence in the workplace, where victims feared reporting abuse (Khalil, 2009:215). In workplace sectors other than the healthcare sector, a national study found that black employees were more likely to experience abuse in the workplace when compared to the experience of white employees (Cunniff & Mostert, 2012:10).

In addition to gender, culture and race, studies have also shown that a nurse with less work experience is more prone to being abused by colleagues in the workplace. Nurses with one to five years of experience were nine times more likely to experience workplace violence than those with five or more years of experience (Fute *et al.*, 2015:3; Yildirim, 2009:508).

Aside from these demographic characteristics, there are other factors that seem to passively encourage horizontal violence existing between and being tolerated among nurses. Nurses with

poor self-esteem are more at risk of becoming a victim of horizontal violence than nurses who are self-confident in their professional role. Neophytes, including newly registered nurses and students, are unsure of their roles and capabilities, possibly causing low self-esteem and therefore making them easier targets for abusers and horizontal violence (Johnston *et al.*, 2010:37). In contrast, low self-esteem may be a trigger for a nurse to become an abuser rather than a victim of horizontal violence. In general, people with low self-esteem become easily angered, unable to manage their anger in an appropriate way and tend to lash out at others (Leiper, 2005:44). The ecological model demonstrates this statement in that unaddressed outcomes, such as shame of being a victim of horizontal violence, can cause low self-esteem. This in turn creates an environment where it becomes acceptable to themselves to lash out at others, in this way participating as abusers in horizontal violence themselves and continuing the cycle of violence; simply put, the victim becomes the abuser (Johnson, 2011:57).

Other passive factors that have been shown to encourage horizontal violence among nurses include poor personal time-management skills, poor communication, lack of respect for others and inadequate training in dealing with other personnel (Khalil, 2009:214–215; Leiper, 2005:44). Poor time-management skills on the part of victim can cause an abuser to become irritated with a victim, ultimately creating a stressful and tense environment in the workplace (Leiper, 2005:44). Poor communication between nurses is one of the biggest contributing factors towards horizontal violence among nurses (Khalil, 2009:214-215), with inadequate communication reported by nurses to result in a difficult day (Walrafen *et al.*, 2012:10). An example of where poor ways of communication underpin horizontal violence is where an abuser defends his or her hostile behaviour towards a colleague by publicly and unfairly labelling that colleague's work performance as suboptimal or obstructive in the unit (Walrafen *et al.*, 2012:10). This manner of communication is intentionally demoralising and humiliating towards the person at which it was aimed. Khalil (2009:215) states that with adequate communication about each other's skills, knowledge and abilities, the occurrence of horizontal violence could be limited and perhaps even completely prevented.

Lack of respect for others is another contributing factor of horizontal violence. Lack of respect has many different ways of presenting itself, such as abusers believing that they are better than another, that their way of practising nursing is always the correct way and treating their colleagues as subordinate (Khalil, 2009:215). Research conducted among nurses in

Massachusetts revealed that lack of respect is shown in behaviours such as being humiliated about work performance. In this study, 13% of the participants reported this as a daily occurrence, with 38% of the participants experiencing this weekly. Being ignored was also identified in this study as a behaviour that demonstrates lack of respect for others, with 24% of the participants experiencing this daily and 34% indicating having their opinions and views ignored by others as a weekly occurrence (Simmons, 2008:52).

The impact horizontal violence has on the microsystem lies in the psychological and physical sequelae that nurses who have become victims of horizontal violence experience (Johnson, 2011:57). Victims who are exposed to long-term horizontal violence gradually develop a collection of physiological, psychological and social problems, some of which can have serious consequences for the victims (Felblinger, 2008:237). The intensity of these sequelae varies from victim to victim and may be influenced by the duration of exposure to horizontal violence (Yildirim, 2009:505).

Victims showed physical symptoms after being subjected to horizontal violence. These physical symptoms included fatigue, weight loss and headaches. More acute physical symptoms that have been reported as a result of abuse at work include hypertension and angina (McKenna *et al.*, 2003:95). Registered nurses in their first year of practice who experienced horizontal violence show various physical and psychological signs such as anxiety, depression, headache and hypertension (McKenna *et al.,* 2003:95).

The psychological effects on a victim can range from low self-esteem and anxiety to depression and PTSD (Felblinger, 2008:237). Victims of horizontal violence indicated that their confidence and self-esteem were remarkably lowered after being abused (McKenna *et al*., 2003:95). This left some nurses feeling so negative about themselves and their professional competence that they were convinced they would not find employment elsewhere should they wish to resign. Consequently, nurses remain in an abusive working environment and suffer in silence (McKenna *et al*., 2003:95). Other feelings connected to the experience of horizontal violence as a victim are anxiety and fear of returning to work the next day, as the person anticipates abuse in the workplace. Forty-five per cent of Turkish nurse participants in a study examining the effects of bullying in the workplace indicated having symptoms of depression (Yildirim, 2009:509).

Horizontal violence can cause victims to feel professionally incompetent, and to doubt their own professional capabilities (Deans, 2004:34). Even those nurses who felt competent and confident in their abilities and professional judgements reported that horizontal violence takes its toll when one's competence is constantly being examined and criticised by abusive colleagues (Gaffney *et al.,* 2012:6). Constant unfair scrutiny of one's professional competence can also lead to work-related burnout, with 38% of nurses in a study conducted in Australia developing work-related burnout after being victims of horizontal violence (Allen *et al.,* 2015:386). Horizontal violence diminishes victims' individual coping resources, which in turn predisposes them to higher levels of work-related burnout. This high level of work-related burnout is cause for concern, as it affects any organisation's capability of retaining nurses in the profession. Victims of horizontal violence psychologically detach themselves from their work in order to protect their own well-being and decrease their risk of becoming burned out at work (Allen *et al.*, 2015:386).

Horizontal violence not only has a negative effect on the victim and nurse, but has shown to also have an effect on the quality of patient care. Nurses who have been victims of horizontal violence have reported that their ability to practise efficiently and effectively is compromised, and that they believed patient safety was compromised after they experienced abusive acts towards themselves (Dumont *et al.,* 2012:48; Farrell *et al.*, 2006:778). Felblinger (2008:235) reports that 25% of healthcare workers indicated there was a link between disruptive behaviour and patient mortality, with 75% of the participants indicating a link between disruptive behaviour and adverse clinical outcomes in patient care. Some Australian nurses reported that aggression in the workplace frequently contributed to making errors while on duty (Farrell *et al.,* 2006:778).

Training nurses to deal effectively with hostile staff relations empowers nurses against horizontal violence, giving them the opportunity to determine the environment in which they want to work (McKenna *et al*., 2003:95; Walrafen *et al.*, 2012:10). When nurses lack the skills to deal with negativity and abuse in the workplace, they may become frustrated when having to deal with their anger, causing them to lash out at others and in return becoming the abuser (McKenna *et al.,* 2003:95).

2.7 The mesosystem

The mesosystem level encompasses the immediate work environment and close colleagues of the victim and the abuser. There are various factors that contribute to horizontal violence in the

workplace within the mesosystem level. When colleagues choose to ignore that abuse is taking place, they passively encourage horizontal violence in the workplace. Colleagues can also actively encourage horizontal violence in the workplace by supporting abusers in their abusive actions (Johnson, 2011:58).

The impact horizontal violence has on the mesosystem can lead to decreased job satisfaction, poor commitment to work and decreased productivity among nurses (Johnson, 2011:58). In a study conducted in Turkey, horizontal violence was found to have a negative impact on nurses' job performance, specifically job motivation, energy levels and commitment to work. Job motivation and work morale of staff members are linked, whereby as job motivation decreases, so does work morale (Yildirim, 2009:508). The impact of horizontal violence on victims can prevent nurses from performing well in their profession. Nurses have described their working environment with words such as "poisonous", "toxic", "dangerous" and "laced with bullying"; the environments are seen to be difficult and stressful, and, particularly for new graduates, filled with colleagues who provide little support and create unreasonable demands and overwhelming workloads (Gaffney *et al.,* 2012:6; Parker, Giles, Lantry & McMillan, 2014:153–155). Experience of horizontal violence causes nurses to become disillusioned with the nursing profession. They are likely to choose to be absent from work and consider leaving the profession, with studies reporting around 40% of respondents indicating this to be likely (McKenna *et al.*, 2003:95; Wilson *et al.,* 2011:457). The loss of nurses from the profession can lead to a decrease in effective patient care and a rise in adverse clinical outcomes (Felblinger, 2008:237).

Direct patient care forms part of the mesosystem. Horizontal violence affects the safety and quality of care abused nurses are able to offer to patients. During a review of horizontal violence among nurses, Vessey *et al.* (2010:146) found a positive correlation between experience of horizontal violence with patient falls and medication errors.

The leadership style of a manager can have a great influence on the working conditions of an organisation. Poor leadership creates opportunities for horizontal violence to exist in the workplace and can lead to a decrease in job satisfaction and commitment from staff members. This can ultimately have an effect on the quality and safety of the patient care that is delivered by nurses who are exposed to horizontal violence in the workplace.

2.8 The exosystem

The exosystem extends from the mesosystem and includes the bigger societal structures of the working environment of the victim and abuser. These societal structures encompass the managers with whom they work, the organisation at which they are employed, the neighbourhood in which they live and their government (Bronfenbrenner, 1977:515).

To understand why horizontal violence takes place so frequently among nurses in the workplace, it is first necessary to explore the history of violence within this profession. When one considers nursing through the lens of oppression theory, the profession has been described as an oppressed profession since the late 1800s and early 1900s (Johnson, 2009:38). Oppression theory suggests that nursing is traditionally regarded as being submissive to the world of medicine, making nursing an oppressed group. During the late 1800s and early 1900s the care for the sick transformed from home-based care to hospital care. During this transition, physicians and administrators took over decision-making responsibilities regarding all patient care and treatment. From this change, nurses lost control over their unique practice and, hence, lost autonomy and accountability (Johnson, 2009:38; Roberts, 1983:26; Roberts, DeMarco & Griffin, 2009:289).

In hospitals, physicians and administrators had more hierarchical power than nurses. The former's professional and administrative titles are held in higher esteem than those of the nurses. Organisational structure and hierarchy oppressed nurses, forcing them to remain submissive to the world of medicine. In contemporary practice, the input of highly qualified and experienced nurses regarding the treatment of patients is still generally taken as less useful and influential when compared to the input physicians have (Johnson, 2009:38; Roberts *et al*, 2009:289).

In creating a hierarchy in hospitals, physicians and organisational leaders were able to create an image of an 'ideal nurse' against which they would measure and compare nurses' performances. Nurses were, and to a large extent still are, expected to strive to and uphold this ideal image at all times and perform accordingly. Feminist theory describes this 'ideal nurse' as a person who possesses qualities such as goodness, sympathy and kindness at all times (Farrell, 2001:27–28; Leiper, 2005:44). When nurses adopted this ideal image, they lost their own idea of which qualities a nurse should possess and start adopting the beliefs and values of

physicians and administrators, while minimising their own (Farrell, 2001:27; Roberts, 1983:26–27).

Nurses are placed under constant pressure to perform according to the ideal image of a nurse. Flawlessly upholding this ideal image creates a stressful environment for nurses in which to work (Farrell, 2001:27). When nurses fail to uphold this ideal image, they exhibit feelings of self-hatred and dislike towards other nurses because they perceive this as failure. To release the stress and tension under which nurses' work, they can engage in intergroup conflict. This leads to nurses turning on one another because they are unable to attack the oppressor or change their work environment, as their only option is to adapt to it (Farrell, 2001:27–28; Leiper, 2005:44).

Common behavioural traits of an oppressed group can include participating in occurrences of horizontal violence, inter-group conflict, lack of unity and pride, and aggression among colleagues. In order to adapt to their environment, oppressed nurses start to act in ways similar to those who oppress them, while simultaneously remaining submissive to them. This leads to nurses becoming oppressors within their own group, exhibiting feelings of hatred towards their colleagues. As these nurses adapt to their new role of oppressor, they choose to oppress other nurses, as they will not fight for their own freedom because they fear more violence from their oppressors (Roberts, 1983:26–27; Roberts *et al*, 2009:289–290).

Oppression is insidious and can also be found within nursing education programmes. Healthcare organisations' generalization is that nursing graduates must be able to perform as experienced nurses from their first day of employment. These unrealistic expectations are a form of abuse and place nurses under a great deal of stress in the workplace. Studies suggest that new graduate nurses need a least one year to acclimatise to their new work environment, allowing them to adapt from being a student to being a professional nurse. When new graduate nurses are given unrealistic expectations to uphold, they can develop a defensive attitude towards their work situations in order to cope with the work-related stress (Bjerknes & Bjørk, 2012:7–8). A defensive attitude can lead to new graduate nurses becoming psychologically detached from their work, allowing them to feel a sense of being away from work while working and enabling a culture of horizontal violence to be sustained (Allen *et al.,* 2015:383).

The leadership role of the manager plays a vital part in preventing horizontal violence in the workplace. There are two leadership styles that stand out when considering the presence of horizontal violence in an environment and the type of leadership style of the person managing the environment, namely the autocratic and the laissez-faire leadership styles. These styles can both create an environment in which horizontal violence thrives in the workplace (Johnson, 2009:37; 2011:58).

Autocratic managers are confident in their capabilities and decisions; they follow only their own ideas and judgements and allow little or no input from their colleagues. This type of leadership style can easily be perceived as aggressive, controlling and oppressive; productivity is achieved by imposing force or punishment on colleagues, creating an environment where colleagues feel abused (Hoel, Glasø, Hetland, Cooper & Einarsen, 2010:463-464). Laissez-fair leadership, on the other hand, allows for the colleagues rather than the manager to control the working environment and to make managerial decisions. Laissez-faire managers are unable to take responsibility and accountability for decisions and play a passive role in the workplace. When asked, subordinates who work with laissez-faire types of managers feel that these managers are never around to deal with problems, like horizontal violence, that arise in the workplace. This creates strain among colleagues and leads to a negative atmosphere in the workplace, as there is little or no response when concerns related to role uncertainty and role conflict, or complaints of unrealistic job demands, are raised with managers (Hoel *et al.,* 2010:464).

Poor working conditions and work structuring systems have also been found to contribute to horizontal violence in the workplace (Johnson, 2011:58). The shift work system that is a characteristic structure of nursing work contributes to nurses' experience of horizontal violence, with horizontal violence more commonly experienced among nurses working night shifts (64.2% of nurses, compared to 52.1% of nurses working day shifts). Shift duration also plays a role, with approximately 63% of nurses working a 10- or 12-hour shift reporting experiences of horizontal violence, while during an 8-hour shift, horizontal violence was reported at 49.1% (Dewitty, Osborne, Friesen & Rosenkranz, 2009:32).

The occurrence of horizontal violence and the effects it can have on a victim is of great concern, yet it remains an experience that is frequently unreported. Reasons offered include victims of horizontal violence feeling embarrassed to report the incident and that colleagues would view

them as incompetent. Others fear that reporting the abuse would expose them to further possible abuse from managers within the organisation (Deans, 2004:34; Gates & Kroeger, 2003:27). Poor reporting of horizontal violence can be the end product of a lack of information on the necessary steps to take when a victim is being abused in the workplace. The attitude of and inadequate support by managers can prevent victims from reporting horizontal violence (Gates & Kroeger, 2003:27).

Horizontal violence can also have a financial implication for an organisation or hospital. Nurses who abuse others are more likely to be less productive and make more errors while on duty. Medication errors can cost an organisation or hospital up to R75 400 per patient if the number of 'stay in hospital' days are between 2.2 and 4.6 days. Recruiting new nursing personnel to replace the experienced nurses who leave due to horizontal violence is expensive (Rosenstein, 2011:373–374).

Rosenstein (2011:373) found a positive correlation between horizontal violence in the workplace and patients' satisfaction, the hospital or organisation's reputation and the quality of care delivered to patients. Patients who witness horizontal violence among employees may perceive their surroundings as negative and unpleasant, and are more likely to give negative feedback when participating in patient satisfaction surveys. Patients also tend to tell their family and friends of their unpleasant experience. This can lead to the hospital or organisation obtaining a negative reputation, causing its market share to decrease (Ramsey, 2015:113; Rosenstein, 2011:373–374).

Organisations' reluctance to change or implement new policies to ensure zero tolerance for horizontal violence in the workplace can be connected to cultural inertia and the history of tolerance of workplace violence. This unwillingness to report abuse can also be the result of organisational hierarchy, lack of organisational commitment, ineffective policies and structures, as well as inadequate intervention skills (Rosenstein, 2011:373). Employers are encouraged to implement polices declaring all forms of horizontal violence as unacceptable and steps to be taken if a person is to be found guilty of participating in the abuse of others (Ramsey, 2015:113–114).

Horizontal violence among nurses has been reported since the late 1800s, possibly having its roots in the reorganisation of patient care along an institutionalised medically driven model, resulting in the status of nursing being diminished and nurses not being able to stand up against this oppressive system and its proponents (Johnson, 2009:38). The structures and relationships of healthcare environments continue to tacitly and explicitly enable horizontal violence.

2.9 The macrosystem

The macrosystem represents the existing cultural and societal norms to which the victim and abuser adhere (Bronfenbrenner, 1997:515; Johnson, 2011:56–57). In South Africa this will include our constitution and legal framework as well as how our society functions. Our constitution overtly forbids discrimination against people in terms of age, gender, race, religion, and nationality, and in this way establishes a basic foundation that stipulates that horizontal violence must not be ignored, tolerated or encouraged.

The impact horizontal violence can have on society has not been well documented. However, the ripple effect it may have, starting with employees and ranging to the organisation, can have serious financial implications (Johnson, 2011:58–59). Employees may deem it necessary to resign from their current position, leading to financial strain on themselves and their families as well as financial strain on the organisation to replace its employees.

Cape Town was rated in 2015/2016 as the ninth most violent city in the world (BuisnessTech, 2016). Living in a society where violence has become a norm ultimately filters through to all aspects of people's lives. When considering the violence to which nurses are exposed outside of work, it is understandable that such violence has spread though the profession and into hospitals.

Other possible reasons for the existence of horizontal violence in nursing can include an increase in workload, which in return increases staff stress levels, creating an environment in which horizontal violence can exist. Departments with a higher patient intake have been found to have a higher occurrence of horizontal violence. This can be explained by the increase in unplanned admissions and the higher intake of patients and trauma cases (Farrell *et al.,* 2006:785).

ICUs are classified as high-risk units in hospitals in which horizontal violence may occur (Park *et al.,* 2015:90). The working environment in an ICU is stressful due to the complexity of care that must be provided to these patients. Nurses can feel powerless and demeaned in stressful environments, creating a gateway for horizontal violence to take place (Dumont *et al.*, 2012:48). A total of 82.8% of nurses working in South Korea indicated at least one type of horizontal violence in their ICU. Physical violence was found to be the highest in the ICUs at 48.5%. Threats of violence was reported at 61.4%, verbal abuse at 75.8% and sexual harassment at 23.2% (Park *et al.,* 2015:90). Nurses have commented that these stressful working environments can lead to poor productivity and negative coping behaviours. Horizontal violence has detrimental effects on nurses, as well as on the quality of patient care, and should be addressed within all organisations.

2.10 Conclusion

Research conducted internationally and nationally demonstrates that horizontal violence among nurses is a real and significant problem and that it can have serious implications for the victimised nurse as well as the quality and the safety of patient care being delivered. Horizontal violence creates a hostile and stressful atmosphere in the workplace. Intensive care environments are already stressful environments due to the complexity of care needed to care for ICU or ICU/HC patients. Allowing horizontal violence to exist in such a stressful environment puts more strain on nurses who work in these environments. This highly stressed environment creates a gateway for making mistakes when delivering patient care and putting patients in harm's way.

Chapter 3: RESEARCH METHODOLOGY

3.1 Introduction

Chapter 3 provides a detailed explanation as to how the chosen research methodology and methods were applied to investigate horizontal violence among nurses working in an intensive care environment in the private healthcare sector within the Cape Metropole.

3.2 Study setting

A study setting refers to the place where data are collected (Grove *et al.,* 2013:37). For this study, the setting was identified as ICUs and ICU/HCUs of private hospitals within the Cape Metropole.

The Cape Metropole is part of the City of Cape Town Metropolitan District, and is situated in the southern peninsula of the Western Cape Province. The Cape Metropole District runs along the Atlantic Ocean coastline from Gordon's Bay to Atlantis. The Swartland and West Coast districts are north of the Cape Metropole boarder, while the northeast border is adjacent to the Drakenstein, Cape Winelands and Stellenbosch districts. The Theewaterskloof, Overberg and Overstrand districts are southeast of the Cape Metropole border (Municipalities of South Africa. s.a.).

A private hospital provides services to people who are able to self-fund healthcare services or people who fund their healthcare through a medical insurance scheme. Within these hospitals the study was located in the intensive and high-care environments. The final setting of this work was across eleven ICUs and ICU/HCUs in six private hospitals within the Cape Metropole.

3.3 Research design and methods

A research design provides a structure within which the study is done. The research design originated through the research problem, research question, variables and the conceptual framework identified for the study. This research design was used to formulate a research plan through which the data were collected and analysed. A research design allows the researcher to identify factors that can interfere with the validity of the study findings, thereby enabling the researcher to have better control over such factors. Rigorous control over these factors allows

for more reliable study findings that truly reflect reality (Burns & Grove, 2011:253; Grove *et al*., 2013:195).

For this study, a quantitative approach was chosen as appropriate to investigate the problem of horizontal violence among nurses working in an intensive care environment in private hospital within the Cape Metropole. A quantitative approach enables the researcher to formulate a logical and systematic research plan to objectively collect numerical data (Grove *et al*., 2013:23), in this case with respect to horizontal violence among nurses working in the intensive care environment. By making use of numerical data, the researcher was able to measure the frequency of occurrence and different forms of horizontal violence among nurses working in intensive care environments and therefore to quantify and describe the study phenomenon. Furthermore, the numerical data collected allowed the researcher to measure the effects horizontal violence has on victims' interpersonal relationships, relationships with their colleagues and their ability to care for patients. Within the broader quantitative approach, a descriptive design was used to gather more information about horizontal violence. A descriptive survey design enabled the researcher to identify horizontal violence as an existing problem among nurses in an intensive care environment and the relationships that exist among study variables.

The unit of analysis in this study was the occurrence of horizontal violence among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. The particular variables described and quantified in this study were the manner, frequency and effects of horizontal violence on nurses.

3.4 Population and sampling

3.4.1 Study population and sample

A population is a particular group that has one or more characteristics in common. This group of individuals becomes the focus of the study (Grove *et al*., 2013:351). The researcher identified three major private hospital groups within the borders of the Cape Metropole District, and thirteen private healthcare hospitals within these three private hospital groups. Permission was granted to conduct the research in six private healthcare hospitals within the three private healthcare groups. All six private healthcare hospitals have ICUs and ICU/HCUs.

For this study there were four populations consisting of the following: three private healthcare hospital groups, six individual private healthcare hospitals within the Cape Metropole, eleven intensive care environments within these private healthcare hospitals, and the nurses working in these intensive care environments.

The study population included nurses performing direct patient care in one of the 11 ICU/HCUs within one of the six private health hospitals within the Cape Metropole who were willing to participate in the study. The precise number of nurses working in each ICU or ICU/HCU could not be determined, as the number of nurses working each shift is variable and influenced by many factors such as patient acuity and absenteeism. On the advice of the statistician consulted for this study, the most accurate population size was obtained by determining the average number of nurses working in each ICU or ICU/HCU for one 12-hour shift. The average number was then multiplied by 4, as the units usually have four shifts of nurses working in the unit. The four 12-hour shifts included two day shifts and two night shifts. The number of nurses working in each ICU or ICU/HCU depended on the number of beds within the unit. Over four shifts the estimated average population for this study was 484 nurses in the 11 ICU or ICU/HCU. Table 1 provides a breakdown of the estimated number of nurses working in each hospital over four 12-hour shifts.

Table 1: Estimated number of nurses working in each hospital over four 12-hour shifts

	Professional nurse	**Enrolled nurse**	**Enrolled nursing assistant**
Hospital 1	76	32	16
Hospital 2	8	8	4
Hospital 3	52	36	8
Hospital 4	52	36	8
Hospital 5	40	20	16
Hospital 6	32	24	16
Total	**260**	**156**	**68**

A sample represents the selected group of individuals included in the study drawn from a population (Grove *et al*., 2013:351). The study sample included participants who would most

likely provide real-life data about horizontal violence among nurses working in an intensive care environment. Based on the literature regarding horizontal violence, these individuals were those nurses who were actively involved in patient care in the ICU or ICU/HCU at the time of the study. The following inclusion criteria were applied in the sampling strategy to identify and invite nurses to participate in the study. The person had to:

- be a professional nurse, enrolled nurse or enrolled nursing assistant as specified by the Nursing Act No. 33 of 2005 (South African Nursing Council, 2005:25–26); and
- provide direct patient care to critically ill patients in an ICU or ICU/HCU in a private hospital in the Cape Metropole.

Professional nurses employed in positions of unit manager or nurse manager were not included in the study sample. Nurses in these positions do not generally provide direct patient care for critically ill patients on a daily basis, as their work profile focuses on managerial-type functions that are often at arm's length from direct patient care. While people in these positions are also subject to workplace violence, the type of violence they would primarily be exposed to in the unit they manage is lateral violence (see Chapter 2) from their nursing staff whom they manage.

3.4.2 Sample size

The researcher consulted a statistician to determine what sample size was required prior to the start of the data-collection process. The sample size was initially calculated on the assumption that nurses working in eight private hospitals would be included in the study sample. The sample size was based on assuming a population prevalence of 56.6%. Population prevalence is a statistical concept referring to the number of nurses who have experienced horizontal violence in the workplace in a particular population at any given time.

The statistician determined that a sample size of 200 participants would be appropriate. This was determined as follows: At a 95% level of confidence, n = 168 participants would achieve a precision level of ±7.5% (half-width of the confidence interval). This sample size will be achieved assuming a 70% response rate of ±30 nurses per hospital, at eight randomly selected private hospitals within the Cape Metropole (i.e. ((8 x 30) x 0.7) = 168). In order to account for within-hospital clustering, an interclass correlation (ICC) of 0.1 was assumed and a design effect of 2,

to determine that 10 facilities with an average of 20 nurses participating would ensure adequate precision (i.e. n = 200).

The study made use of a two-stage cluster-sampling method. A cluster-sampling method was necessary, as during the first stage, the researcher applied for permission to conduct the research in 13 private healthcare hospitals within the Cape Metropole. Cluster sampling made provision for random selection of the six private healthcare hospitals that gave permission to conduct the research in their facilities. The second stage of the cluster-sampling method allowed the researcher to invite all qualifying nurses working in the six private healthcare hospitals to participate in the study.

Cluster sampling therefore incorporated the sampling weight (N/n) for each private hospital's participants. The sample weight was used to weigh the sample back to the population from which the sample was selected. The sample weight is the inverse of the probability of being included in the study. The sampling weight is calculated as N/n, where N = size of the population and n = size of the sample. The sample weight was applied to each of the six private hospitals in the Cape Metropole.

In the first stage of the two-stage cluster sampling, the private hospitals were sampled and a final sample size of six private hospitals in the Cape Metropole was achieved in the study. During the second stage, the nurses who met the inclusion criteria were approached and invited to participate in the study. The final study sample consisted of 118 participants.

3.4.3 Sampling strategy applied

As stated in the previous section, a two-stage cluster-sampling method was used. Fawcett and Garity (cited in Grove *et al.,* 2013:360) defined cluster sampling is a probability sampling method that is applied when the population is heterogeneous but share similar characteristics, forming natural clusters. The study population was heterogeneous, as it was comprised of nurses from different ages, genders, levels of experience and professional categories. The potential participants shared similar characteristics, such as their profession and type of nursing care units in which they worked. Furthermore, the researcher was not able to precisely determine the size of the population, as the number of nurses working during each shift changes on a daily basis. The most accurate population size was determined by obtaining the average number of nurses

working in each ICU or ICU/HCU, as described in Section 3.4.1. The two-stage cluster-sampling method used to select the participants for the study is discussed below.

Stage 1: Random sampling of private hospitals from each private hospital group

Stage 1 of the two-stage cluster-sampling method determined which ICUs or ICU/HCUs would be accessible to the researcher to recruit participants. Random sampling occurred during Stage 1 of the cluster sampling, as the researcher had no control over which private hospital groups and individual private hospitals would grant permission for the research to take place in their facilities. Random sampling is appropriate for this stage, as it reduces the risk of sampling error (Grove *et al.,* 2013:357). All the private hospitals in the Cape Metropole had a fair chance of being selected for the study sample.

The researcher applied for permission to conduct the study in three private hospital groups that own private hospitals within the Cape Metropole. Within the three private hospital groups, access was a granted to six private healthcare hospitals for the researcher to utilise to approach potential participants.

Stage 2: Inviting all nurses within the randomly selected hospitals to participate in the study

Stage 2 of the two-stage cluster-sampling method determined the participant sample. A non-probability purposive convenience sampling method was applied to invite participation in the study. On each day of data collection, all the nurses working in an intensive care environment in one of the six private hospitals in the Cape Metropole, and who met the inclusion criteria, were invited to participate in the study. This is explained further in the following section.

3.5 Data collection

The research data were collected from participants who met the inclusion criteria and consented to participate in the study. Data can be collected through various methods, such as questioning, observing, recording or a combination of these methods (Grove *et al.,* 2013:523). For this study, a survey tool, in the form of a questionnaire, was developed for the purpose of data collection.

A questionnaire was deemed appropriate for this study, because the researcher wanted to elicit information from participants in a consistent manner. Questionnaires are designed to solicit appropriate information regarding a particular field of study through the responses of participants

to the questions posed about the topic under study; in this case information about horizontal violence among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. The questionnaire allowed the researcher to obtain facts and opinions about horizontal violence from nurses who have experienced horizontal violence in the workplace either as a personal experience or as an observed experience. A questionnaire allows for information to be gathered in a consistent manner throughout the study, thereby decreasing the risk of bias from the researcher. Furthermore, a questionnaire allows for gathering of information from large samples, thereby providing a broad spectrum of information to the study (Burns & Grove, 2011:353). The questionnaire for this study made use of different types of questions, including open- and closed-ended, dichotomous, multiple-choice and scaled questions and checklists.

Open-ended questions (questions 1, 5, 6) gathered information about the participants' age, years worked in the current unit and whether they have a nursing speciality. Another open-ended question (question 32) allowed the participants to share further information with the researcher which they felt was important regarding horizontal violence among nurses working in intensive care environments.

The remaining items on the questionnaire consisted of different types of closed-ended questions in which possible responses were provided to the participants to choose from. Dichotomous questions (questions 2, 6, 8, 20, 21, 24, 28–30) provided the participants with only two possible responses, "Yes/No". Multiple-choice questions (3, 4, 7, 9–19, 22, 23, 26, 27) provided more than two possible responses, allowing for the researcher to observe a finer difference in the responses. The two checklists (questions 25 and 31) provided the participants with multiple responses to select the most appropriate options.

3.5.1 Survey tool: Questionnaire

Data collection was done through a survey using a questionnaire. A 32-item questionnaire was developed by the researcher through combining items from three separate survey tools used in different studies with reference to the literature review. The three survey tools were developed by researchers who have studied horizontal violence among nurses. The first tool was the Horizontal Violence Survey developed by Dumont *et al.* (2012:44–49) and used to establish how often horizontal violence was experienced by nurses. The second tool was Management of

violence in nursing (only section D was supplied by author) developed by Khalil (2009:207–217) and used to establish whether nurses feel supported should they have experienced horizontal violence in the workplace. The third tool was the "RN Horizontal Violence Survey" developed by Wilson *et al*. (2011:453–458) and used to establish the impact horizontal violence has on nurses. Permission was granted by the authors for the surveys to be used for this study (see Annexure C).

A combination of three questionnaires was used to develop the research questionnaire for this study, as no single questionnaire available covered all three research objectives set out for this study. From the first tool (Dumont *et al.,* 2012:44–49), 19 questions were used to collect demographic data of the participants and to determine the frequency and type of horizontal violence existing among nurses and the effects it can have on victims. Two of the questions were used to determine who the perpetrator of horizontal violence was. Four of the questions were adapted to collect more accurate information by changing the question about the participants' age to an open-ended question, while questions used to determine the participants' professional category and determine the perpetrators of horizontal violence were adjusted to the correct terms used in South Africa such as professional nurse, enrolled nurse and enrolled nursing assistant, shift leader and unit manager.

From the second tool (Khalil, 2009:207–217), three questions were used to determine possible reason as to why horizontal violence exists among nurses and whether there were any support systems in place for nurses to utilise if they become victims of horizontal violence. No changes were made in any of the three questions from the second tool.

From the third tool (Wilson *et al.,* 2011:453–458), 10 questions were used to determine the various effects horizontal violence can have on a victim as well as the effect different staff members and shift leaders can have on the atmosphere of the unit. The term 'horizontal hostility' was changed to 'horizontal violence' to make it more appropriate for this study.

The questionnaire was available in English. Despite a diversity of languages being spoken among nurses who work in ICU or ICU/HCU, the common language used among nurses to communicate formally in their professional work spaces (that is, in records, patient hand-over, etc.) is English. The researcher is fluent in English as well as in Afrikaans and was available for

one hour after distributing the questionnaires to assist the participants should they have required any assistance with the questionnaire. The average time it took for participants to complete the questionnaire was 20 minutes.

3.5.1.1 Validity of the research questionnaire

The validity of the questionnaire relates to how accurately the instrument measures what it is claimed to measure and reflects the reality of what it is expected to measure or examine (Grove *et al.,* 2013:393–394). Face validity and content validity were established for the study questionnaire.

Face validity of the questionnaire was determined through conducting a pilot test (Grove *et al.,* 2013:393–394). The results of the pilot test showed that the questionnaire elicited data necessary to determine whether horizontal violence existed, the forms and frequency of occurrence, the ways in which horizontal violence manifests and the effects it has on victims. The outcome of the pilot test (see Section 3.6) demonstrated that horizontal violence exists among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. The questionnaires and consent forms were completed without difficulty by the five pilot test participants. The feedback received from the pilot test participants was positive regarding the data-collection process and research questionnaire.

Content validity examines the extent to which the questionnaire includes all key elements relevant to the phenomenon being studied. Content validity was achieved by using three different sources to validate the content of the instrument being used. The three sources included literature, representativeness of the relevant population and content experts (Grove *et al.,* 2013:394). For this study, an in-depth literature review was conducted on the phenomenon of horizontal violence among nurses. The content of the final questionnaire was drawn from this literature. The three surveys used to develop the research questionnaire were developed by various content experts (Dumont *et al*., 2012; Khalil, 2009; Wilson *et al.*, 2011), who have published their research findings in this field. The questionnaire content was interrogated by the study supervisor, who is an expert in critical care nursing with both clinical, teaching and research experience in this discipline, to establish its relevance to the critical care environment.

3.5.1.2 Reliability of the research questionnaire

Reliability of an instrument/questionnaire refers to the stability and consistency of the instrument/questionnaire. The research questionnaire for this study did not lend itself to reliability testing, as it made use of both nominal and ordinal levels of measurement, therefore not using one consistent level of measurement. The study made use of a heterogeneous sample that had more between-participants variability, making the research questionnaire more reliable (Grove *et al.*, 2013:389). The questionnaire measured the same thing more than once and had the same outcomes, and was therefore a reliable questionnaire. Both nominal and ordinal levels of measurement were applied through the questionnaire. In the research questionnaire the nominal level of measurement measured the participants' response in "True/False" and Yes/No" answers. Nominal levels of measurement allow for variables to be classified and divided into categories. The nominal variables included age, gender, professional category, years worked in the current unit and nursing specialty. Ordinal levels of measurement classify and rank observations. The ordinal variables included the frequency of occurrence of the different forms of horizontal violence and the effects it had on victims (Online Stats Book, s.a).

3.5.1.3 Questionnaire structure

The 32-item questionnaire was divided into five sections, with each section focusing on a different aspect of horizontal violence that exists among nurses working in ICU or ICU/HCU (see Appendix E).

Section 1 of the questionnaire (questions 1–8) consisted of two parts. Part 1 was related to the participants' demographical data in order to establish the context in which horizontal violence exists among nurses working in ICU or ICU/HCU. To gather demographical data, open-ended, dichotomous and multiple-choice questions were used. The following demographic data were collected from the participants: age, gender, professional category, years of experience, years worked in the current unit and whether they were specialised in any nursing discipline.

Section 2 of the questionnaire (questions 9–14) comprised of multiple-choice questions designed to establish whether horizontal violence existed among nurses working in ICU or ICU/HCU, the frequency of occurrence thereof and who the abuser is. The multiple-choice questions also aimed at determining why the participants thought violence exits in nursing

Section 3 of the questionnaire (questions 15–22) consisted of multiple-choice and dichotomous questions to establish the effects horizontal violence had on victims.

Section 4 of the questionnaire (questions 23–25) consisted of three questions to elicit how the participants felt quality of care may be influenced by horizontal violence. Three types of questions were used in this section, namely multiple choice and dichotomous questions and a checklist. The checklist provided the participants with eight possible scenarios in which the quality of patient care was affected because of horizontal violence in the workplace. The participants were asked to choose the options they felt were the most relevant to their experience after being abused or witnessing abuse in the workplace.

Section 5 of the questionnaire (questions 26–32) was to establish who abusers were and why horizontal violence might not be reported by victims. The last question was posed as an open-ended question to elicit any additional insights from the participants into their experience of horizontal violence that may not have been covered by the previous questions. The open-ended question allowed the participants to elaborate on their own thoughts regarding horizontal violence among nurses working in ICU or ICU/HCU in the private healthcare sector within the Cape Metropole.

3.6 Pilot test

The pilot test was a smaller version of the research study and was conducted in a similar setting to that of the research study. The same data-collection tool and data-collection process were utilised with a group of participants who met the same inclusion criteria as determined for the main study. The researcher used the information gathered from the pilot test to check the feasibility and appropriateness of the research questionnaire.

The pilot test indicated that the research study was feasible. The necessary study subjects were accessible and available for the research study. The researcher had enough time to conduct the research study over a period of five months and the financial means to conduct the study. The questionnaire was appropriate for the research study, as the information gathered from the study answered all three of the research objectives (see Section 1.7)

After access permission was granted from the six private hospitals, the researcher applied convenience sampling to select a private hospital from the six private hospitals at which to conduct the pilot test. The researcher corresponded with the unit manager of the department in which the five pilot test participants worked and scheduled an appointment to conduct the pilot test.

On the day of the pilot test, the researcher made use of convenience sampling and identified nurses who met the inclusion criteria. The five nurses were willing to participate in the pilot test and were given two participant information leaflets; these included the study consent form (see Annexure D) and a questionnaire (see Annexure E). The documents were given to the participants in an envelope, and they were asked to place the completed questionnaire back in the envelope before handing it back to the researcher.

The participants were asked to complete one of the consent forms and hand it back to the researcher before completing the questionnaire. They were given the second participant information leaflet to keep. The researcher was available in the unit for one hour after distributing the questionnaires. However, the participants chose to complete the questionnaire at home. The researcher and the participants made arrangements as to when the questionnaires were to be collected.

Each consent form was paired with a questionnaire by means of a unique number, but no other identifiers. In this way, the researcher was able to determine that all five questionnaires were returned. Only the researcher had access to completed consent forms and questionnaires and theses were removed from the study setting once completed by the participants. All five consent forms and questionnaires were returned.

The completed questionnaires were kept separate from the consent forms. Both documents were kept in a locked filling cabinet to which only the researcher had access. The completed questionnaires were reviewed and the participants of the pilot test were asked for commentary on the data-collection process, questionnaire and participant information leaflet and consent form. Positive feedback from the participants was received regarding the content, format and language of the questionnaire and accompanying documents. No changes were made to the questionnaire, participant information leaflet and consent form. The researcher realised that

some participants may want to take a longer time than initially planned for, and so the data-collection plan was adapted and the researcher planned additional return trips to each facility to collect outstanding questionnaires. The data from the pilot test were not included in the final data set. The participants from the pilot test was not invited to participate in the main study.

3.7 Data-collection process

The study participants were accessed through six private hospitals that offered intensive care services within the Cape Metropole. Once access permission had been granted, the researcher corresponded with each of the nursing managers of the six private hospitals to schedule an appointment to introduce the research study. After meeting with the nursing managers, the researcher then scheduled appointments with each of the unit managers of the ICU's or ICU/HCU's within the six private hospitals. During this meeting, the researcher discussed the research study and asked permission to conduct the study in each relevant unit. Afterwards, dates and times that were the least disruptive to the units were scheduled to conduct the study.

Data collection in each hospital was done over a period of four days and nights to ensure that all nurses working in the units were given a fair chance to participate in the study. On each day of data collection, the researcher invited all nurses who met the inclusion criteria to participate in the study. The researcher approached each nurse individually to enquire whether they were willing to participate. This conversation took place in the ICU or ICU/HCU with the consent of the unit manager and the person being approached. All the nurses were given the opportunity to refuse to participate in the study or withdraw from the study at any point without suffering any consequences.

The nurses who indicate their willingness to participate in the study were given two participant information leaflets, which included a consent form (see Annexure D) and a questionnaire (see Annexure E). The participants completed one of the consent forms and handed it back to the researcher before being asked to complete the questionnaire. Some participants chose to return the documents to the researcher after a longer period than the time the researcher was available in the ICU or ICU/HCU. This contingency had been anticipated and the researcher adapted her visits to the units accordingly. The participants were encouraged to keep the second participant information leaflet. The participants were asked to complete the questionnaire while the

researcher was available in the unit and to hand it back before the researcher left the unit. The researcher was available in the unit for one hour after the distribution of the questionnaires.

Each consent form was paired with a questionnaire by means of a unique number such that the researcher was able to determine that all questionnaires were returned. The consent forms were separated from the questionnaire and therefore the participants, and were taken out of the study setting by the researcher on the day of the data collection, therefore only the researcher knew which nurses participated in the study. Any consent form that could not be paired with a questionnaire or vice versa was excluded from the final data set.

Participants who wished to complete the questionnaire at home were given the opportunity to do so and arrangements were made as to when the questionnaires would be collected by the researcher. The participants were also given the opportunity to place the completed questionnaires in a sealed container left in the unit. The sealed container was placed in an area in the unit that was accessible to the participants but still private should they have chosen to place the questionnaire in the sealed container instead of personally handing it back to the researcher. The sealed container was left in the unit by the researcher for approximately four hours and collected by the researcher.

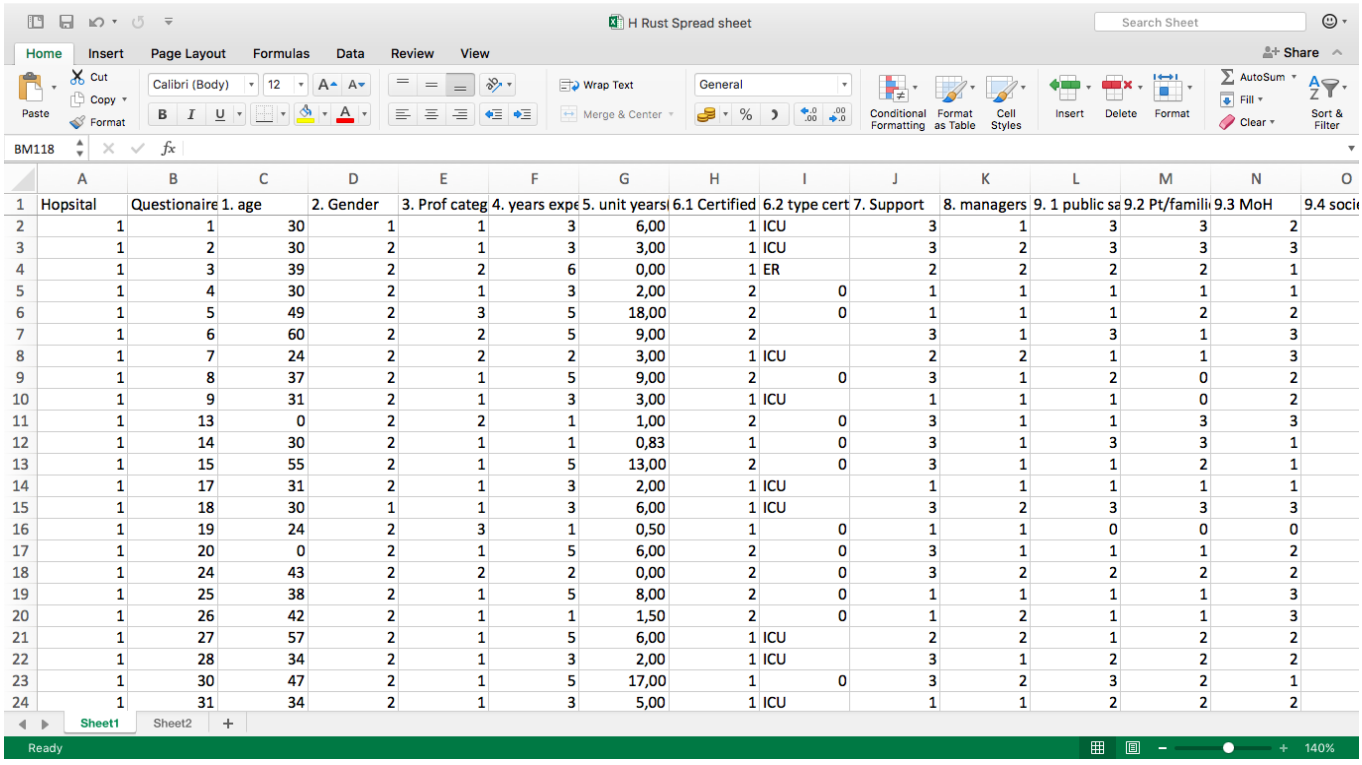
The researcher distributed 182 questionnaires within the 11 ICUs and ICU/HCUs. Thirty-two questionnaires and consent forms were not returned, while 22 consent forms could not be matched with a questionnaire and were therefore excluded from the study. Of the 128 returned questionnaires that could be matched with a consent form, 10 questionnaires were excluded from the study because these were incomplete (3), unclear (4) or the consent forms were incomplete (3). A total number of 118 questionnaires was included in the final data set and therefore a response rate of 65% (n = 118) was achieved.

The completed questionnaires and consent forms were kept separately. All documents were kept in a locked filling cabinet to which only the researcher had access. The completed questionnaires were reviewed and analysed by the researcher. This method protected the participants' identities as well as the identity of the private hospitals and private hospital groups.

3.8 Data analysis

Data analysis refers to reducing and organising the information gathered during data collection to allow for useful information to be highlighted from the data (Grove *et al*., 2013:45). The data collected for this study were for descriptive purposes. The study aimed at describing horizontal violence among nurses working in an intensive care environment in the private healthcare sector within the Cape Metropole.

The study made use of a survey to collect data, which entailed data collection by means of participants completing a self-administered questionnaire. Data received from the participants were entered into an Excel spreadsheet by the researcher. The researcher randomly rechecked 10% (12) of the questionnaires to ensure that the data were entered correctly. The completed Excel spreadsheet was sent to the statistician via e-mail for data analysis. The statistician made use of the Stata version 14.2 for Windows to analyse the data for the study. Figure 2 represents an example the Excel data spreadsheet used in this study.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Hopsital	Questionaire	1. age	2. Gender	3. Prof categ	4. years expe	5. unit years	6.1 Certified	6.2 type cert	7. Support	8. managers	9. 1 public sa	9.2 Pt/famili	9.3 MoH	9.4 soci
2	1	1	30	1	1	3	6,00	1	ICU	3	1	3	3	2	
3	1	2	30	2	1	3	3,00	1	ICU	3	2	3	3	3	
4	1	3	39	2	2	6	0,00	1	ER	2	2	2	2	1	
5	1	4	30	2	1	3	2,00	2	0	1	1	1	1	1	
6	1	5	49	2	3	5	18,00	2	0	1	1	1	2	2	
7	1	6	60	2	2	5	9,00	2		3	1	3	1	3	
8	1	7	24	2	2	2	3,00	1	ICU	2	2	1	1	3	
9	1	8	37	2	1	5	9,00	2	0	3	1	2	0	2	
10	1	9	31	2	1	3	3,00	1	ICU	1	1	1	0	2	
11	1	13	0	2	2	1	1,00	2	0	3	1	1	3	3	
12	1	14	30	2	1	1	0,83	1	0	3	1	3	3	1	
13	1	15	55	2	1	5	13,00	2	0	3	1	1	2	1	
14	1	17	31	2	1	3	2,00	1	ICU	1	1	1	1	1	
15	1	18	30	1	1	3	6,00	1	ICU	3	2	3	3	3	
16	1	19	24	2	3	1	0,50	1	0	1	1	0	0	0	
17	1	20	0	2	1	5	6,00	2	0	3	1	1	1	2	
18	1	24	43	2	2	2	0,00	2	0	3	2	2	2	2	
19	1	25	38	2	1	5	8,00	2	0	1	1	1	1	3	
20	1	26	42	2	1	1	1,50	2	0	1	2	1	1	3	
21	1	27	57	2	1	5	6,00	1	ICU	2	2	1	2	2	
22	1	28	34	2	1	3	2,00	1	ICU	3	1	2	2	2	
23	1	30	47	2	1	5	17,00	1	0	3	2	3	2	1	
24	1	31	34	2	1	3	5,00	1	ICU	1	1	2	2	2	

Figure 2: Screenshot section of the Excel data spreadsheet used to enter the collected data

The two-stage cluster-sampling method allowed the researcher to collect data from geographically dispersed populations. A disadvantage of applying a two-stage cluster sampling method in the study is that it may have resulted in a high level of bias due to a possible discrepancy in participants being selected for the study. The possibility existed that the majority of the participants who partook in the research study were victims of horizontal violence, while the nurses who had never been victims of horizontal violence chose not to participate in the study. Inferring from this, each nurse may not necessarily represent the same number of nurses in the population. To account for this a sampling weight (N/n) was incorporated for each of the private hospitals within the Cape Metropole. The sampling weight is the sum of the population (N) divided by the sample (n) of each of the six private hospital. Equation 1 was used to calculate the sample weight for this study.

$$\text{Sample weight} = \frac{N \text{ (population size)}}{n \text{ (sample size)}}$$

Equation 1: Sample weight

The sample weight is a miniature sample selected to represent the sample from where it was selected. An adjusted weight was applied to each private hospital. Participants from underrepresented groups were given a weight larger than 1. The overrepresented groups were given a weight smaller than 1. During the calculation of the results, the weight values were used in combination with the values of the variables. This allowed for a better representation of the population of nurses working in intensive care environments in the private healthcare sector within the Cape Metropole (Bethlehem, 2009:249-250).

The data collected were organised into univariate descriptive statistics using frequency distribution, where the number of times each event occurs is counted. The frequency distribution included the types of horizontal violence that took place, how often it was experienced by nurses and the effects horizontal violence had on the nurses as well as the quality of patient care being delivered by the victimised nurses.

The data provided in answer to the final open-ended question were analysed by simple thematic analysis. This narrative data were collected with the intention that they may add depth and

substance to the quantitative data. The researcher read through each of the comments provided by the participants; these were extracted from the questionnaire and entered into a Word document. The researcher read thoroughly and iteratively through the comments written by the participants and grouped the comments according to the levels of the ecological model. Grouping and adding the comments to the appropriate hierarchal levels of the ecological model allowed the researcher to add depth to the numerical data. Furthermore, the comments offered the researcher an opportunity to identify any new insights that were not covered in the literature review. The organised narrative data are used in Chapter 4 to provide depth to the numerical and ordinal findings.

3.9 Summary

Chapter 3 of the study provided comprehensive information about the study methodology. The research aim, design, population and sampling method were discussed in detail. Specific details about the research questionnaire, such as its validity, were discussed in this chapter. The manner in which the pilot test and the study was conducted was explained, as well as how the study data were analysed and interpreted. The following chapter provides an in-depth presentation of the research findings.

CHAPTER 4: RESEARCH FINDINGS

4.1 Introduction

The purpose of this chapter is to report on the findings from the data collected during the study. The purpose of the study was to quantify and describe horizontal violence occurring among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole.

A self-administered questionnaire and consent form were handed out to 182 nurses who met the study inclusion criteria and agreed to participate in the study. Of the 182 survey tools distributed, 118 were valid and included in the final data set. The response rate was therefore 65%.

For a questionnaire to be valid and thereby included in the final data set, the participants had to meet the inclusion criteria (see Section 1.9.3) and return a completed questionnaire with a completed and signed consent form. The questionnaires and consent forms were identified with a unique serial number to ensure that each questionnaire could be paired with a consent form (see Section 3.7).

The research findings are presented according to the hierarchical systems of the conceptual model, the Ecological Model of Workplace Violence (see Section 2.4). In this chapter, the findings are presented and then discussed in Chapter 5 within the context of published literature.

4.2 Demographic characteristics of study participants

In Section 1 of the questionnaire, demographic data of the participants were collected. Specifically, the demographic characteristics of interest and described in this section are: age, gender, professional category and years of experience, years worked in the current unit, and specialisation in a nursing discipline.

The average age of the study participants was 39 years. The age range of the participants was 24 years to 61 years.

The majority of the participants were female. Eighty-six per cent (n = 101) of the participants self-classified as being of the female gender and 14% (n = 17) of the participants as being of the male gender.

Nurses' professional category is determined by their registration category with the South African Nursing Council. All nurses who practise in South Africa must be registered or enrolled with the South African Nursing Council after completing an accredited education programme as specified by the Nursing Act No. 33 of 2005 (South African Nursing Council, 2005:25–26). In this study, 67% (n = 79) of the participants indicated being a professional nurse, 27% (n = 32) an enrolled nurse/staff nurse and 6% (n = 7) an enrolled nursing assistant.

The average number of years worked in the current unit by the study participants was four years, with the range being 1 month to 28 years. In their current professional category, 39% (n = 46) of the participants had over 15 years of experience. The participants with 11 to 15 years of experience constituted 10% (n = 12). Those with six to ten years of experience constituted 18% (n = 21). The participants with three to five years of experience constituted 21% (n = 25), and the participants with less than two years of experience constituted 11% (n = 13).

A professional nurse can specialise in a nursing discipline such as intensive care, emergency care or advanced midwifery. Fifty-two per cent (n = 57) of the participants self-classified as having a specialist qualification; of these, 30% (n = 35) had specialised in intensive care nursing, 2% (n = 2) in emergency care nursing and 1% (n = 1) in advanced midwifery. The remaining 19% (n = 14) of the participants self-classified as having a specialist nursing qualification, but did not specify the specialised discipline of nursing, while 48% (n = 53) self-classified as not having a specialist nursing qualification.

In summary, the majority of the study participants were female with an average age of 39 years. Most of the participants were registered nurses who had worked in their current intensive care environment for an average of four years. The average period spent by the participants in their current intensive care environment (at the time of the study) was four years. Half of the participants had at least 11 years or more experience as a nurse. Approximately half of the professional nurses who participated in the study held a specialist qualification in a clinical discipline such as midwifery or emergency nursing, with most participants having specialised in intensive care nursing.

4.3 Overview of conceptual model

The conceptual model used to frame this study was the Ecological Model of Workplace Violence (Johnson, 2011:55–61). This model proposes that workplace violence is an abusive act with four interrelating hierarchical systems. These hierarchical systems can interact to create an environment within which horizontal violence can be experienced. The findings of this study are presented according to the hierarchical levels of this model.

By applying this model to the study, the researcher was able to describe horizontal violence occurring among nurses working in intensive care. Furthermore, the conceptual model allowed for describing the way horizontal violence influences nurses and patient care delivered by victimised nurses.

4.4 Research findings

4.4.1 The abusive act

Horizontal violence between the abuser and the victim manifests through either psychological abuse or physical abuse (Reynolds *et al.*, 2014:24). The focus in this study was on psychological abuse as a form of horizontal violence among nurses working in an intensive care environment in the private healthcare sector within the Cape Metropole.

Five common behaviours of psychological abuse were used in the study to determine the type and frequency of horizontal violence among nurses working in intensive care. These five behaviours are the abusive acts that occur in the workplace, and therefore represent the centre point of the conceptual model or the bullying incident. The five behaviours were identified through the literature review and are: ignoring colleagues, complaining about colleagues, displaying negative facial gestures, criticising colleagues and vilification.

Questions 10 to 14 in Section 2 of the questionnaire were designed to establish how often these abusive behaviours were observed or experienced by nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. A six-point Likert scale was used in the questionnaire in order determine how often participants felt they experienced psychological abuse. The participants were asked to only consider their experiences of these horizontal violence behaviours during the previous 12 months and to indicate whether these

were experienced or witnessed never, once, a few times, monthly, weekly or daily. It is important to note that the option 'a few times' was interpreted as the abuse occurring several times during the past year.

The questionnaires asked the participants to consider not only their own experiences of horizontal violence, but also that of other nurses which they had witnessed in the workplace. The participants' responses were therefore interpreted as their personal observations of either experiencing horizontal violence or witnessing horizontal violence taking place in their workplace.

Psychological abuse can be divided into two forms, namely covert abuse and overt abuse. The findings related to covert abusive behaviours are presented first. Table 4.1 presents two types of covert abuse possibly found in an ICU or ICU/HCU. Covert abuse includes behaviours such as vilification towards others and purposeful ignoring of others when they need help. Vilification means making harmful remarks or belittling someone.

Table 2: Covert abuse: Abusive behaviour experienced or witnessed by nurses within the last 12 months

Abusive behaviour	Daily	Weekly	Monthly	A few times	Once	Never
Vilification	n = 19 16%	n = 11 12%	n = 4 3%	n = 68 60%	n = 5 2%	n = 9 7%
Being ignored	n = 35 32%	n = 6 6%	n = 2 2%	n = 60 49%	n = 2 2%	n = 12 9%

Table 2 shows that most participants (n = 68, 60%) experienced or witnessed vilification behaviours a few times a year, with being ignored as an abusive behaviour occurring a few times in a year noted by almost half of the participants (n = 60, 49%). The covert behaviour most frequently experienced/witnessed on a daily basis was being ignored by colleagues. Some participants had never experienced/witnessed either vilification (n = 9, 7%) or being ignored (n = 12, 9%).

Comments provided by the participants in Section 5 of the questionnaire that relate to the abusive act provided further insight into the specific types of vilification and ways of ignoring colleagues that occur in the workplace. Gossip among colleagues, backstabbing and lack of respect was found among nurses working in intensive care environments. The participants experienced colleagues gossiping about them behind their back, then acting in a friendly manner towards them when managers are around, as confirmed by the quotation below.

> *Cliques exist and they tend to spread harmful stories/gossip/make untrue statements about other staff members and then still act friendly/nice when management is on duty. Most horizontal violence happens after hours when management is not on duty. Staff also feel that there is no use in addressing the issue as it does not get resolved, because the 'bullies' are more senior/management.* (Q011)

Other participants felt a sense of a lack of respect because of their professional category and the duties they fulfil in the workplace, for example:

> *ENAs in the unit I work are more like cleaning staff, consist of dusting, fix phone, maintenance, cleaning after staff, senior staff, bedsides.* (Q100)

In addition to a lack of respect from colleagues, participants who worked in a part-time capacity, through contracted nursing agencies rather than in a permanent capacity for the hospital. Agency nurses reported through means of written comments in the questionnaire receiving less respect from colleagues due to their manner of employment. Furthermore, fair treatment and equality of all nurses regardless of their professional category or employment status were reported as a need among nurses:

> *Nurses have no respect for agency staff. We are here to help permanent staff. But sometimes we are treated like a piece of nothing. This makes it difficult for us. No thank you at the end of the shift.* (Q106)

Overt abuse is the second form of psychological abuse investigated in this study and includes behaviours through which colleagues criticise and complain about others or display negative facial gestures, refer to Table 3.

Table 3: Overt abuse: Abusive behaviours experienced or witnessed by nurses

Abusive behaviour	Daily	Weekly	Monthly	A few times	Once	Never
Criticism	n = 19 16%	n = 12 13%	n = 7 5%	n = 62 52%	n = 7 7%	n = 11 7%
Complaining	n = 25 21%	n = 16 15%	n = 3 2%	n = 61 54%	n = 4 3%	n = 8 6%
Negative facial gestures	n = 26 20%	n = 14 15%	n = 6 6%	n = 53 44%	n = 7 5%	n = 12 10%

Table 4.2 shows that most participants (n = 61, 54%) experienced or witnessed having complaints made about themselves or others a few times a year, while criticism towards others was noted a few times in a year by almost half of the participants (n = 62, 54%). The overt behaviour most frequently experienced/witnessed on a daily basis was having complaints made about victims by colleagues (n = 25, 21%). Some participants have never experienced/witnessed negative facials gestures from colleagues (n = 12, 10%), never had colleagues criticise them (n = 11, 7%) or never had colleagues complain about fellow colleagues (n = 8, 6%).

Comments provided by participants in Section 5 of the questionnaire that relate to the abusive act provided further insight into the specific forms of criticism, complaints and negative facial gestures. An example was provided by a participant in which he was repeatedly criticised for his time-management skills:

> *Horizontal violence I experience mostly is when pressure [is] put on me, for example to transfer a patient quickly. I want to do my work as it should be done – do not want to leave something undone. The question then is: when I do it faster than what I can to the best of my ability: What can I leave undone?? Had more times the remark that I work "slow"! but never could one have said my work was undone or not complete – and would rather been called slow, although I know I am not slow – than to be a hero for working fast but my is not complete.* (Q006)

Another participant reported experiencing horizontal violence because of his sexual orientation and culture:

> *Personal aspects such as sexual orientation and cultural habits have been sources of discontent. Most noticeable is the utilisation [of] 'talking to no one in general', i.e. making general statements but which are only applicable to specific people. Most of the violence experienced has been indirect, i.e. colleagues [have] been told that my sexual orientation 'will rub off' or that I will be discussed when not present.* (Q028)

It is evident that horizontal violence exists among nurses working in intensive care environments in private hospitals within the Cape Metropole. Victims of horizontal violence were exposed to covert and overt abuse daily, while others experienced this abuse less frequently.

Throughout the study, the most frequently reported abusive behaviours that occurred daily was participants being ignored by their colleagues. The most frequent abusive behaviour that occurred monthly was participants having complaints laid against them and receiving negative facial gestures from their colleges. Vilification was the most common form of abuse to be experienced by the participants several times a year. From these findings it appears that covert abusive behaviours were more commonly experienced than overt behaviours. These findings demonstrate that horizontal violence exists among nurses working in intensive care environments in private hospitals within the Cape Metropole, with nurses observing or experiencing a form of horizontal violence every day.

Irrespective of the abusive behaviours through which horizontal violence manifests among nurses working in intensive care environments, this can have an impact on the victims, the relationships the victims have with colleagues as well as the organisation for which they work (Johnson 2011:55–61). Throughout the rest of the chapter the researcher reports on the study findings related to each of the hierarchical systems of the conceptual model, and the impact horizontal violence has on each of the systems.

4.4.2 The microsystem

The microsystem represents the interpersonal relationship of the victims or abusers with themselves as well as the relationship between the victims and abusers. Within the microsystem, horizontal violence negatively affects people's interpersonal relationships, leading to changes in their professional capabilities, as they become unsure of their own personal capabilities (Johnson, 2011:57). Question 9 of Section 2 of the self-administered questionnaire aimed at

determining possible reasons as to why horizontal violence exists among nurses. Four of the 16 possible reasons as to why horizontal violence exists among nurses were part of the microsystem and the results are presented as follows. The remaining 12 possible reasons as to why horizontal violence may exist among nurses are discussed in the sections on the mesosystem, exosystem and macrosystem. The participants' responses to these possible reasons is presented in Table 4.

Table 4: Participants' responses to possible reasons as to why horizontal violence exists among nurses

Violence exists in nursing because	True	False	No views
Not all nurses are compassionate to colleagues	n = 99 87 %	n = 11 7 %	n = 5 6 %
Not all nurses are compassionate to patients	n = 97 85 %	n = 16 12%	n = 2 3 %
Some nurses equate quality patient care with bullying of other nurses	n = 58 47 %	n = 33 28 %	n = 21 25 %
Nurses as professionals do not support each other	n = 74 66%	n = 32 25%	n = 9 9%

Compassion for others, such as colleagues and patients, is a personal character trait. Table 4 shows that 87% (n = 99) of the participants reported that a lack of compassion towards colleagues and 85% (n = 97) that a lack of compassion towards patients contribute to horizontal violence existing among nurses. A further 47% (n = 58) of the participants reported that their fellow nurse colleagues equate quality care with bullying others, while 66% (n = 74) reported that a lack of support from colleagues contributes to the existence of horizontal violence among nurses.

The impact horizontal violence has on victims gradually develops into a collection of physiological, psychological and social problems. These problems can have serious consequences for the victims, as they can suffer from minor to major physical and psychological symptoms (Felblinger, 2008:237). Questions 15 to 24 of the self-administered questionnaire

determined the impact and effects horizontal violence can have on nurses who have experienced or witnessed horizontal violence in the workplace and is presented in Table 5.

Table 5: The effects horizontal violence can have on a victim's psychological and physical well-being

	Daily	Weekly	Monthly	A few times	Once	Never
Professional discouragement	n = 15 12%	n = 11 12%	n = 3 4%	n = 57 49%	n = 10 8%	n = 21 16%
Internalised negative feelings	n = 5 3%	n = 2 3%	n = 2 3%	n = 58 51%	n = 19 13%	n = 31 27%
Experience physical symptoms	n = 2 2%	n = 3 3%	n = 0 0%	n = 42 32%	n = 17 15%	n = 53 47%
Refrain from asking questions out of fear of being ridiculed	n = 5 4%	n = 5 5%	n = 3 5%	n = 44 32%	n = 9 10%	n = 52 44%
Nurses not speaking up because of fear of retaliation	n = 7 6%	n = 9 12%	n = 2 1%	n = 47 37%	n = 11 10%	n = 41 33%

Table 5 shows that most participants (n = 58, 51%) had experienced internalised negative feelings about themselves after experiencing or witnessing horizontal violence in the workplace a few times a year. Professional discouragement was experienced by almost half of the participants (n = 57, 49%) a few times a year, while more than one-third (n = 47, 37%) of the participants did not speak up about concerns in the workplace because they feared retaliation from their colleagues. Twelve per cent (n = 15) of the participants experienced feelings of professional discouragement daily after either experiencing or witnessing horizontal violence in the workplace. However, 47% (n = 53) of the participants had never experienced physical symptoms after experiencing or witnessing horizontal violence. For 44% (n = 52) of the participants, the fear of becoming a victim of horizontal violence had never prevented them from asking questions at work.

The study results demonstrate that horizontal violence has interpersonal effects on victims. Victims can become unassertive and even present with physical symptoms. An abuser's

presence or absence has the potential to influence a victim's function ability. This can be seen in a comment provided by a victim of horizontal violence extracted from Section 5 of the questionnaire:

> *I am highly sensitive. I am unassertive and more likely to be bullied by shift leader/unit manager. At the start of my time at [name of hospital], I started having neurological vague symptoms due to victimisation from my unit manager. She has left now. Having become more accepted. I am a little tougher (but still a target).* (Q118)

The study findings support the statement that horizontal violence can lead to nurses not pointing out others' mistakes, as they fear becoming victims of abuse. Forty-six per cent (n = 56) of the participants reported 'sometimes' and 7.7% (n = 9) 'always' on the statement that fear of becoming a victim keeps them from pointing out a colleague's mistakes. Forty- seven per cent (n = 52) of the participants reported that they have never avoided pointing out a colleague's mistakes because they fear abuse in the workplace. Table 6 presents participants responses towards horizontal violence being a cause for nurses to call in sick to work.

Table 6: Participants' responses to horizontal violence leading to nurses taking sick leave or even resigning

	Yes	**No**	**Undecided**
Nurses call in sick to work because of horizontal violence	n = 86 75%	n = 28 25%	N/A
Participants themselves have called in sick to work because of horizontal violence	n = 30 74%	n = 87 25%	N/A
Horizontal violence causes participants to resign from their permanent employment	n = 23 16%	n = 51 51%	n = 42 33%

In total, 75% of the participants responded that horizontal violence contributes to nurses calling in sick. The reverse was noted, in which participants reported that for 74% of them horizontal violence has never caused them to call in sick to work. For just more than half of the participants (n = 51, 51%), experiencing or witnessing horizontal violence had never led them to resign from their permanent employment. Thirty-three per cent (n = 42) of the participants have not yet

decided on resigning from their permanent employment because of horizontal violence. One participant reported thinking about resigning form their work because of a hostile work environment.

> *And this makes me think to resign and work somewhere where things aren't so hostile.* (Q077)

Horizontal violence can have an effect on victims' intrapersonal relationship with oneself and may later lead to changes in their professional capabilities (Johnson, 2011:58). Question 25 of the self-administered questionnaire determined possible unsafe nursing practices that nurses who are abused at work may undertake because they fear asking for help from their colleagues. Participant's responses to undertaking such unsafe nursing practices are presented in Table 7.

Table 7: Unsafe practices performed by nurses who fear becoming victims of horizontal violence

Unsafe nursing practices	Applicable
Does not apply – I have never personally experienced horizontal violence	n = 35 29%
I have muddled through patient procedures that I felt unclear about rather than asking someone to show me	n = 16 13%
I have used a piece of medical equipment that I was unfamiliar with, or only partly familiar with, rather than seek help from a co-worker	n = 21 20%
I have lifted or assisted extremely heavy or debilitated patients alone rather than ask for assistance	n = 44 36%
I have given a medication or performed a treatment I was unsure about rather than call a physician to obtain clarification or new/different orders	n = 9 9%
I have interpreted an unreadable order the best I could rather than calling for clarification ("I *think* it says…")	n = 4 3%
I have withheld treatment from a patient because I did not understand the instructions but was afraid to ask for help from my colleagues	n = 4 3%
I have carried out an order that I did not feel was in the best interest of my patient without challenging it	n = 20 20%

Table 7 shows possible practices that nurses undertake alone because they fear being victimised in the workplace when asking for help. Thirty-six per cent (n = 44) of the participants reported that they have lifted or mobilised heavy patients on their own, 20% (n = 21) reported using medical equipment without having the knowledge of how to operate it, and 20% (n = 20) carried out an order that they felt was not in their patient's best interest without asking for help because of their fear of being victimised. For 29% (n = 35) of the participants, horizontal violence had never caused them to perform unsafe practices.

Throughout the study, the most frequently reported effects horizontal violence may have on victims was that of a psychological nature, in which participants daily felt professionally discouraged after not receiving positive feedback from their colleagues. The most frequent psychological effect that occurred monthly was participants not asking questions at work because they feared being ridiculed by their colleagues. Participants feeling negative about themselves several times a year was the most common effect horizontal violence had on nurses in the workplace. From these findings it appears that psychological effects are more commonly experienced than physical symptoms, as physical symptoms were reported to be experienced the least. Other effects horizontal violence had on nurses included lifting or assisting extremely heavy patients alone and carrying out orders they felt was not in the best interest of their patients, but they feared challenging the orders. These findings demonstrate that horizontal violence has an impact on nurses working in intensive care environments in private hospitals within the Cape Metropole and can affect the quality of patient care they deliver.

4.4.3 The mesosystem

The mesosystem represents the immediate work environment of the victims and abusers and their colleagues. The mesosystem does not include managers, as they function on a different hierarchical level than the nurses who work directly with patients.

In this section, the nurse colleagues who work with both the victim and abuser is discussed, and how these nurses can influence the environment in which they work, creating an environment that allows for the existence of horizontal violence. Questions 28 and 30 of Section 5 of the self-administered questionnaire focused on the environment changing depending on which colleagues are on duty. And is presented in Table 4.7.

Table 8: Atmosphere changes in the working environment

	Yes	No
The environment at work feels more 'hostile' on certain days compared to other days	n = 94 83%	n = 22 17%
The atmosphere at work feels more 'hostile' depending on which colleagues are on duty	n = 98 87%	n = 16 13%

Table 8 shows that for 83% (n = 94) of the participants, their work environment feels more 'hostile' on some days than others, while 87% (n = 98) reported a more 'hostile' atmosphere at work when certain colleagues are on duty. Comments provided by the participants in Section 5 of the questionnaire relating to their colleagues' behaviours provided further insight into how the working environment can change depending on which nurses are on duty.

> *The reality is today that in this era it feels at times that nursing [has] become a 'war zone' due to less staff, more pressure and at times difficult patients, nurses and all consequent behaviour.* (Q037)

Questions 26 and 30 of Section 5 of the self-administered questionnaire determined whether participants are abused by their colleagues who work with them in ICU or ICU/HCU. The colleagues of the victim and the abuser focused on in the mesosystem included all nurses who work within the immediate working environment of the victim and abuser. These colleagues include the nurses who work directly with the victim and abuser. An example of these nurses include professional nurses, enrolled nurses and enrolled nursing assistants. Abuse from these colleagues is presented in Table 9.

Table 9: Nurse colleagues as the abusers in the workplace

	Daily	Weekly	Monthly	A few times	Once	Never
Nurse colleagues as the abusers	n = 18 14%	n = 14 15%	n = 2 2%	n = 63 55%	n = 10 6%	n = 10 8%

Nurse colleagues included professional nurses, enrolled nurses and enrolled nursing assistants who work with the participants in the ICU or ICU/HCU of private hospitals within the Cape Metropole. Fourteen per cent (n = 18) of the participants experienced or witnessed abuse from their colleagues daily, while 15% (n = 14) experienced or witnessed abuse from their colleagues weekly. More than half of the participants (n = 63, 55%) experienced or witnessed abusive behaviours from their colleagues a few times a year.

Shift leaders function on the same hierarchical level as the nurses working in the intensive care environments. Eighty-nine per cent (n = 101) of the participants reported that certain shift leaders cause the working environment to become more 'hostile', while 11% (n = 12) reported this not to be true.

Question 7 of Section 1 of the self-administered questionnaire reported on participants' views of the support systems within their organisation that are in place to help victims report and deal with horizontal violence in their workplace. Forty-two per cent (n = 47) of the participants were uncertain of the support systems in place, 22% (n = 22) reported that no support systems were in place and 36% (n = 43) reported there are support systems in place within their organisation to assist personnel in dealing with abuse in the workplace.

Victims of horizontal violence can choose to keep quiet about being abused at work or they can choose to report the abuse. Question 31 of Section 5 of the self-administered questionnaire determined to whom participants (who had either experienced or witnessed horizontal violence in the workplace have spoken to abuse the abuse. Table 10 presents possible person in which the participant may have spoken to.

Table 10: Person a victim of horizontal violence spoke to about the abuse

Have not spoken to anyone	n = 8 5%
Have spoken with friends and family	n = 40 35%
Have spoken with some of my co-workers	n = 53 49%

Have spoken with the shift leader	n = 42 35%
Have spoken with my unit manager	n = 59 45%
Have spoken with my nursing service manager	n = 8 8%
Have spoken with Human Resources or another relevant department	n = 8 3%
Have spoken to the person but probably didn't completely express my concerns	n = 13 11%
Have spoken to the person and completely expressed my concerns	n = 20 14%

Table 10 shows that 45% (n = 59) of the participants who experienced or witnessed horizontal violence reported the matter to their unit manager and 49% (n = 53) spoke to their colleagues. Eleven per cent (n = 13) took the matter into their own hands and spoke to their abuser themselves, but did not fully express their concerns, while 14% (n = 20) of the participants fully expressed their concerns to the abuser.

Receiving support from colleagues, managers and the organisation may not only decrease the chances of horizontal violence existing in intensive care environments, but also support nurses who experience stress outside of the workplace. Having adequate support systems in place is therefore very important to prevent the existence of horizontal violence among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole.

4.4.4 The exosystem

The exosystem represents the societal structures outside of the victims' and abusers' immediate working environment. These include the unit managers, organisation at which they are employed, the neighbourhood in which they live and their government (Johnson, 2011:58). Unit managers play an important role within the exosystem and can make a difference in terms of the impact horizontal violence can have on a victim by giving the necessary support to employees who are abused in the workplace. Almost two-thirds of the participants (n = 62, 61%) reported

that they had supportive unit managers, while (n = 49, 39%) reported having unsupportive unit managers. Not only can managers lack in providing the necessary support to nurses who experience horizontal violence, but they themselves can also be the perpetrators of horizontal violence. Table 11 reports on participants responses on managers being the abusers in the workplace.

Table 11: Managers as the abusers in the workplace

	Daily	Weekly	Monthly	A few times	Once	Never
Supervisors such as managers are the abusers in the workplace	n = 11 10%	n = 12 11%	n = 4 5%	n = 70 59%	n = 4 3%	n = 15 12%

Table 11 shows that 59% (n = 70) of the participants were abused by their supervisors several times a year. Ten per cent (n = 11) suffered abuse from their manager daily, while 12% (n = 15) reported their managers have never abused them. Table 12 reports on participants responses towards managers and in-service training programs being able to prevent the occurrence of horizontal violence in the ICU or ICU/HCU.

Table 12: Participants' responses to managers and in-service training programmes to prevent horizontal violence

Violence in nursing exists because -	True	False	No views
Nurse managers bully junior nurses	n = 48 40%	n = 51 47%	n = 15 13%
All nurses must undergo assertive training	n = 97 83%	n = 8 7%	n = 11 9%
Nurses need to be trained in basic self-defence techniques	n = 78 64%	n = 22 23%	n = 15 13%
In-service training programmes will increase the confidence of nurses	n = 104 90%	n = 7 5%	n = 5 5%

Health and safety at work must focus more on nurses exposed to violence	n = 94 76%	n = 12 13%	n = 9 11%
Some nurses are rude to senior managers only	n = 28 22%	n = 63 53%	n = 24 25%

Table 12 shows that participants reported being abused by their nurse managers (n = 48, 40%) and that in-service training such as assertiveness training (n = 97, 83%) will increase nurses' confidence (n = 104, 90%).

In the context of South Africa, especially Cape Town, the society in which nurses live is a dangerous one. In 2016, Cape Town was rated as one of the most dangerous cities (Staff Writer, s.a.). The exosystem of the conceptual model not only includes the organisation at which nurses are employed, but also the society in which they live. Table 13 reports participants' responses on the influence society may have on the existence of horizontal violence amongst nurses.

Table 13: Participants' responses to the influence society has on the existence of horizontal violence amongst nurses

Violence in nursing exists because -	**True**	**False**	**No views**
The public is not happy with service provided by nurses	n = 29 23%	n = 59 56%	n = 22 21%
Patients and their families have no respect for nurses	n = 49 40%	n = 43 44%	n = 20 16%
Nurses are the street-level bureaucrats for the ministry of health	n = 36 31%	n = 28 24%	n = 44 44%
Violence in society has spread to the hospitals and clinics	n = 63 59%	n = 34 27%	n = 17 15%

The violence that exists in the society of Cape Town can be said to be a reason as to why nurses are abusive towards others. Fifty-nine per cent (n = 63) of the participants reported that societal violence has spread to hospitals and clinics and 40% (n = 49) reported that patients and their families have no respect for nurses.

There are numerous reasons as to why horizontal violence exists among nurses – a lack of respect from patients and the community and societal violence, to mention only a few. Lack of support or even being abused by their managers creates an environment in which horizontal violence can flourish in the workplace. However, nurses themselves can also be a reason as to why violence exists in their workplace. The macrosystem focuses on two possible interpersonal reasons nurses may have for taking part in abuse in the workplace.

4.4.5 The macrosystem

Violent societies and patients are not always to blame for violence existing in nursing. Nurses themselves can be a possible reason for the existence of violence in their profession. Table 14 further reports on possible reasons why horizontal violence exists amongst nurses.

Table 14: Interpersonal reasons for nurses to take part in horizontal violence

Violence in nursing exist because -	True	False	No views
Some nurses are in the job because of financial reasons	n = 93 84%	n = 18 12%	n = 6 3%
Nursing is no longer a calling but just like any other job	n = 74 70%	n = 26 20%	n = 13 10%

On the statement, “Nursing is no longer a calling but just like any other job”, 70% (n = 74) of the participants reported this to be true. Further, labelling nursing as a ‘calling’ implies that no matter what financial income or stability the profession offers, nurses across the board do it for the love of the job. Eighty-three per cent (n = 93) of the participants reported that some nurses are only in the profession for financial reasons.

Irrespective of reasons why people choose to become nurses, horizontal violence remains a big concern, as it originates from within the persons themselves and then only spreads to others.

4.5 Summary

The research findings demonstrate that horizontal violence occurs among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. The

most common forms through which horizontal violence occurs are covert and overt abusive in the form of belittling others, making complaints about colleagues, negative facial gestures and ignoring colleagues. These abusive acts lead to victims suffering from emotional distress and even presenting with physical signs. Not only does the victim suffer from the abuse, but the quality of patient care rendered by the victimised nurse is also affected. Nurses turn to unsafe practices, placing their patients' safety in jeopardy, as they are too sacred to ask for help from their colleagues. Throughout chapter 5 the research findings are discussed in relation to relevant literature.

CHAPTER 5: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In Chapter 5 the findings of the study are discussed in relation to relevant literature and conclusions are drawn from the research findings. The limitations of the study and recommendations made by the researcher are discussed. This chapter draws together the threads of the study as developed in the previous chapters. In chapters 1 and 2 the study rationale and an in-depth literature review were presented with regard to horizontal violence among nurses working in a hospital setting. In chapters 3 and 4 the research methodology, analysis and interpretation of the collected data were presented and discussed.

Horizontal violence is abuse among colleagues who function on the same hierarchical level. Various forms of abuse can manifest among colleagues, including psychological and physical abuse (Wilson *et al.*, 2011:453). Victims who are exposed to long-term horizontal violence gradually develop physiological, psychological and social problems as an outcome of their experiences at the hands of abusers. Horizontal violence can have serious consequences for victims as a result of physical and psychological symptoms that can have a minor or major effect on the abused person (Felblinger, 2008:237).

5.2 Discussion of study findings

The aim of this study was to investigate the frequency and form of horizontal violence among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole as well as the effects this may have on a victimised person. The researcher's intention was to quantify and describe this phenomenon (horizontal violence) as it occurs and therefore data were collected from participants working in eleven intensive care environments across six private hospitals. A final sample size of 118 was achieved. The findings from the data presented in Chapter 4 are discussed further in this section.

Three research objectives provided the framing of the study to enable the researcher to describe the phenomenon of horizontal violence among nurses in intensive care environments. The following research objectives were formulated:

- Determine the frequency of horizontal violence as experienced by nurses working in intensive care environments
- Identify and describe the ways horizontal violence is experienced by nurses working in intensive care environments
- Describe the effects of horizontal violence as identified by nurses working in intensive care environments.

In the following subsections, an overview of the demographics of the participants is provided and then the findings relevant to each study objective are discussed.

5.2.1 Participant demographic profile

The majority of the study participants self-identified as female (86% [n = 101], with 14% (n = 17) of the participants self-identifying as male. The average age of the participants was 39 years with the range being 24 years to 61 years. The gender distribution demonstrated in these findings reflect the data provided in the 2016 annual statistics released by the South African Nursing Council. These statistics show the gender distribution of nurses registered in the Western Cape to be 95.9% female, while 7.6% of the nurses were male (*South African Nursing Council*, s.a.). This gender pattern in nursing is not unique to South Africa, with a similar picture shown through a scoping review on workplace aggression among nurses working in Tasmania. In that study, 92.8% of nurses were female, while 7.2% were male (Farrell *et al.,* 2006:781).

Professional nurses constituted 67% (n = 79) of the study sample, with enrolled nurses comprising 27% (n = 32) of the study sample and enrolled nursing assistants 6% (n = 7). The South African Nursing Council's registration of 2016 showed that 53% of nurses registered in the Western Cape were professional nurses. The enrolled nurses were 21%, and the enrolled nursing assistants were 26% (*South African Nursing Council*, s.a.). The majority of the participants had a specialist nursing qualification (52%, n = 57). Of these participants, 30% (n = 35) had a specialist qualification in intensive care nursing, with 2% (n = 2) of the participants holding a specialist qualification in emergency care nursing and 1% (n = 1) in advanced midwifery. The remaining 19.4% (n = 19) of the participants self-classified as holding a specialist qualification but did not specify in which discipline of nursing.

The average number of years worked in the current unit by the study participants was four years, with the range being from one month to 28 years. In a study exploring horizontal violence among nurses in the USA, most of the participants (n = 102, 45%) had more than 21 years of experience as a nurse/specialist nurse (Hader, 2008:16), which were similar to the demographical profile of the participants for this study. In the current study, 39.3% (n = 46) of the participants had more than 15 years' experience.

Therefore, in this study, the participants were mostly female professional nurses who held a specialist qualification in intensive care nursing, had worked in an ICU or ICU/HCU for an average of four years and had more than 15 years of experience as a nurse. This profile is similar to that of other studies conducted on horizontal violence in countries such as the USA and Australia.

5.2.2 Study objectives 1 and 2: Discussion of findings

Objectives 1 and 2 together describe the forms and frequency of horizontal violence as experienced among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole.

Five forms of abuse, namely vilification, ignoring colleagues, criticising colleagues, complaining about colleagues behind their back and making negative facial gesture towards colleagues were investigated. Both covert and overt forms of abuse were reported as being experienced by the participants. Covert abusive behaviours include vilification and being ignored by one's colleagues, while overt abusive behaviours include being criticised by colleagues, having complaints made about a person by colleagues and having colleagues displaying negative facial gestures towards a person.

The study participants reported being ignored by their colleagues in the workplace as the most common form of abuse from the five forms of abuse investigated. More than one-third of the participants (n = 35, 32%) self-reported being ignored by their colleagues as a daily experience, while almost half of the participants experienced this covert form of abuse at least several times a year (n = 60, 49%). The second-most common form of abuse reported by the participants was having colleagues complaining about each other; 21% (n = 25) experienced this form of overt abuse daily and 54% (n = 61) experienced this several times a year. The third-most common

form of abuse to occur among nurses was of a covert nature, in which colleagues displayed negative facial gestures towards each other. Twenty per cent (n = 26) of the participants reported experiencing this form of overt abuse daily and 44% (n = 53) several times a year.

These study findings are supported by those of a local study as well as international studies conducted on horizontal violence. In the public healthcare sector hospitals in Cape Town, 30% (n = 471) of participants self-reported as being victims of covert abuse in the workplace (Khalil, 2009:211), with gossip being the most often-reported form of covert abuse. Internationally, a study among Turkish nurses revealed that 56% of the participants reported vilification as the most common form of horizontal abuse to occur in their workplace. Furthermore, 34% of the participants reported that their fellow colleagues were the abusers (Yildirim, 2009:507). In an online survey conducted in Virginia in the USA among nurses (Dumont *et al.,* 2012:45), vilification was reported as the third-most frequent form of abuse to occur in the workplace. Other findings from this study showed being ignored by their colleagues and receiving harsh criticism from colleagues as the fourth-and fifth most common form of abuse to occur in that workplace (Dumont *et al.,* 2012:45).

In this study, forms of overt abuse investigated included colleagues complaining about victims and responding to colleagues with negative facial gestures, such as raising an eyebrow or rolling their eyes. Harsh criticism of colleagues is a form of overt abuse, where abusers make a public display of humiliating their victims in front of others (Farrell, 1997:501; Wilson *et al*., 2011:453). While some forms of overt abusive behaviours were experienced by some participants as a daily occurrence, overt abuse was experienced at least a few times a year by more participants.

Being complained about by colleagues was reported as a daily occurrence by 21% (n = 25) of the participants and 20% (n = 26) of the participants reported having colleagues responding with negative facial gestures towards them. More participants experienced overt abusive behaviours at least a few times a year; for example, 54% (n = 61) reported having complaints made about them, 52% (n = 62) reported being harshly criticised and 44% (n = 53) reported having negative facial gestures made towards them by colleagues.

Both local and international studies support this study's findings on the form of overt abuse. In a local study, 348 (26%) nurses working in public healthcare sector hospitals reported

experiencing overt abusive behaviours in their workplace (Khalil, 2009:215). In a study conducted in New Zealand among newly registered nurses, 34% (n = 188) reported experiencing harsh and unjust criticism, with inappropriate racial comments and gestures experienced by 4% (n = 25) of the participants and a further 3% of participants being harassed through formal complaints by colleague*s* (McKenna et al., *2003*:93). Furthermore, 59.7% (n = 960) of Tasmanian nurses reported encountering unjustified criticism in the workplace. Verbal abuse as an overt abusive behaviour has been reported by 89.6% of nurses working in southern Ethiopia (Fute *et al.,* 2015:3) and 69% (n = 82) of nurses working in intensive care environments in Tasmania (Farrell *et al.,* 2006:783).

From the findings of this study, it can be concluded that both covert and overt abusive behaviours occur among nurses working in ICU or ICU/HCU The most common form of covert abusive behaviour is being ignored by colleagues and that of overt abusive behaviour is colleagues complaining about one another in the workplace. Both covert and overt abusive behaviours occur daily (e.g. being ignored); however, more participants experienced some form of covert and/or overt abusive behaviour at least a few times a year.

5.2.3 Study objective 3: Discussion of findings

The intention of Objective 3 was to establish the effects of horizontal violence as reported by the nurses who participated in the study. Personal psychological effects and the experience of physical symptoms by a nurse after abusive interactions were investigated as well as the participants' perspectives related to the impact of horizontal violence on the quality of care.

The most-reported psychological effects were participants having internalised negative feelings (51%, n = 58), professional discouragement (49%, n = 57) and fear of retaliation from their colleagues (37%, n = 47). Most participants reported feeling these effects several times a year. In terms of physical symptoms, 32% (n = 42) reported symptoms such as headaches, an inability to sleep and abdominal pains. The majority of the participants reported experiencing these physical symptoms at least several times a year. In the current study, the participants reported that their work environment feels more 'hostile' on some days than others and that the atmosphere changes depending on which colleagues are on duty. These experiences may further aggravate the psychological effects experienced by a person due to horizontal violence, as well as negatively influence teamwork and care delivery.

The physical and psychological findings in this study are consistent with those reported by McKenna *et al.* (2003:95), albeit with a different population. In this study, New Zealand nurses in their first year of practice reported feeling less confident and having a lower self-esteem after experiencing horizontal violence. Participants also reported being anxious, afraid and sad. In the same study, nurses reported having experienced physical symptoms such as headaches, fatigue and weight loss (McKenna *et al.,* 2003:95). Seventy-five per cent (n = 86) of the current study's participants reported that horizontal violence contributes to other nurses calling in sick. However, 76% (n = 87) of the participants reported that they themselves have never called in sick to work because of horizontal violence. The current study findings are supported by a study done in Arizona, in which 95% of the participants indicated that the experience of or concern with horizontal violence contributed to nurses calling in sick. Similarly, 80% of the nurses reported that they have never called in sick as a result of horizontal violence (Wilson *et al.,* 2011:457).

Horizontal violence can also affect the quality of care provided to patients. Almost half of the participants (46%, n = 56) indicated that they have refrained from pointing out mistakes made by colleagues because they fear victimisation, with 8% (n = 9) having never pointed out a colleague's error due to the same concern of becoming a victim. Furthermore, 46% (n = 51) of the participants reported that being exposed to horizontal violence has caused them to make mistakes in the workplace. It is clear from this study and supporting literature that a person's experience of horizontal violence can lead to serious physical, psychological and social problems. The psychological consequences of horizontal violence may influence a nurse's professional capabilities (Johnson, 2011:58) where, for example, a nurse may not report mistakes made by colleagues for fear of reprisals. A positive correlation was established between nurses experiencing horizontal violence and their job performance, professional motivation, energy level and commitment to work (McKenna *et al.,* 2003:95).

In Tasmania it was found that up to two-thirds (n = 965) of nurses reported having at least occasionally made errors in their work and had their work productivity affected through their experience of aggression and horizontal violence in the workplace (Farrell *et al.,* 2006:783). A much smaller number of participants (0.7%, n = 4) in the New Zealand study indicated that horizontal violence compromised the safety of their patients (McKenna *et al.,* 2003:95).

Quality of care is also negatively affected when a nurse chooses to engage in unsafe practice behaviours rather than ask for assistance for fear of negative responses from colleagues. The four most-reported unsafe behaviours noted by the participants in this study were: lifting or mobilising heavy patients on their own (36%, n = 44), using unfamiliar medical equipment without asking for help (20%, n = 21), carrying out orders they felt were not to the best interest of the patient without questioning the orders (20%, n = 20) and muddling through procedures of which they were uncertain because they feared asking for help from their colleagues (13%, n = 16). In the context of caring for a critically ill patient, any of these behaviours holds serious negative consequences and potential injury for the patient as well as the nurse.

Sufficient appropriately qualified personnel are another necessary element of being able to provide quality care to a critically ill patient. Nurses who have been victimised through incidents of horizontal violence are likely to consider leaving or else do leave their employment. In studies conducted in the USA and Australia, between 19% and 24% of the study participants had considered leaving their current employment as a result of experiencing horizontal violence, with 11% reporting that they left their previous employment because of horizontal violence in the workplace (Farrell *et al.,* 2006:782–783; Wilson *et al.,* 2011: 457). Similar results were seen in the current study, where 19% of the study participants reported having considered leaving their current employment. Nurse colleagues who abuse their colleagues daily were reported by 14% (n = 18). Supervisors and managers being the abusers were reported by 10% (n = 11) of the participants. Furthermore, 55% (n = 63) of the participants reported their colleagues as being the abusers a few times a year and 59% (n = 70) reported their supervisors as being the abusers in the workplace.

After considering these results, it is clear that horizontal violence as it occurs between nurses working in an intensive care environment does exist in the private healthcare sector within the Cape Metropole. This study has shown that nurses working in intensive care environments who experience horizontal violence through covert or overt abusive behaviours suffer psychological and physical symptoms, and even considered extreme solutions such as resigning from their jobs. However, horizontal violence has an impact not only on the nurse victims themselves, but also on the immediate environment and the patients they care for.

5.3 Limitations of the study

The study was conducted in eleven ICUs or ICU/HCU of six private healthcare hospitals within the Cape Metropole. Hospitals in the public healthcare sector were excluded from the study. The study findings can therefore not be generalised to nurses working in intensive care environments in public healthcare hospitals. Furthermore, the study was conducted in private healthcare hospitals located in the Cape Metropole only, and therefore cannot be generalised to all nurses working in intensive care environments in South Africa.

The possibility existed that the majority of the participants who took part in the research study were victims of horizontal violence, while nurses who had never been victims of horizontal violence chose not to take part in the study. Subsequently, each participant may not necessarily represent the same number of nurses in the population, therefore the possibility exists that the study findings are not a true reflection of the horizontal violence that exists among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole.

5.4 Recommendations from the study

The following recommendations are made based on the evidence generated through this study, and are discussed below:

- Zero tolerance policy for horizontal violence in the workplace
- Implementation of training programmes on dealing with horizontal violence
- Implementation of safe and confidential support systems for victims of horizontal violence.

The study findings serve as evidence that horizontal violence is a real problem among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. Further to this, the study showed that nurses, their colleagues and patients are placed at physical and psychological risk as a result of abusive behaviours. Therefore, the overarching recommendations from this work are directed towards empowering nurses to better deal with horizontal violence in the workplace as well as to encourage employing organisations to recognise horizontal violence as a workplace problem, institute measures to ensure that abusive behaviours can be reported and are taken seriously and take a zero tolerance approach to abuse in the workplace.

5.4.1 Zero tolerance policy for horizontal violence in the workplace

The researcher gave feedback to each of the three private hospital groups, the nursing manager of each of the six private hospitals and each unit manager of the eleven ICU/HCUs in the form of a report. By giving feedback, the researcher aimed to raise awareness within these organisations of the existence of horizontal violence and the effect it may have on personnel exposed to abuse in the workplace. The researcher's intent was to encourage the organisations and managers to review policies on horizontal violence in the workplace and instil the importance of having a zero tolerance policy for abuse in the workplace. It is critical for unit managers and hospital managers to create safe environments in which nurses feel comfortable to work and/or report horizontal violence in the workplace.

5.4.2 Implementation of training programmes on dealing with horizontal violence

The feedback to the organisations and managers will aid in raising awareness on the importance of assertiveness and self-confidence training among nursing personnel. Training nurses on essential elements of teamwork and communication will encourage nurses to work together as a team and eliminate horizontal violence among nurses. Training programmes can equip nurses with the necessary skills to stop the cycle of abuse be refusing to be a victim of horizontal violence. Training nurses on the support systems available to them can help with gaining control over the abuse occurring in their workplace, allowing them to report the abuse. In this study, 83% of the nurses reported that assertiveness training is needed and 90% reported that self-confidence training will equip nurses with better skills to deal with horizontal violence.

5.4.3 Implementation of safe and confidential support systems for victims of horizontal violence

In this study, 39% of the nurses felt unsupported by their unit managers in the workplace. Nurses were asked to report on the support systems available within their organisations; 42% were uncertain whether any support systems were in place, while 22% were certain there are were support systems in place to help nurses deal with abuse in workplace. The results serve as evidence that a safe and confidential support system is necessary, allowing nurses to report horizontal violence without fearing repercussions. By giving feedback to the organisations and unit managers, the researcher aimed to better their understanding of horizontal violence and the importance of having effective support systems in place.

5.5 Future research

This study showed that horizontal violence exists among nurses working in intensive care environments in the private healthcare sector within the Cape Metropole. Due to the nature of the quantitative questionnaire the data collected regarding the forms of horizontal violence and the effects it has on victims were limited. Therefore, a qualitative study researching horizontal violence in more depth will be appropriate to collect more in-depth data.

Future research is needed to determine whether there is a possible link between participants' profile (age, gender, professional category and years of experience) and either being a victim of horizontal violence or being the abuser indulging in behaviours associated with horizontal violence.

The research study was conducted in intensive care environments in the private healthcare sector within the Cape Metropole and therefore extending the population for future research to include nurses working in the public healthcare sector would add more value to the study. Furthermore, extending the study population of nurses working in other areas, such as the rest of the Western Cape and other provinces, will provide data that can be used to make generalised findings on horizontal violence among nurses working in South Africa.

5.6 Conclusions

The discussions in this final chapter were based on the achievement of three study objectives. The study results confirmed that horizontal violence exists among nurses working in intensive care environments in private hospitals within the Cape Metropole. Nurses experienced horizontal violence from a few times a year to even daily. These finding are similar to the findings of Khalil (2009:211), in which 29% of nurses were experiencing horizontal violence in a public hospital in Cape Town.

Moreover, the study objectives provided answers in terms of the effects horizontal violence has on nurses as well as on the quality of patient care victimised nurses deliver to patients.

It can therefore be concluded that the research question, "What is the extent and nature of horizontal violence among nurses working in the private healthcare sector intensive care environment?" has been answered.

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Appendix A: Ethical approval from Health Research Ethics Committee

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
New Application

08-Aug-2016
Rust, Hanri H

Ethics Reference #: S16/06/098

Title: **Investigating horizontal violence amongst nurses working in intensive care environments within the private health care sector**

Dear Ms Hanri Rust,

The **New Application** received on **05-Jul-2016**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **01-Aug-2016** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **08-Aug-2016 -07-Aug-2017**

Please remember to use your **protocol number** (**S16/06/098**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel:

Appendix B: Letters of hospital approvals to conduct the study

!R!PSRC100;EXIT;!R!MTYP99;EXIT;!R!spsz8;stm0;exit;

[redacted]

[redacted]

13 September 2016

ATTENTION: H Rust

SUBJECT: APPLICATION TO CONDUCT RESEARCH

TITLE: **Investigating horizontal violence amongst nurses working in intensive care environs.**

Our previous correspondence refers.

The Research Ethics Committee hereby conditionally approves your request.
Approval number: 20160913-06. Valid until 2017/09/30.

The approval is conditional to your agreement on the following provisos:

1. You must request permission (in writing) from the Hospital Manager and Nursing Manager of the [redacted] facility in which you intend conducting your research, accompanied by this letter.
2. [redacted]ill not be liable for any costs incurred during or related to this study.
3. [redacted] patient or institutional confidentiality be compromised [redacted] has the right to withdraw the permission and take legal action.
4. The researcher will provide [redacted] Research Ethics Committee with an update on the progress of the study every four months.
5. An electronic copy of the final research report is submitted to the [redacted] Research Ethics Committee ***prior*** to publication.
6. No direct reference is made to [redacted] or its various facilities in the research report or any publications thereafter.
7. The Company and its facilities are not in any way identifiable in the study.
8. On completion of the degree, an electronic (.pdf) copy of the research report will be provided to [redacted] This copy will be uploaded to the institutional repository.
9. [redacted]indly clear copy-right issues with your supervisor and/or Higher Education Institution prior to accepting these terms and conditions.

Please sign this letter as indicated below and return to the sender within 5 working days:

I, H Rust, hereby agree to the provisos (points 1-9) as listed above.

Signature: H Rust

Date: 15-09-2016

We wish you the best in your studies and look forward to the final results.

Yours sincerely

[redacted]

on behalf of the Research and Scientific Committee.

[redacted]

[redacted]

RESEARCH APPLICATION – H RUST

Date: 29 August 2016

FOR APPROVAL

G VAN WYK
HR Executive

NOTES

- Locality : [redacted]
- Request : **Mediclinic Vergelegen** - only during the last week of October 2016
- Report : Report to nursing managers before distributing the questionnaire
- Employee : No
- Value of Study : Confirmed
- Topic : Investigating horizontal violence amongst nurses working in intensive care environments within the private health care sector
- Impact : 30 healthcare workers
- Supported by Hospital : [redacted]

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2016-0052

Ms H Rust

E mail: hanrirust@gmail.com

Dear Ms Rust

RE: INVESTIGATING HORIZONTAL VIOLENCE AMONGST NURSES WORKING IN INTENSIVE CARE ENVIRONMENTS WITHIN THE PRIVATE HEALTH CARE SECTOR

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

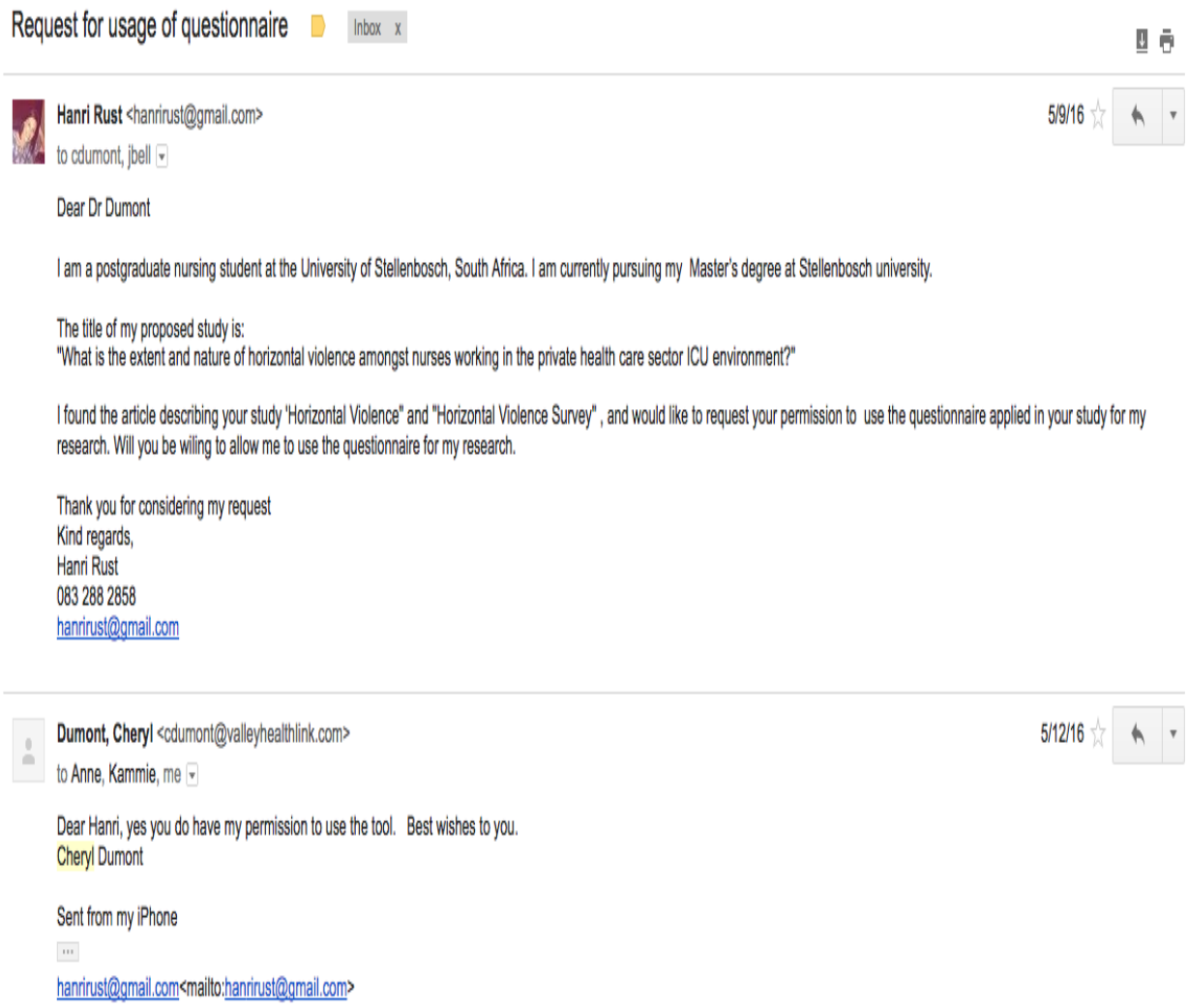
iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.

v) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

vi) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..

vii) The Company has the right to implement any recommendations from the research.

Appendix C: Permission letters for the use of data collection instrument



Request for usage of questionnaire Inbox x

Hanri Rust <hanrirust@gmail.com> 5/9/16

to cdumont, jbell

Dear Dr Dumont

I am a postgraduate nursing student at the University of Stellenbosch, South Africa. I am currently pursuing my Master's degree at Stellenbosch university.

The title of my proposed study is:
"What is the extent and nature of horizontal violence amongst nurses working in the private health care sector ICU environment?"

I found the article describing your study 'Horizontal Violence" and "Horizontal Violence Survey" , and would like to request your permission to use the questionnaire applied in your study for my research. Will you be willing to allow me to use the questionnaire for my research.

Thank you for considering my request
Kind regards,
Hanri Rust
083 288 2858
hanrirust@gmail.com

Dumont, Cheryl <cdumont@valleyhealthlink.com> 5/12/16

to Anne, Kammie, me

Dear Hanri, yes you do have my permission to use the tool. Best wishes to you.
Cheryl Dumont

Sent from my iPhone

hanrirust@gmail.com<mailto:hanrirust@gmail.com>

Request for the usage of questionnaire

Inbox x

Hanri Rust <hanrirust@gmail.com> 9/30/15

to profdkhalil, jbell

Dear Dr Khalil

I am a postgraduate nursing student at the University of Stellenbosch. I am currently pursuing my Master's degree at Stellenbosch university.

The title of my proposed study is:
Investigating the elements of horizontal violence that are experienced by nurses working in intensive care environments?

I found the article describing your study 'Levels of Violence Amongst Nurses in Cape Town Public Hospital", and would like to request your permission to use the questionnaire applied in your study for my research. If you are willing to allow me to use the questionnaire, please will you indicate where I may access a copy of the document

Thank you for considering my request
Kind regards,
Hanri Rust
083 288 2858
hanrirust@gmail.com

Doris Khalil <profdkhalil@gmail.com> 12/6/15

to me, jbell

Dear Hanri,
Apologies for the long delay in responding to your request. AS you appear to be requiring only section c of the questionnaire, I will send a copy as soon as possible. Kindly mail me a reminder if I do not get back to you by Wednesday
regards,
Emeritus Prof. Khalil

Hanri Rust <hanrirust@gmail.com> 12/15/15

to Doris

Good morning Prof Khalil

Thank you for considering my request. Can You please send me the mentioned section of your questionaire?

Happy holiday
Regards,
Hanri Rust

Doris Khalil <profdkhalil@gmail.com> 1/28/16

to me

Dear Hanri,
My sincere apologies for the delay. Please find attached sections of my questionnaire that would be relevant for your study. You are free to add or subtract sections that are not relevant for your study. You can also decide how you want to score the quantitative data.

Wishing you good luck with your study. Kindly acknowledge receipt

regards
Emeritus Prof. Khalil

violence in nursin...

Request for the usage of questionaire

Inbox x

Hanri Rust <hanrirust@gmail.com> 2/10/16
to barbara.wilson, jbell

Dear Dr Wilson

I am a postgraduate nursing student at the University of Stellenbosch, South Africa. I am currently pursuing my Master's degree at Stellenbosch university.

The title of my proposed study is:
Investigating the elements of horizontal violence that are experienced by nurses working in intensive care environments?

I found the article describing your study 'Horizontal Hostility; A Threat to Patient Safety", and would like to request your permission to use the questionnaire applied in your study for my research. If you are willing to allow me to use the questionnaire, please will you indicate where I may access a copy of the document

Thank you for considering my request
Kind regards,
Hanri Rust
083 288 2858
hanrirust@gmail.com

Barbara Wilson <Barbara.Wilson@nurs.utah.edu> 2/10/16
to me, jbell

Hello Hanri
Let me check with my collaborators to see if they're comfortable sharing our survey.
If so, I'd love to collaborate with you on an article!
Kind regards,
Dr. Wilson

Barbara L. Wilson, PhD, RNC
Associate Professor
Associate Dean: Academic Programs
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Fax: 801.581.4642

UNIVERSITY OF UTAH COLLEGE OF NURSING
Annette Poulson Cumming Building

Barbara Wilson <Barbara.Wilson@nurs.utah.edu> 2/11/16
to me, jbell

Hi Hanri,
My colleagues have granted their permission for you to use this form.
They request that you acknowledge it in any presentations / publications.

Keep us posted and best of luck
Barbara

Barbara L. Wilson, PhD, RNC
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Associate Dean: Academic Programs
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UNIVERSITY OF UTAH COLLEGE OF NURSING
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Appendix D: Participation Information Leaflet and Consent Form

PARTICIPATION INFORMATION LEAFLET AND CONSENT FORM
Participation relates to the completion of a questionnaire

TITLE OF THE RESEARCH PROJECT: Horizontal violence among nurses working intensive care environments within the private healthcare sector

REFERENCE NUMBER: S16/06/098

PRINCIPLE INVESTIGATOR: Hanri Rust

ADDRESS:

CONTACT NUMBER: 083 288 2858

Dear colleague

My name is Hanri Rust and I would like to invite you to participate in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask me any questions regarding any part of this project that you do not fully understand. It is very important that you clearly understand what this research entails and how you will be involved should you choose to participate. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the International Declaration of Helsinki, Department of Health ethical guidelines and the Singapore Statement on Research Integrity.

What is this research study about?

As a registered nurse who has worked in various ICU and HC environments I have experienced and witnessed horizontal violence take place amongst nurses working in these environments. The researcher is particularly interested in determining the extent and nature of horizontal violence amongst nurses working in the private health care sector intensive care environments.

The data obtained from you will therefore contribute to the awareness raised about horizontal violence taking place amongst nurses in an ICU/HC environment. The study is conducted in ICU/HC units of private hospitals within the Cape Metropole. I wish to recruit a minimum of 200 participants within ten randomly selected private hospitals in the Cape Metropole.

Why have you been invited?

All nurses who work in an ICU/HC environment within a private hospital in the Cape Metropole are eligible to participate in the study. You are invited to participate in the study due to the fact that you are working in a hospital setting relevant to the study. I wish to explore your experience of horizontal violence amongst nurses working in the private sector intensive care environment.

What will your responsibilities be?

It will be expected from you to complete a questionnaire (will take 20 minutes to complete). Please try to complete the questionnaire on the day of the data collection and hand it back to the researcher. This allows for a better return of questionnaires and in the end more reliable study findings.

Will you benefit from taking part in this research?

Participation in the study might not benefit you directly. The information obtained from you will however be used to develop a better understanding of horizontal violence amongst nurses working in an ICU/HC environment within the private health care sector.

Are there any risks involved in your taking part in this research?

As information is gathered though a questionnaire I do not foresee that you will be harmed in any way. I however recognize the sensitivity that accompanies being a victim of horizontal violence. The possibility exists that some participants may become emotional while completing the questionnaire. I will provide support to participants who experience emotional discomfort and

can be contacted on my cell phone. Participants who feel they would like to talk to a counsellor can contact the trauma counsellor of their relevant employer's support systems (See next page for contact details of the private hospital's trauma counsellor or the relevant agency's trauma counsellor's contact details).

Furthermore, all information obtained via the questionnaires will be managed confidentially. Your name or the name of the hospital where you are employed at will not be recorded in the study findings. Details about who participated, and the information obtained from you will not be linked to an individual or participating hospital.

Participation in the study is voluntary. Should you decline participation in the study you are still free to participate in other research projects.

Will you be paid to take part in this study and are there any costs involved?
Participation in the study will not benefit you financially. There will be no costs involved for you should you choose to participate.

Furthermore, you may contact the Health Research Ethics Committee at 021 938 9207 if you have any concerns or complaints that have not be adequately addressed.

You will receive a copy of this information and consent form for your own records.

Contact details of relevant trauma counsellors

For permanent employees of the private hospital:
Counsellor name:
Contact details:

For nursing agency employees of the private hospital:
Nursing Agency: (Name)
Counsellor name:
Contact details:

(Contact details will change according to which hospital and nursing agency is participating in the study on the day of data collection)

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled Investigating Horizontal Violence Amongst Nurses Working in Intensive Care Environments within the Private Health Care Sector

I declare that:
I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
I have had a chance to ask questions and all my questions have been adequately answered.
I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.

I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2016

Signature of participant Signature of witness

Appendix E: Research Questionnaire

Horizontal Violence Questionnaire

Horizontal violence is a form of workplace violence that occurs in the form of harmful behaviours between colleagues that can contribute to creating a hostile environment in the workplace. This study is being done in an effort to better understand how horizontal violence impacts you at work.

Instructions:
Please complete the questionnaire below by placing a cross in the block next to the response to each item that best fits or explains your experiences. Your responses are completely confidential and anonymous, and no attempt will be made to link the responses to any specific individual. Only the researcher will see the completed questionnaire. The questionnaire should take approximately 10 minutes to complete. This questionnaire consists of four sections; please complete all the questions in all four sections as truthfully as possible and to the best of your ability.

Section 1

1. Please indicate your age _____

2. Please indicate your gender

- ☐ Male
- ☐ Female

3. What is your current professional category?

- ☐ RN (Professional nurse)
- ☐ EN (Enrolled nurse/Staff nurse)
- ☐ ENA (Enrolled nursing assistant)

4. How many years have you practiced in this professional category?

- ☐ 2 or less
- ☐ 3 to 5
- ☐ 6 to 10
- ☐ 11 to 15
- ☐ Over 15

5. How many years have you worked in this unit? _____

6. Are you certified in a nursing specialty?

- ☐ Yes (please specify)_____
- ☐ no

7. Are there support systems in place to assist nurses to deal with violence in the workplace?

- ☐ Yes
- ☐ No
- ☐ Not sure

8. Most ward and unit managers support nurses who experience violence in the workplace

- ☐ True
- ☐ False

Section 2

9. Please, indicate your position on the following statements

Violence in nursing exist because -	Not True	No views	True
The public is not happy with service provided by nurses			
Patients and their families have no respect for nurses			
Nurses are the street-level bureaucrats for the ministry of health			
Violence in society has spread to the hospitals and clinics			
Some nurses are in the job because of financial reasons			
Nurses, as professionals do not support each other			

Some nurses equate quality patient care with bullying of other nurses			
Nurse managers bully junior nurses			
Not all nurses are compassionate to colleagues			
Not all nurses are compassionate to patients			
All nurses must undergo assertive training			
Nurses need to be trained in basic self-defence techniques			
In-service training programs will increase the confidence of nurses			
Health and safety at work must focus more on nurses exposed to violence			
Some nurses are rude to senior managers only			
Nursing is no longer a calling but just like any other job			

Within the last 12 months, how often have you personally experienced or witnessed the following amongst your nursing colleagues:

10. Harshly criticizing someone without having heard both sides of the story

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

11. Belittling or making hurtful remarks to or about co-workers in front of one another

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

12 Complaining about a co-worker to others instead of attempting to resolve a conflict directly by discussing it with that person.

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

13 Raising an eyebrow or rolling eyes at another co-worker

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

14 Pretending not to notice a co-worker struggling with his or her workload.

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

Section 3

Answer these questions from the perspective of how you personally have been affected within the last 12 months at your current workplace

15 I've felt discouraged because of lack of positive feedback.

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

16 I haven't spoken up about something I thought was wrong because I feared retaliation.

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

17 I've hesitated to ask questions because I thought I'd be ridiculed.

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

18 I've left work feeling bad about myself because of my interactions with co-workers.

- ☐ Never
- ☐ Once
- ☐ A few times
- ☐ Monthly
- ☐ Weekly
- ☐ Daily

19 I've had physical symptoms such as inability to sleep, headaches, and abdominal pains because of poor interactions with certain co-workers.

- ☐ Never
- ☐ Once
- ☐ A few times
- ☐ Monthly
- ☐ Weekly
- ☐ Daily

20 Do you believe that horizontal violence contributes to co-workers calling in sick?

- ☐ Yes
- ☐ No

21 Have you ever called in ill because you did not want to be in a hostile environment or were worried about experiencing horizontal violence?

- ☐ Yes
- ☐ No

22 Would you leave your position (by either transferring to another unit within the hospital or resigning your employment at this institution) due to horizontal violence?

- ☐ Yes
- ☐ No
- ☐ I haven't made up my mind yet but it's a possibility

Section 4

23. Would the fear of horizontal violence prevent you from pointing out a co-worker's error?

- ☐ Never
- ☐ Some of the time
- ☐ All the time

24. Studies suggest that sometimes hospital errors are made (such as adverse events, medication errors, and patient falls) due to horizontal violence. Are you aware of an errors made in your unit that may be due to horizontal violence?

☐ Yes
☐ No

25 If you have personally experienced horizontal violence by a co-worker, indicate which of the statements below reflect your behaviour as a result of that experience (indicate as many as you feel apply to you):

	Does not apply – I have never personally experienced horizontal violence
	I have muddled through patient procedures that I felt unclear about rather than asking someone to show me
	I have used a piece of medical equipment that I was unfamiliar with, or only partly familiar with, rather than seek help from a co-worker
	I have lifted or assisted extremely heavy or debilitated patients alone rather than ask for assistance
	I have given a medication or performed a treatment I was unsure about rather than call a physician to obtain clarification or new/different orders
	I have interpreted an unreadable order the best I could rather than calling for clarification ("I *think* it says…")
	I have withheld treatment from a patient because I did not understand the instructions but was afraid to ask for help from my colleagues
	I have carried out an order that I did not feel was in the best interest of my patient without challenging it

Section 5

How often have you observed the following categories of healthcare workers exhibiting the harmful behaviours described in this questionnaire (e.g. criticizing others, belittling, raising an eyebrow, ignoring)?

26 Nurse colleagues who are not supervisors, including RN, EN, and ENA categories

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

27 Supervisors (shift leaders, unit managers, nursing service manager)

☐	Never	☐	Monthly
☐	Once	☐	Weekly
☐	A few times	☐	Daily

28 Does the work environment in your unit feel more 'hostile' some days compared to others?

☐ Yes
☐ No

29 Does the atmosphere in the unit change (e.g., feels more 'hostile') depending on who the shift leader is?

☐ Yes
☐ No

30 Does the atmosphere in the unit change (e.g., feels more 'hostile') depending on which nurses are working that day?

☐ Yes
☐ No

31 If you did witness or experience an incident of horizontal violence, whom would you most likely speak to about this? Indicate all options that apply to your choice:

☐	Have not spoken to anyone
☐	Have spoken with friends and family
☐	Have spoken with some of my co-workers
☐	Have spoken with the shift leader charge nurse
☐	Have spoken with my unit manager

	Have spoken with my nursing service manager
	Have spoken with Human Resources or another relevant department
	Have spoken to the person but probably didn't completely express my concerns
	Have spoken to the person and completely express my concerns

32 Please add any comment to observation to this issue (on separate sheet if necessary)
