

The experiences of nurses regarding bullying at public hospitals in the Cape Metropole

By

Matthew Francis Ruiters

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Supervisor: Mrs Ramona Anthonie

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DECLARATION

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ABSTRACT

Workplace bullying is a worldwide concern. However, it is underreported due to the embarrassment or fear that the victim encounters. Moreover, bullying affects the victims' job performance and places their and the patient's health and safety at risk.

The aim of this study was to explore the experiences of nurses regarding bullying in public hospitals in the Cape Metropole. The objectives of the study were to:

- Describe nurses' experiences of bullying in the workplace
- Gain an understanding of the manifestation of bullying in the workplace
- Describe current organizational management strategies of bullying in the workplace

An exploratory descriptive qualitative design was applied. A sample size of n=12 was drawn from a total population of N=377, by using a purposive sampling technique. A pilot interview was also completed using an individual interview with a semi-structured interview guide that was based on the objectives of the study and validated by experts in the field before data collection. Trustworthiness was ensured by adhering to Lincoln and Guba's criteria of credibility, confirmability, transferability and dependability. All ethical principles were met.

Five themes emerged from the data analysis, i.e. anti-bullying strategies, workplace environment, workforce planning and management, occupational health and safety and quality of patient care. The findings of the study indicated that bullying amongst nurses in the emergency/trauma departments are real. Nurses need guidance in the management thereof, particularly with the reporting system. Furthermore, training and education for both managers and nurses regarding bullying in the workplace require clear policies and procedures.

Keywords: workplace bullying, bully, victim, nurses' perpetrator, manager.

OPSOMMING

Boelie in die werk plek is wêreldwyd 'n bekommernis. Dit word egter nie genoegsaam gerapporteer nie, weens die verleentheid of vrees wat die slagoffer beleef. Origns, affekteer boelie-gedrag die slagoffers se werkverrigting en plaas 'n risiko op hul en die van die pasiënt se gesondheid en veiligheid.

Die doel van hierdie navorsingstudie is om die ervaringe van verpleegsters ten opsigte van boelie-gedrag by staatshospitale in die Kaapse Metropool te ondersoek. Die doelwitte van die studie is om:

- Verpleegsters se ervaringe van boelie-gedrag in die werkplek te beskryf
- 'n Begrip te kry van die verskynsel van boelie-gedrag in die werkplek
- Om huidige organisatoriese bestuurstrategieë van boelie-gedrag in die werkplek te beskryf.

'n Ondersoekende, beskrywende kwalitatiewe ontwerp is toegepas. 'n Steekproefgrootte van $n=12$ is geneem uit 'n totale bevolking van $N=377$, deur 'n doelgerigte steekproeftegniek te gebruik. 'n Loodsprojek onderhoud is ook voltooi deur 'n semi-gestruktureerde onderhoudsgids te gebruik, wat gebaseer is op die doelwitte van die studie en gevalideer is deur kundiges op hierdie gebied, voordat data-insameling plaasgevind het. Geloofwaardigheid is verseker deur die nakoming van Lincoln en Guba se kriteria van geloofbaarheid, bevestigbaarheid, oordragbaarheid en betroubaarheid. Alle etiese beginsels is nagekom.

Vyf temas het voortgespruit uit die data-analise, naamlik anti-boeliegedrag strategieë, werkplek omgewing, beplanning en bestuur van werksmag, beroepsgesondheid en veiligheid en die gehalte van pasiëntsorg. Die bevindinge van die studie dui aan dat boeliegedrag onder verpleegsters in die noodgevalle/trauma eenheid 'n werklikheid is. Verpleegsters het leiding nodig in die bestuur daarvan, veral met die manier van verslaggewing. Verder is duidelike beleidstrukture en prosedures nodig vir die opleiding en onderrig van beide bestuurders en verpleegsters, ten opsigte van boelie-gedrag in die werkplek.

Sleutelwoorde: werkplek boelie-gedrag, boelie, slagoffer, verpleegsters bestuurder

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ABBREVIATIONS

WHO	World Health Organization
SANC	South Africa Nursing Council
RN	Registered Nurses
ANA	American Nurses Association
DENOSA	Democratic nurses organization of South Africa
SAMA	South African Medical Association
CCMA	Commission for Conciliation, mediation and Arbitration
AMA	Against Medical Advice (AMA),
ICAS	Independent Complaints Advocacy Service
DNM	Deputy Nursing Manager

CHAPTER 1: FOUNDATION OF THE STUDY

1.1 Introduction

Bullying is a form of violence and it has detrimental effects on the victim's life, on relatives and on the professional career (El-Houfey, Elserogy & Ansari, 2015:2). The World Health Organization also described bullying as the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that results in either injury, death, psychological harm, mal-development or deprivation (Koh, 2016:2).

Bullying amongst nurses can have serious health-related results for themselves, patients they care for and the hospital they work at (Lee, Bernstein, Lee & Nokes, 2014:1). Senior nurses can be the perpetrators of bullying at work towards their colleagues (Lee, Bernstein, Lee & Nokes, 2014:1). The extent of bullying amongst nurses is sad, especially in a profession that advocates compassion (Koh, 2016:2). According to Lockhart (2017:1), bullying is the indirect or direct way of harassment, intimidation, oppression and embarrassing of others on an ongoing basis. Moreover, workplace bullying is seen as a problem in nursing in countries all over the world, and it has been identified as being detrimental to the victim, patient and organization (Johnson, 2016:1). The main perpetrators appears to be senior nurses and established nurses in a department (Jones, 2017:1). Workplace bullying is seen as under-reported, because of the embarrassing feelings experienced by the victim (Colduvell, 2017:1).

Workplace bullying has a remarkable negative impact on all, including reducing the organization's reputation with potential lawsuits as the result of mistakes made by nurses being bullied. Absenteeism due to bullying can lead to reduced staff levels which can lead to poor quality patient care and litigation (Ariza-Montes, Muniz, Simo & Padilla, 2013:2). Continued subjection to bullying behaviour leads to negative effects on the nurse, quality of work, morale, production at work, mood, self-respect and confidence (Houfey, Elserogy & Ansare, 2015:1). Negative workplace behaviour is being described in using different terms all over the world, such as bullying, mobbing, harassment and incivility (Lee, Bernstein, Lee & Nokes, 2014:2). In this study, the term "bullying" was used. The great concern for nurse managers who should not tolerate bullying amongst nurses, is the increasing demand for healthcare workers and the ongoing nurse shortage (Koh, 2016:2).

However, it remains very subtle and unspoken (Samuels, 2015:1). Thus, 44% of nurses in Cape Town's public hospitals have experienced some form of violence in the workplace (Rust, 2018:1).

Antecedents, for example attitude, work atmosphere and own ideas have been seen as reasons for bullying behaviour (Du Toit, 2013:3). According to the Commission for Conciliation, Mediation and Arbitration (CCMA), every employee has the right to respectful, dignified treatment free of harassment by employers. Moreover, employers should protect their employees by developing a code of conduct, as per the CCMA (The South African Labour Guide, 2018:1).

1.2 Rationale

In South Africa, Cape Town, the public hospitals still deal with bullying amongst nurses in the post-apartheid era, especially with racial tensions. The assumption is that these tensions increase in the workplace and lead to bullying. Furthermore, it was found that bullying occurs frequently in South African public hospitals, with the leading forms of bullying being undermining opinions, over supervising the victim's work or interrupting the other one whilst talking, Workplace bullying is still under-reported due to the fear of victimization (Samuels, 2015:1). Format paragraph.

An urgency for mitigation of this ongoing problem that is getting more attention is imperative. According to Lee, Bernstein, Lee and Nokes (2014:2), it has become a reportable frequency, more than gender discrimination or sexual and racial intimidation. Moreover, the nursing shortage has been attributed to bullying for many years, which causes reduction in nurses, a productivity attrition leading to poor quality of nursing care (Jones, 2017:1).

Bullying in the workplace is experienced by most nurses in the profession, yet it is still very under reported. This behaviour of bullying, harassment and humiliation in the profession is prevalent. However, this culture is a significant phenomenon that compromises patient safety, nurse well-being and the reputation of the nursing profession (Colduvell, 2017:2). The researcher has been the manager of an emergency department for the past five years, with 33 years of nursing experience and has been exposed to bullying in the workplace by doctors, nurses and patients. The researcher detected bullying behaviour amongst nurses and observed how this behaviour amongst nurses has escalated, teamwork declined and absenteeism increased. Owing to this, the researcher endeavoured to explore the experiences of nurses regarding bullying at the workplace, i.e. nurses bullying nurses.

1.3 Preliminary literature review

Beach (2013:3) describes bullying at work as a persistent negative way of acting towards another person. Forms of bullying at work are unfriendly behaviour, insults and ways that may cause the employee not to complete his/her duties. The aim of the perpetrator is to scare another peer (Beach, 2013:4). According to Lockhart (2017:2), the following behaviours are

linked to bullying: making adverse remarks face to face or indirect, rolling one's eyes, giving your back to the other person, making unsuitable gestures, embarrassing the other person, unsuitable language, screaming at another person, degrading another person's work in front of others, repeatedly criticizing, and spreading stories. The British National Health Service reported that one in seven National Health Service employees has a history of being bullied at work, from either their peers or a leader (Mistry & Latoo, 2009:2). Furthermore, an Australian study in 2014 suggested that 14.7% of nurses had a history of being bullied at work by colleagues (Koh, 2016:3). Koh (2016:3) reported that 33% of nurses in Asia are being bullied. A survey in America revealed that 37% of bullying occurred in the workplace. Although America has an anti-bullying law in 47 states, they still have no federal legislation to attend to this problem (Beach, 2013:4). Moreover, nurses encounter more bullying at work than doctors do, as they are more exposed to the public and to the perpetrators. Relatives can also show their frustrations easily towards nurses when their loved ones are in distress and pain. A nurse delaying patients' treatment, reporting late for duty, and shortage of staff are all factors leading to the bullying of nurses by doctors and a patient's family (El-Houfey, Elserogy & Ansari, 2015:7).

To prevent bullying, the South African labour law stipulates how to deal with bullies, i.e. document all cases of bullying, write to the bully to stop the behaviour, inform the manager of the bully in writing and get the help of the unions (The South African Labour Guide, 2018:1).

1.4 Workplace bullying and the nurse

Where workplace bullying is concerned, the victim is more prone to suffer from anxiety and depression. The consequences of bullying of nurses can have harmful effects on the victim, such as sleepless nights due to tension, distress, depression and not communicating well with colleagues (Jones, 2017:2).

Bullying can have a negative effect on retaining staff and can escalate to bodily and/or mental harm (Lockhart, 2017:1). Nurses who experience bullying tend not to participate in discussions, interact with their peers and they may stay away from work. The manager may find that these victims seek transfers out of the department (Lockhart, 2017:2). Furthermore, nurses who are victims of bullying can have increased levels of tension and anger. These emotions can lead to irritability and violence. These bullied nurses can become the bully of other innocent peers. This can lead to a confrontational work environment (Lockhart, 2017:2).

1.5 Workplace bullying and the patient

According to Koh (2016:4), workplace bullying of nurses can have a negative effect on the patient due to the victim's physical and psychological health. Poor sleeping patterns amongst

bullied persons can result in poor quality patient care. It has been proven that sleep disturbances can have a negative effect on a person, leading to lifelong effects on the body. As a result, bullying at work of nurses can endanger the standard of care and well-being of the patient. Brunworth (2015:3) states that when a nurse is being bullied and suffering, he/she can make mistakes, such as giving the wrong prescribed treatment that can result in patient safety issues.

1.6 Workplace bullying and the organization

Bullying can lead to huge expenses for the organization. Examples are the increase of turnovers of nurses with expenses for recruitment, orientation and in-service education of new nurses. Absenteeism of nurses due to bullying has an impact on the organization's financial budget (Dalton, 2016:2). Pay-outs for workman's compensation due to depression, can also have a strain on the financial budget of the company (Dalton, 2016:2). Disorganized institutions can give rise to the bullying behaviour of nurses, which increases the turnover rate and decreases the workplace morale (Jones, 2017:2). Organizational losses due to bullying can be indirect or direct. Indirect losses are the interference with production, like an increase in mistakes due to bullying, losing qualified registered nurses, and absenteeism. Direct losses are payments for legal costs, internal investigations, workman's compensations and pay-outs for nurses being sued, due to mistakes caused by bullying (Lee, Bernstein, Lee & Nokes, 2014:1).

1.7 Management strategies for bullying at the workplace

The effects of bullying remain an important concern not only to nurses' efficiency, the standard of patient care and the hospital's financial losses, but also on the sufferer's physical and mental well-being. Consequently, it is crucial that nurse leaders and hospital administrators develop strategies to modify the healthcare environment into a physical and mentally safe work area (Lee, Bernstein, Lee & Nokes, 2014:5). The following educational programme to highlight bullying in hospitals was recommended by the Joint Commission International: skills-based training and coaching, continuous non-confrontational monitoring, a method of evaluating staff's insight to the significance of bullying, and policies that encourage early reporting with no fear (Lee, Bernstein, Lee & Nokes, 2014:5). According to Johnson (2015:11), organizations should ask workers to monitor and report all negative behaviour of their colleagues to the managers, in order to prevent bullying behaviour. According to Rust (2018:77) zero tolerance policies for bullying in the workplace, implementation of training programmes on dealing with bullying, and implementation of safe and confidential support systems for victims of bullying of nurses in the Cape Town Metropole area, were recommended. Section 12 of the South African constitution states that all citizens are

guaranteed protection against violence, torture and cruel, inhumane treatment (Laas, A, 2014:4).

1.8 Problem statement

Research has shown that bullying negatively influences job satisfaction and the productivity of the nurse, which can lead to nursing errors (Jonson, 2015:2). As stated in the rationale, workplace bullying is under-reported, and ways of bringing this phenomenon to the forefront need to be prioritized. Staff may experience huge frustrations when they know of bullies who will work on the same shift. Many complaints from nurses about their treatment in the workplace and the rudeness from superiors are prevalent in healthcare institutions. The researcher has previous exposure to this phenomenon, whilst working in the public healthcare sector.

1.9 Research questions

What are the experiences of nurses regarding bullying in public hospitals in the Cape Metropole?

1.10 Research aim

The aim of this study was to explore the experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

1.11 Research objectives

The following objectives directed this study to:

- Describe nurse's experiences of bullying in the workplace
- Gain an understanding of the manifestation of bullying in the workplace
- Describe current organizational management strategies of bullying in the workplace.

1.12 Theoretical framework

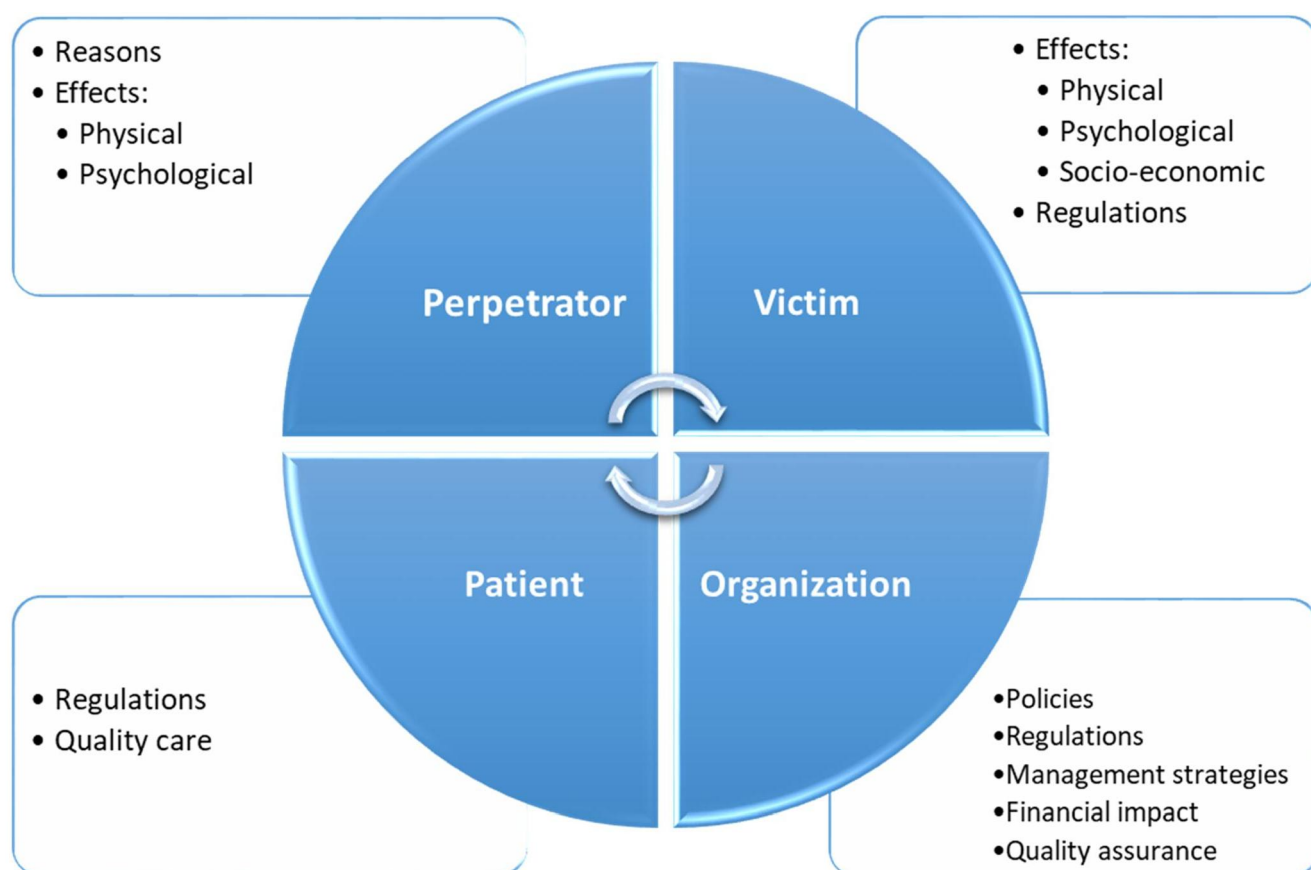


Figure 1.1: Framework of those affected by bullying in the workplace

A conceptual framework describes the phenomena regarding the terms of an idea, as well as related concepts (Burns & Grove, 2009:135). According to Lobiondo-Wood and Haber (2014:8), a theoretical framework serves as the basis on which a study can begin or as a map in helping with the design of a study. This theoretical framework will be based on the literature reviewed. According to Hanks (2017:68) a theoretical framework is a guide that assists to frame, organize a problem, phenomenon, or question. In this study, the theoretical framework will highlight a certain experience. Consequently, the theoretical framework will provide guidance with the design of this study. In this qualitative study, the researcher will use the theoretical framework to shape the presentation for better understanding to the readers. A theoretical framework is a lens used to filter data. Therefore, the theory assists to focus on facts, and suggests that one should see information with an unbiased eye (Hanks, 2017:68). This will assist the researcher to stay focussed on the phenomenon in question.

The perpetrators are usually one hierarchical level above the victim who is sometimes seen by the perpetrator as a threat or too independent. Owing to this, it stimulates the bully to action (Steinman, 2018:6). The perpetrator can be affected emotionally due to the characteristics

they display, such as being impulsive, emotionally reactive and having a low self-esteem (South African Board for People Practice, 2018:8).

The effects of bullying on the victim vary, and may include physical, emotional and socioeconomic stresses. Victims can waste up to 52% of their time on defending, trying to get help and dwelling on the emotional stresses the bully causes (South African Board for People Practice, 2018:9). Unit-specific policies and procedures should be in place in each nursing department regarding protection against bullying. Moreover, nurses have the right to be protected by their employer from bullying behaviour (The South African Labour Guide, 2018:2).

The patient has the right to a safe and stress-free environment when being treated by any healthcare provider (South African Constitution, Act No 108 of 1996). Consequently, healthcare staff should follow the Batho Pele principle, i.e. to put the patient first.

The organization should have an anti-bullying policy or statement that will safeguard nurses against bullying. In addition, punitive action against the perpetrators will create an environment in which a compassionate culture can develop (Brunworth, 2015:2).

1.13 Research methodology

1.13.1 Research design

A qualitative design with an exploratory descriptive approach was applied to explore the experiences of nurses regarding bullying at the workplace. A descriptive approach enabled the researcher to identify the elements in the behaviour of nurses, compare it to previous studies and thereafter he provided a true description at the end. Grove, Gray and Burns (2018:211) refer to a research design, meaning the structure of the enquiry as the blueprint of the study. Furthermore, the qualitative design allowed the researcher to focus on the quality of the information gained from the participant, situation or event in question (Grove, Gray & Burns, 2018: 274).

1.13.2 Study setting

The study was conducted in emergency and trauma departments at two public hospitals in Cape Town, South Africa, with a staff database of about 250 permanent nurses. The nursing staff at these health facilities was often exposed to bullying. According to Frederick (2014:12), nurses leave the profession in the first three years of employment owing to bullying. The selected hospitals are leading tertiary academic hospitals in Cape Town, autonomous, and due to the variety of staff employed and the range of services offered, one could expect some

form of bullying. According to Rust (2018:79), 29% of nurses were experiencing horizontal violence in a public hospital in Cape Town.

1.13.3 Population and sampling

Sampling is the action of choosing representatives of a group in a study whereas, the population is all components, may it be people, things or substances that meet the particular standards for inclusion in a study (Grove, Gray & Burns, 2018: 46). The population for this study were all registered, enrolled nurses and enrolled nursing assistants from two public hospitals in the Cape Metropolitan area. Enrolled nurses were included as the researcher observed that a lower category of nurses is more likely to experience bullying.

The sample size is dependent on when data saturation is established. Data saturation, meaning no new information emerges from the interviews; therefore, all interviews were stopped when the researcher had all the information needed for the study (Lobiondo-Wood & Haber 2018:94). Voluntary sampling was used for this study.

Voluntary sampling is a non-probability technique where participants willingly choose participation in the study. Moreover, these participants had huge interests in the topic. Bullying being such a sensitive subject makes it difficult for nurses to discuss. Hence, the voluntary aspect assisted the researcher in reaching participants that were difficult to locate. In addition, the researcher presented short presentations to nursing staff in the emergency departments at the hospitals on different shifts to highlight the phenomenon of bullying amongst nurses. In addition, the researcher also explained the importance of zero tolerance towards bullying and indicated available resources. Invitations were extended to the audience by leaving the contact details of the researcher to ensure anonymity of their colleagues and supervisors. The researcher interviewed twelve participants until data saturation was achieved (Grove, Gray & Burns, 2018: 274). Owing to the nature of the topic, if there were uncomfortable emotions in some participants, details of the free counselling for public sector workers will be readily available as explained in the ethical considerations section.

1.13.3.1 Inclusion criteria

All registered nurses, enrolled nurses and enrolled nursing assistants, working in the emergency departments and employed at the hospitals in Cape Town, were included. These nurses had been working full time for at least six months, and experienced or witnessed incidents of bullying by their seniors or peers at these specific hospitals.

1.13.3.2 Exclusion criteria

All nurses not attending the information sessions presented by the researcher on the days of recruitment, at these specific public hospitals in the Cape Metropole, were excluded.

1.13.4 Data collection tool

Data collection occurred through individual interviews, using a semi-structured interview guide. An interview was a verbal communication between the interviewee and the interviewer, whereby details of the study were obtained (Grove, Gray & Burns, 2018: 506). The interview guide was developed by the researcher and validated by experts in the field. Open-ended questions were used based on the objectives of the study and literature reviewed. Open-ended questions are questions that have more than one answer. Moreover, this assisted the researcher to obtain a deeper sense of the subject with each interview (Grove, Gray & Burns, 2018: 508).

1.13.5 Pilot interview

A pilot study is the lesser scale of research study to refine the study sample process, for instance the treatment methods and to determine the quality thereof (Grove, Gray & Burns 2015:45). The purpose of the pilot interview is to examine the feasibility of the approach and the interview guide that would be used in the main study. One interview was conducted with one participant who met the selection criteria. The data collected during the pilot interview was included in the findings of the study. The interviews were conducted in the three most common languages spoken in Cape Town, namely English, Afrikaans and isi-Xhosa. The researcher who is fluent in English and Afrikaans conducted those interviews. However, isi-Xhosa interviews were conducted by a registered nurse with a Master's degree, fluent in isi-Xhosa and English. Moreover, the Master's degree graduate underwent similar interview training as the researcher, in order to conduct the interviews.

1.13.6 Data collection

Data collection commenced upon ethical clearance, provincial approval from the Department of Health for the study to be conducted and for institutional permission to be given. The researcher informed the Deputy Nursing Manager (DNM) of the chosen hospitals and permission was requested to interview eligible nurses. A process of recruiting participants was done as follows:

Voluntary sampling, a non-probability sampling method, was used to include participants for the study. Voluntary sampling includes people who self-select into the study and often these volunteers have a strong interest in the main topic of the study (Murairwa, 2015:1). The target participants experienced bullying. Participants who responded to the invitation extended by

the researcher at the presentations, were approached by the researcher to obtain permission for participation in the study.

A suitable venue, time and date for the interviews were arranged between the researcher and participants. Moreover, participants were informed of follow-up sessions to clarify information obtained during data collection (Lobiondo-Wood & Haber 2018:119). Refreshments and a travelling allowance were offered to the participants. On agreeing to participate, a consent form was signed by each participant. Interviews were recorded using a battery-operated tape recorder and detailed notes were made immediately after the interviews.

The researcher worked at one of the hospitals under study 18 years ago, therefore had no knowledge of this hospital's staff since he resigned. In cases where participants were known to the researcher, a fieldworker conducted those interviews in the absence of the researcher. This fieldworker was a qualified registered nurse with a master's degree, who had the same interview training as the researcher. All other remaining interviews were conducted by the researcher. Moreover, these steps were implemented to prevent bias that can cause distortion in the study findings. During data collection, the researcher applied bracketing, i.e. set aside his own personal biases, formed a strong, trusting bond with the participants and stayed objective (Lobiondo-Wood & Haber 2018:106).

1.13.7 Interview setting

The date, time and venue for interviews were arranged that were convenient for the participants. This venue was away from the hospitals to ensure privacy and confidentiality. The venue was private, quiet for good audio-recording quality, had comfortable chairs, good ventilation and lighting. The participants could feel secure and safe, which enhanced a feeling of relaxation, with no interruptions and also assisted the researcher to obtain more information on the particular subject (Grove, Gray & Burns, 2018: 83). The participants were reassured that all information would be strictly confidential and no names would be used. The researcher obtained signed consent from the participants and was the only one to have access to the data and recordings. Furthermore, consent was obtained from participants when the supervisors and fieldworker became part of the research process (Buys, 2017:1).

Duration of each interview depended on the type of questions the researcher asked, and the type of answers the participant gave. Hardwick (2018:1) also states that depending on the subject matter and content, an interview can be between thirty minutes to one-hour long. During the interviews, the researcher considered the comfort of the participant, debriefing and counselling was offered to participants if needed.

1.13.8 Interview procedure

The researcher received training to conduct interviews, therefore in-depth interviews were conducted, whereby the researcher used open-ended questions. This method is to get more information from the participant about the questions asked (Grove, Gray & Burns 2015:83). The researcher worked at one of the hospitals under study 18 years before and did not know participants.

Reflection. The researcher ensured that he continuously examined his own conceptual ideas and assumptions and how these affected research decisions, especially the wording in questions. The researcher reflected the messages from the participant by showing understanding and creating an encouraging atmosphere at all times.

Summarizing. The researcher summarized the participant's response after each question to ensure accurate understanding. The researcher took the information and summarized it until he had a condensed version of the main points which were accurate and distinct.

Bracketing. The researcher set aside his own views and biases about the research topic. This process started before the actual interviews, when the researcher entered into dialogue with peers, discussing personal biases, past experiences and knowledge regarding bullying amongst nurses. The researcher did not allow previous studies to influence his view during the interviewing process.

1.13.9 Data storage and security

Data was collected through audio recordings and transcribed verbatim. In this study, the use of an electronic folder was appropriate. Furthermore, a hard drive and flash disk were used as back-up for safe storage of the data. Hard copies of the consent and recruitment documents were kept safe in a lockable cupboard in a safe area for a minimum of five years (Buys, 2017:1). The electronic data was kept on the researcher's computer with password access only by the researcher. Storage of data in more than one location was recommended, to prevent loss of data in case of computer crash or faulty storage device (Grove, Gray & Burns, 2018: 88). An independent transcriber was used to transcribe the interviews verbatim from a digital recorder. A confidentiality agreement was signed between the researcher and participant, and between the researcher and transcriber.

1.13.10 Data analysis

Data analysis is the technique used to reduce, organize and give meaning to data (Grove, Gray & Burns, 2015: 502). The researcher described how raw data which would be obtained from the transcriptions of the recorded interviews should be handled. Data analysis was done

manually and was organised electronically to manage the amount of information (Lobiondo-Wood & Haber, 2014:79).

Data analysis was done according to the approach described by Terre Blanche, Durrheim and Painter. These five steps were as follows:

1.13.10.1 Familiarization and immersion

The researcher read and re-read transcriptions to immerse himself in the data. This stage was to gain knowledge and understanding of what the participant was telling the researcher. Moreover, this was also to assist the researcher to explore the phenomenon as experienced by the participants.

1.13.10.2 Inducing themes

Induction, meaning general rules from particular occasions. The bottom-up approach was followed. The researcher looked at the information obtained and saw what was significant in the information. The researcher used the language used by the participant, instead of using abstract theoretical language to label the categories. The researcher did not only summarize content, but worked in terms of processes, functions and events for better organizing of the material. If too many themes were present, the researcher rearranged it by adding subthemes.

1.13.10.3 Coding

Coding was done while developing themes. The researcher coded the data that had relevance to the topic. Coding of a phrase, line, sentence or paragraph was done by the researcher. The researcher used two or more codes if there were two or more themes, therefore colour marker pens were used to highlight text pieces. The researcher identified statements related to the subject in question and formulated general meanings to get a clear view. As a result, coding assisted the researcher to identify patterns in the data that could be compared for similarities and differences.

1.13.10.4 Elaboration

By inducing themes and coding, the researcher was able to compare parts of the text that appeared to be similar. The researcher was able to identify all kinds of subthemes that emerged in order to capture the small differences of meaning not captured initially. The researcher also used this opportunity to revise the coding done in step 3. This way of revising assisted the researcher to give a good account of what was happening in his data.

1.13.10.5 Interpretation and checking

In this final stage the researcher interpreted the data and provided a written account of the study. Careful analysis of the data was done and the researcher checked for parts of over

interpretations, prejudice and times when not enough information was given. Furthermore, a detailed and inclusive description of the experiences of the participants, in combination with all clustered themes were given. By doing this, the researcher wanted to ensure clarity and understanding of the participant's experiences whilst being bullied (Terre Blanche, Durrheim & Painter 2011: 325).

1.13.11 Trustworthiness

Trustworthiness is a determination that a qualitative study is rigorous, and of high quality. It is the extent to which a qualitative study is dependable, confirmable, credible and transferable (Grove, Gray & Burns, 2015:392).

1.13.11.1 Credibility

Credibility is to have trust in the veracity of the outcomes. The researcher returned to the participant to determine accuracy, clarify interpretations, allow participants to delete or add information and confirm the credibility of the study findings. The latter is to ensure the participants recognized the experience as their own (Lobiondo-Wood & Haber 2018:126).

1.13.11.2 Transferability

Transferability refers to the generalizability or the extent to which the findings can be transferred or have applicability to other settings and target populations (Ngunyulu, 2012:37). Transferability requires the researcher to indicate that the outcomes have appropriateness in other contexts. In other words, the researcher will be able to use the findings of the study outside the current situation, and apply it to other settings with similar participants (Grove, Gray & Burns, 2015:392). The researcher ensured that all possible information was obtained from all participants, by conducting thorough, in-depth interviews. To further enhance transferability, the researcher provided a full description of the nature of the study participants, the experiences they had, and observations made during the study. The researcher also identified and described data and wrote the report in such a way that it became easier for the reader to assess the applicability of the data to other settings (Ngunyulu, 2012:37).

1.13.11.3 Dependability

Dependability refers to the stability (reliability) of data over time, over conditions and over occasions (Polit & Beck 2008:539). The researcher evaluated the quality of processes of data collection, data analysis and theory generation. Dependability is the documentation of steps taken and decisions made during analysis (Grove, Gray & Burns, 2015:392). To attain dependability, the researcher provided two other researchers with the collected data to study it and compare the outcome to confirm the validity. This assisted the researcher to prove trustworthiness of the study by other researchers performing an audit. Moreover, this ensured

that if the study was to be repeated with the same members and circumstances, the outcomes would be the same.

1.13.11.4 Confirmability

Confirmability is a form of impartiality by the researcher and others to confirm the findings of the study (Loh, 2013:5). The researcher did the study in such a way that others would be able to agree that the conclusion of the study is logic and legitimate, because the information gathered by the researcher is purely based on the participants' responses. Other researchers will be able to review the audit trial and agree that the researcher's findings are sound. This will improve the credibility of the study.

1.14 Ethical considerations

Permission to conduct research was obtained from the Health Research Ethics Committee at Stellenbosch University, the Department of Health and management of the participating hospitals.

The basic ethical principles relevant were maintained whilst conducting the study. Confidentiality, privacy, dignity, anonymity, beneficence and the right to self-determination were maintained throughout the study (Lobiondo-Wood & Haber 2018:236).

1.14.1 Informed consent and voluntary participation

At the beginning of each interview each participant gave written consent to participate in the study. Consent was also obtained for audio recordings and written recordings of the interviews. Voluntary consent, meaning the participant decided to participate in the study of his/her own free will, was obtained by the researcher. The participant had a good understanding of the benefits and risks of the study before signing the consent (Grove, Gray & Burns, 2015:112). Informed consent was signed by the participants, indicating that they participated of their own free will. Participants were reminded that the study was strictly voluntarily, that they could withdraw from the study at any time without any repercussions.

1.14.2 Anonymity and confidentiality

Confidentiality and identity protection were imperative and were guaranteed by the researcher. The hospital's name, participant's name or any other identification were not mentioned in the study and codes instead of names were used (Wood, Haber 2018:236).

1.14.3 Beneficence

The researcher adhered to the principle of beneficence by ensuring the well-being of the participants. It was anticipated that allowing participants to voice their experiences would be beneficial to them. The benefit is that the participant has someone to talk to, which can create

a new perspective of difficult situations, and help them find ways to move on, as well as finding solutions. The researcher is also a qualified psychiatric nurse and could support participants that became distraught or requested counselling, because of reliving the events of bullying. Moreover, if further counselling was required, the researcher could refer participants to an onsite counsellor. Free counselling is offered to all public hospital workers who are in need, therefore the researcher could furnish the details of ICAS (Independent Complaints Advocacy Service), Employee health & wellness programme, toll free number 0800611093, to the participants.

1.15 Definitions

Registered nurse: A person registered in a category under section 31(1) in order to practise nursing or midwifery in terms of the Nursing Act, No 33 of 2005.

Bullying: It is a form of violence that has a negative effect on a person, relatives and work (El-Houfey, Elserogy & Ansari, 2015:2). It refers to repetitive, uninvited conduct, indirect or direct over a period of time (South African Board for People Practices 2018:4).

Workplace: Refers to a place where work is done by people (Collins, 2014:1). For the purpose of this study, it will be the hospital.

Workplace bullying: A persistent pattern of mistreating people at work, causing physical or psychological harm through malicious behaviour, humiliation and undermining of colleagues (Lee, Bernstein, Lee & Nokes 2014:1).

1.16 Timeframe

The time frame for this study is explained in Table 1.1.

Table 1.1: Timeframe

Year	Month	Activity
2019	March	Submission of proposal to Ethics Committee
2019	June	Provincial / institutional permission
2019	July	Pilot test
2019	July	Data collection
2019	August	Data analysis
2019	August	Writing of thesis with continuous review by supervisor
2019	September	Technical and grammar editing
2019	October	Submission of thesis

1.17 Chapter outline

The chapters of the thesis are as follows:

- Chapter 1: Introduction and background
- Chapter 2: Literature review
- Chapter 3: Research methodology
- Chapter 4: Findings (qualitative)
- Chapter 5: Recommendations and conclusion

1.18 Budget

The budget was self-funded by the researcher. It is a detailed statement, which outlines the estimated study costs. The categorical list of the expenses by the researcher is set out in Table 1.2:

Table 1.2: Is a self-funded estimated study budget

Item	Unit cost	Estimated cost
Travelling for participants	R 3.00 x 100km	R1200.00
Stationery e.g. for informed consent forms	R50.00 per participant	R500.00
Refreshments for participants	Bottled water at R12.00 per 500ml bottle x 15	R180.00
Voice recorder	Per Unit price R150.00	R150.00
Transcription of audio tapes	R5.00 per audio minute X approx. 90 minutes per person 10 people	Approx. R4 500.00
Language editing and technical formatting	30 cents per word	R9000.00
Printing and binding of thesis		R1 500.00
Total		R17 030.00

1.19 Significance of the study

The nursing profession is unfortunately faced with huge difficulties regarding bullying amongst health professionals. However, this behaviour has a negative impact on dedicated nurses, patients and the organisation. The findings of this study could be useful for hospital management to formulate and develop updated policies that will protect the staff, especially the nurses who experience bullying. This study can also assist hospital management to determine the extent of bullying at their institution. Furthermore, the findings of the study will be distributed to the management of the hospitals under study, as well as the department of health. Articles derived from this study will be published in peer-review journals.

1.20 Summary

In chapter one, the researcher discussed the context of the study, the rationale, research problem, the research methodology and ethical principles that were upheld at all times throughout the study to protect all participants human rights. Chapter two will present the literature review conducted to get an in-depth perspective regarding bullying amongst nurses.

1.21 Conclusion

Workplace bullying negatively affects the victim, perpetrator, patient and the organization. Strict and concise policies and procedures should be in place if any manager wants to maintain a safe and bully-free environment. Good support systems should be in place for anyone who needs advice and assistance regarding bullying. New nurses should be trained on how to identify bullies and their behaviour, and they should know how to defend themselves.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A literature review provides an overview of the research concluded previously on a phenomenon and the present knowledge thereof (Brink, Van der Walt & Van Rensburg, 2012:54). In this literature review, the researcher identified and discussed the experiences of nurses regarding bullying in the public hospitals in the Cape Metropole. The effects of workplace bullying on the perpetrator, nurse, patients and the organization are explained in this chapter by means of a theoretical framework.

2.2 Selecting and reviewing the literature

The literature review was undertaken to find current similar studies that can serve as a starting point for this research study. The literature review assisted the researcher to develop a theoretical framework for the study. Furthermore, the literature review was done over a period of three months. Textbooks, journals, theses and reports relevant to the study were selected, resulting in a comprehensive study (Brink, Van der Walt & Van Rensburg, 2012:54). Search engines such as PubMed and CINAHL were utilised, as well as the ongoing support and assistance of the librarian and supervisor. Moreover, limited published research was found on the chosen topic nationally. Keywords that were used are workplace bullying, violence in the workplace and incivility.

2.3 Findings of the literature review

The findings from the literature review will be described under the following headings:

- Definitions of bullying
- Manifestations of bullying
- The act of bullying
- Theoretical framework

2.3.1 Definitions of bullying

For a behaviour to be considered as bullying, it has to include three elements. The first element is a target, i.e. a target must be present, whether it is a person or a group. Secondly, the act must be harmful to the target. The third and last element is that it must be a repetitive act. This is the most significant element of bullying, however, it must occur several times over the course of a week or so.

Bullying refers to continuous adverse interpersonal behaviour; sabotaging degrading behaviour, attacks on the character of a person, competence and reputation, malicious

defamation, and attacks via work assignments. Bullying occurs when the perpetrator intentionally causes harm to the victim in the workplace, causing injury to the victim's health, professional life and social life (Gordon, 2019:1). Bullying of a nurse in the workplace, can have negative psychological and physical consequences that can be detrimental to the patient and the organization (Cunniff & Mostert, 2012:1).

Incivility is different from bullying. Incivility is your typical rude, inconsiderate, or just grumpy nurse (Thompson, 2019:1). The American Nurses Association (ANA), refers to incivility as one or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them, whereas bullying is repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress to the recipient (Woolforde, 2019:1). Subsequently, a bully is mean to a target group, whereas incivility is being mean to everyone.

Incivility is when bad behaviour at work, such as unfairness and being rude usually starts very small; however, these behaviours can steadily increase to bullying, causing damage to the victim and the organization (Eli, 2018:1). Incivility also refers to disregard, fraudulent, ignorant, exclusion, professional disgrace, threatening others, unprofessional approach and negative remarks regarding appearance (Sliter, 2011:3:1). These abnormal bizarre behaviours, with equivocal intentions in the workplace can be extremely harmful to the victim. The researcher also indicates that incivility in the workplace is very low in intensity, though very high for occurrences.

2.3.2 Manifestations of bullying

Workplace bullying presents an extensive variety of behaviours, such as humiliation in front of others, verbal insults, excluding others socially, intimidation, false allegations, gossiping of and sabotaging others (Cunniff & Mostert, 2012:1). Three personalities in a bullying environment are identified. The first personality is the bully, who first does a test run and gains confidence. Followed by the victim, who puts blame on himself or herself for trying to avoid the bullying. Then the bystander, usually an individual or group who watches (Dale-Jones, 2015:1).

Bullying in the nursing contexts comprises of an attack on competence and reputation, personal attacks, i.e. continuous attempts to belittle and undermine the work of the victim, continuous unreasonable criticism and monitoring of work, continuous efforts to humiliate, erode personal integrity, creating unfair jokes and starting bad gossiping and rumours. Furthermore, it refers to an attack via work assignments, meaning holding back important work-related information, being disregarded and excluded, unaccommodated in leave application, no training and promotion opportunities, unfair pressure to produce work, setting

non-achievable deadlines and taking away responsibilities without consultation (Magee, Gordon, Caputi, Oades, Reis & Robinson, 2014:19). Bullying behaviour also varies from months to years, i.e. the bully will gradually cause harm and continuously disparage the victim (Johnston, 2010:37). The behavioural repertoires the perpetrator displays, make the victim feel intimidated, degraded and humiliated (Sansone, 2015:2). Owing to this, victims feel ashamed of being bullied, but do not report these incidents (Rust, 2018:3).

According to Williams (2016:47) prior to the year 2000, bullying amongst nurses were called, “paying your dues or the rite of passage”— an old, known form of scaring and harassing victims on all levels of nursing education. The senior nurses enjoyed assigning the most difficult, unfair revolting tasks, difficult patients, and the most unfriendly physicians to the novice nurse. Moreover, this enabled senior nurses to delegate the work and the patients they disliked, to the novice nurse (Williams, 2016:35).

2.3.3 The act of bullying

Bullying can be characterized as aggressive, offensive, threatening and disrespectful behaviour (Lawrence, 2010:2). Rust (2018: 79) indicates that 29% of nurses working in a public hospital in Cape Town encounter horizontal bullying in the workplace. Gordon (2019) postulates that bullying is usually induced by the urge to control the chosen victim. Horizontal bullying occurs when nurses of the same rank, engage in interpersonal bullying amongst themselves in the workplace. According to Adams (2010:24) the term horizontal violence started to appear in the literature, mainly referring to nurse-on-nurse violence. Nurses have become more aware of the term “bully” and its implications. More emphasis is on how to recognize bullying behaviour and more organizations have zero tolerance for bully behaviour stipulated in policies lately. Moreover, 44% compared to 29% in 2009 of nurses working in Cape Town public hospitals experienced horizontal bullying in their workplace ((Khalil, 2009:210). Horizontal bullying can be overt or covert.

2.3.3.1 Overt/direct bullying

This refers to an obvious way of bullying in which the perpetrator makes obvious attempts to bully others (Khalil, 2009:215). Overt bullying can occur physically or verbally. Examples of physical assault are to trip, push intentionally, restrain and strike. In contrast, verbal abuse involves shouting, aggressive behaviour, personal attacks, belittling colleagues in the presence of others, making threats, disrespectful comments regarding promotions, evaluations and career opportunities (Lawrence, 2010:2). Furthermore, Johnston (2009:37) suggests that verbal bullying can damage the victim’s self-image through insults, mocking, ridicule, and making sexist and homophobic remarks. Other humiliating actions are asking the nurse to do unskilled tasks beneath their work description, e.g. cleaning the floor or porter

duties, having a negative and disparaging effect on the nurse's confidence. Consequently, causing the victim to feel low and worthless (Hutchinson et al., 2010:2323–2324).

2.3.3.2 Covert/Indirect bullying

Covert abuse is a hidden way of bullying and is often not identified as bullying at all (Rust, 2018:21). Micromanagement, gossiping of others, isolating others, always interrupting others during conversation and setting difficult targets are examples. Other actions to humiliate the victim is when the bully takes credit for work done by others and not ever taking blame in the event of mistakes (Lawrence, 2010:2).

According to Beach (2013:5) indirect bullying, means that the victim is being isolated at all times, fabricating a work atmosphere not conducive to job satisfaction. Covert/indirect social bullying is to propagate lies or rumours, denigrate, humiliate, look at the victim in a scornful or threatening manner, isolate or exclude a person (Harding, 2016:1). Another example of indirect bullying is the burnout of victims that are generally divided into two groups, situational elements inclusive of job demands and individual elements that are lack of resources and staff. The organization can reduce these forms of indirect bullying by being compliant to the resource demands (Desrumaux, Gillet & Nicolas, 2018:1).

2.3.3.3 Verbal, social or material bullying

According to Shetgiri (2013:4), this type of bullying occurs through information and communication technologies (social networks, text messages, emails, blogs, websites, etc.) namely, cyberbullying, which is real in the nursing profession. Methods used comprise of mobile phones, laptops, computers online emails, game sites, sending attacking messages, posting offensive pictures, and stalking persons on the internet. This can cause anger and disturbances in the nurses' lives. Disturbances caused are bad relationships with family, poor quality of interactions with a spouse and children by depressed victims. Cyber bullies usually stay anonymous and do not see the trauma they inflict on the victim, however the perpetrators are very difficult to trace (Shetgiri, 2013:4).

2.4 Theoretical framework

The theoretical framework is based on proposed statements resulting from an existing theory and integrates observations and facts into an orderly scheme (Brink, Van der Walt & Van Rensburg, 2018:21).

See figure 1 for a schematic diagram illustrating the interrelated factors between the perpetrator, nurse, patient and organization:

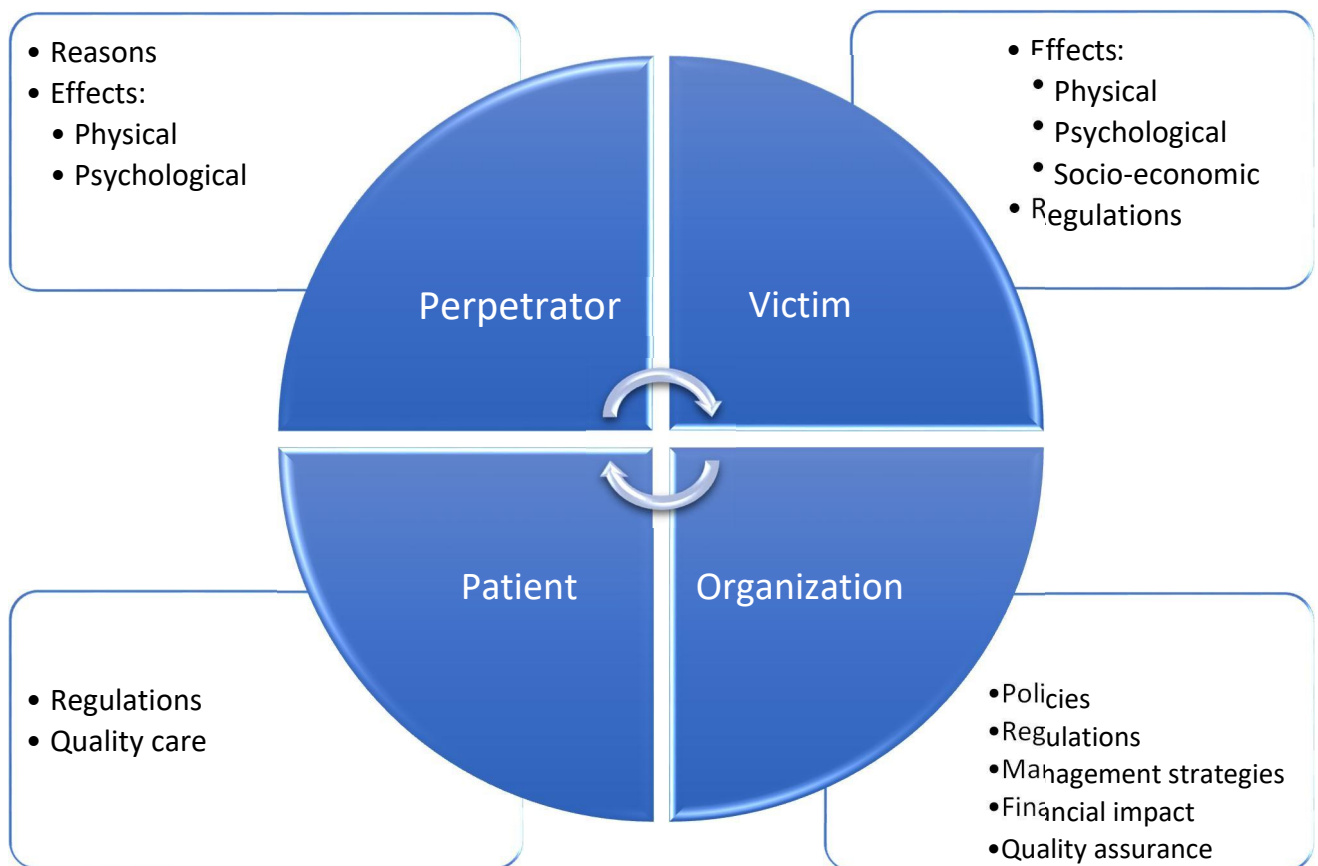


Figure 2.1: Theoretical framework for bullying in the workplace

2.4.1 Workplace bullying and the perpetrator

Workplace bullying is the repeated, annoying behaviour aimed towards a colleague or a group working together that can generate a risk to health and safety of others (Magee, Gordon, Caputi, Oades, Reis & Robinson, 2014:20). Moreover, bullies in nursing evince similar attributes as bullies in other establishments. Their behaviour is intentional with the aim to discredit the victim (Johnston, 2010:37). According to Johnston (2009:37), nurse managers are the principle perpetrators to their juniors, due to their authoritative position in the profession. Characteristics of bullying are regarded as a power imbalance between the perpetrator and the victim, which can be displayed in different ways, such as hierarchical power and physical power with the focus on the frequency and longevity of the phenomena (De Wet, 2014:1).

2.4.1.1 The physical effects of bullying on the perpetrator

The bully perpetrator thrives in organisational environments that enable bullying to occur (Magee, Gordon, Caputi, Oades, Reis & Robinson, 2014:20). The perpetrator can experience frustrations and strains, such as pressure at work, stresses at work, change in roles and management styles. Mismanagement of conflict at work can ignite a bullying behaviour

(Harding, 2016:2). Nevertheless, conflict and disagreement are normal, whereas bad conflict management skills by managers make the problems worse.

According to Cunniff and Mostert (2012:10), bullies abuse their power due to the professional authority they have over the victim, and this bullying tends to be more hurtful as it is often executed in public with shouting and swearing. In addition, man-to-man bullying, accounts for 62% of bullying incidents as male bullies like to shout, scream and make threats in public (Cunniff & Mostert, 2012:11). Nurses at a lower category can feel inferior, resulting in aggressive feelings towards their peers and subordinates, because of stress since they cannot defend themselves from the bully behaviour by their oppressors (Johnston, 2010:37).

A study has shown that women have lower self-esteem than men do, and that people with low self-esteem have anger management difficulties, consequently taking their anger out on others. This behaviour is prevalent amongst nurses as most nurses are women (Johnston, 2010:37). Furthermore, new nurses who are victims of bullying take this type of behaviour as a norm in the profession, resulting in them becoming bullies themselves eventually. The bully's undermining acts towards the victim always put him/her in a disadvantaged position, because bullying behaviour is subjective to the victim. Nonetheless, the behaviour is unwanted and is humiliating, frightening, embarrassing and insulting (Johnston, 2010:37).

2.4.1.2 *The psychological effects of bullying on the perpetrator*

The perpetrators' purpose is usually deliberate and their acts are to degrade the victims (Johnston, 2010:37). Characteristics of the perpetrator are, not having any social competencies, a threatened self-esteem and competition at work. De Wet (2014:569) suggests that the perpetrator further displays characteristics such as anxiety, dominant behaviour, defensive behaviour and aggression. Furthermore, they display assertiveness, lack social competence and bullying others is seen as a coping mechanism (De Wet, 2014:569). Cunniff and Mostert (2012:10) found that bullying by nurse leaders is more prevalent than bullying by peers. The researchers also indicated that perpetrators, who outrank their victims, do 71% of bullying in the workplace.

2.4.1.3 *Signs to identify the perpetrator*

In general, nurses may not realize that their managers are bullying them. They might think that the manager is strict; however, it is crucial for nurses to be able to recognize workplace bullying. Gordon (2019:1) indicates that a bully is identified if he is verbally abusive towards subordinates. Bullies are known for humiliating subordinates in front of an audience, e.g. they will shout, curse or scream on a consistent basis. The victims explained how the perpetrators intimidated them as the subordinates, e.g. consistent threats of firing the person will make the

bully feel in control and powerful (Beach, 2013:3). How they were doubted in their adequacy and dedication: bullies will belittle others' suggestions and viewpoints, with or without an audience (Gordon, 2019:1).

Victims expressed their sad experiences of how the perpetrator would invade their privacy. Bullies will stalk and spy on their victims. They might even listen in on the victim's conversations, read the victim's private letters and try to find negative evidence to use against the victim. Bullies also spread rumours about the perpetrator undermining the victim's work (Harding, 2016:2). The bully will set impractical time limits for the victim to fail. Projects are consistently changed, causing more work leading to failure. Obstructing the victim's success, e.g. bullies do not want to see the victim being successful, due to the fact that they will lose control over the victim. The victim will be blamed for other's mistakes. No opportunities for promotion or transfers will be shared with the victim. According to Thompson (2015:1), bullies spread bad gossip stories about the victim, and make them appear bad in front of others. Examples are bad rumours about the victim's work, family life, looks and health, just to harm the victim's reputation. The goal of the bully is to convince others of the victim's unfair treatment, justifying their bad behaviour. According to Dryden-Edwards (2019:1), the bully will focus on trying to exclude the victim from the group, by ways such as verbal threats, bad mouth the victim, and other forms of intimidation. Another characteristic of the perpetrator is that bullies tend to show positive viewpoints regarding violence and no empathy towards the victims (Shetgiri, 2013:3).

2.4.2 Workplace bullying and the nurse

A study done by Lockhart (2017:2) found that bullying amongst nurses was more prevalent in the medical and surgical wards with 23%, intensive care units 18%, emergency departments 12%, operating theatre 9% and obstetrics 7%, with the bullies being senior nurses 24%, charge nurses 17% and head nurses 14%. In addition, Samuels (2015) established that 27, 3% of emergency nurses revealed that they were exposed to bullying while on duty and about 50% of the victims blamed managers as the perpetrators, while others accused fellow nurses. Beach (2013) indicates that professional jealousy and nurses feeling threatened by one another are because of bullying. As a result, the victim is more prone to suffer from anxiety and depression. Woods (2018:1) postulates that a 30-year-old nurse and mother committed suicide in a hospital in the United Kingdom in 2018, due to being bullied in the workplace.

According to Koh (2016) a study done in 2014 indicates that 14.7% of Australian nurses have a history of being bullied at work, whereas 33% of nurses in Asia are victims of bullying. A Taiwanese study done in 2011 confirmed that 29.8% of nurses were exposed to bullying and 51% exposed to verbal abuse (Lowenstein, 2013:2). A study done at the Vanderbilt University

in America showed that 60% of new nurses leave their jobs within the first six months of employment because of bullying (Colduveil, 2017:1). Despite the previously mentioned, Beach (2013:4) revealed that no federal legislation is in place to manage the problem of 37% of nurses being victims of bullying in the workplace. Moreover, a South African study on workplace bullying confirms that in three public hospitals in the Western Cape 61.1% nurses reported that they frequently experienced bullying in the workplace (Hewitt, 2010:22). Nevertheless, nurses who are victims of bullying are more anxious, introverts and fearful to report the events due to fear of losing their jobs (Gordon, 2019:5).

2.4.2.1 Physical effects of bullying on the nurse

Physical consequences prevalent in victims of bullying comprise headaches, neck pains, musculoskeletal pains, fibromyalgia and heart conditions (Sansone & Sansone, 2015:4). Bullying is deleterious, pervasive and has no place in a profession that symbolizes caring and compassion (Thompson, 2017:18). The physical effects of bullying may go away when the victim is not at work, away from the perpetrator. The only real way of treating and preventing the physical effects of bullying is to stop it as soon as the signs are there (Harding 2016:5). The Australian Public Service Commission (2019) recommends that it is of vital significance to identify and respond to early warning signs of victims who have been effected by this phenomenon and to assist them in getting aid. Moreover, bullying is remarkably associated with self-harm ideations and attempted suicides (Shetgiri, 2013:9). According to Borchers (2015:56), some nurses accept being bullied, as they are powerless to change this behaviour, because they are female, as nursing is predominantly a female profession. The impact of nurse bullying involves lower morale, increased unhappiness at work leading to higher turnover of qualified nurses (Michek, 2017:1).

The nurse who is the victim can experience emotional pain leading to physical pain and absence from work (Thompson, 2017:18). Bullies will go so far as putting traps in place that may cause very serious consequences such as hiding laboratory results, tampering with intravenous pumps and sabotaging a patient's documentation (Williams, 2016:7). Clarke (2009:13) postulates that nurses described the work environment as hostile, when compared to a field of combat.

2.4.2.2 Psychological effects of bullying on the nurse

Emotional/psychological consequences of workplace bullying may include increased mental distress, sleep disturbances, fatigue in women and lack of vigour in men, depression and anxiety, adjustment disorders, and even work-related suicide (Beach, 2013: 8). According to Sansone and Sansone (2015:3) increased stress and mental distress, are possible emotional repercussions of workplace bullying, hence these symptoms can persist for up to two years.

These nurses being victimized can encounter different psychological experiences such as incompetence, post-traumatic stress disorder, having no confidence, feelings of humiliation, low self-esteem and depression (Thompson, 2017:18). Emotional problems, namely depression, anxiousness and other personality disorders are prevalent amongst victims of bullying (Harding, 2016:5).

Nurses can have clever ways of bullying others by incivility undermining others, stratification and to alienating their victims (Brunworth, 2015:1). Research has shown that nurses who are victims of bullies might end up becoming bullies themselves (Lockhart, 2017:2). Bullies are deceitful and cunning, and are often referred to as “two-faced” (Johnston, 2009:37). Owing to this, their acts will make the victim feel isolated and can destroy their confidence. According to Williams (2016), many nurses do not have the confidence to defend themselves against the perpetrators in fear of being called a troublemaker. Beach (2013: 32) indicates that bullying in the workplace is a predictor of a nurse that is anxious, unable to focus on tasks, depressed and not satisfied in her/his work, causing absenteeism and huge turnovers.

2.4.2.3 Socio-economic effects of bullying on the nurse

Effects of bullying on the victim are that they have difficulty staying at work and managing their finances, difficulty making friends, having trouble making and keeping long-term relations with people. Moreover, nurses might leave their profession, seeking other work elsewhere, due to being bullied which causes low morale to the victim (Lowenstein, 2013:1). As a result, this will cause high unemployment rates either through job loss or through leaving voluntarily (MacIntosh, 2012:762–768).

The bully environment can be created easily in the nursing profession as nursing is such a busy, highly stressful job, with long working hours and little time for breaks (Lockhart, 2017:1). Nurses who are victims of bullying often retreat from educational activities like debates, their interaction with other colleagues are minimal and their absenteeism record higher due to sick leave (Lockhart, 2017:2). Therefore, absenteeism because of sick leave, results in long-term absence that can ultimately cause loss of job or resignations (Sansone & Sansone, 2015:4).

Another form of bullying that will inevitably affect the socio-economic aspect is racist bullying. According to The Victoria State Government Journal (2019), racial bullying is a real phenomenon in Australia. Racial bullying is when the perpetrator belittles, mocks, intimidates or shames the victims, due to their physical looks, ethnic background, religious and cultural beliefs or the manner in which the person clothes or talks. Lowenstein (2013:3) revealed that racism is prevalent in the United Kingdom, especially towards the trained nurses recruited from overseas, non-Western countries, particularly during their initial few months of

employment. However, no recent studies in South Africa are available on how sociodemographic groups differ with regard to their experiences of being bullied in the workplace (Cunniff & Mostert, 2012:2).

2.4.2.4 Regulations

In general, there are many rules and regulations pertaining to the nurse. As citizens of the country, nurses have human rights, which are governed by the Constitution of the Republic of South Africa, Act 108 of 1996, whereas employee rights of nurses are contained in the labour laws of the country, including the Labour Relations Act 66 of 1995. Professional rights of nurses are set out specifically in the Nursing Act, 33 of 2005 as follows:

2.4.2.5 The Nursing Act 33 of 2005

The main aim of nursing practice acts is for public protection against nurses not practising safe patient care, with the outcome of rendering high standard of nursing care by qualified, competent nurses.

2.4.2.6 South African Nursing Council (SANC)

According to the South African Nursing Council (SANC), the nurse has the right to operate within the ethical rules as follows:

The nurse in the emergency/trauma units has the right to safe working conditions, i.e. the manager must ensure that the environment in the departments are free from threats, harassment and conducive for the nurse to render safe and quality patient care. The nurse manager has the right to be an advocate for her/his patient and nurses for whom she/he is responsible. Furthermore, the nurse manager has the obligation to protect her staff if he/she recognises any form of bullying. The nurse has the right not to participate in unethical practices like being part of bullying activities in the hospital. The ultimate goal of SANC is to create a safe working environment that is consistent with efficient patient care and equipped with at least the minimum physical, material and personnel requirements (SANC, 2013:1).

2.4.2.7 International Council for Nurses (ICN) Code of Ethics

The ICN Code of Ethics for Nurses has four principal components that defines the standards of ethical conduct.

Nurses and people: the main responsibility of the nurse is her/his professional responsibility to people who need nursing care in a bully-free environment.

Nurses and practice: the nurse is accountable and responsible towards herself and the patient for continuous education, especially regarding bullying in the workplace, to provide quality nursing care.

Nurses and the profession: the nurse accepts the fundamental role in deciding and executing good standards of clinical nursing practice in an organisation with good standards and policies regarding bullying in the workplace.

Nurses and co-workers: the nurse maintains a cooperative and gracious correlation with colleagues in nursing and other fields. This enhances a culture of good teamwork, consequently avoiding bully trends to start.

2.4.2.8 World Health Organisation (WHO)

According to the World Health Organisation (WHO), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. An environment where human rights are protected is an environment where the health of employees is upheld and promoted. For nurses to function effectively, the working environment must be therapeutic, stress-free and conducive to work. Protecting nurses' rights can be an effective way to ensure positive health for nurses, as well as patients in their care. Human rights violations can have serious consequences physically and psychosocially. The happier the nurses, the more pleasant the hospital environment will be and the more positive the impact will be on patients' recovery.

2.4.2.9 The Labour Relations Act 66 of 1995

The purpose of the Labour Relations Act (Western Cape Government: 1995) is to not only protect everyone in the workplace, but also promote economic development, fair labour practices, peace, democracy and social development. The act also protects the workers and comprises four rights, i.e. right to refuse unsafe work. The victim of bullying has the right to participate in the workplace health and safety activities through the Health and Safety Committee (HSC) or is free to join as a health and safety representative. The Act also protects the victim by enabling her/him the right to know, or the right to be informed about, actual and potential dangers in the workplace.

2.4.2.10 Democratic Nursing Organisation of South Africa

The Democratic Nursing Organisation of South Africa (DENOSA) is a trade union for nursing professionals that ensures that the role of nurses is recognised, that service conditions are improved and that opportunities are afforded for ongoing professional and personal development (DENOSA, 2019:1). As stated by the Democratic Nursing Organisation of South

Africa/South African Medical Association (DENOSA / SAMA 2013-2015:3), a positive practice environment, and safety of healthcare professionals are key to quality healthcare service provision to patients. As a result, workplace safety goes beyond the safety of nurses, into the safety of the beneficiaries of healthcare service and the care environment. The organization upholds that a safe working environment enables nurses to do their work fearlessly, without threats of danger or harm to their well-being.

2.4.3 Workplace bullying and the patient

The focus of nursing practice is to provide safe and quality patient care, with high standards and total compassion (Alexander, 2018:1). The researcher also revealed that bullying has become a serious concern in the nursing profession, which is committed to promote wellness and health of the patient (Alexander, 2018:1). Moreover, the act of nurses being bullied in the workplace can have detrimental effects on the patient, because of the victim's emotional and physical state (Koh, 2016:4). Intimidation and disruptive attitudes can lead to nursing errors that can cause adverse patient satisfaction and preventable mistakes (Beach, 2013:7). According to the National Patients Right Charter, patients have the right to a safe and healthy environment that will ensure physical and emotional safety. The patient has also the right to participate in the decision making of policies affecting his/her health.

2.4.3.1 Regulations

The Constitution of the Republic of South Africa Act 200 of 1993 (as amended), Chapter 2: Bill of Rights states:

“No person shall be unfairly discriminated against, directly or indirectly, and, without derogating from the generality of this provision, on one or more of the following grounds in particular: race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language”. It further states, “No person shall be subject to torture of any kind, whether physical, mental or emotional, nor shall any person be subject to cruel, inhuman or degrading treatment or punishment”.

2.4.3.2 Patients' rights

The Republic of South Africa (Act No 108 of 1996) in the constitution, states that access to healthcare services are guaranteed, however, the Health Department is dedicated to upholding, promoting and protecting this right in the Patients' Rights Charter. Owing to this, the patient is protected by his/her rights from any harm due to the effects of bullying amongst nurses. The patient has the right to refuse being treated by a healthcare provider if he/she feels unsafe due to the effects of bullying on the victim.

2.4.3.3 Batho-Pele principles

The Batho Pele principles were developed to assist as policy and legislative framework for better delivery of care to the public, consistent with the Batho-Pele vision which refers to a better life for all South Africans by putting people first (Department public service and administration, 2017:1). In order to ensure patient safety and quality of care, nurses should comply with this vision. As per the Batho-Pele principles, patients have to be informed regarding the quality of care they will receive in preparation of what to expect, therefore it is imperative for the nurse to conduct her duties in a stress-free environment. This will ensure that the patients' rights are met, by rendering patient care in a healthy and safe domain.

Nurses should also inform patients about the nature, quality and quantity of services that will be provided to prepare the patient for what to expect. Moreover, the bully, victim and organization have a responsibility to create a harm-free environment for the patient (Department of Public service South Africa, 2014:3). Patients should be treated politely, therefore, the unhappy and bullied nurse will be unable to comply with this Batho-Pele principle. According to the Batho-Pele principles, if a public dissatisfaction system is in place for patients to submit complaints, these complaints can be obtained and handled effectively by management.

2.4.3.4 Impact of bullying on quality of patient care

Bullying of nurses may also affect the quality of patient care delivered by the victim (Rust, 2018:1). Furthermore, the researcher indicated a positive correlation between bullying of nurses and the occurrences of patient falls and medication discrepancies. The safety of patients is at risk if a nurse, with psychological and physical health problems is on duty. This can cause errors in diagnosis, medication and missed opportunities for interventions (Brunworth, 2015:3). Moreover, it should be an enjoyable, fulfilling experience to work as a nurse (Johnston, 2010:36). Nonetheless, if nurses work in a non-therapeutic environment, patient safety and quality of care will be compromised. High risk areas, such as emergency units and intensive care units are stressful areas, due to the high demand of patient care required, thus, bullying can have detrimental effects on the patients in these areas where the demand is so high (Rust, 2018:1). Subsequently, bullying may influence the quality of patient care the victim renders to patients. Woolforde (2019:49) confirms that bullying has serious consequences for the nurse as it impedes the victim's ability to render optimal, quality patient care.

Nurses being victims of bullies are less likely to seek assistance from their colleagues if in need. The inability of the nurse to cope with a heavy workload, may result in burnout which in turn leads to poor patient care (Thompson, 2017:18). Moreover, victims of bullying may leave

the profession, causing a shortage of nurses in the hospitals, which is a patient safety risk (Thompson 2017:18). According to Townsend (2012:3), bullying tends to interfere with teamwork, communication, and collaboration and are patient safety issues when the victim is not comfortable working with the perpetrator. The researcher also mentioned that when a shift leader withholds important information, deliberately assigns too heavy a patient load, and does not assist when needed, patient safety will be compromised which can have serious consequences. Consequently, for the safety of patients, bullying amongst nurses must be stopped to avoid skilled, competent and compassionate nurses leaving the profession (Alexander, 2018:1).

2.4.4 Workplace bullying and the organization

Bullying comes from organizational cultures that allow bullying in the workplace (Johnston, 2010:38). Organizational characteristics are critical antecedents of bullying (Lowenstein, 2013:2). Therefore, bullying behaviour will subconsciously become the norm in organizations if management does not set limits to this phenomenon (Johnston, 2010:38). Organizations that strengthen positive behaviour by teambuilding and group identity will maintain good team spirit and reduce incidents of bullying (Cunniff, & Mostert, 2012:12). Healthcare managements are urged to take bullying seriously, by monitoring and assessing the behaviour and to create a non-bully climate in their organizations. Consequently, management support in this area is pivotal, as they will be responsible for initiating and sustaining the successful implementation of anti-bullying policies (Michek, 2017:1).

2.4.4.1 Workplace policies and regulations regarding bullying

Senior management in any organization should have a zero tolerance against workplace bullying (Beach, 2013:9). Through maintaining zero tolerance, managers can create a nonbully culture and respect in the organization (Sliter, 2013:3). The support of management is crucial since they are accountable for introducing and maintaining anti-bullying policies (Michek, 2017:1). According to Johnston (2010), bullying behaviour can cause huge problems not only to the organization, but also to the victims of the tolerated behaviour.

Employers are responsible for creating a safe environment free of bullying (Woolforde, 2019:1). Organizations are also obliged to address bullying behaviour that threatens the performances of the nurses they employ (Beach, 2013:8). Confronting bullying in the workplace is always the right thing to do, and it shows the employer cares about his/her workers. Consequently, prevention is more cost-effective than to intervene or mediate in negative effects of bullying (Gordon, 2019:3). The researcher also indicated that leaders, bosses and those in authoritarian positions, must be given education opportunities, as most

of the bullying comes from these leading figures. This will enhance a workplace atmosphere that cultivates teamwork, collaboration and positive relationships (Gordon, 2019:3).

Governmental policies and regulations are in place to guide organizations and protect victims of bullying. The Employment Equity Act, No 55 of 1998, (SAICA, updated October 31), states that all employees should be treated fairly and that equal opportunities for employment should be achieved through elimination of unfair discrimination and implementation of affirmative action measures to redress the disadvantages in employment. The Basic Conditions of the Employment Act recommends that the Commission for Conciliation, Mediation and Arbitration (CCMA) must follow the principles of non-discrimination, fair labour practice and the reasonable rights and duties of employers and employees. This must be exercised in each hospital, when formulating policies and procedures regarding the treatment and steps to take in the case of negative behaviour in the workplace.

2.4.4.2 Code of Good Practice and Handling of Sexual Harassment

The Commission for Conciliation Mediation and Arbitration (CCMA) refers and describes various forms of sexual harassment. According to the South African Labour Guide (2019), sexual harassment may include unwelcome physical, verbal or non-verbal conduct. Employers should create and maintain a working environment in which the dignity of employees are respected. All employers/management and employees have a role to play in contributing towards creating and maintaining a working environment in which sexual harassment is unacceptable. They should ensure that their standards of conduct do not cause offence and they should discourage unacceptable behaviour on the part of others. Persons who have been subjected to sexual harassment in the workplace have a right to raise a grievance should it occur and the employer must take appropriate action.

2.4.4.3 The Compensation for Occupational Injuries and Diseases Act, No 130 of 1993 (COIDA)

The Amended Act - Compensation for Occupational Injuries chapter 14 states that nurses will be compensated in the event of disablement caused by injuries or illnesses sustained or contracted by victims in the course of their employment, or for death resulting from such injuries or diseases.

2.4.4.4 The Unemployment Insurance Act

According to the South African Institute of Chartered Accountants (2019), the purpose of the Unemployment Insurance Act, No 63 of 2001, is to provide nurse's payment from the Fund of Unemployment benefits to certain nurses and for the payment of illness benefits related to the unemployment of such a nurse. The Unemployment Insurance Contributions Act, No 4 of

2002, provides for the imposition and collection of contributions for the benefit of the Unemployment Insurance Fund, for when the unemployed nurse needs it.

2.4.4.5 *Employment Equity Act, No 55 of 1998 and the Skills Development Act.*

According to the Summary of the Employment Equity Act, chapter 1, the purpose of the Employment Equity Act, No 55 of 1998 is to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment of nurses. This is done through elimination of unfair discrimination and implementing affirmative action measures in the hospital settings to redress the disadvantages in employment experienced by nurses. Consequently, this is to ensure equitable representation in all nursing categories and levels in the hospital.

2.4.4.6 *Occupational Health and Safety Act (OHASA)*

To provide for the health and safety of nurses at work and the protection of persons other than persons at work from hazards to health and safety arising from or in connection with activities such as bullying of nurses in the workplace.

2.4.4.7 *The Basic Conditions of Employment Act 75 of 1997*

This recommends that recommends that the Commission for Conciliation, Mediation and Arbitration (CCMA) must follow the principles of non-discrimination, fair labour practice and the reasonable rights and duties of employers and nurses. In each hospital, policies and procedures regarding the treatment and steps to take in the case of negative behaviour, such as bullying in the workplace must be formulated according to these principles. The Act further regulates labour practices and sets out the rights and duties of the nurse and employers. The aim of the Act is to ensure social justice by establishing the basic standards for employment with regard to working hours, leave, payment, dismissal and dispute resolution.

2.4.4.8 *Hospital policy and procedure*

The employee relations policies refer to policies and practices that are concerned with the management and regulation of relationships within the working environment between the organization, the individual employee and staff groups (Dinwayo, 2017:4). The “Workplace relations policy”, is the policy and procedures followed by the researcher where he works. Zero tolerance for bullying in the organization is explained in the policy, to protect the staff against this dangerous behaviour. The steps on how to prevent and how to deal with this phenomenon are set out in a systematic manner (Dinwayo, 2017:4).

2.4.5 *The financial implications on the organization due to bullying*

Bullying can result in huge expenses for the organization. Examples are the increased turnovers of nurses, with expenses for recruitment, orientation and in-service education of new

nurses. Absenteeism of nurses due to bullying has an impact on the organization's financial budget (Dalton, 2016:2). The unit manager will have to replace the nurse who is off sick by hiring nurses from the various agencies to ensure patient safety. In addition, the organization will have to pay for the nurse who is off sick and the nurse coming to replace her, adding financial strain on the budget. Expenses for worker's compensation due to depression can also put strain on the financial budget of the healthcare organization (Dalton, 2016:2). Nurses resort to absenteeism, as they do not have the support or skills to cope with the bully while on duty. Moreover, absenteeism contributes to extra expenses to the organization and an extra burden on their colleagues causing high turnovers and disengagements of nurses (Thompson, 2018:2).

Organizational losses due to bullying can be indirect or direct losses. The outcome stays the same, whether direct or indirect losses because of bullying, the bottom line is, the hospital is losing (Williams, 2016:50). Indirect losses are the interference with production, e.g. a rise in mistakes due to bullying, resignations of qualified registered nurses, and absence from work. Examples of indirect costs are associated with time spent in recruiting, hiring, and training of new staff, tardiness, absenteeism, decreased productivity, low morale, sub-standard quality of patient care, and non-engagement by staff (Williams, 2016:50). Bullying is an adding factor to the rapid increase of indirect costs. The researcher also postulates that habitual absence from work and tardiness, is costing the US more than \$3 billion annually.

Direct costs are goods easily recognised and quantified in a company's financial report, e.g. lost salaries, workman's compensation and medical insurance claims, damaged supplies, hospital furniture, beds, computers, wheelchairs, etc. all contribute to direct costs (Williams, 2016:50). Direct losses are also payments for legal costs, internal investigations, and pay-outs for nurses being sued due to mistakes caused by bullying (Lee, Bernstein, Lee & Nokes, 2014:1).

2.4.6 Management strategies for bullying at the workplace

According to the Australian Public Service Commission (2019:1), the best way to deal with workplace bullying, is to prevent it from happening before it undermines individuals' well-being or workplace relationships, or becomes a risk to health and safety, and the best way to do this is by encouraging a culture in which bullying behaviour cannot thrive. Each member of an organization, including leaders, has to contribute to preventing bullying and managing it at work.

The most powerful tool to fight bullying is to develop healthy work environments by improving communication, increasing retention and to promote safe patient-centred nursing care

(Lockard, 2017:2). The researcher also indicates that communication with one another must always be with respect, not aggressive or judgemental. As a result, these strategies empower nursing staff and add value to the job.

2.4.6.1 The role of management

It is vitally important that nurse managers and hospital administrators create strategies to modify the healthcare environment into a physical and emotionally safe work environment (Lee, Bernstein, Lee & Nokes, 2014:5). Bullying should be recognised and acted upon early, in order to send a message of a zero tolerance for bullying in the organization (Australian Public Service Commission, 2019:1). The Joint Commission International recommends two leadership standards in that institutions are required to have a code of conduct that describes inappropriate behaviours, as well as processes on how to manage unacceptable, disruptive behaviours (Beach, 2013:8). Consequently, workers should monitor and report all bullying behaviour of their peers to the managers, to prevent bullying in the workplace (Johnson, 2015). Complainants should feel confident that their complaints will be addressed with positive outcomes, i.e. the perpetrators will be identified and confronted, resulting in a fair hearing and appropriate disciplinary actions (Lowenstein, 2013: 11). Nonetheless, to prevent bullying in the workplace management should proactively convey policies and procedures about acceptable behaviour in the workplace. Furthermore, policies should be a clear statement of the expected behaviour workers should follow. Managers are responsible for monitoring the institution's policy and processes if there is non-compliance to the expected behaviour (Australian Public Service Commission, 2019:1).

2.4.6.2 Education and training strategies

Education and training of newly graduated nurses ensure that negative behaviours are recognised in the workplace, which is imperative to ensure that this behaviour is immediately addressed. This strategy will attract newly graduated nurses, which is the ultimate goal for retaining nurses in the workplace (Gillespie, Grubb, Brown, Boesch & Ulrich, 2017:1).

An educational programme focussing on bullying in hospitals was recommended by the Joint Commission International, e.g. skills-based training and coaching, continuous non-confrontational monitoring, a method of evaluating staff's insight of the significance of bullying, and policies that encourage early reporting with no fear (Lee, Bernstein, Lee & Nokes, 2014:5). Policies against zero tolerance for bullying in workplaces, implementation of training programmes on how to deal with bullying and implementation of safe and confidential resources for victims of bullying on nurses in the Cape Metropolitan area, were recommended (Rust, 2018:77). According to Samuels (2015:9), as per rigid policies and procedures, nurses must have good support from the employers with opportunities to voice their problems, and

not allow perpetrators to walk free. Information given to nurses and managers to identify and manage bullying behaviour in the departments have been proven to be effective, such as ways in mitigating the behaviour, e.g. role-play imitation to practise how to confront the perpetrator assertively (Michek, 2017:2).

2.4.7 Quality assurance

Quality assurance is a process used to assess if the service rendered is up to standard, and if the customers receive the kind of service that will keep them returning. The idea is to deliver a high consistent quality service. This is very important for patient satisfaction (Rouse, 2019:1).

A quality assurance audit is a documented, systematic process, performed in a planned manner by competent independent personnel with the objective of evaluating the application by an organization according to the principles and requirements of defined quality regulations and customer expectations (Ingram, 2019:1). The main aim of audits is to determine how effective an audit programme is at recognising and minimizing mistakes and to give guidance for improving quality assurance efforts (Ingram, 2019:1).

According to Townsend (2012:3), an unhealthy workplace environment adds to hospital acquired illnesses, leading to prolonged stay or re-admissions of patients. Bullying amongst nurses is increasingly prevalent and creates consequences that are harmful to patients (Johnston, 2009:37). Nurses who are dissatisfied due to the work environment, are not fully engaged, this eventually leads to an unstable, and disengaged team, resulting in poor quality patient-care conditions (Johnston, 2009:38). Furthermore, Michek (2017:1) agreed that bullying and hostile actions not only generate an aggressive work environment, it connects bad behaviours with compromised patient safety in hospitals. The researcher also revealed that a bully could endanger the safety of patients in a subversive manner. According to Michek (2017:1) bullying behaviour generates a difficult and aggressive work environment, however, a study linked negative behaviour with compromised patient safety in hospitals. According to

Clarke (2009:15) about 2 000 nurses were surveyed and 7% admitted to being involved in administering wrong medication to patients, due to the effects of bullying. These disruptive actions can negatively influence the victim's cognitive ability to quality patient care, which can result in an increase of mistakes.

The quality of patient care rendered by bullied nurses are linked to unsafe practice, with nurses putting the patient's and their own safety at risk (Rust, 2018:3). Nurses are unable to render high quality patient care when they work in a culture of bullying, causing job dissatisfaction, consequently having psychological and physiological effects (Lowenstein, 2013:4). It is very

disturbing to patients and co-workers to witness nurses bullying one another in the hospital and even worse, if it occurs in front of others (Thompson, 2015:1). Patients have signed Against Medical Advice (AMA), because of fear of harm coming to them by nurses being bullied (Williams, 2016:30). Moreover, safe and quality patient care depends on good teamwork, good communication and team-spirit building (Beach, 2013).

2.5 Conclusion

Research indicates that bullying amongst nurses is a reality and poses notable problems. Bullying in the workplace can be detrimental to the patient, nurse and organization. It also negatively influences the retention of good, competent staff. Effective policies and procedures should be available at the healthcare organization with the aim to provide a safe and bully free culture for the staff and patients alike.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter encompasses a comprehensive explanation on how the selected research methodology and methods were used to explore bullying among nurses working in the public healthcare sector within the Cape Metropole. Research methodology is the use of specific skills and processes to recognize, choose and analyse details regarding a subject. The reader can evaluate a research study entirely, and assess if the study is valid and reliable after reading the methodology section (Libguides, 2019:1). The researcher made use of the qualitative research approach to explore the experiences of nurses regarding workplace bullying.

3.2 Research aim

The aim of this study is to explore the experiences of nurses regarding bullying in the public hospitals in the Cape Metropole.

3.3 Research objectives

The objectives are as follows:

- To describe the experiences of victims of bullying in the nursing profession
- To gain an understanding of the manifestation of bullying in the workplace
- To describe the strategies of the organizations in managing bullying amongst nurses

3.4 Study setting

A study setting is the place where participants are recruited and data is collected. (LobiondoWood & Haber, 2018:93). The study was conducted in two tertiary hospitals emergency/trauma units, in the Cape Metropole.

Government hospitals in South Africa are classified as district (level 1), regional (level 2), and tertiary hospitals. A government or a public hospital provides healthcare services to all people and is funded by the government. These hospitals receive patients from referral hospitals. Patients admitted to these hospitals must have a mandatory referral from a primary or tertiary hospital, may it be from a clinic or private physician (Western Cape Government, 2019:1). Tertiary hospitals will also refer patients between themselves for the purpose of services not available at the one hospital.

The hospitals are located in the northern and southern regions of the Cape Metropole. The type of patients treated in these hospitals are linked to road traffic accidents and interpersonal

violence that contribute significantly to the trauma burden in South Africa (Prinsloo, Kotzenberg & Seedat, 2007). Admissions to the trauma unit are patients who have suffered gunshots to the face, panga slashes, bricks to the head and stabbings. For penetrating trauma, the hospital achieves exactly the same outcomes as a major Level 1 trauma centre in the US, and they have six times the amount of staffing (Geach, 2019:1). To achieve those sorts of results are phenomenal, because the trauma units in question, are rendering care which compares to international standards, thus the resources should be readily available.

3.5 Research design and methods

Grove, Gray and Burns (2015:211) refer to a research design, meaning the structure of the enquiry as the blueprint of the study. The design enables the researcher to recognize factors that can hinder the validity of the study findings, thereby allowing the researcher to have more control over such factors (Grove, Gray & Burns, 2015:63). The research design is the plan on how the research will be done (Lobiondo-Wood & Haber, 2018:92). It starts with the research problem, then the research question and the framework. According to Adams (2010:29), an advantage of qualitative research is to have an understanding and provide life experiences in their entirety, instead of focusing on specific conceptions. The researcher used this design to explore bullying of nurses at the workplace, so that appropriate strategies to prevent and stop bullying can be implemented.

3.5.1 Qualitative research

A qualitative research is used to describe life experiences and circumstances in a systematic, yet subjective manner (Grove, Gray & Burns, 2015:20). For the purpose of this study, a qualitative design with an exploratory descriptive approach was chosen as appropriate to explore the experiences of nurses regarding bullying in public hospitals in the Cape Metropole. A qualitative approach allows the researcher to have a systematic approach to narrate experiences and circumstances from the viewpoint of the person in the situation (Grove, Gray & Burns, 2015:67). Exploratory designs are initiated to furnish information and insight into clinical or practice problems. The theoretical orientation of exploratory descriptive qualitative research may differ, based on the purpose of the study, but frequently the researcher has a realistic orientation during his research (Grove, Gray & Burns, 2015:77). Qualitative research deals with creating clarifications of social phenomena (Hancock, Ockleford & Windridge 2009:7).

This raises questions such as below, stated by Hancock, Ockleford and Windridge (2009:7):

- Why humans act the way they do
- How viewpoints and attitudes are established
- How persons are affected by what happens around them

3.5.2 Exploratory-descriptive design

An explorative descriptive qualitative design refers to all qualitative studies that do not exactly qualify to be named as ethnographic, grounded or phenomenological (Grove, Gray & Burns, 2015:76). Descriptive research strives to describe a population, condition or occurrence correctly and thoroughly. Questions such as when, what and how can be answered, however, the why question can only be answered by experimental research to determine cause and effect (McCombes, 2019:1). The researcher also pointed out that descriptive research is a good choice when the aim is to identify attributes, prevalence, tendencies and classifications. Furthermore, it provides the researcher with ways to find a fresh definition, to report what exists, to establish the extent of a phenomenon and to group the information (Schlebusch, 2016:16).

An exploratory-descriptive design was used for this study to enable the researcher to give meaningful answers to the research question. The researcher focused on the information provided during the interviews by the participants, regarding their experiences of bullying in the workplace. Subsequently, this enabled the researcher to present a precise account of the participant's experiences.

3.6 Population and sampling

Population is all components that meet specific standards to be included in a study (Grove, Gray & Burns, 2015:46). Population may consist of persons, animals, items or events (Lobiondo-Wood & Haber, 2018:212).

The population included all registered nurses, enrolled nurses and nursing assistants who were working in the trauma/emergency departments of the two public healthcare facilities. The total number of permanent nursing staff in the trauma/emergency departments are approximately 300 nursing staff of all categories. According to Latham (2018:1) a sample size of 11 is adequate in qualitative research, hence a total of 12 nurses were interviewed.

Sampling is the process of choosing participants from the population in the study (Lobiondo-Wood & Haber, 2018:213). A sample is a subgroup of the population being chosen for a specific study, thus these members are the participants (Grove, Gray & Burns, 2015:46). Voluntary sampling, a non-probability technique was used in this study where participants willingly choose to participate in the study (Murairwa, 2015:187). Bullying is a sensitive subject that nurses have difficulty in discussing, hence, voluntary sampling assisted the researcher to reach participants that were difficult to locate. In addition, the researcher gave short presentations to nursing staff in the emergency departments at the hospitals on different shifts, to highlight the phenomenon of bullying amongst nurses. Interviews continued until data

saturation was reached, which means, nothing new emerged from the interviews from the population of nurses who met the inclusion criteria and volunteered to participate in the study (Lobiondo-Wood & Haber, 2018:94). Voluntary sampling allowed the researcher to recruit twelve participants that were considered to be representing the nurses in the public healthcare facilities, trauma/emergency departments, and who could furnish valuable data that were essential to the study. Thirteen out of fifteen participants met the inclusion criteria, however only twelve participants were interviewed as the others declined to be interviewed. Moreover, if data saturation was not reached after the 12th interview, more participants would have been included in the study. Data saturation was reached at participant number twelve as no new information was discovered during the interview.

3.6.1 Inclusion criteria

The inclusion criteria for this study were all registered nurses, enrolled nurses and enrolled nursing assistants who had been working in the emergency/ trauma departments and were permanently employed at the public hospitals in the Cape Metropole. These nurses worked for at least six months, and experienced or witnessed incidents of bullying by their seniors or peers at these specific hospitals.

3.6.2 Exclusion criteria

All enrolled or registered nurses who did not attend the information sessions in the emergency departments, presented by the researcher on the days of recruitment, at the public hospitals in the Cape Metropole, were excluded. The information that was given at these sessions was crucial for participant's knowledge to be part of the study.

3.7 Instrumentation

Instrumentation is the way or manner used by the researcher to obtain data from participants, in order to complete a study (Grove, Gray & Burns, 2015:44). In order to reach the objectives of the study, the researcher used a semi-structured interview guide to collect data.

3.7.1 Semi-structured interview guide

Individual interviews with a semi-structured interview guide based on the objectives of the study was used and was validated by the supervisor of the study before data collection. Moreover, semi-structured interviews enabled the researcher to obtain in-depth information regarding the topic under study, as well as thorough understanding of answers given (Harrell & Bradley, 2009:27). The interview guide consisted of two sections. One section included the demographic profile to collect data such as participants' age, gender, marital status, educational level, professional rank, work experience and years in the current

emergency/trauma departments. The second section comprised of four open-ended questions to obtain information regarding the experiences of nurses being bullied at the workplace.

The interviews were commenced with a non-intimidating question, which was, “What can you tell me about your experiences regarding bullying at your workplace”? This question was then followed by probing, e.g. “What support structures are put in place for you to use”? The participants felt comfortable to talk with this strategy used, and it encouraged them to elaborate with ease. Questions then followed: “What are the reasons for bullying at the workplace”? “What can you tell me about the strategies that are used by management to address bullying at the workplace”? “How can the institution help to support nurses being bullied in the workplace”? These questions were asked to determine the experiences that participants endured when bullied at the workplace.

3.8 The data collection

Data collection is the accurate, systematized gathering of information pertinent to the research purpose (Grove, Gray & Burns, 2013:47). An interview is verbal communication between the participant and the researcher where facts and particulars are obtained by the researcher (Grove et al., 2013:302). Interviews are methods of collecting data where the researcher asks open-ended or closed-ended questions to participants (Lobiondo-Wood & Haber, 2018:253).

Data collection was performed by the researcher, who received training on how to conduct interviews from the coordinator and lecturer of the master’s programme at the University of Stellenbosch and supervisor of the study. When interviewed, participants described their experiences regarding workplace bullying and how it affected their lives. Data saturation was reached after the 12th interview, when no new information emerged. The researcher also gave the assurance that he was not familiar with any of the participants to prevent bias, which can cause distortion in the study. In case the author knew the participants, a fieldworker with expertise in interviewing and qualitative research was available to conduct interviews.

Electronic files were generated for all the data collected such as transcripts, interviews and all research literature. The researcher is keeping a portable hard drive as backup to ensure extra measures of safety are in place. These electronic data are kept on the personal computer of the researcher and secured with a personal password, only known to the researcher. All hard copies such as consent forms, recruitment forms and interview questions are being kept in a lockable cabinet with only the researcher having a key and access to it. On completion of the interviews, an independent transcriber transcribed the interviews verbatim from the recordings. This transcribed data were marked and coded individually. These codes are only known to the researcher. The participants stayed anonymous, however, all identification

details of the participants are being stored for safe keeping with only the researcher having access to it.

The researcher started the analysis process by listening to the recordings several times in search of meaning and understanding.

3.8.1 Interview setting

Interviews were conducted in a suitable, neutral and private venue, time and day as arranged by the researcher and the participants (Grove, Gray & Burns, 2015:276). The venues were quiet areas, free from any disturbances. All cell phones were on silent or switched off to ensure confidentiality. Most participants chose to be interviewed in the work environment. These interviews were conducted either in the seminar room or in the operational manager's office, during the participants' lunch hour so as not to interfere with the operational duties. No entry signs were posted on the outside of doors to prevent any disturbances. Furthermore, all telephones were off the hook. The participant's comfort during the interview was of great concern, thus the researcher ensured that chairs were comfortable, rooms well-ventilated and bottled water was provided. The aim and purpose of the study were explained to the participants and they had the opportunity to raise any concerns, which were addressed to their satisfaction by the researcher.

3.8.2 Interview procedure

The study was conducted after approval from the Health Research Ethics Committee at Stellenbosch University, followed by permission from the Department of Health and management of the participating hospitals. Once the managers of the two public hospitals granted permission, the researcher could start recruiting the participants. The researcher arranged a meeting with the managers of the emergency departments, followed by a meeting with the nurses. During these meetings, the researcher gave information regarding the study such as the purpose of the study, voluntary participation, etc.

The researcher gave presentations regarding bullying to nursing staff in the two emergency/trauma departments and distributed business cards with his contact details. Participants contacted the researcher via telephone and WhatsApp to affirm their voluntary participation in the study. On agreeing to participate, written consent was obtained for participation in the study, as well as the recording of interviews. The participants were reassured to speak without fear of retaliation and withdraw without fear of repercussions.

The interviews were recorded with a digital recorder and transcribed verbatim, thus the information was stored in an electronic folder with a password known only to the researcher.

A second recorder was available in case of power failure. The interviews started with open-ended questions that allowed the participants to describe their experiences and feelings in their own words and thoughts regarding bullying in the emergency/trauma departments in the public hospitals in the Cape Metropole. To ensure anonymity, the researcher made use of pseudonyms and referred to the participants as participant 1, 2, etc. The interviews were conducted in the two languages most comfortable for the participants, English and Afrikaans. However, none of the participants preferred to speak in any other language. Interviews lasted from 30 minutes to 50 minutes per participant.

By reflecting, the researcher ensured that he continuously examined his own conceptual ideas and assumptions and how it would affect research decisions, especially the wording in questions. The researcher reflected the messages of the participant and showed understanding and created an encouraging atmosphere at all times.

The researcher summarized the participant's response after each question to ensure accurate understanding of the responses. The researcher then took the information gained; summarized it until he had a condensed version of the main points which was accurate and distinct.

Bracketing. The researcher set aside his own views and biases about the research topic. This process started before the actual interviews, when the researcher dialogued with peers, discussed personal biases, past experiences and knowledge regarding bullying amongst nurses. The researcher did not allow previous studies to influence his view during the interview process.

3.9 Pilot interview

A pilot study is the lesser scale of a research study to refine the study sample process, for instance the treatment methods and to determine the quality thereof (Grove, Gray & Burns, 2015:45). The purpose of the pilot interview was to assess the feasibility of the approach and the appropriateness of the interview guide. No changes were made as no pitfalls were encountered with the semi-structured interview guide during the pilot testing. In this study, a pilot interview was conducted with one participant (Registered Nurse) who met the selection criteria. Furthermore, it assisted the researcher in establishing that enough proof was found to give grounds for a larger research study (Lobiondo-Wood & Haber 2018:225). Data collected from the pilot interview, were included in the findings of the main study, as the study was conducted in a similar manner to the proposed study, with the same subject, similar settings, and treatment similar to the data collection (Grove, Gray & Burns, 2015:45).

3.10 Trustworthiness

Trustworthiness is a confirmation that a qualitative study is meticulous, and of high standards. It is the extent to which a qualitative study is movable, credible, dependable and confirmable (Grove, Gray & Burns, 2015:392).

3.10.1 Transferability

Transferability refers to the generalization or the extent to which the findings can be transferred or have applicability to other settings and target populations (Ngunyulu, 2012:37). Transferability requires the researcher to indicate that the outcomes have appropriateness in other contexts. The researcher will be able to use the findings of the study outside the current situation and is applicable to other settings with similar participants (Grove, Gray & Burns, 2015:392). The researcher described in detail the selection of the participants, the collection, analysis and interpretation of data. To further enhance transferability, the researcher provided a thick description of the study participants, the experiences they had, and observations made during the study. The researcher also identified and described data and wrote the report in such a way that it became easier for any reader to assess the applicability of the data to other settings (Ngunyulu, 2012:37).

3.10.2 Credibility

Credibility of a study extends to the truthfulness of the findings (Lobiondo-Wood & Haber 2018:119). In this study, credibility was ensured by conducting semi-structured interviews, tape recordings and verbatim-transcribed interviews. Credibility is to have trust in the veracity of the outcomes. Subsequently, member checking was done whereby the researcher returned to the participant to clarify interpretations, allow participants to delete or add information and to query and confirm accuracy of their views as reflected in the transcripts. The latter is to ensure that the participants recognized the experience as their own (Lobiondo-Wood & Haber 2018:126).

The researcher remained unbiased by putting aside any preconceived ideas regarding bullying in the workplace. The supervisor reviewed transcriptions for appropriateness of themes, whether the interpretations of the researcher actually reflected the participants' realities and determined that it was sufficient and adequate for the study (Grove, Gray & Burns, 2015:89).

3.10.3 Dependability

Dependability refers to the reliability of data over time, over conditions and over occasions (Polit & Beck 2008:539). The researcher evaluated the quality of processes of data collection, data analysis and theory generation. Dependability is the documentation of steps taken and

decisions made during analysis (Grove, Gray & Burns, 2015:392). To attain dependability, the researcher made the collected data available to two other researchers (Master's Degree Graduates with experience in qualitative research), to study it and compare the outcome to confirm the validity. This assisted the researcher to enhance trustworthiness of the study by other researchers performing an audit. Moreover, this ensured that if the study were to be repeated with the same members and circumstances, the outcomes would be the same (Brink, Van Der Walt & Van Rensburg, 2018:111).

3.10.4 Confirmability

Confirmability is a form of impartiality by the researcher and others to confirm the findings of the study (Loh, 2013:5). The researcher did the study in such a way that others will be able to agree that the conclusion of the study is logical and legitimate, because the information gathered by the researcher is purely based on the participants' responses. Other researchers were able to review the audit trail and agreed that the researcher's findings are sound. This improved the credibility of the study.

The supervisor confirmed findings through auditing of the taped recordings and transcriptions. The researcher created themes and subthemes, which were audited against the transcriptions for similarities by the supervisor (Brink, Van der Walt & Van Rensburg, 2012:127).

3.11 Ethical considerations

Permission to conduct research was obtained from the Stellenbosch University, Health Research Ethics Committee, followed by approvals from the management of two public hospitals in the Cape Metropole. The researcher has the responsibility to respect and protect the human rights of the participants during research (Brink, Van der Walt & Van Rensburg, 2012:34). The researcher adhered to the following ethical principles.

3.11.1 Informed consent and voluntary participation

The participants signed a consent form if they agreed to participate in the study. They were also asked to give permission to be recorded during interviews (see Annexure 2). Participants were also informed that they are free to cancel participation at any time during the study without any consequences (Grove et al., 2015:177).

3.11.2 Beneficence

Beneficence requires the researcher to do good and above all, do no harm to the participants (Grove, Gray & Burns 2015:108). The study did not have direct benefits. Nevertheless, the findings of the study are anticipated to assist the organization to implement policies to prevent and stop bullying of nurses in the workplace. In addition, the interview allowed the participants

a chance to voice their feelings and experiences, and consequently reduce the build-up of emotions, thus making the interview beneficial to the participants.

3.11.3 Non-maleficence

Non-maleficence requires that no harm should come to a participant, due to their participation in a research study (Gelling, 2015:1). One participant experienced emotional discomfort during the interview, especially when she had to re-live the moments of belittling, humiliation, anger, sadness, frustration, victimization and fear. The participant was given time to compose, and counselling was offered whereby the participant refused. The interview continued after a 15minute break, with the participant feeling much better. The researcher advised free counselling services offered to all public hospital workers who are in need thereof and provided participants with the contact details of ICAS (Independent Complaints Advocacy Service), Employee health & wellness programme, toll free number 0800611093.

3.11.4 Autonomy

Autonomy means independence, therefore the participants were informed about the study and they had the choice to voluntarily make the decision to participate (Grove, Gray & Burns 2015: 500). The researcher viewed participants as autonomous agents, by providing true facts regarding the study. All queries were handled in the most honest way possible by the researcher. The participant's decision to participate or not was respected, they had the choice to withdraw without fear of being victimized or negative treatment being imposed.

3.11.5 Justice

Justice is an ethical principle in which the researcher ensured that the participants are treated fairly regarding the benefits and the risk of research (Grove, Gray & Burns 2015: 98). Justice also ensured that the participant benefitted from the interview by expressing their stresses and concerns (Lobiondo-Wood & Haber 2018:235). All participants were selected on the grounds of the principles of the research problem. The researcher provided various information sessions to all trauma/emergency nursing staff regarding the research, thus equal opportunities were given to all participants to be included in the study. Participants who withdrew from participating in the study were treated with respect and no judgements were made towards them.

3.11.6 Veracity

The researcher approached the study with honesty and accuracy (Brink, Van der Walt & Van Rensberg, 2012:34). Telling the truth enhances good communication, honour and builds trust. The researcher showed respect towards the scientific community by providing a truthful account in the study (Brink, Van der Walt & Van Rensberg, 2012:43). The researcher provided

a truthful account of the study, i.e. the participants' views stated and not the researcher's own preconceived ideas.

3.11.7 Anonymity and confidentiality

The researcher ensured that there was no breach of confidentiality and anonymity. As a result, interviews were conducted in a private room to prevent others from identifying the participants. Furthermore, the transcriber and the independent coder signed confidentiality agreements. The identity of the participants were not revealed. Subsequently, each participant was allocated a number (e.g. Participant 1 or P1). The transcriptions were coded with a number, corresponding with the sequence in which participants were interviewed. Number coding was done to prevent the name of the participant being linked to the transcriptions during data analysis. The identity of the participants were only known to the researcher and supervisor, who could link the participants' names to the numbers as assigned.

For safekeeping, the researcher has kept all the data on electronic media, as well as on hard copies. Hard copies will be stored and locked in a secure area for a minimum period of 5 years at the researcher's home. The soft copies will be copied onto an external hard drive and locked away for a period of 5 years. All information on the computer will be managed by a password known only to the researcher.

3.12 Data analysis

Data analysis is a rigorous process. Imagination and deep thought can introduce new ideas to analyse data; however, the exercise requires discipline to generate data analysis plans, consistent with the particular analytical method of study (Grove, Gray & Burns 2015: 88). Qualitative researchers will handle raw data such as transcriptions and recorded interviews, find commonalities and differences and group it into themes (Lobiondo-Wood & Haber 2018:95). The researcher started the data analysis process by listening to the recordings several times in search of meaning and understanding.

Data analysis was done according to the approach described by Terre Blanche, Durrheim & Painter. These five steps were as follows:

3.12.1 Familiarisation and immersion

The researcher read and re-read transcriptions to immerse himself in the data. The purpose of this stage is to gain knowledge and understanding of what the participant is telling the researcher. Moreover, this was also to assist the researcher to explore the phenomenon as experienced by the participants (Terre Blanche, Durrheim & Painter 2011: 325).

3.12.2 Inducing themes

Induction, meaning general themes gathered from particular occasions. The bottom-up approach was followed where the researcher created many simple codes, then grouped them together, found patterns, and inferred a higher level of meaning by formation of themes. (Turner, 2014:1). The researcher assessed and analysed the data obtained for its significance. The researcher used the same language as the participant, instead of using abstract theoretical language to label the categories. The researcher not only summarized content, but also worked in terms of processes, functions and events for better organizing of the material.

If too many themes were present, the researcher rearranged themes by adding subthemes.

3.12.3 Coding

Coding was done while developing themes. The researcher coded the data that had relevance to the topic. Coding of a phrase, line, sentence or paragraph was done by the researcher. The researcher used two or more codes if there were two or more themes, therefore colour marker pens were used to highlight certain sections in the text. The researcher identified statements related to the subject in question and formulated general meanings to get a clear view. As a result, coding assisted the researcher to identify patterns in the data that could be compared for similarities and differences. To ensure and maintain the privacy of participants, numerical codes such as P1 or P2 were used.

3.12.4 Elaboration

By inducing themes and coding, the researcher was able to compare parts of the text that appeared to be similar. The researcher was able to identify themes and subthemes that emerged, in order to capture the small differences of meaning not captured initially. The researcher also used this opportunity to revise the coding done in step 3. This way of revising assisted the researcher to give a good account of what transpired during data collection and analysis.

3.12.5 Interpretation and checking

In this final stage, the researcher interpreted the data and provided a written account of the study. Careful analysis of the data was done and the researcher checked for parts of over interpretations, prejudice and times when not enough information was given. The supervisor further verified the interpretations of the researcher and a conclusion was reached. Furthermore, a detailed and inclusive description of the experiences of the participants, in combination with all clustered themes were given. Owing to this, the researcher ensured clarity and understanding of the participant's experiences whilst being bullied. Finally, the researcher compiled a report of the interpretations that emerged from data analysis.

3.13 Conclusion

This chapter provided an account of the research design and methodology used in this study. Five steps of data analysis as advised by Terre Blanche, Durrheim and Painter were used to explore the experiences of nurses regarding bullying in the workplace. The trustworthiness of this study, determined that the study is rigorous and of high standards. Furthermore, the ethical principles applied were discussed. The next chapter comprises the findings of this phenomenon under study.

CHAPTER 4: RESEARCH FINDINGS

4.1 Introduction

The purpose of this chapter is to present and report on the findings from data during the study. The aim of the study was to understand the experiences of nurses regarding bullying in the workplace in public hospitals in the Cape Metropole. Raw data were transcribed verbatim, followed by a 5-step data analysis process as described by Terre Blanche. These steps are described in chapter 3, section 3.11.

The findings are illustrated in two sections. Section A describes the demographic data and Section B describes the themes and subthemes that emerged from the data collected.

4.2 Section A: Demographical data

Demographic data collected, comprised characteristics such as age, gender, professional category, years of experience with years worked in the current department.

4.2.1 Age

The ages of participants varied between 26 and 58 years. One participant was younger than 30 years of age. Four participants were between 30 to 40 years, three participants between 40 and 50 years and four participants between 50 to 60 years of age. Novice nurses and new nurses in the units, who are the youngest employees, are more at risk of being victims of bullying (Deniz, 2010:1).

4.2.2 Gender

All participants who took part in the study were females. The all-female participation could be attributed to the sensitivity of the topic, where male nurses are very reluctant to acknowledge that they are being bullied (Moore, 2018:1).

4.2.3 Nursing category

Twelve (n=12) nurses working in the emergency/trauma departments of public hospitals were interviewed. Four (n=4) were enrolled nurses, and eight (n=8) were registered nurses. Four nurses worked on night duty and eight nurses worked on day duty.

The South African Nursing Council (SANC) regulates the professional category of nurses in South Africa. All nurses practicing in South Africa, must be enrolled or registered post a successful completion of exams accredited by SANC as stipulated by the Nursing Act No. 33 of 2005 (South African Nursing Council, 2005:25–26). Enrolled nurses work under the direct supervision of the registered nurse, and the registered nurse works under the supervision of

the Operational Manager. Therefore, in this study the prevalence of bullying of registered nurses by their manager is high, due to the position of authority the manager misuses.

4.2.4 Years of experience in emergency/trauma department

The twelve participants were all females, working in the trauma/emergency departments of the two tertiary hospitals. The work experience of participants ranged from one to more than 21 years. The duration of employment of four participants was two to six years. The majority of participants had worked one to five years in the trauma/emergency departments. According to the Workplace Bullying Institute (2019:1), conversations with many victims have confirmed that victims appear to be the more experienced and most skilled workers in the place of work.

4.3 Section B: The emergence of themes and subthemes

Table 4.1 presents the five main themes and fourteen subthemes that emerged from the data.

These are discussed below. Participants' verbatim statements are in italics.

Table 4.1: Themes and subthemes that emerged

Themes	Subthemes
Workplace environment	<ul style="list-style-type: none"> • Working conditions • Psychosocial environment • Workplace culture • Leadership support
Workforce planning and management	<ul style="list-style-type: none"> • Staff allocation and delegation • Leave allocation
Anti-bullying strategies	<ul style="list-style-type: none"> • Conflict resolution • Staff support • Education and training
Occupational health and safety	<ul style="list-style-type: none"> • Physical health • Psychological health
Quality of patient care	<ul style="list-style-type: none"> • Delayed patient care • Patient neglect • Patient centred care

4.3.1 Workplace environment

The two emergency/trauma units had a combined total of 250 nurses on their database. Different categories, such as registered nurses and enrolled nurse. These nurses are working 12-hour day and night shifts. Participants indicated that the workplace environment was not always conducive to work due to an insufficient number of nurses on duty, because of sick leave and nurses on vacation. Consequently, this negatively affect patient outcomes and staff

effectiveness. Other issues related to the critical care work environment that emerged were working conditions, physical and social environment and leadership support. These issues are discussed below.

Working conditions - Participants indicated that the current work conditions are non-therapeutic and do not support the needs of the patient and staff. Participants further emphasized that they nursed the patient holistically in the past; however, it is impossible with the current shortage of staff. Moreover, they feel that the senior management is deliberately keeping staff to a minimum. Participants revealed that the senior manager has no emergency/trauma experience and therefore has not the authority to make the staffing decisions.

“We were five nurses, we were able to do everything for our patients, and we were able to manage ventilated patients from head to toe. With the lesser staff on duty, we do not have the time to nurse patients from head to toe.” (Participant 1, RN).

Participants revealed that there is no appreciation from the managers, and that they are despondent due to the negative circumstances at work, consequently they did not want to be at work.

“Why do I have to come here, what is the benefit? Many times you feel that you do not want to be here.” (Participant 2, ENA).

Another participant echoed the same sentiment of unhappiness in the workplace but remains out of duty.

“Because at the end of the day I am unhappy I’m just here because I must be here.” (Participant 3, RN).

Several participants mentioned that managers do not have the authority to defend them when decisions are made. When staff complain to their unit managers, they do not have the authority to make decisions, because their decisions are vetoed by a higher hierarchy. Another participant (shift leader) felt that her authority to manage staff was undermined by the manager.

“She is saying, if you don’t go where I tell you to go, your shift will be cancelled.” (Participant 3, RN).

Participants were adamant that they could not render optimal, effective nursing care with the current working conditions. Participants are complaining of the managers coming into the

department with negative attitudes, not greeting, talking to them with no respect, in front of other colleagues. Shortage of staff and working with incompetent agency staff are patient safety concerns to all. Consequently, upon leaving the department for the day or weekend, the nurse manager has to staff the department with sufficient and competent staff.

Psychosocial environment - Bullying in the emergency/trauma department has greatly influenced the social environment. Participants revealed that there is a high level of frustration due to bullying. This in turn affects communication with friends and family. Bullying has resulted in nurses withdrawing to prevent conflict. This particular participant, newly graduate, being respected by the nurses, however, the unit manager would reprimand her in front of the staff. This type of behaviour saddens her so much that she ends up living with these emotions at home.

"I am very frustrated, I will be angry most of the time. I will be quite most of the time and not talk, because no one at home will understand my frustrations. I cannot talk to friends for they know not how I feel." (Participant 10, RN).

Another participant disagreed and stated that she regularly discussed being bullied with her family who support her. Participants mentioned bully behaviour from their managers such as, being belittled in front of others, speaking to staff in a rude manner, leaving the department under staff deliberately, gossiping about senior staff with juniors.

"I talk regularly to my family and my husband, my husband will just say, just do your work, leave the people and do not argue with people." (Participant 11, RN).

Some participants felt that due to their unhappiness and frustrations at work they were unable to lead a normal family life at home. Nurses love their jobs but the manager in the department should create a positive and supportive atmosphere for all staff.

Workplace culture – Participants received tasks from management without any explanation or directive. Furthermore, staff indicated that management did not value them. Participants revealed that the ones in management do not replace staff on sick leave despite the shortage of staff as shown below. The senior manager of the trauma unit wrote in the communication book that no person going off sick will be replaced, according to this particular participant.

"The assist director of nursing makes the decision to not replace off sick nurses." (Participant. 1, RN).

Some participants revealed that they were humiliated, especially when the managers yelled at them. Furthermore, feelings of being useless and not able to defend themselves, create a negative physical environment in the department.

“She shouting most of the time and it makes me feel down and inferior feel like mmm powerless or useless something like that.” (Participant 9, RN).

One participant voiced her dissatisfaction with the manager screaming at her in front of patients as the patient might see her as incompetent.

“The patient will see me as incompetent.” (Participant 10, RN).

Another participant expressed a similar view regarding public humiliation as the manager reprimanded her in front of nursing and medical staff members.

“You are being reprimanded, in a bad way in front of doctors, medical students and everyone listens to this story.” (Participant 8, RN).

The participant further shared her dissatisfaction as the manager discussed problems of staff with other staff members. This in turn results in a toxic workplace culture whereby bullying is tolerated or condoned, nurses whisper and gossip, leaders ignore the value and important contributions of staff, etc.

“I mean if you are immediate supervisor and you have problems to go and speak to her about, it you can’t because then the whole floor will know cause she even speaks to the nurses about the operational managers, how bad they are, about me the clinical facilitator not doing my work. You know things like that, she discusses with staff on the floor.” (Participant 4, RN).

Participants revealed that the managers are rude to them by shouting at them, humiliating them in front of others, and gossiping about the nurses. Managers should value nurses in their departments. Moreover, there should be mutual respect between managers and nurses, to ensure best outcomes for patient and staff satisfaction.

Leadership Support - Participants were dissatisfied with the leadership style of management. Participants were of the opinion that those in management disregard their authority as stated below. The senior manager would go to the registered nurses with three bars on the epaulettes and disregard the shift leader with no bars when she comes into the ward to discuss patient related matters.

“That lady came here, she did not recognise my authority, and I have witnesses and saw it.” (Participant 6, RN).

Participants expressed their disappointment in management for not showing enough support and appreciation after a busy weekend in the trauma departments.

“The managers do not support us. They would rather put us down. They knew we were busy, and won’t come to us to say thank you, we are proud of you and we appreciate what you are doing for our patients, this doesn’t get done.” (Participant 7, RN).

One participant acknowledged being bullied by the manager of the department. She was off sick, and on her return the manager confronted her in front of patients regarding her sick leave, this manager also confronted her on the day when she was absent to take her child to the doctor, asking her why the father of the child cannot take the child to the doctor. All this in front of the others.

“I am being bullied by our head of department.” (Participant 3, RN).

Another key aspect that emerged was when the participant felt disrespected, and not supported by the manager when she copied and pasted the previous work performance evaluation and asked her to sign it as the latest one.

“When she did my SPMS report and then I sat with her. And I spoke to her, little things that needed to be said in the report and things like that and telling her what I was doing, what my work entails and then when I signed, this is now after signing my SPMS form, just to find out that everything that she wrote in the fourth quarter was copied and pasted from the first quarter, right down to the fourth quarter. And it just showed me that she doesn’t think anything of my work.” (Participant 4, RN).

One particular participant stated that the supervisor threatened her if she reported being bullied.

“Well I will take you out of this unit, I will remove you from this unit and I will.” (Participant 6, RN).

Several participants expressed the need for frequent meetings with the unit manager to discuss work-related issues such as staffing. One participant voiced her frustration as they are forced to cope with staff shortages even if the one in management is aware of this.

“I ask my immediate or supervisor and had a meeting, because there’s lot of issues with her and us also, she will reject us, she will leave us just so. Today we’re working without a staff, she wasn’t once here.” (Participant 6, RN).

Participants revealed that the manager abused her authority. They also stated that she changed off duties of staff without consulting them. This particular manager will do changes and nurses will notice the changes accidentally or via a colleague. This participant reveals that nurses are too afraid of victimization if they will confront the manager.

“She will change my off duties without informing me, you do not have a say.” (Participant 10, RN).

Another participant revealed that the managers treated nurses like children and suggested that staff behave like children. This participant feel that this particular senior manager wants to force her authority onto the staff, and that it makes them feel like children who has no power to defend themselves. The participant expressed that the senior manager has a very dominant personality, that her way is the right way.

“We are treated like children and she actually told us that you act like two-year olds and a couple of months later, we progressed to what was it ohm like kindergarten kids.” (Participant 4, RN).

Participants reported that they were afraid of the manager and questioned the reasons for being afraid of someone with mood swings.

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“My self-esteem is down in my shoes, it’s very low. It went so low and I was so scared of the woman, because she is unapproachable, she’s unsympathetic.” (Participant 4, RN).

Participants do not want to talk or lodge complaints about bullying for fear of victimization as explained below.

“Everyone is afraid of the matrons, maybe they are afraid of the repercussions.”
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Participants were also unhappy with the bad behaviour of the manager. They alluded that she was arrogant and did not greet when entering the emergency/trauma department.

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Participants revealed that some nurses were ostracized by the manager and in doing so isolate the victim. Moreover, to belong to a group is a basic human need and when co-workers exclude one of their own, there is no teamwork. This is illustrated in the statement below.

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Another participant was in agreement and expressed her concerns that her manager treats her differently to her other colleagues with the three bars on the epaulettes. The manager is friendlier towards them. The manager will encourage them more than she would do to the participant.

“Yes, she will think more from them as professionals and feel, as you people know nothing, so her way, it’s not in so much words, but the way she speak to you and treat you it’s different.” (Participant 6, RN).

One participant was given unpaid leave without being notified by her manager.

“Unpaid leave was given to me and no communication from the management. Only two weeks after deduction from my salary did I receive a letter from human resource department?” (Participant 4, RN).

One participant highlighted the unfairness when the manager of the trauma unit was on a 3-month holiday and the senior manager appointed someone else although others qualified for the job, i.e. worked in the office before. The participants revealed that the chosen person is a friend of the senior manager, which is why this person was chosen to manage the trauma unit. They felt that other more qualified registered nurses could have been chosen.

“It is unfair. I have everything that fits the criteria, I worked in the office before. If the opportunity is given to me, I will be able to do it. I do not under estimate Z (name omitted for confidentiality), but we need fairness in this place.” (Participant 7, RN).

Similarly, another participant shared a similar view regarding the unfair treatment of the manager. In this case, the participant was placed on night duty because of her hearing disability. The manager felt that the ward is too busy during the day, hence the participant would be more effective on night duty, for the shift is not so busy.

“So if I am here during the day and with this hearing of mine so I’m not fit for the day, so I’m fit for night is not busy because it is not busy so I’m fit for the slow pace...” “Oh ha...a, not fair, not fair I mean I know that when I come here I was ready for both shifts for night shift and day shift...” (Participant 9, RN).

Another participant explained that her leave was denied although she requested it two months in advance.

“I don’t feel that’s fair I’ve asked them two months in advance. I’ve never had leave I’ve asked them my sister is coming from London. We have booked a place.” (Participant 3, RN).

Managers must treat all staff equally and fairly to enhance teamwork and establish respect for one another. As a result, nurses will develop trust in the manager resulting in stability amongst nurses with positive staff and patient outcomes.

4.3.2 Workforce planning and management

Nurse Managers should implement a staffing plan according to patient acuity in their departments. Participants voiced their disappointment in the management of staff in the department, which can influence patient safety. Participants indicated that they were unhappy with the staff allocation and delegation in the emergency/trauma department.

Staff allocation and delegation – Participants expressed their frustration of staff shortages that negatively influence patient safety and result in legal action.

“I am feeling stressed out, because of short staff. What if something happens to the patient due to shortage of staff, then I will have to appear in court. I’m afraid, stressed and frustrated.” (Participant 1, RN).

Numerous participants expressed the stressful situations they endure when they are understaffed, work with incompetent agency staff who do not know the unit, and management is doing nothing about it.

“The stress that you as registered nurse must carry, to work understaff and sometimes with nurses who never worked trauma before. A sister that does not know how to suction a patient?” (Participant 8, RN).

Participants felt overworked and under a lot of stress because nurses on sick and annual leave are not replaced by managers.

“I don’t know why the staffing numbers are less, I feel burnt-out, because I come on duty with no one else on duty.” (Participant 1, RN).

Another participant shared the same sentiment and voiced her frustration as the unit manager uses excuses for not replacing staff who are on sick leave.

When I ask the manager why the nurse off sick was not replaced, they always refer to “the office” we don’t know the office. But they will not replace nurses who are off sick.” (Participant 8, RN).

Participants voiced their concerns regarding the legal consequences of working in understaffed emergency/trauma departments, and how it negatively influenced their lives. Managers have the responsibility to ensure sufficient staff is allocated in emergency/trauma units to ensure safe and quality patient care.

Leave allocation - One particular participant voiced her anger regarding the fact that she booked her vacation according to departmental instructions, a year in advance, yet the decision was made by her senior manager not to grant the leave without informing her.

“I came on the Monday, the Wednesday and the Thursday and just remember I had asked them a whole year for that leave. I then I’ve booked my places for my partner, because my partner doesn’t stay in Cape Town. He stays in Namibia. We had to cancel, because I was threatened by them I’m not going to get it.” (Participant 3, RN).

Participants voiced their dissatisfaction regarding being disciplined by the managers for going off sick for less than two days, whereas the policy allows them 2 days’ sick leave without medical certificate.

“The thing they gave us when we started to work here 2012, you get two days’ sick leave without certificate.” (Participant 2, ENA).

One participant revealed she was sick and needed to rest her voice as she could not speak, however when her daughter phoned on her behalf to inform the manager, she insisted to hear it from the participant.

“like when I was sick the one day, I didn’t have any voice, I could not speak, then I asked my daughter to phone in and she just insisted that I must phone, even though I didn’t have a voice and ok, I know the policy says that you must phone in when you’re sick, but what is this?” (Participant 4, RN).

Managers should realise that nurses need time off from work. This will ensure that the nurse gets the rest they need. Furthermore, it stimulates creativity where a person can come up with new ideas.

4.3.3 Anti-bullying strategies

Anti-bullying strategies include conflict resolution, support, education and training of emergency/trauma nursing staff. Nurse leaders and hospital administrators should develop strategies to modify the healthcare environment into a physical and mentally safe work place. Conflict at work is unavoidable when a group of nurses are together for 12 hours per day, 3 to 4 days per week. The findings reveal conflict strategies such as avoiding bullying, giving in, withdrawing, accommodating and collaborating.

Conflict resolution - Conflict should not be avoided but dealt with immediately, as avoidance can raise tension in the group. Conflict must be resolved peacefully between nurses who has disagreements with each other. It is always best to resolve disputes with negotiations. Emotional strain can contribute to negative feelings in the workplace.

Participants felt like crying, were sad and intended to resign, as managers treated them with disrespect as stated below. Participants also revealed that they do not want to be at work; however, they felt powerless.

“I sometimes feel that I do not want to be here in this place, what must I do?”
(Participant 2, ENA).

Another participant argued that despite working in the department for 20 years, nobody listens or shows respect. Owing to this, she resigned. She continues by reiterating that they are not being informed regarding any new implementations in the department.

“I feel sick, I feel that this is the reason why I resigned. I feel no one is listening to us. There is no respect towards us. I am working here for 20 years. This is the reason I resigned.” (Participant 8, RN).

Some participants suggested in order to resolve conflict, managers should listen to their concerns and respond appropriately. Moreover, participants indicated that due to the lack of support in conflict situations, they show little or no emotions and try to stay calm. This participant was new in the department when she did not get the support from her seniors or peers, who would rather shout and mistreat her.

“I feel like I could, I could...shout back and I feel hurt and I wish I could cry as well but I had to be strong.” (Participant 9, RN).

Part of conflict resolution, is for the manager to find commonalities and agreements that show the willingness to find common ground, thus building good relationships. Some of the participants alluded that whatever the work relationship, even if they feel powerless, they have to obey the manager. This participant was scared of her manager, she felt that the manager was in the department for many years and that no one will be able to change her bad behaviours. She felt powerless with no resources.

“Yoh, it continue since I started working I feel useless I couldn't even talk/work and even if maybe sister is asking me to work my duty I cannot even protect myself or fight for myself or so I had to obey her, because I feel powerless so it's like I must obey the work...” (Participant 9, RN).

The same participant reiterated her emotional views with regards to powerlessness when bullied by the manager, who will always criticize, instead of teaching her. She was new in the department when no one showed her how the documentation was done. She had to teach herself by looking at previous notes of others, hence she felt her manager was unfair shouting at her when she did wrong documentation.

“I feel so useless, I feel useless serious. I started to feel useless like my... and I cannot defend myself, I was defenceless.” (Participant 9, RN).

Numerous participants felt the managers did not regret or had remorse about the negative feelings they created amongst the staff. Participants expressed their feelings as managers will know that the department is short with staff, however, they will not replace the staff member that is on leave or sick. The participants' felt that they are not shown any appreciation by the managers, not a thank you as they work sometimes for days with not enough staff.

“The managers can attack you as they like, and just turn and walk off without even a sorry I was angry or I did not mean what I said.” (Participant 7, RN).

Managers should learn not to favour one above the other as this can cause conflict. In addition, managers should realize that they are there to advice, lead and assist nurses in solving their problems. One participant stated the manager did not treat them fairly. The manager would enter the department and greet the nurses that she likes. She will have conversations with the registered nurses and not the lower categories of staff.

“She is always taking sides to whom she wants to have conversations with.” (Participant 3, RN).

Conflict can be resolved by a clear resolution that acknowledges hurt emotions and ways to resolve the problem. A participant new to the emergency/trauma department and still learning the ward routine was humiliated but stayed, as she needed the job. This particular participant had a hearing impairment. She was shouted at by her managers and colleagues, especially when she was a new recruit. She acknowledged the fact that a manager should not shout at her subordinates, but should talk in a calm manner.

“when the other nurses shouted at me, because I have no other idea other feeling, I was still learning the work in the wards, so I was feeling like I could leave my work and find a job somewhere, but I had to be patient, because I was working for agent for many years, so I was so happy to get the job, at least a permanent post, otherwise I feel like I could leave and find work somewhere but I had to be patient.” (Participant 9, RN).

Participants felt that managers became more hostile towards nurses by pointing the finger at one participant and invading her space. Nevertheless, the participant kept quiet for fear of reprisal. This particular manager reprimanded the participant in front of other staff members in an inappropriate manner.

“He (manager) just put his finger and said you, you will keep quiet that’s what...he was pointing at me you, you keep quiet he actually invade my space. I never had a chance, when I turned back, he came to me already and said you keep, he didn’t say why you are cross no, no man, stop all of that. He just burst down and say you keep quiet and that put me off.” (Participant 6, RN).

This same participant got into a heated argument with the manager and felt that this was avoidable if the manager had a way of talking to others. The participant threatened the manager out of fear of physical contact with him.

“And you must just touch me, if you touch me, I will get my union in and then we will see who will sit long in that nice chair.” (Participant 6, RN).

It seems that those in management lack understanding in how to deal with bullying at the workplace and may choose to overlook it. Although bullying can occur among colleagues, the most common form of bullying includes managers' abuse of power against subordinates.

Staff support – Staff shortages can be very frustrated to nurses working such long hours. This situation contributes to poor work relationships, conflict and ultimately bullying. Participants did not know why there was a shortage of staff. Owing to this, they experienced burnout if no other staff were on duty as explained below. Staff that were on leave or sick was not replaced in this particular emergency department. Participants felt that they were being bullied for having to work without the needed manpower, especially over weekends and month-end days when the trauma units are busy. They felt that no communication from management was evident.

“I don't know why the staffing numbers are less, I feel burnt-out, because I come on duty with no one else on duty.” (Participant 1, RN).

Furthermore, a number of participants raised concerns regarding the shortage of staff as it influences the standard of patient care as stated below.

“Why, why is it like this? I feel torn into pieces, it is so difficult”. “Short staff influences the standard of care given to the patient, how can you expect a good standard of care when the staff is so short.” (Participant 1, RN).

Participants revealed that managers are not consistent in their management strategies. The Unit manager will give an explanation that the nurse will be replaced, only to find that the senior manager has vetoed that decision, that no nurse will be replaced. This in turn caused stress, conflict and harmful work environment which can result in bullying.

“The workload, I mean, is too much in this place, managers in this place says the one day this, and the next day a different story, however they do not accommodate nurses that is off sick.” (Participant 5, RN).

Another participant felt demotivated, stressed, exhausted and wanted to resign due to being ignored by management as shown below. She felt that she was being bullied by the senior manager in the department. She asked for leave which was unfairly denied after it was promised to her every time she asked for it a year previously. She was scolded at inappropriately when she went off sick. She felt humiliated when her senior manager did not believe her when she stayed at home to take her sick child to the doctor.

“The only advice I can give to myself is to leave this place, because I am overtired, I am overstressed, but no one is seeing it” (Participant 3, R/N).

Another participant argued that management did not value nurses' views and without their input implemented orders, such as no nurse will be replaced when she/he is off sick or on leave. Furthermore, the participant felt that nurses were not entitled to an opinion as nobody was listening. This participant felt that the nurses in her team was overworked and stress build-up was evident because the morale was very low amongst the nursing staff in this particular trauma unit.

“Things are being implemented without the input of the nurses. We do not have the right to an opinion because nobody listens.” (Participant 6, RN).

Participants highlighted the need for more emergency/trauma nursing staff and appeared discouraged by the lack of support by management. Moreover, managers are responsible to staff in the emergency/trauma unit with sufficiently trained and experienced nursing staff to ensure safe and quality nursing care.

Education and training - Training and education of staff provide guidance on how to take a stand against bullying in the workplace. Participants were of the opinion that education regarding bullying can be included at departmental meetings. Participants highlighted that no meetings occur in these departments as demonstrated below.

“We have never meetings in the ward. (name of ward omitted for confidentiality)...”
(Participant 6, RN).

Another participant confirmed that no meetings were scheduled in the unit or with management. Another participant reiterated that departmental meetings are conducive for educational opportunities.

“No, there are no meetings, not even with ADN (assistant director of nursing, i.e. management).” (Participant 1, RN).

Participants revealed that no educational opportunities regarding workplace behaviour such as bullying were available in the departments. They were also not familiar with policies and procedures that could provide guidance in bullying in the workplace.

“I am not sure if there are policies regarding bullying in the workplace, in this department.” (Participant 1, RN).

The participant also did not know who to contact and where to go to report bullying as evident in the following statement.

“I do not know the reporting system, I do not know where to go.” (Participant 1, RN).

It was evident that participants had a need for education regarding bullying in the workplace. They voiced their concern that no policies and procedures are available regarding the steps to follow when they need to report bullying in the workplace. Managers have the responsibility to ensure that all policies in the hospital are available to all nurses.

4.3.4 Workplace environment

The two emergency/ trauma units had a combined total of 250 nurses on their database. Different categories, such as registered nurses and enrolled nurse. These nurses are working 12-hour day and night shifts. Participants indicated that the workplace environment was not always conducive to work due to an insufficient number of nurses on duty, because of sick leave and nurses on vacation. Consequently, this negatively affect patient outcomes and staff effectiveness. Other issues related to the critical care work environment that emerged were working conditions, physical and social environment and leadership support. These issues are discussed below.

Working conditions - Participants indicated that the current work conditions are non-therapeutic and do not support the needs of the patient and staff. Participants further emphasized that they nursed the patient holistically in the past; however, it is impossible with the current shortage of staff. Moreover, they feel that the senior management is deliberately keeping staff to a minimum. Participants feel that the senior manager has no emergency/trauma experience, consequently, has not the authority to make the staffing decisions.

“We were five nurses, we were able to do everything for our patients, and we were able to manage ventilated patients from head to toe. With the lesser staff on duty, we do not have the time to nurse patients from head to toe.” (Participant 1, RN).

Participants revealed that there is no appreciation from the managers, and that they are despondent due to the negative circumstances at work, consequently they did not want to be at work.

“Why do I have to come here, what is the benefit? Many times you feel that you do not want to be here.” (Participant 2, ENA).

Another participant echoed the same sentiment of unhappiness in the workplace but remains out of duty.

“Because at the end of the day I am unhappy I’m just here because I must be here.” (Participant 3, RN).

Several participants mentioned that managers do not have the authority to defend them when decisions are made. When staff complain to their unit managers, they do not have the authority to make decisions, because their decisions are vetoed by a higher hierarchy. Another participant (shift leader) felt that her authority to manage staff was undermined by the manager.

“She is saying, if you don’t go where I tell you to go, your shift will be cancelled.” (Participant 3, RN).

Participants were adamant that they could not render optimal, effective nursing care with the current working conditions. Shortage of staff and working with incompetent agency staff are patient safety concerns to all. Consequently, upon leaving the department for the day or weekend, the nurse manager has to staff the department with sufficient and competent staff.

Psychosocial environment - Bullying in the emergency/trauma department has greatly influenced the social environment. Participants revealed that there is a high level of frustration due to bullying. This in turn affects communication with friends and family. Bullying has resulted in nurses withdrawing to prevent conflict.

“I am very frustrated, I will be angry most of the time. I will be quit most of the time and not talk, because no one at home will understand my frustrations. I cannot talk to friends for they know not how I feel.” (Participant 10, RN).

Another participant disagreed and stated that she regularly discussed being bullied with her family who support her.

“I do regularly to my family and my husband, my husband will just say, just do your work, leave the people and do not argue with people.” (Participant 11, RN).

Some participants felt that due to their unhappiness and frustrations at work they were unable to lead a normal family life at home. Nurses love their jobs but the manager in the department should create a positive and supportive atmosphere for all staff.

Workplace culture – A safe and supportive work environment can prevent bullying. Nurses should feel and be safe everywhere in the work environment, which must be created by the whole team, led by the manager. Participants received tasks from management without any explanation or directive. Furthermore, staff indicated that management did not value them. Participants revealed that the ones in management do not replace staff on sick leave despite the shortage of staff as shown below.

“The assist director of nursing makes the decision to not replace off sick nurses.” (Participant. RN).

Some participants revealed that they were humiliated, especially when the managers yelled at them. Furthermore, feelings of being useless and not able to defend themselves, create a negative physical environment in the department.

“She shouting most of the time and it makes me feel down and inferior feel like mmm powerless or useless something like that.” (Participant 9, RN).

One participant voiced her dissatisfaction with the manager screaming at her in front of patients as the patient might see her as incompetent.

“The patient will see me as incompetent.” (Participant 10, RN).

Another participant expressed a similar view regarding public humiliation as the manager reprimanded her in front of nursing and medical staff members.

“You are being reprimanded, in a bad way in front of doctors, medical students and everyone listens to this story.” (Participant 8, RN).

The participant further shared her dissatisfaction as the manager discussed problems of staff with other staff members. This in turn results in a toxic workplace culture whereby bullying is tolerated or condoned, nurses whisper and gossip, leaders ignore the value and important contributions of staff, etc.

“I mean if you are immediate supervisor and you have problems to go and speak to her about, it you can’t because then the whole floor will know ‘cause she even speaks to the nurses about the operational managers, how bad they are, about me the clinical facilitator not doing my work. You know things like that, she discusses with staff on the floor.” (Participant 4, RN).

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Leadership Support - Participants were dissatisfied with the leadership style of management. Moreover, nurses need the support of the leader in the department, to make them feel safe and to be a mentor. Nurse leaders should lead by example, encourage nurses to communicate to resolve conflict and to create an environment conducive to provide quality nursing care. Participants were of the opinion that those in management disregard their authority as stated below.

“That lady came here, she did not recognise my authority, and I have witnesses and saw it.” (Participant 6, RN).

Participants expressed their disappointment in management for not showing enough support and appreciation after a busy weekend in the trauma departments.

“The managers do not support us. They would rather put us down. They knew we were busy, and won’t come to us to say thank you, we are proud of you and we appreciate what you are doing for our patients, this doesn’t get done.” (Participant 7, RN).

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“It is unfair. I have everything that fits the criteria, I worked in the office before. If the opportunity is given to me, I will be able to do it. I do not under estimate Z, but we need fairness in this place.” (Participant 7, RN).

Similarly, another participant shared a similar view regarding the unfair treatment of the manager. In this case, the nurse was placed on night duty because of her hearing disability.

“So if I am here during the day and with this hearing of mine so I’m not fit for the day, so I’m fit for night is not busy because it is not busy so I’m fit for the slow pace...” *“Oh ha...a, not fair, not fair I mean I know that when I come here I was ready for both shifts for night shift and day shift...”* (Participant 9, RN).

Another participant explained that her leave was denied although she requested it two months in advance.

“I don’t feel that’s fair I’ve asked them two months in advance. I’ve never had leave I’ve asked them my sister is coming from London. We have booked a place.” (Participant 3, RN).

Managers must treat all staff equally and fairly to enhance teamwork and establish respect for one another. As a result, nurses will develop trust in the manager resulting in stability amongst nurses with positive staff and patient outcomes.

4.3.5 Occupational health and safety

Nurses have the risk of becoming ill due to stresses in the workplace. These ailments could be short term or/and become chronic. Ailments such as musculoskeletal disorders, changes in mental health, cardiovascular symptoms, blood pressure, etc. are the conditions caused by stress and can be detrimental to victims of bullying.

Physical Health – One participant developed physical illnesses due to the bullying by the manager as stated below.

“I developed three years ago, hypertension. I was tensed up every time I see this women. I’m tensed up, developed hypertension three years ago, my hernia also keeps on fleeting up and I think it’s also related to my situation. I’m always tense and worked

up and what am I going to expect today again. What did I do wrong again today?"
(Participant 4, RN).

One participant indicated that she was overworked and tired, resulting in "malaise" and headaches as shown below.

You are so tired in your off days, I feel malaise with headaches. You don't feel like doing anything due to the heavy workload when on duty (Participant 10, RN).

In order to look after others, one should make sure that one is physically healthy. Nurse Managers have the responsibility to ensure that the environment has minimal stress and is bully-free.

Psychological Health - Participants expressed their anger towards their managers who put them in a state of depression and unhappiness due to their bullying behaviour. They also felt like resigning, but due to family commitments were obliged to stay.

"So I feel like resigning. I feel I can go work somewhere else, I don't need this, I feel like I need to, for me, I want to be happy and when I'm happy, I love being at work at this present moment. I'm not, I'm just here because I must be here and I'm here because of my child." (Participant 3, RN).

One participant was depressed after she learned that her manager copied her quarterly evaluation from previous ones.

"So then I withdraw and I go into a little cocoon and it made me very depressed and I actually went to go see a psychologist... to try and find out how I can handle the situation." (Participant 4, RN).

Other participants indicated the various nursing tasks they performed without proper training contribute to a "huge load" and depression as stated below.

"It puts a huge load on you, adding to depression and other things. Because you cannot work in a unit where we do things and did not have training for it." (Participant 12, ENA).

One participant needed the social support from her manager when her child was sick, however, the manager did not believe her.

"When my child was sick, you could see she was sick, she was admitted into the hospital. The manager did not believe me." (Participant 3, RN).

The same participant expressed that no psychological and social support was given when her child was admitted to hospital. The manager phoned the nurse not out of compassion but to check if she was in fact at the hospital with her child.

"I'm going to admit your child, because your child's bowl is impact and that's the reason why. They phoned me just to hear if I was in the hospital with my child, why I must lie." (Participant 3, RN).

Participants felt that the department's workload management was inadequate, as staff who calls in sick during the day are not replaced, resulting in a shortage of staff at night.

"We always short staff. When the night matron comes on duty and the person called in sick during the day. The staff office is suppose the arrange replacement staff. It is difficult for the night matron to get staff during the night". (Participant 1, RN).

Another participant revealed that she loves to learn new information and challenges, however she did not practice within her scope and no training is offered in the department.

"I am a person who loves to learn new information, I like challenges, but I feel in this place I work out of my scope and there is no training". (Participant 12, ENA).

Several participants revealed that very little is done by management to ensure the physical safety of staff at the workplace. They further alluded that more security guards should be on duty in the trauma unit, especially during weekends when it is busy.

"We need more securities in the department especially over weekends when it is busy in trauma. There is only one security sitting there. He doesn't come inside to check if we are ok. We told management on several occasion that we feel unsafe." (Participant 8, RN)

Furthermore, participants voiced that the training and development opportunities are not happening in the department.

"So I said but we don't get training at the back we were never ever trained so I don't know what we're supposed to do. So she said only if it's needed to be done, so I said why do you ask me about the form and want me to have the form, but you don't want me to train to be on the system." (Participant 6, RN).

Participants expressed unhappiness with the manager's behaviour causing psychological problems. Nevertheless, the manager is accountable to create an environment in which nurses

feel safe and comfortable. The manager should provide resources when nurses need psychological assistance.

4.3.6 Quality of patient care

Trauma/emergency nurses disclosed that the physical working environment in these departments are non-therapeutic, therefore, it may have negative implications for patients due to the emotional experiences some of the nurses are having. Staff are not motivated by management, no team work are present amongst nurses. Therefore, participants described the work situation as emotionally draining. Furthermore, participants revealed that even when management is informed in advance that a staff member will be off sick, no replacement is offered.

“One of the registered nurses phoned in sick over the weekend. This was end of month weekend which is usually busy, she, Assistant director of nursing, wrote in the communication book, that no replacement was to be given.” (Participant 1, RN).

Participants remained scared and afraid to communicate with the manager, because they might become the next target of workplace bullying. Consequently, this cause staff to be nervous and stressed out, interfering with the quality of patient care.

“I think there is that afraidness of her, because I’m afraid of, of how she’s going to answer me back and how she’s going to, the wording that she uses and I don’t like, I said I don’t like the way she speaks. She treats you totally like a child and I mean we are all adults.” (Participant 4, RN).

The majority of the participants revealed that they were afraid of the manager, who bullied them.

“They are afraid. They are afraid of her. They are being bullied by her. And they are doing it to us now. I saw them running away, when they saw their manager approaching their way.” (Participant 2, ENA).

One participant felt that her confidence was seriously affected by the bad behaviour of the manager, influencing her patient care.

“With my confidence yoh, it was affected...I don’t want to learn, so that’s why I feel sometimes like even if I do my work, sometimes I’m not sure if I did right. Not like because I am not sure, but I can say if it is right I don’t know if she will accept that I did it right.... it’s like still this query, if I didn’t do it right so my confidence was affected...when I write incident report, so it’s like I must write it in a certain way that

she wanted me to write. So I cannot write it in my own way you know.” (Participant 9, RN).

Delayed patient care – Participants indicated that they have to avoid defending themselves for the sake of peace in the department, and to be able to give the best nursing care to the patients.

“You think, you must come back to work, and to avoid trouble keep quiet. You cannot talk about the problem. You have to face the colleagues again.” (Participant 11, ENA).

Participants argued that during busy times they do not have time to orientate agency staff who do not know the unit as this will cause delay in patient care. They further suggested that agency staff be orientated regarding prior working shifts in order for them to know what to do as shown below.

“I suggested that agency staff gets orientation before they coming for shifts in the department. Then they will know what to do. We cannot still do orientation, then we might as well stay short staff.” (Participant 7, RN).

Participants were concerned that they are delaying treatment of patients because they are too few on duty take care of too many patients at a time. The nurse patient ratio for ventilated patients are 1:1 however, two RNs were expected to take care of nine patients with six requiring mechanical ventilation.

“They expect us two sisters to work with up to 9 patients in the resuscitation area, with 6 ventilated patients. How are we going get treatment to them?” (Participant 8, RN).

Patients not getting their treatment due to a delay, can have detrimental effects on the initiation of care. Therefore, the nurse has a responsibility towards the patients to render nursing care the best way possible in a timely manner.

Patient centred – Medical and nursing staff have to enhance the quality of life of patients by providing quality comprehensive care based on the individual needs of the patient. One participant revealed that the patient’s needs come first, therefore she did not follow the standard procedure as it was crucial at the time to save the patient from having a heart attack.

“We can’t do everything by the book, because you have to save the patient’s life... morphine is at that moment crucial to save a patient. The patient’s going to get another heart attack if you’re not going to ease the pain”. (Participant 6, RN).

Another participant explained to the manager the importance of keeping the patient's identity confidential.

"I said but I'm working in the ward, I should know where's the patient it's not somebody come and check it's mos not confidential., you have to ask this is professional, morning sister I need I'm looking for Mr Smit, is Mr Smit here, yes what are you of Mr Smit and family member or whatever, so if random people just come and read on the list it's not professional". (Participant 6, RN).

One participant expressed disappointment as she was reprimanded after she used her initiative to move a patient to the ward, to prevent an up to eight hours delay of admission.

"Yes, according to me the patient comes first and if I do not do something according to policy, I do it because it is right for the patient as long as it is done right, the patient is my greatest concern. If the policy says there must be a bed, and there is no bed, what must I do?" (Participant 8, RN).

Participants also revealed that they gave their best when going home after their shift.

"When I go home at the end of my shift, I feel I have done the best for my patients." (Participant 1, RN).

Nurses have to treat patients as a whole. The focus is not only on the complaint, but also on the total wellness of the patient.

Patient neglect – Participants revealed that due to preventable circumstances, they do neglect to act on the patients' needs at times. Some participants indicated that the agency nurses who do not get orientation to the department is a threat to the patients. Subsequently, permanent staff are blamed for the mistakes of agency staff.

"Because if things go wrong, the permanent registered nurse will have to answer". (Participant 7, RN).

One participant revealed that due to staff shortages, she neglected her patient while she had to do documentation, the patient deteriorated and no additional nurse was available to assist.

"I knew I have to write about my patient and my patient is deteriorating. I'm afraid I'm going to miss some events if I don't write now and there is nobody else here to help me." (Participant 1, RN).

Some participants postulated that they do not perform duties within their scope of practice in order to assist the registered nurse who has to care for ventilated patients and patients (unexpected) admitted to the department.

“There is maybe five ventilated patients. They expect one sister to do everything for those patients, and help with unexpected patients coming in. We as nursing assistants help her though it is not in our scope.” (Participant 2, ENA).

A participant voiced her frustration regarding the patient safety concern of one agency sister’s incompetence. The agency sister did not know how to suction, triage patients or how to connect the oxygen cylinder. As a result, the participant laid a formal complaint for management to address this issue.

“That sister doesn’t know how to suction a patient, she doesn’t know how to categorise patients. That sister does not know how to connect an oxygen bottle. I wrote a letter of complaint to management.” (Participant 8, RN).

Quality nursing care can only be rendered in an environment that is free from bullying. Participants indicated that fear of the manager negatively influenced their ability to provide safe and quality nursing care. Nursing staff in a department has the right to feel safe, free from threats at the workplace and the manager has the responsibility and accountability to create such an atmosphere.

4.4 Conclusion

In this chapter, the researcher has explored the experiences of nurses being bullied in the workplace in the public hospitals in the Cape Metropole. He analysed the data and described them by using themes and subthemes from the data. The nurses agreed that bullying in the workplace is a reality in their workplace, and they expressed their experiences regarding this phenomenon. They described the effect of workplace bullying on themselves, others and the work environment, and they discussed their views on the management of bullying in the workplace.

CHAPTER 5: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The previous chapters described the rationale for this study and provided an in-depth literature review regarding experiences of nurses being bullied in the public hospitals in the Cape Metropole. In this chapter, the findings based on the objectives and literature are discussed.

Recommendations will be made based on the findings of the study.

5.2 Discussion of findings

The aim of the study was to explore the experiences of nurses regarding bullying in the workplace in two public hospitals in the Cape Metropole. The discussion on the findings of the study in relation to each objective follows:

5.2.1 Objective 1: To describe nurses' experiences of bullying in the workplace

Bullying is prevalent at the workplace. In this study, all the participants indicated that they either witnessed or experienced bullying. The high prevalence of bullying in the public hospitals became evident as participants experienced effects of bullying behaviours such as sadness, stress, anxiety, powerlessness, incapacity to work and reduced quality of home and family life, "I feel so sad, I want to cry, and I want to resign" (see Chapter 4, Section 4.3.1). Participants continuously reiterated that the emotional strain they endured, contributed to the negative feelings in the workplace. These emotional stressors can gradually cause harm to the victim with detrimental consequences for the patient (see Chapter 4, Section 4.3.1). These feelings were mostly caused by the negative treatment from senior managers and unit managers at the institutions where the study was conducted. Managers will shout at nurses and talk to them inappropriately in front of patients and other nursing staff. Consequently, nurses will go home with these emotional feeling, unable to lead a normal family life. According to Cunniff and Mostert (2012:1), psychological consequences include sleep and eating problems, anxiety, intentions to leave the job and low self-esteem.

The participants specified that bullying is mostly done by the female gender in the hospitals, reason being that the nursing profession is predominately populated by female nurses, hence the victims in this study were all female (see Chapter 4, Section 4.2.4). Participants highlighted that managers are responsible for the bullying of subordinates working in the emergency/trauma departments, "I am being bullied by our head (manager) of department" (see Chapter 4, Section 4.3 .2). Direct and indirect forms of bullying were the types of bullying

reported by the participants (see Chapter 4, Section 4.3.2). According to Shetgiri (2013:19), direct bullying is a form of verbal abuse, such as shouting, aggressive behaviour, personal attacks, belittling colleagues in the presence of others and making threats. In contrast, indirect bullying is a form of jeopardizing the reputation of the victim, spreading negative rumours of others, excluding others, interrupting the victim during conversation and allocating difficult tasks are examples. A participant revealed how a senior manager came up to her with so much anger that he invaded her personal space, pointed his finger at her and shouting inappropriate words at her.

The participants in the current study also indicated that being afraid of their manager's response to their requests, is the most common form of bullying in the departments (see Chapter 4, Section 4.3.2). Participants revealed that they were being yelled at and humiliated in front of other nursing staff by managers in their workplace (see Chapter 4, Section 4.3.2). Johnston (2009:37) confirmed that belittling of others in public is part of bullying, which is why the manager of a department has the responsibility to protect the nurses from bullies.

Another common form of abuse reported by the participants was the understaffed departments which resulted in heavy workloads (see Chapter 4, Section 4.3.1). Management also ignored the fact that trauma units are busy during weekends, especially month-end; however, managers do not replace staff who are booked off sick or on vacation, "One of the registered nurses phoned in sick over the weekend. This was end of month weekend which is usually busy... no replacement was to be given" (see Chapter 4, Section 4.3.5). In addition, participants indicated that the shortage of staff impedes safe and quality of patient care. Occasionally, when staff are replaced, agency staff who are not familiar with the routine were allocated for high-risk areas such as emergency/trauma units, "I was still learning the work in the wards... was working for agent for many years" (see Chapter 4, Section 4.3.1). Moreover, insufficient, incompetent number of nurses made it difficult for the shift leader to do appropriate allocation of the proper skill mix. According to Ndikwetepo (2018:40) nursing skill mix is inappropriate when the majority of nurses in the unit are not permanent employed as this adds to the workload of the permanent employed nurse, which can lead to burn out and frustration.

Participants recognised that managers have a very important job to do, however they also know that there are subtler ways of dealing with conflict (see Chapter 4, Section 4.3.1). They also agreed that a manager should have special skills and qualities to work with people. Qualities such as respect, confidence, competence, patience, an open-door policy, being approachable and being fair. If a manager displays these qualities, bullying amongst nurses can be prevented and nurses will respond in a more positive manner to their work resulting in effective, efficient patient care (Alexander, 2018:1). According to Cuffiff and Mostert (2009:12),

hospitals that practise positive behaviour and teambuilding amongst their staff will have a reduction in bullying behaviour.

Participants felt that managers became hostile towards them and this resulted in finger pointing and invading the victim's space at times in front of other colleagues (see Chapter 4, Section 4.3.2). Cunniff and Mostert (2012:10) also agreed that bullying from managers are often verbal in nature and in front of peers in the form of verbal abuse, swearing, threatening others and humiliating staff.

Participants were concerned about the hostile behaviour of the manager. The manager will come on duty without greeting the staff, is unfriendly towards staff and use negative comments most of the time (see Chapter 4, Section 4.3.2). Another comment from participants was the fact that the manager showed no form of appreciation. For example, no thanks to the staff after they worked a heavy weekend shift (see Chapter 4, Section 4.3.2). Cunniff and Mostert (2012:15) state that workplace bullying from the managers are more prevalent because of their higher rank in the profession. Beach (2013:3) also found that workplace bullying is the repeated negative behaviour like swearing at staff, name calling, verbal harassment and malicious teasing from the perpetrator towards the victim and can be regarded as threatening or aggressive. These behaviours can prevent the victims from being effective in their duties.

Participants stated that the effects of bullying negatively influence their family life, thus they would become very quiet and withdraw from the family (see Chapter 4, Section 4.3.2). In contrast, another participant regularly discussed her ordeals regarding bullying with her husband and this assisted in dealing with the phenomenon, "I do (speak) regularly to my family and my husband" (see Chapter 4, Section 4.3.2). Johnston (2009:41) encourages open communication between staff members and reiterates the importance of an open-door policy that managers should practise to allow nurses to speak about their concerns and prevent bullying.

5.2.2 Objective 2: To gain an understanding of the manifestation of bullying in the workplace

Shetgiri (2013:19) reveals that manifestations of bullying can be direct bullying such as kicking, pushing intentionally, restraining and striking. It can also be verbal, in the form of insult, mock, threaten, and make remarks that are sexist, homophobic, transphobic or racist, discriminatory on the basis of age or other personal characteristics. Hence, indirect bullying could be slandering, sabotaging others, persuading peers to exclude the nurse, and always interrupting the victim during conversation. Furthermore, it can be social such as propagate rumours or

lies, degenerate and humiliate, look at in a scornful or threatening manner and to isolate someone.

The manifestations of direct bullying, i.e. physical assault, did not occur in the hospitals under study. Moreover, it was evident that direct bullying such as verbal abuse, is most prevalent in the trauma/emergency departments of the two hospitals. Participants verbalized that they experienced a build-up of negative feelings due to the bullying behaviour of the managers towards the nurses (see Chapter 4, Section 4.3.2). Fear of retaliation was one of the feelings mentioned. Participants were afraid of the consequences that might ensue if they retaliate, hence they thought it was best to accept the bullying to continue and hoped it will improve in time. Furthermore, even if nurses complain of being bullied, managers do not often respond genuinely to complaints of bullying in the workplace (Colduvell, 2017:2).

Some participants reported experiencing some physical symptoms such as headaches and hypertension, as a result of the effects of bullying by the perpetrators (see chapter 4, section 4.3.4). Two of the participants resigned due to unhappiness in the workplace caused by the manager (see Chapter 4, Section 4.3.2) and another participant being treated by a psychiatrist due to the effects of bullying (see Chapter 4, Section, 4.3.4). Harding (2016:6) confirms that psychological counselling is helpful for the handling of the situation and is also beneficial in preventing it from repeating itself.

Participants reported feeling less confident and having feelings of low self-esteem due to bullying in the workplace. Participants also claimed that they would call in sick to avoid being at work when the bully is on duty. Furthermore, participants verbalised feelings of insecurity due to the effects of bullying. Participants also indicated that they always have to look over their shoulders, expecting the perpetrator (see Chapter 4, Section, 4.3.4). It appeared that the effects of being bullied have consequences such as anger, feelings of not being accepted, and withdrawing from friends and family. Some of the participants felt that they were always on the lookout for ways to escape the perpetrator or how they could do better to satisfy the perpetrator (see Chapter 4, Section 4.3.1). According to Lowenstein (2013:6) the victims should feel confident after they have lodged a complaint about bullying in the workplace.

Johnston (2009:38) reveals that hospital managers that do not deal with bullying behaviour in their organization will create problems for all. Participants verbalized that they felt powerless and incapable of defending themselves, because of the pressure forced on them by the manager in authority (see Chapter 4, Section 4.3.4). They also voiced feelings of fear when there is a lack of support from those in management, e.g. the manager yelled at a nurse during her first few weeks in the department (see Chapter 4, Section 4.3.1). The participants revealed

their frustration when the manager always chose with whom she wanted to converse and always avoided certain nurses (see Chapter 4, Section 4.3.1). It was evident in this study that most acts of bullying came from the managers. Similarly, Cunniff and Mostert (2012:3) revealed that bullying by managers could have destructive effects of trust among the subordinates.

Participants revealed how the managers used their authority to threaten nurses (see Chapter 4, Section 4.3.2). Unit managers making excuses for not replacing staff that are off sick or on vacation was another concern voiced by the majority of participants (see Chapter 4, Section 4.3.3). Participants feel that the managers are creating an environment making them despondent and not wanting to be at work (see Chapter 4, Section, 4.3.2). According to Johnston (2009:41) managers should be advocates for the nurses and should go to great lengths to create a healthy place of work. The manager should create standards and create a healthy team spirit amongst the staff. The unit manager's decisions are vetoed by the senior manager, resulting in mistrust as revealed by the participant (see Chapter 4, Section 4.3.2). Participants shared their unhappiness regarding the lack of interest shown by management. As a result, they kept quiet, calm and showed no more emotions (see Chapter 4, Section 4.3.1). Participants voiced their concern regarding the impact bullying has on their physical status, some symptoms indicating hypertension (see Chapter 4, Section 4.3.4). Furthermore, participants revealed that they developed psychological problems, such as depression due to bullying by managers (see Chapter 4, Section 4.3.4). According to Johnston (2009:38) unhappy and dissatisfied nurses will create an environment of absenteeism and disengagement.

5.2.3 Objective 3: To describe current organizational management strategies of bullying in the workplace

According to the Australian Public Service Commission (2019:1) the best way to deal with workplace bullying is to prevent it before it impedes individuals' well-being or workplace relationships or becomes a risk to health and safety. The best way to do this is by encouraging a culture in which bullying behaviour cannot thrive. Participants revealed that bullying occurs in the hospitals, however, it occurs not horizontally but vertically (see Chapter 4, Section 4.3.1). The findings of the study confirmed that the managers bullied nurses at the workplace. One participant revealed, "The managers can attack you as they like..." (see Chapter 4, Section 4.3.1). Gordon (2019:1) confirms the latter that the most awkward circumstances to be confronted with, is when your manager is the bully.

Communication was identified as the main reason for participants being bullied. Nevertheless, participants indicated that communication with each other must always be with respect, not aggressive, judgemental or shouting as by managers, “She shouting most of the time... feel down and inferior... powerless or useless” (see Chapter 4, Section 4.3.2). Two-way communication skills empower nursing staff and add value to the job. Lockard (2017:2) confirms the most powerful tool to fight bullying is to develop healthy work environments by improving communication, increasing retention and to promote safe patient-centred nursing care.

Participants agreed that they worked under extreme strenuous conditions that can have dangerous consequences for patients and nurses, with the decision made by the senior manager not to replace nurses who are off sick or on vacation. Subsequently, it is vitally important that nurse managers and hospital administrators create strategies to modify the healthcare environment into a physical and emotionally safe work environment (Lee, Bernstein, Lee & Nokes, 2014:5). According to the participants no real policies are in place to confirm this practice (see Chapter 4, Section 4.3.1).

It was evident that nurses were not knowledgeable regarding policies and procedures in their departments. However, the policies and procedure manual lays out the foundation for orientation and staff development, and it is a ready reference for nurses when unclear circumstances arises. Moreover, it is also an instrument on which to develop administrative procedures, and it provides a firm basis for discussion. These manuals establish boundaries within which the institution should operate and convey its beliefs, and without these manuals, management lacks direction and is vulnerable to inconsistent decisions (Jooste, 2010:95).

Participants indicated that they had no support when being shouted at or degraded, because the immediate manager is the perpetrator and they felt top management, to be unsupportive (see Chapter 4, Section 4.3.1). According to Johnston (2009:37) managers who lack personal power usually become abusive towards their staff.

The majority of participants were not aware of policies and procedures that provide guidance in the event of bullying, “I am not sure if there are policies in place in this department” (see Chapter 4, Section, 4.3.1). They were not aware of the human resource department that supports them, “I do not know the reporting system, I do not know where to go” (see Chapter 4, Section 4.3.1). They were also not aware that bullying in the workplace has a zero tolerance policy in most organizations (see Chapter 4, Section 4.3.1). Therefore, education regarding this phenomenon is very crucial in the hospitals in question. An educational programme focusing on bullying in hospitals was recommended by the Joint Commission International,

e.g. skills-based training and coaching, continuous non-confrontational monitoring, a method of evaluating staff's insight of the significance of bullying, and policies that encourage early reporting with no fear as per Lee, Bernstein, Lee and Nokes (2014:5). Managers of organizations should be proactive in putting policies and procedures in place regarding what is acceptable and unacceptable behaviour in the workplace. According to Cunniff and Mostert (2012:13) these policies and procedures should be easily accessible to all nurses in the unit for referencing.

Furthermore, policies should be a clear statement of the expected behaviour workers should follow. Managers are expected to monitor the hospital policies and procedures and ensure compliance to the expected behaviour (Australian Public Service Commission, 2019:1). Rigid policies must be clear, that employees have the full support of the management of the hospital; this will enhance victims to speak without fear of negative consequences. According to the South African Board for people practices (2018:13), policies giving guidance regarding bullying in the workplace and implementation of training programmes on how to deal with bullying should be implemented in hospitals. Employers must ensure that safe and confidential resources for victims of bullying are in place.

Education of novice nurses ensures that bullying behaviours are identified in the workplace, which is important to ensure that this behaviour is immediately addressed. This strategy will ensure that new applicants will be attracted to the hospital, which is the ultimate goal for the retention of nurses in the hospital, "I feel so sad, I want to cry, and I want to resign" (see Chapter 4, Section, 4.3.1). Some participants indicated that managers should listen more to their concerns, which can have positive effects on the relationships in the department, "I feel no one is listening to us" (see Chapter 4, Section 4.3.1). Johnston (2009:37) states that new nurses are easy targets due to their unfamiliarity with the new surroundings. Participants agreed that managers should not favour one nurse above the other, to prevent bad feelings amongst nurses (see Chapter 4, Section 4.3.1). Participants further reiterated that they do love their job; however, managers should create the happy, conducive environment (see Chapter 4, Section, 4.3.2). According to Johnston (2009:36) nursing should be enjoyable as they spend many hours at work.

5.3 Limitations of the study

The study was conducted in two trauma/emergency departments of two tertiary public hospitals in the Cape Metropole. Private hospitals, secondary public hospitals and primary public clinics were excluded from the study. Furthermore, nurses working in these trauma/emergency departments may have different views. Another limitation is the fact that

only females and no males participated. Males are very reluctant to acknowledge being bullied due to embarrassment (Moore, 2018:1).

5.4 Recommendations

The following recommendations were made to address bullying in emergency/trauma departments of public healthcare institutions. Recommendations were based on the nurses' experiences regarding bullying in the workplace at trauma/emergency departments of the two public hospitals in the Cape Metropole.

5.4.1 Supportive work environment

A supportive work environment refers to the person's everyday life that includes the family, the social, religion, education and the everyday activity the person lives and the support structures that are available in the community (World Health Organization (WHO), 2019:1). Victims of bullying may need these support structures that are usually in the form of a priest, social worker, teacher, the neighbour and the family that can help with the healing process. Moreover, a supportive environment in the hospital setting is very important to create a productive department and ensure the well-being of the nurse. In a supportive environment, nurses feel comfortable going to their managers with all concerns, knowing their problems will get the full, undivided attention of the manager, in this way ensuring staff satisfaction (Bickmeier, Luu & Rogelberg, 2016:1).

Conflict should not be avoided but dealt with immediately. Managers should listen to nurses concerns and respond appropriately. Furthermore, should the manager find commonalities and agreements that show the willingness to find common ground, thus building good relationships.

Characteristics to enhance a supportive work environment are that managers sincerely care for their staff and to genuinely identify their staff's accomplishments, promote succession plans in their departments and set achievable goals for the staff (Bickmeier, Luu & Rogelberg, 2016:1). This will retain staff and eliminate bullying behaviour in the workplace.

5.4.2 Education and training

An educational programme focusing on bullying in hospitals was recommended by the Joint Commission International, e.g. skills-based training and coaching, continuous non-confrontational monitoring, a method of evaluating staff's insight of the significance of bullying, and policies that encourage early reporting with no fear (Lee, Bernstein, Lee & Nokes, 2014:5).

The findings of this study revealed that bullying amongst nurses comes primarily from managers. The feedback to the hospitals and managers will assist in raising awareness

regarding the significance of treating the subordinates with dignity and respect. In doing this, nurses will gain their self-confidence and give optimal cooperation with their duties in the department. Managers will gain confidence in their roles as leaders, managers, educators and confidants. Training managers on these crucial aspects of communication will enhance team spirit amongst nurses and encourage managers to strive for best practices and best outcomes, consequently eradicating any bullying environment in the department (Johnston, 2009:41). The training of managers can equip them with the required skills to stop the cycle of bullying amongst nurses in the department.

In-service training on workplace bullying should be provided to nurses during their orientation period at the hospitals. These programmes should be mandatory and refresher programmes should run annually. Consequently, nurses will gain the necessary knowledge and skills on how to deal with this phenomenon. Nurses will be empowered on how to deal with bullies. They will know the chain of communication to report these negative behaviours before it starts. Therefore, it is crucial for all managers in the departments and hospitals to ensure that hospital environments are safe and free from bullies and create a comfortable working place for nurses (Johnston, 2009: 41). Training nurses regarding the importance of teamwork and communication, will give them confidence to work as one force and get rid of bullying behaviour amongst nurses. In addition, education regarding bullying should also include the following:

How to react to being bullied - Set boundaries to what is allowed and what is not allowed. Tell the perpetrator to stop with the negative behaviour and describe it to him/her as to make it clear. Tell it in factual words and not words such as “you are awful to me” (Heathfield, 2019:4).

Steps you can take - Familiarise yourself with bullying and harassment policies in your department. Speak to the Human Resource Department and get advice. Talk to your union representative at your organization. Take formal action by getting legal advice from a legal department.

Further support - advice and free counselling services are available to all public hospital workers who are in need thereof with the contact details of ICAS (Independent Complaints Advocacy Service), Employee health & wellness programme, toll free number 0800611093 (Colin, 2019:1).

5.4.3 Policies

Policies against zero-tolerance for bullying in workplaces, implementation of training programmes on how to deal with bullying and implementation of safe and confidential

resources for victims of bullying on nurses in the Cape Metropolitan area, were recommended. Research found that bullying is predominantly coming from the managers, therefore the recommendation is for victims to follow the hospital's human resource department's procedures as it is the most appropriate way to address the concerns. As a result, hospital management should review the existing policies and procedures regarding bullying in the workplace and the significance in having a zero-tolerance policy. Moreover, the Joint Commission recommends adopting zero-tolerance policies for intimidation and rowdy behaviours in the workplace (Johnston, 2009: 41). Nurses should be encouraged to be more aware of the existence of bullying in the workplace and training on how to identify and deal with bullies should be in place.

Risk management policies - Workplace bullying is prevalent in the hospitals as this study has shown. The South African Board for people practices (2018:13) has recommendations for drawing up policies against workplace bullying:

Management must state that they are committed to this policy. There must be an agreement that bullying is occurring in the hospital. All staff must be informed that bullying is unlawful with a zero-tolerance policy against bullying in the hospital. Examples of unacceptable behaviours must be made known to all e.g., shouting at staff, gossiping of others, etc. All staff must know steps that are in place in the hospital to prevent bullying. Staff must be reassured regarding confidentiality of complainants. Protection of the victims must be in place.

The Occupational Health and Safety Act (1993:2) is giving guidance regarding the protection of people at work against danger to health and safety arising out of or in connection with the activities of persons at work. This includes the victims of bullying in the workplace.

Furthermore, all employers must ensure, as far as is reasonably possible, that all staff under his/her employment must be free and safe from all hazards to their health or safety. The act also states that all employees have the responsibility to take good care of his/her health and safety. All employees have the responsibility to report any act that poses as unsafe or unhealthy to the manager as soon as possible. This includes bullying behaviour, which can be detrimental to the health and safety environment of an organization (Woolforde, 2019:1).

According to the Australian Public Service Commission (2009:1), managers have the obligation to be proactive in the prevention and managing of workplace bullying. They have designed a tool to identify the potential bullying behaviour, and to create a good environment free from bullying, which includes: identify the threat of potential harm and then do an

assessment on the threat to identify areas to prioritize for protection and then control the threat either with policies or by management thereof.

Since 2003, in North America 25 states have introduced workplace-bullying laws, which give victims the opportunity to sue the perpetrators of bullying without any evidence of discrimination (Maurer, 2013:1). According to Maurer (2013:2) managers become compliant to the countries' laws by drawing up departmental policies. Furthermore, the author states that the real reason for legislation regarding workplace bullying is for managers to stop the bullying behaviour in the workplace with policies and procedures for all staff in the hospital. These acts can provide compliant managers with good inducements by avoiding legal actions that can cost the organization lots of money.

5.4.4 Quality assurance

Quality assurance is a process used to assess if the service rendered is up to standard, and if the customers receive the kind of service that will keep them returning. The idea is to deliver a high consistent quality service. This is very important for patient satisfaction (Rouse, 2019:1). With the nurse not having to worry about being intimidated or harassed, optimal quality care can be guaranteed by having appropriate standards in place and nurses can provide the quality services that meet the appropriate standard. According to Nock (2016:1) hospital managers must create a good hospital culture by doing the following, find out what nurses need, and have regular staff engagement meetings, encourage collaboration by giving nurses projects, show nurses how they are making a difference in the hospital, encourage and offer many learning opportunities and recognise nurses for their efforts done. This will ensure a non-threatening environment in the nursing culture.

5.5 Recommendations for further research

A quantitative research study is recommended to provide more information on workplace bullying at the trauma/emergency departments. Moreover, a quantitative study will give accurate data and will enable researchers to make generalised statements regarding bullying amongst nurses in the workplace in public hospitals in the Cape Metropole.

5.6 Dissemination

The public will be able to access this study through the website of the University of Stellenbosch. The findings of the study will be distributed to the management of the two different hospitals. The study will also be presented at academic seminars. Articles derived from this study will be published in peer-reviewed journals.

5.7 Summary

The findings on the achievement of the three objectives of this study sparked the conversation in the final chapter of this study. The study results confirmed that bullying amongst nurses in the emergency/trauma units of the public hospitals within the Cape Metropole is real and occurs in the profession. Furthermore, the objective regarding the experiences nurses described of bullying in the workplace, the understanding of the manifestations of bullying in the workplace and the current organizational strategies of bullying in the workplace were discussed at length and in detail. Moreover, participants expressed their feelings regarding the bullying effect they endured. However, the study objectives provided answers in terms of the effects bullying amongst nurses have on the patient, the perpetrator the victim and the organization.

Therefore, the research question, “What are the experiences of nurses regarding bullying in public hospitals in the Cape Metropole?” was answered in the study.

5.8 Conclusions

The study findings revealed that direct and indirect bullying are evident in the workplace. These incidents occur on a daily basis and resources are not readily available. Participants were not well informed regarding the policies and procedures pertaining to workplace bullying, as well as the reporting system in their hospitals. Working under conditions such as managers shouting at nurses, managers gossiping about their staff, staff shortages, threatening behaviours coming from managers and many more negative behaviours, can influence staff and patient satisfaction negatively, ultimately becoming quality of patient care concerns. Participants revealed that they do love their jobs; however, managers must be held responsible for creating the environment conducive for optimal patient care.

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Addenda

Addendum A: Semi-structured interview guide

Participant identification code: _____

Date: _____

Time: _____

Reminder:

Start the interview in a friendly manner, listening to any questions the interviewee may have about the process.

Demographic data:

Age of participant:

20 to 30	31 to 40	41 to 50	51 to 60	60+
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Gender:

Male	Female
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Years of service as an enrolled or registered nurse at the workplace:

Less than 1 year	01 to 05 years	06 to 10 years	11 to 15 years	16 to 20 years	More than 20 years
------------------	----------------	----------------	----------------	----------------	--------------------

RESEARCH AIM

The aim of this study is to explore the experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

RESEARCH OBJECTIVES

The following objectives will direct this study:

- To describe nurses experiences of bullying in the workplace

- To gain an understanding of the manifestation of bullying in the workplace
- To describe current organizational management strategies of bullying in the workplace.

Question 1

What can you tell me about your experiences regarding bullying at your workplace?

Probing words: causes, influences (individual, workplace), frustrations.

Question 2

What are the reasons for bullying at the workplace?

Probing words: power issues, organizational culture, personalities, off duties, staffing issues, gender, nursing categories.

Question 3

What can you tell me about the strategies that are used by management to address bullying at the workplace?

Probing words: policies and procedures, reporting system, training (staff, supervisor)

Question 4

How can the institution help to support nurses being bullied in the workplace?

Probing words: policies and procedures, reporting system, training (staff, supervisor)

Addendum B: Letter requesting consent for research

Addendum B: Letter requesting permission for research

LETTER REQUESTING PERMISSION FOR RESEARCH

17 June 2019

Chief Executive Officer

██████████

██████████

Cape Town

RE: Research Request for data collection

I am currently registered as a Master's Degree student in Nursing at the University of Stellenbosch and I am required to undertake a research study as part of my thesis.

The focus of my research will be the experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

The following objectives will direct this study:

- To describe nurses experiences of bullying in the workplace.
- To gain an understanding of the manifestation of bullying in the workplace.
- To describe current organizational management strategies of bullying in the workplace.

The primary data will be collected through a qualitative approach using a self-administered interview approach for the data collection by all the emergency department staff. The research will strictly adhere to all ethical considerations including anonymity and confidentiality.

I therefore ask for your approval to conduct the above research, which I expect to commence at the 1 July 2019 and complete by the 1st August 2019. To assist you in reaching a decision, I have attached to this letter:

- (a) A copy of an ethical clearance certificate issued by the University

- (b) A copy of the research questions which I intend using in my research
- (c) A copy of the synopsis.

Yours sincerely

Matthew Ruiters

Student no. 13681117

Addendum C: Hospital research application**RESEARCH ANNEXURE 2
PROPOSAL SUMMARY**

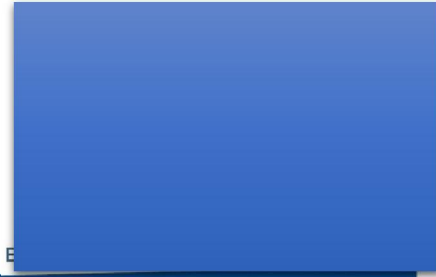
For Official Use: Research Proposal Number

ANNEXURE 2 PROPOSAL SUMMARY	
Name of Institution/organisation conducting research	Stellenbosch University
Name of Investigators	Matthew Francis Ruiters
Postal Address	77 Lancaster Way Gordons Bay Cape Town 7140
Telephone Number	021 8560754
Fax number	
Mobile Number	0766828174
Email Address	mfruiters@yahoo.com
Institution which gave ethical approval	Health Research Ethics Committee Stellenbosch University
Date of Ethical approval	13 June 2019
Date research expected to commence	1 July 2019
Proposed data collection dates at requested facilities	1 July 2019—1 August 2019
Date research expected to end	1 August 2019
Date research reports should be expected	December 2019
Western Cape Districts where research will be done: (Please mark with an X)	Metro X Westcoast Cape Winelands Overberg Central Karoo Eden
WC DOH Facilities where research will be done: (Please list the name of the facility under appropriate category)	Tertiary Hospitals: ██████████ District Hospitals: Community Health Centres: Clinics:
Other facilities in the WC DOH where research will be done (Please specify)	Psychiatric Hospitals: TB Hospitals. Other: Databases :
Research title	Experiences of Nurses regarding bullying in public hospitals in the Cape Metropole.
Research aim	To explore the experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

ANNEXURE 2 PROPOSAL SUMMARY		
Research objectives	<ul style="list-style-type: none"> To describe nurses experiences of bullying in the workplace. To gain an understanding of the manifestation of bullying in the workplace. <p>To describe current organizational management strategies of bullying in the workplace</p>	
Key Words	Bully, workplace, registered nurse, workplace bullying	
Brief description of methodology (Please specify estimated sample size and duration of contact with each participant e.g. interview length, clinical exams)	Exploratory, descriptive approach will be applied, with a qualitative design. Sample size depending on when data saturation is established. Interview time will be approx., 30minutes to 1 hour.	
Type of Study Design: e.g. Case Control, RCT, Survey	Exploratory, descriptive design	
Budget for research	Approx. R17000,00 See proposal for break-down of budget	
Source of funding for the research	Self-funded	
The research will have implications for the requested facilities regarding:	Yes or NO	If Yes what are these implications and how does your project plan to mitigate the impact
1. Additional load on nursing	No	
2. Support services	No	
3. Consumables	No	
4. Laboratory tests	No	
5. Equipment	No	
6. Space	No	
7. Communications	No	
8. Additional OPD visits	No	
9. Admission of patients	No	

ANNEXURE 2 PROPOSAL SUMMARY	
How will the sites be prepared to participate in your research?	My study will target the Emergency department of your hospital. I would like to request to meet with the different shifts to give a talk on what my research topic is and to do my recruitment of participants as such.
Results dissemination plan 1. Tick which groups will be affected by your research findings	Provincial managers <input type="checkbox"/> District Directors <input type="checkbox"/> Facility manager and staff <input checked="" type="checkbox"/> Patients <input checked="" type="checkbox"/> Community <input checked="" type="checkbox"/> Other (please specify) _____
2. What is the earliest date or period from the end of research collection that the feedback (at least the minimum requirements*) will be expected? * Minimum research findings feedback template	Within one month <input type="checkbox"/> Within one to three months <input type="checkbox"/> Within three to six months <input checked="" type="checkbox"/> Longer than six months <input type="checkbox"/>

Addendum D: Approval



Mr Matthew Ruiters
STELLENBOSCH UNIVERSITY

E-mail: mfruiters@yahoo.com

Dear Mr. Ruiters,

RESEARCH PROJECT: The Experience Of Nurses Regarding Bullying In Public Hospitals In The Cape Metropole

Your recent letter to the hospital refers.

You are granted permission to proceed with your research, which is valid until **13 June 2020**.

Please note the following:

- a) Your research may not interfere with normal patient care.
- b) Hospital staff may not be asked to assist with the research.
- c) No additional costs to the hospital should be incurred i.e. Lab, consumables or stationary.
- d) **No patient folders may be removed from the premises or be inaccessible.**
- e) Please provide the research assistant/field worker with a copy of this letter as verification of approval.
- f) Confidentiality must always be maintained .
- g) **Should you at any time require photographs of your subjects, please obtain the necessary indemnity forms from our Public Relations Office (E45 OMB or ext. 2187/2188).**
- h) Should you require additional research time beyond the stipulated expiry date, please apply for an extension.
- i) Please discuss the study with the HOD before commencing.
- j) Please introduce yourself to the person in charge of an area before commencing.
- k) On completion of your research, please forward any recommendations/findings that can be beneficial to use to take further action that may inform redevelopment of future policy / review guidelines.
- l) **Kindly submit a copy of the publication or report to this office on completion of the research.**

I would like to wish you every success with the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J.E. Nauder', written over a white background.

CHIEF OPERATIONAL OFFICER

Date: 8 July 2019



Addendum E: HREC Approval



Approval Notice

New Application

13/06/2019

Project ID : 9458

HREC Reference #: S19/03/064

Title: The experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

Dear Mr Matthew Ruiters,

The **Response to Modifications** received on 11/06/2019 15:15 was reviewed by members of **Health Research Ethics Committee 2 (HREC2)** via **expedited** review procedures on 13/06/2019 and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: This project has approval for 12 months from the date of this letter.

Please remember to use your **Project ID [9458]** 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 you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see [Forms and Instructions](#) on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC 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.

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. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: <https://www.westerncape.gov.za/general-publication/health-research-approval-process>. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: [Forms and Instructions](#) on our HREC website <https://applyethics.sun.ac.za/ProjectView/Index/9458>

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Mr. Francis Masiye,

HREC Coordinator,

Health Research Ethics Committee 2 (HREC2).

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1) · REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1) IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the [World Medical Association \(2013\). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects](#); the [South African Department of Health \(2006\). Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa \(2nd edition\)](#); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.

Addendum F: Approval



REFERENCE:
Research Projects
ENQUIRIES: Dr GG

Project ID: 9458


Ethics Reference: S19/03/064


TITLE: The experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

Dear Mr Matthew Ruiters

PERMISSION TO CONDUCT YOUR RESEARCH AT

1. In accordance with the Provincial Research Policy and Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Hospital.
2. Researchers, in accessing Provincial health facilities, are expressing consent to provide the Department with an electronic copy of the final feedback within six months of completion of research. This can be submitted to the Provincial Research Co-Ordinator (Health.Research@westerncape.gov.za).



G.G. Mannus
MBChB,MPA,
DHM
MP0370865
Manager: Medical Services
MANAGER: MEDICAL SERVICES


CHIEF EXECUTIVE OFFICER
Date: 4 September 2019

Project ID: 9458

Ethics Reference: S19/03/064

TITLE: The experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

BY  _____
An authorized representative of [REDACTED] Hospital

NAME Dr DS Erasmus


TITLE CEO

DATE 4 September 2019

Addendum G: Budget**Table 2: Is a self-funded estimated study budget**

Item	Unit cost	Estimated cost
Travelling	R 3.00 x 100km	R1200.00
Stationery e.g. for informed consent forms	R50.00 per participant	R500.00
Refreshments for participants	Bottled water at R12.00 per 500ml bottle x 15	R180.00
Voice recorder	Per Unit Estimation price R150.00	R150.00
Transcription of audio tapes	R5.00 per audio minute X approx. 90minutes per person 10 people	Approx. R4500,00
Language editing and technical formatting	30 cents per word	R9 000,00
Printing and binding of thesis		R1500.00
Total		R17030.00

Addendum H: Turnitin report


Close

Dashboard » My courses » 2019 » Medicine and Health Sciences » Nursing And Midwifery » Navorsingstels - Research thesis - 876 » Thesis submission » Thesis submission



My Submissions


Part 1

Title	Start Date	Due Date	Post Date	Marks Available
Thesis submission - Part 1	2 Nov 2019 - 13:12	10 Dec 2019 - 13:12	10 Dec 2019 - 13:12	100

Summary:
Use this link to submit your thesis.

[Refresh Submissions](#)

	Submission Title	Turnitin Paper ID	Submitted	Similarity	Grade	
View Digital Receipt	Thesis: The experiences of nurses regarding bullying in hospitals in the Cape Metropole	1222008152	7/12/19, 14:19	12%	--	Submit Paper   --



NAVIGATION

- Dashboard
- Site home
- My courses
 - 2018
 - 2019
 - Medicine and Health Sciences
 - Nursing And Midwifery
 - Navorsingstels - Research thesis - 876
 - Participants
 - Badges
 - Competencies
 - Grades
 - Thesis submission
 - Thesis submission**
 - Verpleegkunde - Nursing science - 888
 - Training Courses
 - Courses

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

Submission Author	MATTHEW FRANCIS RUITERS
Turnitin Paper ID (ref. id)	1222008152
Submission Title	Thesis: The experiences of nurses regarding bullying in hospitals in the Cape Metropole
Assignment Title	Thesis submission
Submission Date	07/12/19, 14:19

[Print](#)

USEFUL LINKS

- [MBCHB 1 Study Guide](#)
- [Physiotherapy 1 Study Guide](#)
- [Dietetics 1 Study Guide](#)
- [Library Guide](#)
- [Podcasts](#)
- [Student Support Booklet\(Download\)](#)

NETWORK SERVERS

- [Home - Eportfolio](#)

STUDENT FEEDBACK

Addendum I: Certificate for Language Editing



Lona's Language Services

English/Afrikaans
Afrikaans/English

3 Beroma Crescent Beroma Bellville
Tel 0219514257
Cell 0782648484
Email illona@toptutoring.co.za

* Translations * Editing * Proofreading
* Transcription of Historical Docs
* Transcription of Qualitative Research
* Preparation of Website Articles

TO WHOM IT MAY CONCERN

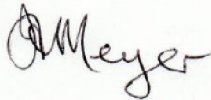
This letter serves to confirm that the undersigned

ILLONA ALTHAEA MEYER

has edited and proofread the **thesis of Matthew Ruiters** for language correctness and translated the ABSTRACT.

TITLE: THE EXPERIENCES OF NURSES REGARDING BULLYING IN PUBLIC HOSPITALS IN THE CAPE METROPOLE

Signed



Ms IA Meyer

07 December 2019

Addendum J: Certificate of technical formatting



To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the language editing and technical formatting of Matthew Francis Ruiters's thesis entitled:

The experiences of nurses regarding bullying in public hospitals in the Cape Metropole.

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

Lize Vorster
Language Practitioner