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Workplace bullying in emergency nursing: Development of a grounded theory using situational analysis

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ABSTRACT

Background: The Institute of Medicine recognizes that the workplace environment is a crucial factor in the ability of nurses to provide safe and effective care, and thus interactions that affect the quality and safety of the work environment require exploration.
Objectives: The purpose of this study was to use situational analysis to develop a grounded theory of workplace bullying as it manifests specifically in the emergency care setting.
Methods: This study used a grounded theory methodology called situational analysis. 44 emergency RNs were recruited to participate in one of 4 focus group sessions, which were transcribed in their entirety, and, along with field notes, served as the dataset.
Results: This grounded theory describes the characteristics of human actors and their reactions to conditions in the practice environment that lead to greater or lesser levels of bullying, and the responses to bullying as it occurs in U.S. emergency departments.
Discussion: Workplace bullying is a significant factor in the dynamics of patient care, nursing work culture, and nursing retention. The impact on patient care cannot be overestimated, both in terms of errors, substandard care, and the negative effects of high turnover of experienced RNs who leave, compounded by the inexperience of newly hired RNs. An assessment of hospital work environments should include nurse perceptions of workplace bullying, and interventions should focus on effective managerial processes for handling workplace bullying. Future research should include testing of the theoretical coherence of the model, and the testing of bullying interventions to determine the effect on workplace environment, nursing intent to leave/retention, and patient outcomes.

1. Introduction

The Institute of Medicine (IOM) recognizes that the workplace environment is a crucial factor in the ability of registered nurses (RNs) to provide safe and effective care [1]. Dysfunctional work environments in which bullying occurs can have a significant impact on the ability of RNs to safely and effectively care for patients.

Investigation of a complex social phenomenon requires an examination of multiple factors. This led to the selection of Clarke's [2] situational analysis model, which extends and expands the grounded theory methodology that is based on a constructivist, interpretive paradigm [2–4]. Clarke uses three main types of mapping to analyze data: *situational maps* that lay out the main human and nonhuman elements and examine relationships between them; *social worlds maps* that describe the actors, key nonhuman elements and the areas of commitment within which they engage and help to interpret situations, and *positional maps* that describe the major positions taken (and not taken) about complicated issues in the phenomenon of interest [2].

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2. Literature review

Workplace bullying occurs when employees (i.e., the targets of bullying) face prolonged exposure to negative behaviors against which they feel unable to defend themselves [5]. For the purposes of our research inquiry, we used the terms lateral/horizontal violence, bullying, and incivility/aggression interchangeably (despite some differences in meaning); however, for simplicity we've chosen to exclusively use the term workplace bullying.

Research findings suggest that bullying frequently occurs among RNs [6] to the extent that up to 40% of nurses report an intent to leave because of it [7]; this is significant especially for new nurses, in that new RNs reported being bullied at work which resulted in 30% of new RNs leaving their jobs within the first year [8] and 57% by the second year [9].

Bullying is associated with emotional exhaustion, poor mental health [10], psychological distress symptoms [11], job dissatisfaction, absenteeism, intention to leave, and high turnover rates [12–16] and acts as a trigger for lateral violence [17]. Workplace bullying is described as both a cause and an effect of physical and emotional fatigue [18] and is reported as an ordinary and too often tolerated part of nursing socialization [18–21]. Bullying was also identified as a barrier to addressing workplace violence originating from patients and visitors [22], and potentially affects overall health and safety of the entire workplace [23,24].

Bowie [25] describes four types of violence that exist both independently, and concurrently. Types 1 and 2 involve perpetrators having no connection to the workplace (*Intrusive violence*) and patients committing acts of violence on nurses (*Consumer violence*), respectively. Types 3 and 4 have more relevance to this study. Type 3 (*Relationship violence*) involves aggressive acts by persons who have an employment based relationship with an organization, which could include an employee's current or former spouse, family or significant other. Type 3 violence could also include cases of stalking or former employees seeking justice for perceived previous wrongs as well as workplace bullying and harassment. Type 4 (*Organizational violence*) involves organizations knowingly placing their workers in dangerous or violent situations or allowing a climate of bullying or harassment to thrive in the workplace. This becomes important when nurses who are victims of type 3 violence attempt to seek help from administration and experience type 4 violence when they fail to receive assistance and/or are further bullied.

2.1. Purpose

The purpose of this study was to explore and develop a substantive theory of workplace bullying as it manifests specifically in the emergency department (ED) setting, using a modified, grounded theory approach.

3. Methods

This study used a methodology called *situational analysis* as described by Clarke [2]. Clark's situational analysis model uses maps derived from qualitative data to describe the type and relationship of elements that make up the phenomenon of interest. Situational maps lay out the main human and nonhuman elements and examine relationships between them; social worlds maps describe the actors, key nonhuman elements and the areas of commitment within which they engage and help to interpret situations at the organizational level, and positional maps describe the major positions taken (and not taken) about complicated issues in the phenomenon of interest. This approach allowed for rich, thick descriptions that lend themselves to the development of a substantive theory of workplace bullying in the ED and to interventional strategies. Furthermore, it provides the reader context to understand the complexities involved with this social phenomenon as it is related to the ED and as the relevant literature is presented; the depth and breadth of this approach helps to establish the credibility, transferability, dependability, and confirmability of this study.

Table 1
Participants' demographics (N = 43).

Characteristic		Participants (%)
Gender	Female	86.0
	Male	14.0
Age	25–34	4.7
	35–44	23.3
	45–54	34.9
	55–64	32.6
	> 64	4.7
Highest Educational Degree in Nursing	Nursing Diploma	2.3
	Associate	18.6
	Bachelor	55.8
	Master's	20.9
	Doctorate	2.3
Primary ED Role	Case Manager	2.3
	Charge Nurse	9.3
	Clinical/Nurse Educator	9.3
	Director	9.3
	Manager	16.3
	Staff Nurse	51.2
	Other	2.3
ENA Member	Yes	95.3
	No	4.7

Years of Experience		Mean	SD	Min	Max
	As a nurse in all areas, including the ED	22.2	14.0	1.0	44.0
	As an emergency nurse only	17.7		1.9	
	In current ED	8.5	11.3	0.4	43.0
	In all areas of emergency care, excluding nursing (e.g., tech)	8.0	7.8 10.7	0.0	29.4 40.1

3.1. Sample

A purposive, convenience sample of 43 emergency RNs was recruited through email and social media from a list of registered attendees at the Emergency Nurses Association's Conference in Los Angeles, CA (Table 1). To ensure sampling representation by gender, geographic location, and work role, both staff nurses and those who were in administrative positions were recruited (Table 2).

Four separate focus groups were held at EN2016, with attendees separated into two employee categories, one consisting of staff RNs (N = 28), and the other of managers, directors, and educators (N = 15). Prior to implementation of the study, we obtained Institutional Review Board (IRB) approval from the Chesapeake Institutional Review Board (Pro00018760) and a Certificate of Confidentiality (CoC) from the National Institutes of Health (NIH). No compensation or incentive was offered to participants who completed the demographic survey and/or participated in the focus groups.

3.2. Data collection

Demographic information was collected about individual participants and the practice settings in which they worked (Table 1), using online survey software (Qualtrics, Provo, UT). All the members of the research team are fulltime researchers or faculty who may have been known to the participants by name. The purpose of the study was explained to participants before the start of each one-hour focus group session. Focus groups took place at the EN2016 conference, and were