Management of workplace bullying in hospital: A review of the use of cognitive rehearsal as an alternative management strategy

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Abstract

Lateral violence is not uncommon in workplaces. Unfortunately, nursing, a profession that builds its practice on compassion and code of ethics while caring for their patients is not spared from this phenomenon of lateral violence. Studies have reported cases of lateral violence among nurses to occur frequently worldwide. The impact of lateral violence has serious repercussions not only on the health of bullied victims but also on the structure and financial spending of the organisation. More importantly, the potential latent impacts on the patients’ safety and health is of great concern. This literature review suggests that the contributing factors towards lateral violence are mainly due to characteristics of perpetrators, victims’ reaction to bullying and organisation’s characteristic. To mitigate the impact of lateral violence among young and inexperienced nurses, a cognitive rehearsal scripted response is proposed to prevent harassment and bullying incidents from becoming a feature at the workplace for nurses.

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1. Introduction

Workplace violence is not uncommon in healthcare organisations. The most common and explicit types of workplace violence in the hospital setting are reportedly verbal and physical abuse from patients and their relatives. However, many studies have also indicated that nurses can potentially be the perpetrators of workplace violence towards their own colleagues, in what is defined as ‘workplace bullying’. Therefore, it is unfortunate that despite the fact that nursing is a profession built on the practice of compassionate care and following a strong code of ethics it is not spared from this particular aspect of workplace violence.

Workplace bullying could possibly lead to high turnover rates, resulting in staff shortages. The rising demand for healthcare coupled with the on-going shortage of nurses remains a paramount concern of nursing leaders and healthcare organisations worldwide. This shortage in the population of practicing nurses is a profound issue affecting the nation of Singapore, which is currently struggling to meet the growing healthcare needs of its ageing population. To mitigate the impact of manpower shortage, Singapore has recruited a large pool of foreign nurses, constituting 60.5% of its current nursing workforce [1]. In addition to recruiting staff from abroad, it is important to develop more innovative and effective strategies to attract younger nationals to the nursing profession is important. However, pursuit of each of these approaches needs to be accompanied by systematic exploration to identify and subsequently address the push–pull factors of the current nursing environment that influence retention of nursing staff in their profession.

This review was carried out to explore the factors contributing to workplace bullying among nurses working in hospitals. The findings led to a thoughtful discussion, here, of the current interventions that mitigate such behaviour and the proposal of an educational strategy targeted at empowering newly qualified nurses to handle workplace bullying.

2. Background

The World Health Organisation [2] defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in injury, death, psychological harm, mal-development or deprivation”. The aspect of workplace bullying was first described in the 1980s by Heinz Leymann, who coined the term ‘mobbing’ to refer to “hostile and unethical communication directed towards an individual at least once a week up to a six months duration”.

In relation to the nursing profession, Duffy [3] defined workplace violence as “nurses overtly or covertly directing their dissatisfaction inward towards each other, themselves and towards those who are less powerful and influential than themselves”. Examples include direct and indirect, verbal and non-verbal reactions, such as raising of eyebrows or voices in response to colleagues, making rude or demeaning comments, acting in a way that undermines the ability of a colleague to help others, sabotaging a colleague by withholding information, infighting, scapegoating, passive-aggressive communication, gossiping and failure to respect privacy, and breaking confidentiality entrusted to nurses in positions of authority or power.

Workplace bullying exists worldwide, with a varied but marked prevalence in nations across the globe. A recent national survey by the National Health Service [4] of the United Kingdom suggested that 1 in 4 NHS staff (25%) had experienced bullying in the workplace, specified as harassment or abuse from their manager or colleagues. This 2014 percentage represented a slight increase (of 1%) over the 2013 levels. An earlier cross-sectional study conducted in Australia by Roche, Diers [5] had found 14.7% of Australian nurses having experienced workplace violence perpetrated by their co-workers.

Studies in Asia reported the highest levels of nurses having experienced workplace violence, up to 33% [6,7].

The international variation in levels of workplace bullying, however, could be due to differences in sample size, type of measurement used, organisational/service setting, and culture of reporting. Nonetheless, when the data is considered collectively, a remarkable portion of nurses working in the hospital setting has experienced workplace violence, with bullying being the most common.

A prospective study conducted in Singapore, investigated workplace bullying among nurses in a local tertiary hospital’s operating theatre department and reported that 33.7% of the respondents reported having experienced verbal abuse, with 17.6% alleging abuse by nurse managers; importantly, the study also found that more than 70% of the staff choose not to report workplace bullying incidents. Chan and Huak [8] highlighted similar results from their study, in which nurses reported that they were less than satisfied with colleague cohesion and support from their superiors. A more recent study by Carter et al. (2013) [30] confirmed this, reporting that despite a high prevalence rate of workplace bullying only 2.7%–14.3% of nurses reported bullying cases to higher authorities. This huge contrast between incidence and reporting rates implies that workplace bullying victims face multiple challenges when dealing with aggressive colleagues. The low reporting rate could also highlight workplace bullying as a sensitive topic that is seldom raised in the employing organisation (i.e. the hospitals). As such, there may be a greater need to investigate workplace violence in hospitals and address both prevention and intervention to mitigate its impacts.

Apart from its high prevalence rate worldwide, workplace bullying has serious consequences on the victims’ physical and
emotional health, which could in turn affect an organisation’s function and, ultimately, the quality of care given to its patients. These impacts can be broadly categorised as personal-physical, personal-emotional, and organisational. To this end, Hallberg and Strandmark [9] reported that nurses who experienced negative workplace behaviour had increased health issues, including headaches, respiratory conditions and worsening of chronic diseases. Numerous cross-sectional studies have confirmed the association between bullying and poorer health outcomes of the victims. A separate longitudinal study confirmed this association by showing that 1 in 2 nurses who were bullied in the workplace experienced sleep disorders. The known complications of sleep disorders are lowered efficiency and reduced quality of day-to-day activities, and persistent detrimental health impacts. Based on the collective evidence, workplace violence, especially extreme cases, may have an adverse impact on physical health.

A plethora of studies have demonstrated associations between bullying and negative psychological outcomes, as well. In a Portuguese study, conducted by Sa and Fleming [10], nurses who were bullied at work were shown to have experienced career burn-out at significantly higher levels than their non-bullied counterparts ($p = 0.03$), as well as higher levels of emotional exhaustion ($p = 0.01$) and depersonalisation ($p = 0.01$). Studies by Tehrani [11] and Hansen, Hogh [12] further confirmed this relationship by showing that nursing respondents who were exposed to workplace bullying had more post-traumatic stress related symptoms than non-bullied respondents. It is important to note here that such negative consequences can also spread from the victimised individuals to their immediate family members, eroding those non-workplace relationships.

Workplace violence can also have a macro impact on the efficiency of the employing organisation. Studies by Kivimaki, Elovainio [13] and Ortega, Christensen [14] highlight the higher absenteeism rate among bullied staff, compared to non-bullied staff. The absence of nurses at work creates additional workload for their fellow colleagues; this consequence is a particular problem in Singapore, where there is already a higher patient to nurse ratio.

A wealth of studies have demonstrated associations between workplace bullying and lower job satisfaction as well as poor productivity resulting in a higher tendency to leave the employing organisation. A shortage of nurses can also increase an organisation’s financial burden, due to the additional costs incurred in training new nurses to cover or replace the absent of lost nursing employees. The annual cost of bullying to organisations in the United Kingdom alone is estimated to be as high as £13.75 million. This significant sum of money could potentially be allocated otherwise to improve work productivity and patient care.

2.1. Potential impact on patient care

Beyond financial costs to the employing healthcare facility, bullying could also have a latent impact on patient safety and quality of health/recovery. Roche, Diers [5] demonstrated a positive association between medical errors and workplace bullying, suggesting that lower quality of care for patients may be attributed to personal effects and impaired functioning levels among bullied individuals. Lallukka, Rahkonen [15] suggested that bullying and the related sleeping disorders among nurses led to poorer levels of nursing care. It is well recognized that sleeping disorders can negatively affect a person’s day-to-day activity as well as produce long-term negative impacts on their daily life. Therefore, it could be argued that workplace bullying jeopardises the quality of patient care and safety. On the basis of these collective data from the literature, the aim of this review was to investigate the key factors contributing to workplace bullying among nurses working in a hospital setting in order to develop appropriate and informed interventions to mitigate the impact of such behaviour.

3. Methods

The literature databases of Medline, PsycINFO, Embase, Health and Psychosocial instruments, EBM Reviews (Evidence Based Medicine Reviews) were searched via the interface programme OvidSP and CINAHL Plus (Cumulative Index to Nursing and Allied Health Literature). Search terms applied were related to the topical population (i.e. nurses, nursing staff), topic of interest (i.e. bullying, mobbing, aggression, antecedent, causes), and topical context (i.e. hospital, workplace, occupational). Since certain root words may have different endings, truncations such as nurs$ and contribut$ were also applied in the search strategy to allow for various word endings and spellings. Finally, the search was date restricted to publications from 2005 to 2015 (Refer to Table 1 for search strategy).

<table>
<thead>
<tr>
<th>Table 1 – Search strategy.</th>
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<tr>
<td><strong>Databases searched for articles publishing in 2005–2015</strong></td>
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<tr>
<td>OvidSP (Medline, PsycINFO, Embase, Health and Psychosocial instruments, EBM Reviews)</td>
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<tr>
<td>CINAHL Plus</td>
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<tr>
<td>Total titles and abstracts reviewed (duplicates removed)</td>
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<tr>
<td>Total articles reviewed for inclusion</td>
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<tr>
<td>Paper used as dissertation</td>
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Towards ensuring high quality of papers selected for inclusion in this literature review, the Critical Appraisal Skills Programme (CASP) tool for qualitative research and the Downs & Black’s Checklist for Non-randomised Studies were used (Refer to Fig. 1 for PRISMA flow diagram).

4. Results

The following three themes emerged from the nine papers selected for literature review: Characteristics of perpetrators, Characteristics of Victims, and Characteristics of Organisation.

4.1. Characteristics of perpetrators

All nine papers implied that workplace violence occurs among nurses. Five of the papers suggested an association between characteristic of perpetrators and workplace bullying.

Autrey, Howard [16] reported that 44 of the nurses in their study cited the perpetrators’ characteristics as being experts in their respective fields of practice. Furthermore, the perpetrators were associated with traits such as being powerful figures in the workplace with the ability to decide whether to share their knowledge and resources with others, having strong personalities, and having negative working relationships (e.g. professional jealousy, insecurity, and hate) with coworkers.

Strandmark and Hallberg [17] suggested that a major characteristic of workplace bullying involved power struggles between victims and perpetrators. Similarly, Abe and Henly [6] reported that the most commonly experienced negative aspect that was perceived by recipients of bullying involved the withholding of information, which was described as being used as an act of ‘power’ by the perpetrators. A correlation coefficient analysis further showed that workplace bullying by perpetrators was characterised by persistent criticism ($r > 0.65$), reminders of error ($r = 0.65$), and excessive monitoring ($r = 0.66$), and that these features correlated with workplace bullying among nurses working in Japan.

Purpora, Blegen [18] reported that a common negative act experienced by bullying victims involved their having been ordered by the perpetrator to do work that was below one’s level of competency. Yildirim [19] reported that such characteristics took the form of “having someone speak about you in a belittling and demanding manner while in the presence of others” (56%), followed by “making you feel like you are being controlled” (49%).

Despite the different study designs, the theme that emerged in the findings of each was similar. As such, it is evidently clear that perpetrators are often seen as someone who is a more powerful figure with better working knowledge than the victims. This finding may help to highlight gaps in the current interventions available towards mitigating workplace violence, especially to address the related potential hindering of victims from reporting cases of workplace violence to higher authorities.

4.2. Characteristic of victims

Four out of the nine papers suggested an association between the characteristics of victims and prevalence of workplace bullying.

Pai and Lee [7] reported that nurses younger than 30 years old were 2.4-times more likely to experience workplace bullying (confidence interval: 1.24–4.46). Purpora, Blegen [18] also reported a statistically significant correlation ($p < 0.1$) between tendency of workplace bullying and years of working experience. Regression analysis by Yildirim [19] supported the finding by Purpora, Blegen [18] for significant association between younger nurses and bullying ($p < 0.01$).

Apart from age and experience, the personality of victims was also found to be a risk factor in workplace bullying. The
from reporting incidents of workplace violence. Although anxiety and bullying appear to be independent variables, a cross-sectional study by Purpora, Blegen [18] using regression analysis indicated that for every increase in minimization of self-score, there was a concomitant 0.288 increase in workplace violence score ($p < 0.05$). Based on these findings, it is evident that nurses of younger age with less experience have a higher probability of experiencing bullying.

### 4.3. Characteristic of organisations

Three out of the nine papers suggested organisation characteristics as factors linked to workplace bullying among nurses. Autrey, Howard [16] suggested that nurses' stress levels and working conditions were also a source of aggression. Similarly, Balducci, Cecchin [20] reported that role ambiguity ($R = 0.54$, $p < 0.01$) was a strong predictor of bullying in nurses and that manpower shortages were significantly associated with workplace bullying among nurses ($p < 0.05$).

Bortoluzzi, Caporale [21] further performed a regression analysis combining organisation, individual and leadership factors and found an acceptable threshold of association ($RR = 0.335$, $p = 0.005$). These findings suggest that a stressful work environment could be conducive to workplace violence. Ambiguity of a nurse’s role could lead to work performance at less than their best capability, which could lead to a cycle of persistent criticism and reminder of errors, providing a possible explanation for workplace bullying as an environmental condition.

Management plays a vital role in mitigating such factors by providing clear job descriptions for nurses, which could potentially mitigate workplace behaviours like persistent criticism, thereby reducing stress factors resulting from doing work below one's competency level. More importantly, findings related to organizational characteristics suggest the existence of a gap between the available interventions to address workplace bullying among nurses. Although organisations can take a strong stance against workplace bullying, ineffective leadership portrayed by nursing leaders may potentially prevent victims from reporting incidents of workplace violence.

### 5. Summary

Considering the accumulated data in the literature it may be argued that the findings are complex and multidimensional. There is, however, evidence for a link between the risk factors, bullying behaviour and outcomes (see Fig. 2).

#### 5.1. Strengths and limitations of included studies

Although the two qualitative studies, six cross-sectional studies, and one longitudinal study in this review were from the lower hierarchy of the evidence, their research designs were appropriate for the aims of this dissertation. Similarly, the sampling methods used in each were justifiable when accounting for the sensitive nature of workplace violence among nurses. While qualitative studies are susceptible to researcher bias, the researchers of these nine studies reported extra measures that were taken to maintain the credibility and reliability of their findings. The greatest limitation of the papers selected for this review is the ability for generalisability. Therefore, one needs to apply the findings within local contextualization and exercise levels of caution when it comes to generalisability.

### 6. Discussion

The themes uncovered in this review highlight the vulnerability of young, inexperienced nurses as potential victims of workplace violence. If one were to critically analyse such perspectives using macro implications, workplace violence in nursing may be seen as a potential barrier to recruitment and retention of talented young nurses.

#### 6.1. Implications for current nursing practice

The local government and hospitals in Singapore have a zero-tolerance policy for workplace bullying. Trade union interventions seek to protect workers’ rights at the workplace. Local hospitals also have measures in place, such as the “staff support staff system”, through which nurses can make anonymous calls to report bullying and seek emotional support. In addition, hospital administrators are also trained to encourage staff to report negative workplace behaviour to higher authorities. Thus, considering the review findings, we propose that an education package using cognitive rehearsal script responses can be helpful as a broad and early intervention strategy to raise awareness and empower nurses with knowledge on how to mitigate workplace violence.

#### 6.2. Rationale for utilising cognitive rehearsal script responses

The intervention approach of cognitive rehearsal script responses was build upon the theoretical framework of cognitive learning theory, wherein Piaget [23] and Ausubel, Novak [24] argued that a person's behaviour and response to events can be modified through the use of techniques that emphasize learned specific responses through listening or reading instruction. As such, the advantage of cognitive rehearsal scripted response allows individuals to hold in their mind information which they have just received and subsequently process that information through elicited scripted responses based on what they have been previously taught in situations where they might face aggressive confrontations from colleagues.

Nurses could be taught to mitigate the acts of workplace violence by using scripted verbal response when faced with negative workplace behaviour, rather than being intimidated by perpetrators. In support of this, Griffin [25] reported that nurses who underwent interactive cognitive rehearsal training and were instructed in the use of appropriate script responses to ten of the most frequent acts of bullying were able to mitigate negative workplace behaviour exhibited by perpetrators. Roberts, Demarco [26] further suggests that a
cognitive rehearsal script training programme may be associated with as high as 80% of the nurse retention rate.

A separate quasi-experiment conducted by Stagg, Sheridan [27] reported moderate correlation for observed bullying (RR = 0.644, p < 0.05) and adequacy of cognitive rehearsal scripted responses training (RR = 0.569, p < 0.05) but weak correlation (RR = 0.299, p > 0.05) in the ability to defend oneself against bullying. Griffin [25], Stagg et al. [27] and Illing, Carter [28] suggest that cognitive rehearsal scripted responses used as an intervention approach produces a positive impact at the individual level and may be the best single means of preventing and intervening in such issues. It is, therefore, an appropriate choice of intervention. The limitations of using the scripted response, however, seem to be that recipients of bullying might not know how to respond to perpetrators if the bullying acts are unusual or extreme in nature. Therefore, it is also important to educate the nursing staff on the limitations of the intervention approach and instruct them in how to deal with aggressors in unusual or extreme situations.

7. Conclusion

This literature review has identified the characteristics of perpetrators, victims and organisations related to workplace bullying among nurses in the hospital setting, and suggests an

<table>
<thead>
<tr>
<th>Organisational impact</th>
<th>Perpetrators</th>
<th>Victims</th>
<th>Threats to professional status</th>
<th>Physical impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Poor working environment</td>
<td>- Powerful figure</td>
<td>- Younger</td>
<td>- Belittling remarks</td>
<td>- Headaches</td>
</tr>
<tr>
<td>- Stressful environment</td>
<td>- Highly influential</td>
<td>- Inexperienced</td>
<td>- Persistent criticisms</td>
<td>- Respiratory conditions</td>
</tr>
<tr>
<td>- Job ambiguity</td>
<td>- More authoritative</td>
<td>- Less assertive</td>
<td>- Intimidation</td>
<td>- Worsening of chronic diseases</td>
</tr>
<tr>
<td>- Shortage of manpower</td>
<td>- Takes on role of oppressor</td>
<td>- Lower confidence</td>
<td>- Humiliation</td>
<td>- Sleeping disorder</td>
</tr>
<tr>
<td>- Poor leadership</td>
<td></td>
<td>- Vulnerable personality</td>
<td>- Withholding information</td>
<td></td>
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</tbody>
</table>

Threats to professional status

- Belittling remarks
- Persistent criticisms
- Intimidation
- Humiliation
- Withholding information
- Exclusion/isolation
- Work overload
- Removing responsibility
- Work under-competency
- Shouted at
- Lack of autonomy
- Under utilisation

Physical impact

- Headaches
- Respiratory conditions
- Worsening of chronic diseases
- Sleeping disorder

Emotional impact

- Anxiety
- Depersonalisation
- Burn-out
- Post-traumatic stress disorder

Organisational impact

- Increase in absenteeism
- Lower job satisfaction
- Lower productivity
- Higher intention to quit
- Increased staff turnover rate
- Increased organisation spending in recruiting and training new nurses

Patient impact

- Medical error
- Poorer patient health outcome

![Summary model adapted from Moayed, Daraiseh [22.]](image)

Fig. 2 – Summary model adapted from Moayed, Daraiseh [22].
interlinked relationship between all. The review’s findings suggest that bullying victims feel more comfortable sharing their experience in bullying incidents with close friends, family members and colleagues rather than reporting their experience to higher management or sharing the incident with a counsellor at the workplace. The indications are that managers know little about workplace bullying. The intervention approach of cognitive rehearsal scripted responses was proposed to empower newly qualified nurses with knowledge and confidence to manage workplace violence. It is an effective individual tool for enabling individuals to protect themselves against workplace violence.

The implementation of cognitive rehearsal scripted responses requires multi-level collaboration between different levels of the hospital’s infrastructure, specifically of its workforce including administrators and staff members. Due to the sensitive nature of the topic, however, this proposed intervention poses major challenges that must be overcome to ensure successful implementation. Effective teamwork is required in order to implement such an initiative.

Further interventions are required to better mitigate the negative impacts of workplace bullying at an organisational level. It is suggested that all staff should be educated about negative working behaviours and their risk management, as well as effective communication to promote reporting as being viewed as an acceptable and necessary behaviour. This overall strategy is likely to help manage the adverse impacts of workplace bullying and to create a more sustainable environment for nursing professions to thrive and grow.

**Appendix**

<table>
<thead>
<tr>
<th>Table A1 – Literature review and thematic matrix.</th>
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</thead>
<tbody>
<tr>
<td>Authors and research topic</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>Risk factors for workplace violence in clinical registered nurses in Taiwan [7]</td>
</tr>
<tr>
<td>Horizontal violence among hospital staff nurses related to oppressed self or oppressed group [18].</td>
</tr>
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</table>

(continued on next page)
<table>
<thead>
<tr>
<th>Authors and research topic</th>
<th>Research aims</th>
<th>Methods and sample group</th>
<th>Findings of research</th>
<th>Themes found</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying (ljime) among Japanese hospital nurses.</td>
<td>To describe responses and explore dimensionality of a Japanese translation of the 23-item revised Negative Acts Questionnaire A cross sectional study. N = 881 (85% response rate)</td>
<td>The most commonly experienced negative act was withholding information Followed by being humiliated and being shouted at Correlates with persistent criticism and reminding of errors 19% of the respondents never experience any negative acts</td>
<td>Bullying was not related to work itself but more towards the person Victims were often isolated Demanding working condition set by organisation</td>
<td></td>
<td>Unable to determine causation Vague sampling method Potential for self-reporting bias</td>
</tr>
<tr>
<td>Bullying among nurses and its effects [19].</td>
<td>To assess workplace bullying among nurses in Turkey and its effect on nursing practice Cross-sectional study N = 286 (58% response rate) 5 parts validated questionnaire that covers workload, organisation effects, depression, workplace bullying behaviour, and working hours</td>
<td>Most common type of bullying behaviour was attacks on professional status and personality Belittling of victims in front of other colleagues Sources were mangers (40%), followed by co-workers (34%) Second most common bullying behaviour was controlling one's work Sources were managers (49%), followed by co-workers (22%) Bullying behaviour was associated with workload (p &lt; 0.01) and young nurses (p = 0.01).</td>
<td>Superiors are the sources main source of violence Perpetrator often belittles victim Association with workloads Victim are mainly new nurses</td>
<td></td>
<td>Low response rate Unable to determine causality Vague sampling method Potential for self-reporting bias</td>
</tr>
<tr>
<td>Psychosocial antecedent and consequences of workplace aggression for hospital nurses [29]</td>
<td>To test a full model of the antecedents and consequence of workplace bullying among nurses working in hospital Cross sectional study N = 207 (26.9% response rate) Validated questionnaires that cover aggression, work conditions, and individual impact</td>
<td>High job demand from colleagues were significant associated with bullying (p = 0.01) Poor co-worker support (p = 0.01).</td>
<td>Co-worker is the common source of bullying Perpetrator often high demands on their fellow colleagues</td>
<td></td>
<td>Low response rate, Unable to determine causality, Vague sampling method Potential for self-reporting bias</td>
</tr>
<tr>
<td>Does participative leadership reduce the onset of mobbing risk among nurse working teams [21]</td>
<td>To evaluate the impact of empowering leader style on the risk of mobbing behaviour among nurses To evaluate organisational and individual related mobbing predictors Cross-sectional study N = 175 (75.5% response rate) Empowering leadership questionnaires</td>
<td>Manpower storage is associated with risk of bullying (p = 0.05) Individual factors are not a significant contributor to bullying (confounding) Factors could be older nurses (34.9%) and more than 10 years of work experience (3.6%) Leadership has a significant impact on workplace bullying Combination of individual, organisation and leadership has a key role in preventing workplace violence</td>
<td>Organisation factors have a significant impact on workplace violence Effective leadership plays a vital role in mitigating workplace violence among nurses</td>
<td></td>
<td>Potential risk of self-reporting bias Unable to establish causation</td>
</tr>
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</table>
### Table A1 – (continued)

<table>
<thead>
<tr>
<th>Authors and research topic</th>
<th>Research aims</th>
<th>Methods and sample group</th>
<th>Findings of research</th>
<th>Themes found</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The impact of role stressors on workplace bullying in both victims and perpetrators, controlling for personal vulnerability factors: A longitudinal study [20]</td>
<td>To assess whether role conflict and role ambiguity predicts being a victim of bullying over personal vulnerability</td>
<td>Longitudinal study over 12 months N = 234 (21.6% response rate)</td>
<td>Role stressor had an impact on negative workplace behaviour</td>
<td>Work environment and personal traits of perpetrator and victims had an impact on bullying</td>
<td>Poor sample size Short time frame period of studies Unable to generalise findings</td>
</tr>
<tr>
<td>Sources, reactions, tactics used by RNs to address aggression in an acute care hospital [16]</td>
<td>To identified sources of, reactions to and tactics nurses use to address aggression in the workplace</td>
<td>Grounded theory, qualitative study 1 h group interview with 15 nurse managers 60–90 min semi-structured individual interview of 47 RNs All recordings were audio and transcribed verbatim</td>
<td>Top sources of aggression are from physicians and nurse mangers Issues such as - Professional jealousy - Insecurity - Experienced worker with superiority in terms of knowledge and resources - Stress and heavy workloads</td>
<td>Perpetrators are people with power and knowledge at work Maintain power though display of aggression Stressful working environment Victim reaction to perpetrator was apologetic and in shock Victims tend to address issue with perpetrators (people in the higher hierarchy) in a calm and professional manner - Some victims even apologise despite it not being warranted - For perpetrators of lower hierarchy, victims tend to report the incident to higher authority</td>
<td>Convenient sampling might not be representative of other health organisations No field notes were taken during data collection Results cannot be generalised</td>
</tr>
</tbody>
</table>

### REFERENCES


