NURSING STUDENTS' EXPERIENCES OF BULLYING IN A PRIVATE NURSING EDUCATION INSTITUTION

Lize van Niekerk

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing

Johannesburg, 2017

DECLARATION

I, Lize van Niekerk declare that this Research Report is my own, unaided work. All sources quoted have been indicated to the best of my ability by the use of complete referencing using the Harvard referencing style.

This Research Report is being submitted for the degree of Masters of Science in Nursing at the University of the Witwatersrand, Johannesburg. This report has not been submitted for any other degree or examination at any other University.

Signature: _____ Date: 11/5/2017

Protocol number: M160372

Student number: 751470

DEDICATION

This research study is dedicated to my late parents Neville Milne and Lynette Milne who always encouraged me to do my best and reach for my dreams. I believe that they would've been very proud and is celebrating this achievement with me.

ABSTRACT

Background

Bullying is a reality in working environments including institutions of learning and can thus impact negatively on the creation and maintenance of an environment as well as relationships conducive for effective teaching and learning. Bullying is seen as a type of workplace violence with literature revealing that bullying is seen as negative behaviour and treatment directed at a person or group. The literature also reveals that nursing students experience bullying form their fellow students, from the nursing faculty and in the clinical settings.

Purpose/Aim

The purpose of this study was to investigate bullying amongst nursing students in a private nursing education institution in Gauteng.

Method

This study used a qualitative descriptive design. Data was collected by in-depth face to face interviews asking three main questions.

Data analysis

Data was analysed through a thematic content analysis. Data was organised and a general sense was developed and then coded through developing words and phrases from the information collected. Themes and subthemes were identified and then linked to the research questions and objectives.

Setting

The setting for this study was a purposively selected Private Nursing Education Institution, attached to a private hospital group in Gauteng.

Main findings

Bullying was described by words like being "oppressed" or being "forced" to do something. All participants reported experiences of bullying in one form or another with psychological abuse as the most prevalent form of bullying. Communicating in Afrikaans and other African languages not understood by all students was experienced by some participants as racism and xenophobia. Some nursing students

felt that they were not part of the team and that there was no sense of belonging in the units where they have had these experiences. Participants reported that some of them felt comfortable enough to report on these experiences where as others did not feel comfortable reporting it. The participants who did not report it felt that they did not want anything to affect their studies or to be victimised

Key words

Experiences, nursing students, bullying, Private Nursing Education Institution

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

This chapter provides an overview of the study discussing the background, the motivation, rationale and significance of the study. In addition, the problem statement is given, purpose and objectives of the study are stated, operational definitions are given as well as a brief overview of the research design and method.

Literature reveals that workplace violence and aggression, such as bullying, is a global and national concern in nursing. Murray (2009) concludes that workplace bullying is a serious problem in nursing that cannot be ignored.

1.2 Background to the Study

According to the International Labour Organisation (ILO, 2012) workplace violence (WPV) is a worldwide phenomenon in contemporary workplaces which may result in many negative outcomes, if not addressed and managed effectively. Bullying in nursing is even more wide spread as what people think and it has been documented that even Florence Nightingale was a bully (Bostridge, 2008; Strachey, 1918). Nurses of lower social standing who worked with Florence Nightingale in the Crimean war reported that she was intimidating and domineering and treated nurses with disrespect and unkindness all of which constitute bullying (Bostridge, 2008; Strachey, 1918). Nurses are seen as subservient to others in the healthcare profession which gives rise to bullying from the people higher up in the hierarchical structuring of nursing.

Bullying is a form of WPV and a reality in many workplaces, including institutions of learning, and thus can impact on the motivation and productivity of staff members as well as on the performance of the students. This issue is addressed by Clark and Springer (2007), as cited in de Villiers, Mayers and Khalil (2014), who are of the opinion that uncivil behaviour, also known as bullying, has a negative impact on the academic setting which negatively affects both the teaching and learning environment. According to Kolanko, Clark, Heinrich, Olive, Serembus and Sifford (2006), problematic relationships amongst staff and students lead to poor work

performance, errors and accidents, and ultimately affect attrition and throughput rates as well (Hutchinson, 2009).

In a study done in the Western Cape by de Villiers et al. (2014) titled: *Pre-registration nursing students' perceptions and experiences of violence in a nursing education institution in South Africa*, revealed that nurses generally felt that violence was an on-going problem at the institution. Reasons for their perceptions of violence were grouped into ten categories namely theft and burglary, vandalism, physical fights, robbery, alcohol and drug abuse, racial tension, discrimination, no management supervision, feeling unsafe, and rudeness.

Carter, Thompson, Crampton, Morrow, Burford, Gray and Illing (2013) stated that even though bullying is rife and harmful to employees, it is still under-reported. In addition, the same authors argue that the eradication of bullying in the workplace will depend on understanding the reasons behind victims not reporting this problem. Furthermore, Carter et al. (2013) conclude that healthcare professionals have a duty to report any behaviour which can be classified as bullying to ensure a safe working environment, so that quality nursing care is provided. The same authors also identified that staff are of the opinion that they would be victimised if they reported bullying, and that there is lack of faith that the problem would be appropriately addressed (Carter et al., 2013).

Cooper, Walker, Askew, Robinson and McNair (2009) are of the opinion that educators who supervise students are the superiors while the students are the subordinates during the teaching and learning experience. Furthermore, the same authors concur that students have a need for support, guidance and respect, and if the bond between the teacher and the students is negative, their needs can be overlooked which in turn leads to the disempowerment of the student (Cooper et al 2009).

1.3 Motivation and Rationale for the Study

The researcher, as a nurse educator in a private institution of learning, has observed and experienced during the past year many situations in this work setting which can be classified as bullying. Bullying has diverse negative effects on the teaching and learning landscapes and therefore needs to be managed effectively. Managing bullying requires information and knowledge. Thus the researcher wanted to

investigate what the nursing students consider to be bullying, and what experiences they have had of bullying during their education.

1.4 Significance of the Study

This study will add to the body of knowledge regarding nursing education, nursing practice, educational and counselling psychology, occupational health and human resources management. The findings will provide evidence and guidance for enhancing positive practice environments for nurse educators, nursing students and other professionals in the field of nursing education. Bullying has diverse negative effects in the teaching and learning landscapes and therefore needs to be prevented and managed effectively. It is emotionally painful and hurtful as well as humiliating for nursing students to experience bullying. According to Condon (2014) the concern is if nursing students are exposed to bullying as part of the norm of the units, they in turn might adopt the same practice in the future and this might be difficult to escape from once it is embedded in their daily work activities (Condon, 2014). The findings of this study can potentially contribute to addressing and managing the problem of bullying in nursing practice and nursing education thus preventing nursing students becoming bullies themselves. It is envisaged that the information from this study can be used in revising the existing WPV policy and contribute to the implementation of zero tolerance to any form of WPV in the clinical and educational settings.

1.5 Statement of the Problem

Clark, Olender, Cardoni and Kenski (2011: 324) state, "Although incivility in the academic setting is not a new phenomenon, the types and frequency of this behaviour is increasing and have become a significant problem in higher education, including nursing education". International and national studies on bullying of nursing students have been described in the literature studies, albeit no literature was found on bullying in the private nursing educational institutions in South Africa. Thus the meaning that nursing students attach to bullying and their experiences of bullying in private institutions is not known. Anecdotal evidence and observation show that bullying does, indeed, take place in Private Nursing Education Institutions. Despite a policy being in place for the management of bullying in this work setting, the practice was still evident.

1.6 Purpose and Objectives of the Study

The purpose of this study was to investigate bullying in a private nursing education institution in Gauteng.

The research objectives were to:

- Determine what nursing students consider bullying to be.
- Describe the nursing students' experiences of bullying in the clinical and classroom/academic learning environment.
- Describe on how comfortable/secure the students feel about reporting bullying.

1.7 Research Questions

The questions below guided this study.

What do student nurses consider as bullying?

What are the experiences of student nurses with regard to bullying both in the clinical and in the classroom/academic setting?

How comfortable /secure do students feel in reporting bullying?

1.8 Research Design and Method

This study used a qualitative descriptive design. Data was collected by means of in-depth face to face interviews with nursing students who volunteered to participate in the study after ethical clearance and permission was obtained from the relevant committees at the University of the Witwatersrand and the private nursing education institution. A thematic content analysis was conducted which was then related to the research questions and objectives. A detailed description of the research design and method is discussed in chapter three.

1.9 Paradigmatic Perspectives

Paradigms are norms regarding different units and how they interrelate with each other or with norms for different systems which can be used for developing and testing theories about these units (Brink, van der Walt and van Rensburg, 2012). Brink et al. (2012) further explains that metaparadigms consist of a comprehensive

viewpoint of different fields of studies/disciplines which act as a guideline for the development of other models, paradigms and theories.

Peplau's Theory of Interpersonal Relations is applicable in this research study in the sense that positive interpersonal relations are required to ensure a positive experience during teaching and learning in nursing education (Peplau, 1952).

1.9.1 Meta-theoretical Assumptions

There are four main concepts agreed upon in health sciences metaparadigms, namely, "person, health, environment and action" (Brink et al., 2012: 26). This study is based on the researcher's meta-theoretical assumptions regarding these four concepts.

Person:

The "person" in this study refers to the participants (students), nurse educators (professional nurse who holds Nursing Education as an additional qualification) and clinical health professionals involved during the process of teaching and learning. The student as a person is a unique human being with his/her own needs that need to be fulfilled. According to Peplau's definition of a person, a person is an organism that strives to reduce its level of anxiety caused by its needs being unmet or only partially met (Peplau, 1952). If the needs of nursing students are not met during their nursing education experience, high levels of anxiety can result, impacting negatively on their performance or ability to function.

Nurse educators refer to the academic staff members responsible for the theoretical and clinical component of the programme which the participants are registered for. During this time, they work with other health professionals who are referred to as clinical health professionals and that make up the multidisciplinary team who work together to meet the needs of the patients. The interpersonal relations between these members need to be positive to ensure that an environment conducive to learning is created for nursing students.

Health:

According to the Oxford Dictionary (2012), health refers to the state of a person's mental or physical condition, or the absence of illness or harm. In the context of this study, health will refer to the participants' body, mind and spiritual health. Peplau

(1952) defines health as implied mobility of behaviour and human processes in the right direction in all spheres of life.

Bullying has negative effects on all of these aspects related to the health of the student, and can ultimately have an impact on whether the student will experience mobility in the right direction and successfully complete his/her studies.

Environment:

The environment, in the context of the study, will be the academic environment, be it in the clinical field, simulation laboratory or in the classroom. Peplau (1952) defines the environment as powers that exist outside of the person in a cultural context.

Educators need to ensure that an environment conducive to teaching and learning is created to enable students to be physically and psychologically receptive to the learning experience, and through creating this environment to ensure that the educational needs of the students are being met. This also includes creating a sense of safety, and building a teacher-student relationship which is built on trust.

Action:

In this study, actions refer to the activities which result in positive interpersonal relations during teaching and learning, in the context of nursing education. These actions can create a positive experience during teaching and learning and in turn lead to completion of the Bridging Course for Enrolled Nurses, resulting in registration as a General Nursing second year student is offered under Regulation 683 of the South African Nursing Council (SANC, 1989).

1.10 Operational Definitions

Bullying: Bentley, Cately and Cooper (2009) state that bullying consists of a variety of behaviours which negatively affect the person on the receiving end. These behaviours are done in a way that is not easily noticed by others, is non-verbal at times, and can be related to the job tasks or even based on personal feelings about the person. In addition, the same authors are of the opinion that bullying occurs when individual perceive themselves as being the target or at the receiving end of negative behaviour which persists over a period of time (Bentley et al., 2009).

Private nursing education institution: this refers to a nursing education institution that is not affiliated with the government. Such private nursing educational institutions provide training for nursing students in programmes accredited by the South African Nursing Council (SANC).

Nursing student: this refers to a student that is enrolled in one of the programmes that will lead to registration as a nurse Regulation 683 or Regulation 2175 (SANC, 1989 and SANC, 1993).

Bridging Course: is a short term that is used that refers to the programme for Enrolled Nurses which leads to registration as a general nurse on successful completion. This course is offered under Regulation 683 of the South African Nursing Council (SANC, 1989).

Regulation 683: this is the regulation relating to the minimum requirements for a Bridging Course for Enrolled Nurses Leading to Registration as a General Nurse or a Psychiatric Nurse (SANC, 1989).

Regulation 2175: this is the regulation relating to the course leading to enrolment as a nurse (SANC, 1993).

Nurse educator: a nurse educator (SANC, 2014) is a professional nurse who holds an additional qualification in nursing education which is registered with South African Nursing Council

Clinical Facilitator: a clinical facilitator is a professional nurse who holds an additional qualification in nursing education (SANC, 2014) who is responsible for clinical teaching and learning of nursing students.

Experiences: for the purpose of this study, experiences will refer to situations where a person has had contact with bullying or has observed bullying (Oxford Dictionary, 2012).

Psychological abuse: also referred to as emotional abuse, can be defined as instilling a sense of anxiety, guilt or fear in a person whether verbally or non-verbally and making unreasonable requests (Newfoundland Violence Prevention Initiative, 2014), i.e. any acts which impact on a person's sense of worth and self-esteem. This can include screaming, name-calling, criticism that is not constructive, insulting, threats and intimidation amongst others (Newfoundland Violence Prevention Initiative, 2014).

Physical abuse: is any action that can cause injury to another person, which includes grabbing, hitting, punching, pushing, and throwing of objects and the use of weapons amongst others (Newfoundland Violence Prevention Initiative, 2014).

Power abuse: can be defined as a leverage that superiors have on their subordinates and using it to the best interest of themselves, whether it impacts negatively on others or not (Tehrani, 2005).

1.11 Outline of the Research Report

Chapter 1: This chapter presented an overview of the research study.

Chapter 2: This chapter will make up the literature review. The researcher will discuss what is known or not known about bullying from published literature.

Chapter 3: In this chapter the researcher will discuss the research methodology, design, population, sample, and data collection.

Chapter 4: In this chapter the researcher will discuss the process of data analysis and the findings derived from the data analysis.

Chapter 5: This chapter will consist of the conclusions, summary, main findings, limitations and recommendations of this study.

1.12 Summary

It is evident from the literature that bullying in the nursing teaching and learning situation can take many forms and have negative consequences for the students.

In this chapter, a brief overview of the study related to the background, motivation for conducting the study, statement of the problem, research questions, purpose and objectives of the study, research design and method was done. A description of the paradigmatic perspectives and operational definitions pertaining to this study was also provided.

The next chapter will consist of a literature review related to different aspects of bullying.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature relevant to bullying and addresses the following focus areas: clarification of the concept bullying, workplace violence in the health care sector and nursing, prevention and management of bullying, quality learning and teaching environment and bullying as an occupational health concern.

Articles used for this literature review were selected from CINAHL, EBSCHO Host, PubMed and Google Scholar using the following key words: experiences, nursing students, bullying, private nursing education Institution.

2.2 Clarification of the Concept Bullying

According to the International Labour Organisation *SOLVE: Integrating Health Promotion into Workplace OSH Policies: trainer's guide* (ILO, 2012), bullying resorts under violence in the workplace. The ILO's SOLVE programme is a health and wellness programme specifically designed to assist in policy development and action implementation in the workplace. It mainly focusses on management of psychosocial issues such as workplace violence (WPV), and incorporates the promotion of health and wellness into occupational health and safety policies. The programme addresses the prevention of stressors related to work, alcohol and drug abuse, bullying in any form, HIV/AIDS prevention, as well as creating a workplace that is healthy and safe to work in. Another goal of this programme is to promote healthy lifestyles in the form of healthy nutrition, rest, sleep and exercise.

ILO/SOLVE also takes into consideration physical and psychological violence, otherwise known as emotional abuse. The *ILO Code of Practice on Workplace Violence and Measures to Combat this Phenomenon* defines work-related violence as any conduct which deviates from reasonable behavior and which can harm a person physically or psychology in some way including assault, threats or physical injury, to name just a few (ILO, 2012:114). ILO/SOLVE defines bullying/mobbing as, "Repeated and offensive behavior through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or a group of workers" (ILO, 2012:115).

The Chartered Institute of Personnel Development (CIPD) unpacks the definition of bullying by looking closer at the concepts that constitute bullying (Tehrani, 2005). Firstly, negative behaviours that can be classified as bullying could be intimidation, personal insults, work related harassment like withholding important information or expecting an employee to cope with an unmanageable workload, as well as social exclusion in the workplace. Secondly, persistence also plays a role in bullying. Negative actions should be persistent over a period of time to constitute bullying. Thirdly, these actions usually occur long term and are very seldom seen as bullying if it is a once-off occurrence. Branch, Ramsay and Barker (2013) as well as Matthiesen and Einarsen (2007) agree that bullying takes place over a time period and are not a once-off occurrence. Fourthly, it can result from a power struggle amongst employees. Tehrani (2005) stated that intent alone does not establish whether the actions can be classified as bullying, but rather the effects of the actions do. It could be unintentional bullying, which indicates that there was a lack of sensitivity or awareness of the negative effects that result from these actions (Tehrani, 2005). Rudeness and disrespect are among many other examples that are classified as bullying in the workplace (Luparell, 2011).

It is evident from the literature that numerous definitions prevail to describe bullying. Most of these definitions have similarities such as negative behaviours or treatment directed towards a person when the person cannot defend her/himself against it.

2.3 WORKPLACE VIOLENCE /BULLYING IN THE HEALTHCARE SECTOR AND NURSING

The healthcare sector is particularly vulnerable to violence in the workplace as is evident from the literature (ILO; ICN; WHO; PSI, 2002; Bostridge, 2008; Joint Commission, 2008 and Stelmaschuk, 2010).

2.3.1 Types of bullying

Bullying can take many different forms but can be categorized into two main types which are psychological and physical abuse/bullying. Psychological abuse, also referred to as emotional abuse, can be defined as instilling a sense of anxiety, guilt or fear in a person whether verbally or non-verbally and making unreasonable requests. The abuse of power can also fall under psychological abuse which is defined as a form of leverage that superiors have on their subordinates and using it to the best interest of themselves, whether it impacts negatively on others or not (Tehrani,

2005). Any acts which impact on a person's sense of worth and self-esteem including screaming, name-calling, criticism that is not constructive, insults, threats, and intimidation are regarded as forms of emotional abuse (Newfoundland Violence Prevention Initiative, 2014). Physical abuse is any action which can cause injury or harm to another person including grabbing, hitting, punching, pushing, throwing of objects and the use of weapons, amongst other things (Newfoundland Violence Prevention Initiative, 2014).

Cunniff and Mostert (2012) stated that bullying can be classified as either direct or indirect bullying. Direct bullying occurs face-to-face between the bully and the person on the receiving end whereas indirect bullying is not as obvious and can be harmful on a psychological level.

2.3.2 Nature and extent of bullying

A study done internationally by the ILO, International Council of Nurses (ICN), World Health Organization (WHO) and Public Services International (PSI) in 2002, found that more than 50 % of workers in the healthcare industry surveyed in eight different countries and spread across six continents reported that they had experienced at least one case of psychological or physical violence in the past year (ILO; ICN; WHO; PSI, 2002).

Table 2.1 below reveals that verbal abuse in the private health sector totaled 52 %, bullying 20.6 % and physical attacks 9 %.

Table 2.1: Results specific to South Africa

	Physical attack	Verbal abuse	Bullying/Mobbing
South Africa (Private Health Sector)	9.0 %	52.0 %	20.6 %
South Africa	17.0 %	60.1 %	-

It is evident from the literature that bullying in nursing shares many similarities with bullying in other workplaces. Bullying is common in professions or occupations that

are demanding and stressful on the employees (Di Martino, 2002). Health professionals spend most of their working hours in contact with people in distress which is very demanding and contributes to increased stress and tension in the workplace and which could act as generators of violence (Di Martino, 2002).

2.3.3 Causes and effects of bullying

Hutchinson, Vickers, Jackson and Wilkes (2008) and Johnson (2009) claim that tolerance of bullying behaviours, the power balance of authority, and the lack of proper implementation of workplace policies and procedures for addressing workplace bullying are the main organizational factors that lead to bullying in the nursing workplace (Hutchinson, Vickers, Jackson and Wilkes, 2008; Johnson, 2009).

It has been reported by biographers that even Florence Nightingale was seen as a bully. Nurses of lower social standing who worked with Florence Nightingale in the Crimean war reported that she was intimidating and domineering and treated nurses with disrespect and unkindness (Bostridge, 2008; Strachey, 1918). Exhibiting these behaviours not only causes physical and psychological harm to nurses, but also undermines the creation of a safe environment for patients and visitors (Joint Commission, 2008). Workplace bullying can also contribute to work errors and decreased satisfaction from patients which can result in an increase in healthcare costs related to medico-legal risks. Poor retention rates of nurses can also be correlated to workplace bullying (Joint Commission, 2008), contributing to the staff shortages already experienced in nursing in South Africa.

In a study done by Stelmaschuk (2010) in Ohio in the United States of America which investigated *Workplace Bullying and Emotional Exhaustion among Registered Nurses and Non-nursing Unit-based Staff,* found that physicians and registered nurses are the largest culprits of bullying behaviour in the health care setting. The same study reported that there is a positive link between bullying and emotional exhaustion, indicating that burnout can also result from workplace bullying. This then indirectly leads to an increase in staff absenteeism and increased staff turnover (Stelmaschuk, 2010).

The effects of bullying can lead to negative results. De Villiers et al. (2014) states the effects of bullying in the classroom can lead to loss of interest on the part of students and result in increased absenteeism rates during lectures as well as to students becoming intolerant of their peers who share the classroom setting with them.

Bullying in the clinical environment can result in high levels of anxiety on the part of the students, poor interpersonal relationships in the clinical setting, withdrawal from and intolerance of others (de Villiers et al., 2014). Kolanko et al. (2006) noted that poor interpersonal relationships among student nurses can lead to accidents, errors and poor work performance.

Clark, Nguyen and Barbosa-Leiker (2014) conclude that student nurses experience high levels of stress and adding the additional burden of bullying, can lead to a severe imbalance in psychological well-being. The same authors also state that some students choose to manage these stressors through a positive approach, seeking emotional support from their fellow classmates, working out schedules together to manage the large amount of work, sharing of difficult experiences, physical activity and spirituality to combat these stressors. Another means of coping is the use of alcohol and drugs, over or undereating, detachment, showing no concern for their studies and dropping out. Some students go into 'survival mode' to ensure that they pass their studies and they will go as far as cheating in their examinations to achieve this goal (Clark et al., 2014).

Johnson and Rea (2009) argue that bullying goes unreported by most victims due to fear, shame and a belief that nothing will be done. Felblinger (2008) explains that the reaction of nurses to bullying is unique because they feel shame when they are bullied; end up taking responsibility for the bullying as a result of believing it is their own fault, and thus decreasing the chances of fighting against it.

Carter et al. (2013) are of the opinion that healthcare professionals have a duty to report any behaviour that can be classified as bullying to ensure a safe working environment and quality nursing care. The same authors also indicate that staff is of the opinion that they would be victimised if they do report bullying and that there is lack of faith that the problem will be addressed appropriately (Carter et al., 2013). This indicates that there is lack of trust by staff members regarding the effective management of bullying. This may be the reason why so many incidences of bullying go unreported.

2.3.4 Prevention and management of bullying

The first step in solving the problem of bullying is creating awareness in the workplace. This can be done by developing educational programmes which focus on

bullying and the negative outcomes attached to it, so that healthcare professionals can be equipped to decrease this behaviour (Joint Commission, 2008; Johnson, 2009; Johnson & Rea, 2009; Rosenstein and O'Daniel, 2005).

Bartholomew (2006) is of the opinion that nurses and nurse managers need to explore and find ways to tackle this phenomenon in order to decrease bullying behaviours. The same author suggests that the process begins with an acknowledgment of the problem in the workplace culture, followed by interventions to support, educate, and develop a trusting work environment (Bartholomew, 2006).

Early detection of signs of bullying by nursing managers and supervisors in the nursing workplace can assist with effective interventions for individual nurses as well as with educating employees to improve their knowledge of bullying and its secondary impacts on quality of patient care, financial loss, and negative image of workplace (Lee, Lee and Nokes, 2014). Researchers indicate the necessity of educational programs that can be used to inform nursing staff of workplace bullying and in turn it can be prevented and addressed effectively (Demir and Rodwell, 2012).

2.4 Bullying in Nursing Education

Bullying can occur on different levels in nursing education. It may occur between educators and students, students and students, students and educators or even staff and staff which also includes administrators (Clark, Barbosa-Leiker, Gill and Nguyen, 2015).

A study done by Clark and Springer (2007) at the Boise State University in Idaho in the USA examined the perceptions of faculty and students of incivility (bullying) in nursing education and found that 71% perceived incivility as a moderate to serious problem and believed that stress, high-stake testing, faculty arrogance, and student entitlement contributed to the incivility. While mild levels of stress can act as a motivating factor to complete work, achieve results and meet deadlines, higher stress levels which are accompanied by ineffective coping mechanisms can result in effects such as anxiousness, defeat and severe tension. This is over and above the stress that students already experience from the challenging curricula and demanding coursework, complex material and stress that is experienced during clinical placement (Clark et al., 2014).

All this stress can result in physical and psychological illness and have a negative impact on the students' ability to meet the requirements as set out by their curriculum. Stress can also give rise to bullying amongst students in an attempt to get rid of high stress levels. A study done in Turkey found that verbal abuse is the most common form of bullying experienced by nursing students and found that most of the time their fellow students were the instigators of this verbal abuse (Celic and Bayraktar, 2004).

Cooper, Walker, Askew, Robinson, and McNair (2011) examined students' perceptions of bullying behaviours by nursing faculty at the University of Mississippi in the USA. The findings of this study indicated that the nursing faculty were the most frequently reported source for "three of twelve bullying behaviours" (Cooper et al., 2011:9). These behaviours include "(a) assignments, tasks, work, or rotation responsibilities made for punishment rather than educational purposes, (b) a bad grade given as punishment, and (c) unmanageable workloads or unrealistic deadlines" (Cooper et al., 2011:9). In this study the faculty were also found to be the number two source of "belittling or humiliating behaviour" (Cooper et al., 2011:9). This can be direct bullying or even being a witness of bullying within the teaching and learning environment. Students can be negatively affected, which in turn will impact negatively on the creation and maintenance of an environment conducive to learning and relationships necessary for effective teaching and learning.

It is important to know the impact of bullying in nursing education so that strategies can be developed and implemented to improve academic workplaces, the teaching and learning environment, retention rates of staff and students as well as to change the culture of bullying in the nursing practice (Clark et al., 2015).

A study done by de Villiers et al. (2014) titled: *Pre-registration nursing students' perceptions and experiences of violence in a nursing education institution in South Africa* found that students felt that violence is an ongoing phenomenon at this specific institution. The results of this study found that the most prevalent type of violence was related to verbal abuse, more specifically shouting, fighting, swearing and discrimination (de Villiers et al., 2014). Students (62.3%) reported that they have had an experience with violence with 46.2% experienced verbal abuse, 38.87% experienced threatening behaviour and 26% reported physical assault (de Villiers et al., 2014).

2.5 Quality Learning and Teaching Environments

2.5.1 Positive practice environments

The International Council of Nurses (ICN)'s fact sheet (2007) defines a positive practice environment as, "Settings that support excellence and decent work. In particular, they strive to ensure the health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations." (ICN, 2007:1).

According to the ICN (2007), a positive practice environment in the context of nursing students and nurse educators is characterized by having policies in place for effective management of occupational health, safety and well-being. Workloads should be manageable for both nursing students and nurse educators with adequate support from peers and effective management and leadership practices. Participation in work practices and in decision making must be fostered. The ICN (2007) furthermore states that there must be a positive work-life balance with equal opportunities and fair treatment of all in the workplace which includes opportunities for career growth and continues professional development. A positive practice environment allows for a certain degree of autonomy and professional identity in the workplace. Nursing students and nurse educators should feel a sense of job security with an agreed upon benefit and remuneration scale. Staffing levels must be of such to ensure provision of safe and quality nursing care with adequate support and supervision from seniors with adequate supply of stock and equipment. A system that allows for open communication and transparency must be in place (ICN, 2007).

There are many benefits of a positive practice environment. One in particular is that when nurses are satisfied in their workplace, the absenteeism decreases and staff turnover rates improve, more positive attitudes are observed which in turn improves productivity which has a positive impact on work performance (ICN, 2007).

The United Kingdom (UK) Professional Standards Framework for Teaching and Supporting Learning in Higher Education drawn up by the Higher Education Academy (HEA) and the Standards to Support Learning and Assessment in Practice by the Nursing and Midwifery Council (NMC) identified that educators need to advocate for students, develop the learning environment effectively and develop approaches to provide students with support and guidance (HEA, 2011 and NMC, 2008). The students' interest in learning must be maintained and they must be

assisted with engaging in the learning process. Poor motivation must be identified and addressed and inappropriate behaviour must be curbed. Students must be taught the value in becoming life-long learners (HEA, 2011 and NMC, 2008). All of these aspects contribute to the creation of an effective environment for teaching and learning to take place that is physically and psychologically safe for the student.

2.5.2 Clinical learning environment

A positive practice environment must also be created in the clinical learning environment. According to the Nursing and Midwifery Board of Ireland (NMBI) a quality clinical learning environment is an environment that is lively and vibrant and allows for some level of autonomy (NMBI, 2003). The NMBI (2003) furthermore concludes that the unit that the nursing students are allocated to allows for the sense of being valued as part of the team, which in turns motivate nursing students to deliver quality nursing care. In addition, the clinical learning environment must allow for adequate support structures, team coherence and positive team morale. This includes good communication structures and interpersonal relationships among all clinical staff and nursing students (NMBI 2003). The nursing student needs to be accepted as part of the team that can contribute positively to the workplace as well as quality nursing care (NMBI, 2003).

2.5.3 Classroom learning environment

A healthy and safe teaching and learning setting must be created in the classroom to ensure that the environment is conducive to learning. Health and safety does not only pertain to the physical environment, but to the psychosocial environment as well.

The environment where teaching and learning takes place is ideal when there is a non-threatening atmosphere with the absence of conflict and tension. This allows the learning experience to be more valuable and allows students to better reflect on the experience of learning (Quinn and Hughes, 2007).

2.6 Workplace Violence/Bullying as an Occupational Health Concern

2.6.1 The healthy and safe workplace

For workers/employees to flourish, be productive and experience work satisfaction a healthy and safe (physical and psychosocial) work environment is required.

According to the World Health Organisation (WHO) and the International Labour Organisation (ILO)'s Healthy Workplace Model (2010), the work environment consists of the physical and psychosocial environments. These environments must make up a healthy workplace for employees to perform at their best. A healthy workplace can be defined as a place where managers and employees work together to continuously improve processes aimed at protecting and promoting the health, safety and well-being of the employees. This includes the physical and psychosocial environment, proper organisation of work, personal health resources, workplace culture and community participation to improve the health of the employees and their families (WHO, 2010).

2.6.2 Bullying as a psychosocial hazard and risk

Bullying is a common practice in all workplaces as is evident from the literature, and from an occupational health perspective bullying is seen as a psychosocial stressor that needs to be identified and measures taken to prevent it and manage it. A study done in South Africa by the Work Dignity Institute (2000) found that 77.8% of employees had the impression that they had experienced bullying in the workplace (Cunniff and Mostert, 2012). The study done by Cunniff et al. (2012) which investigated the prevalence of workplace bullying of South African employees showed that 31.1% of the sample reported being bullied frequently in their organisations.

The work environment determines/influences the level of success and productivity of an employee. Employees can be exposed to a great amount of stress related to their role or function in the workplace, not to mention the devastating effects that workplace stress can have on an individual. According to Carter et al. (2013), bullying is one of the biggest factors that contribute to workplace stress and can have detrimental effects on physical and mental health. It can result in depression, the sense of helplessness, anxiety, suicide ideations, musculo-skeletal complaints and psychosomatic problems (Carter et al., 2013).

Apart from these effects mentioned above, bullying impacts on companies as a whole as it interrupts communication processes of the employees and creates a working environment of hostility which can be seen through evidence of distrust, apprehension, anger and suspicion of employees (Djurkovic, McCormack and Casimir, 2008).

According to the International Labour Organisation (2012) workplace bullying is a type of workplace violence which is becoming more and more widely recognized and has become a very widespread research topic in the last few years. Bullying, harassment, intimidation, mobbing and incivility at work can be defined as negative treatment in the workplace, which continues over a period of time, is systematic, and perceived as directed towards one or more people. These recipients of negative treatment also experience difficulty with defending themselves against the perpetrators of this negative treatment (Branch, Ramsay, and Barker, 2013; Matthiesen and Einarsen, 2007). Bentley et al. (2009) are of the opinion that when the environment has negative influences on the employees, they are more likely to become negative themselves and are more likely to start portraying negative behaviour like bullying.

Psychological violence is becoming increasingly recognized as a significant and wide-spread workplace phenomenon with a serious impact on work. In a study carried out by the US National Institute for Occupational Safety and Health it was found that there was bullying present in 24.5 % of the companies surveyed in the past year (NIOSH, 2004).

According to the International Labour Organisation (ILO)'s SOLVE: *integrating health promotion into workplace OHS policies* (2012), states that the effective management of workplace bullying should focus on prevention, rather than acting after it has already occurred. This can be done by managing the cause of bullying rather than the effects of it with a tailor- made solution for the context of that workplace. The prevention and solution implementation interventions should be done systematically at all levels and involve all those concerned in the workplace and not only management involvement (ILO, 2012).

2.7 Concluding this chapter as follows:

Bullying as a form of WPV is described as mean or humiliating behaviour form one person or group to another person/group resulting in psychosocial and physical health deviations such as anxiety, increased stress, even depression and muscular-skeletal problems. Research indicates that bullying may result in negative emotional reactions and distress in the clinical environment.

Workplace violence and bullying is particularly high in the health care landscapes worldwide. Bullying in the workplace is very rife as established from the vast amount of literature available on the phenomenon, more specifically in environments where employees experience high stress levels related to their daily responsibilities. Nursing is a profession which is very stress laden. Nurses attempt to find ways to deal with these high levels of stress which can give rise to bullying behaviour in many forms. Many times as deduced from the literature people bully others without the intension of bullying or causing harm to them, but more as a way of getting rid of excess emotions or as a coping mechanism. Others use bullying as a controlling mechanism and inflict harm to other employees through actions that impact negatively on their working environment. Nursing is a caring profession and it is assumed that nurses are caring individuals. However the possibility exists that nurses that have been bullied as a junior or a student nurse can become bullies themselves. This gives the impression that bullying has become a norm in the nursing profession.

Furthermore workplace bullying correlates with nursing practice errors leading to patient safety being compromised which can result in an increase in healthcare costs related to medico-legal risks. In addition poor retention rates of nurses can also be attributed to workplace bullying contributing to the staff shortages already experienced in nursing in South Africa. Bullying in the nursing education landscape can lead to students' low performance, absenteeism, low motivation and intolerance of other students with resultant negative effects for students and the nursing education institution.

Nurses in all categories are fearful of reporting these experiences with the concern that they will be blamed or victimised in the process. The perception of the cause and who the culprit is during bullying has become so skewed that the person on the receiving end of this behaviour starts believing that they are to be blamed for this occurrence. The concern remains that even with so many anonymous reporting structures, policies and programmes available to prevent this phenomenon; it still prevails in the workplace.

From a nursing education perspective a teaching and learning environment should be created and maintained that is non-threatening and conducive to learning. In

addition nurse educators should advocate for an academic and clinical setting that is free from bullying and other forms of workplace violence.

2.8 Summary

This chapter provided a review of the literature relevant to the concept of bullying, bullying in the workplace, bullying in clinical nursing practice, and bullying in nursing education. The management of bullying was also explored. The literature revealed that bullying is seen as a physical and psychosocial hazard and risk under the broader concept of violence in the workplace and therefore needs to be assessed and managed in the same way as other health hazards and risks. This chapter shows the deleterious impact that bullying can have in the workplace in general, nursing workplace as well as in nursing education and stresses the importance of the effective management of bullying to ensure effective harmony and teamwork in the working environment. The next chapter will describe the research design and method used in this study.

CHAPTER 3

RESEARCH METHOD

3.1 Introduction

In this chapter the following is described: research design and method, the research setting, population and sampling, data collection and data analysis. Furthermore the trustworthiness and ethical considerations pertaining to the study are discussed.

3.2 Research Design and Method

According to Grove, Burns and Gray (2013), a research design is a plan relating to how a study will be conducted. The research design serves as a guide for the planning and implementation of a research study to ensure that accurate results are achieved (Grove et al., 2013).

This study made use of a qualitative descriptive design. Grove et al. (2013) is of the opinion that qualitative research is systematic, interactive, and gives meaning to subjectively described life experiences. Qualitative data obtained from the participants will assist the researcher in promoting understanding of human experiences (Brink et al., 2012). This design was chosen for this study because in-depth face to face interviews provide information allowing comparability. Interviewing is also a flexible technique that can allow the researcher to explore greater depth of meaning which cannot be obtained with other techniques (Grove et al., 2013).

Data was collected by means of in-depth face to face interviews with nursing students who volunteered to participate in the study so as to ensure the most direct information was obtained from the participants (Brink et al., 2012).

3.3 Research Setting

The study was conducted at a private nursing education institution in Gauteng. This institution offers learning programmes leading to enrolment as a nurse; bridging courses for enrolled nurses leading to registration as a general nurse, 1st and 2nd year; an enrolled nurse upgrade programme; advanced diplomas in trauma and emergency nursing, critical care nursing, and pre-operative operating room and surgical nursing as well as in-service certificates and short courses. This institution

aims at educating an estimate of 688 students for the year 2016 excluding the students registered at the other four campuses across South Africa.

3.4 Population and Sampling

Grove et al. (2013: 44) defines population as "all the elements that meet certain criteria for inclusion in a given universe." The population consists of all nursing students of the private nursing education institutions in South Africa. However it was not feasible and realistic to include all, and therefore the accessible population were the students of the selected private nursing education institution in Gauteng. The accessible population consisted of students registered for the Bridging Course for Enrolled Nurses leading to registration as a general nurse second year on one campus of the private nursing education institution.

3.5 The Sample and Sample Size

Grove et al. (2013: 44) states, "A sample is a subset of the population that is selected for a particular study, and sampling defines the process for selecting a group of people, events, behaviours, or other elements with which to conduct a study".

According to Brink et al. (2012), sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest.

3.5.1 Sample size

The sample size of this study depended on the sufficiency of the responses, and data collection continued until saturation was reached. Monette, Sullivan and De Jong (2005: 242) state, "Sufficiency has been achieved when there are sufficient numbers to reflect the range of participants and sites that make up the population so that others outside the sample might have a chance to connect to the experience of those in it." According to Polit and Beck (2008) saturation means that no new or relevant data are emerging from the responses.

The researcher conducted fifteen (15) in-depth face to face interviews with the participants and was of the opinion that data saturation has been reached. The information given by the participants became familiar to the researcher and no new information came to the fore. Monette et al. (2005) indicates that when the researcher notices that the theme has been heard repetitively and no new

information is heard, then the researcher should contemplate concluding data collection.

3.5.2 Sampling method

The sampling method used in this study was purposive sampling which is a non-probability sampling method in which the researcher recruits and selects participants based on personal judgement regarding which ones will be more representative or informative (Polit and Beck, 2004).

Inclusion criteria were as follows:

Nursing students registered for the Bridging Course for Enrolled Nurses leading to registration as a general nurse second year student were chosen for this study because the researcher was of the opinion that these students could provide useful data related to their accumulated experience. The course is offered under Regulation 683 of the South African Nursing Council (SANC).

In addition, the researcher had no supervisory role with the selected student group.

3.6 Data Collection

3.6.1 Data collection instrument

To meet the purpose and objectives of the study as well as answering the research questions, the researcher developed an interview guide with three questions, namely:

Question 1: What do you consider as bullying?

Question 2: Tell me about your experience with bullying in the clinical and in the classroom/academic setting.

Question 3: How comfortable/secure do you feel about reporting bullying?

In addition to the questions above, demographic information was collected from the participants, namely age, gender, marital status and years of nursing experience (Annexure 5).

These questions were deemed valid by a panel of academic assessors of the University of the Witwatersrand.

3.6.2 Pre-testing of the questions

The interview questions were pre-tested on five students similar to those who would be used in the study but who did not form part of the sample group. This was done to determine clarity of questions and relevance of collected data to the problem. If the researcher were to notice that students were not opening up during the pre-testing of the questions, a research assistant would assist in conducting the in-depth face to face interviews. However, this was not necessary, as students felt comfortable and opened up during the pre-test interviews.

3.6.3 Data collection method

Data was collected by means of in-depth face to face interviews. The advantages of using in-depth face to face interviews are that the interviewer can have some influence over the outcome of these interviews (Brink et al., 2012). These interviews are more unstructured which allows the interviewer to probe for more information depending on the participants' replies to the questions (Brink et al., 2012). During such interviews there are interactional events that take place between the interviewer and the participant, and the interviewer attempts to understand the participant's response and experiences from their point of reference (Botma et al., 2010).

The disadvantages of using in-depth face to face interviews are that it becomes challenging to maintain the same degree of flexibility and consistency between the participants during the interviews (Botma et al., 2010). The quality of data received from the in-depth face to face interviews also depends on the communication abilities of the interviewer.

3.6.4 Data collection procedure

The participants were approached by means of a presentation on the study done by a colleague of the researcher. An information letter (Annexure 1.1), explaining the process of data collection, was handed out to the prospective participants. The purpose and method of the study and how confidentially and privacy would be maintained was also included. Then, in-depth face to face interviews were scheduled with the students willing to participate in the study.

Management of the institution provided a private room away from the immediate teaching and learning environment where the interviews took place. A more detailed information letter was then handed out to the volunteering participants indicating

more specific details of the study, as well as contact information of a counsellor available to them if the interviews triggered emotional distress (Annexure 1.2). The participants who participated in the study signed consent for participating in the study as well as for digital recording of the interviews (Annexures 2 and 3). It was envisaged that approximately 15 to 20 interviews would take place.

There were a total of 15 students who wanted to participate in the study. Each interview lasted between 9 and 30 minutes and these interviews were done over a period of three days.

The researcher established rapport by introducing herself and welcoming each nursing student to the session. She also thanked each participant for their willingness to participate and their time. The purpose of the interview, confidentiality and anonymity were confirmed and reiterated.

Interviews were digitally recorded for the purpose of transcribing verbatim during data analysis. The recording of the interview for participant 11 stopped during the interview due to a technical problem with the digital recorder. The researcher continued to make written notes of the interview.

3.7 Data Analysis

A thematic content analysis was conducted using Cresswell's (2009) method of data analysis whereby the researcher organised and prepared the data for analysis. This included transcribing the interviews verbatim and assigning numbers to participants for the use of direct quotes if the need arose.

The researcher then developed a general sense of the data through reading and re-reading until a comprehensive view was obtained from the responses. Notes were made in the margins. The researcher then coded the data (words/phrases) and identified key words or phrases from the information collected from the participants.

Themes were identified, classified and described based on the word/phrases with identified similarities. Themes and sub-themes were also identified by the researcher's study supervisor. The researcher and supervisor then finalised and agreed upon the themes and sub-themes.

The themes and sub-themes that emerged from the collected data will be presented, discussed, interpreted and linked to the research questions and objectives of this study.

3.8 Trustworthiness

In qualitative research, the trustworthiness of the data needs to be ensured. According to the Oxford Dictionary (2012), "Trustworthiness refers to the information being truthful, honest and reliable".

To ensure trustworthiness the researcher used the model proposed by Lincoln and Guba (in Polit and Beck, 2008: 539) to guide the study.

To enhance credibility, the researcher engaged with the collected data over a period of time. The researcher summarized what was said by the participants during the in-depth face to face interviews and repeated it back to them in her own words. This was done to ensure that the researchers' deductions of the responses were understood in the right context. The researcher scrutinised the data before coding to ensure dependability where after co-coding was done by the researchers' supervisor.

Confirmability was ensured through verbatim transcripts and digital recordings that will be kept to establish an audit trail. To ensure transferability, interviews continued until data saturation was reached. Even though only 15 interviews were conducted, the researcher was of the opinion that data saturation was reached. All participants reported similar thoughts and feelings during the interviews.

Authenticity (Polit and Beck, 2004) was enhanced through conveying experiences and feelings of participants as stated in their own words.

3.9 Ethical Considerations

The following ethical requirements were taken into consideration:

- Approval to conduct the study was obtained from the University's Therapeutic Sciences Postgraduate Committee (Annexure 6).
- Ethical approval/clearance was granted by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand. Clearance certificate number M160372 (Annexure 7).

- Permission was requested from and granted by the Research Operational Committee of the private nursing group to conduct the study (Annexure 8).
- Written informed consent was obtained from the participants for the study and digital recording of the interviews (Annexure 2 and 3).
- Confidentiality and anonymity were maintained for the participants and institutions through allocating numbers rather than names to the participants. Participants in the study will be referred to as participants 1 – 15.
- Non-maleficence was ensured by ensuring that the participants academic progress or work related progress was not be affected by participating in the study, and that no harm was done to them through participation in the study.
- The information letter indicated that the participants had a choice to participate and could withdraw at any stage of the research process.
- The researcher did not have any supervisory role for the Bridging Course for Enrolled Nurses leading to registration as a second year general nurse student.
- The name and number of a counsellor was provided in case of emotional distress (Annexure 1.2).
- Transcriptions of the interviews were transferred to a flash drive and removed from the researcher's computer.
- All hard copy data sheets and flash drives were sealed in an envelope and placed in a safe in the Department of Nursing and will be destroyed three years after publishing the report.

3.10 Summary

In this chapter, the research design and methods were discussed. This included a description of the research setting, population, sampling and sample size, data collection, data analysis, trustworthiness and ethical considerations for the study.

In the next chapter the study findings will be presented and discussed.

CHAPTER 4

PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter describes the findings of the in-depth face to face interviews that were held with the participants for the purpose of investigating bullying in a private nursing education institution in Gauteng. Supporting and contesting literature related to the research questions that were asked to the participants will be discussed in this chapter.

4.2 The Participants

Fifteen second year students from the Bridging Course for Enrolled Nurses leading to registration as a general nurse participated in the study. Nine were female and six were male. The average age of the participants was 32.6 years and ranged between the ages of 23 and 45 years. The majority of the participants (n=9) were married. The average years of nursing experience was 7.7 years and ranged between 4 and 15 years. The demographic data is presented in table 4.1 below.

Table 4.1: Demographic data of participants

Participants	Age (years) (Average age = 32.6 years)	Gender	Married	Years of experience (Average = 7.7 years)
Participant 1	31	Male	No	7
Participant 2	33	Female	Yes	8
Participant 3	40	Female	No	15
Participant 4	32	Male	No	5
Participant 5	37	Female	Yes	5
Participant 6	30	Male	Yes	9
Participant 7	26	Male	No	5
Participant 8	45	Female	Yes	4
Participant 9	37	Male	Yes	14
Participant 10	25	Female	No	6
Participant 11	23	Male	No	4
Participant 12	33	Female	Yes	9
Participant 13	39	Female	Yes	13
Participant 14	30	Female	Yes	6
Participant 15	29	Female	Yes	6
	Range: 23 – 45 years	Female = 9 Male = 6	Married = 9 Not married = 6	Range: 4 – 15 years

4.3 Themes and Sub-Themes Arising From the Findings

According to Botma et al. (2010), a theme is a repeated consistency that emerges from the data which brings meaning and identity to the applicable experience. The themes that arose from the data were experiences of abuse, attitudes towards nursing students, and reporting bullying, as is reflected in diagram 4.1 below.

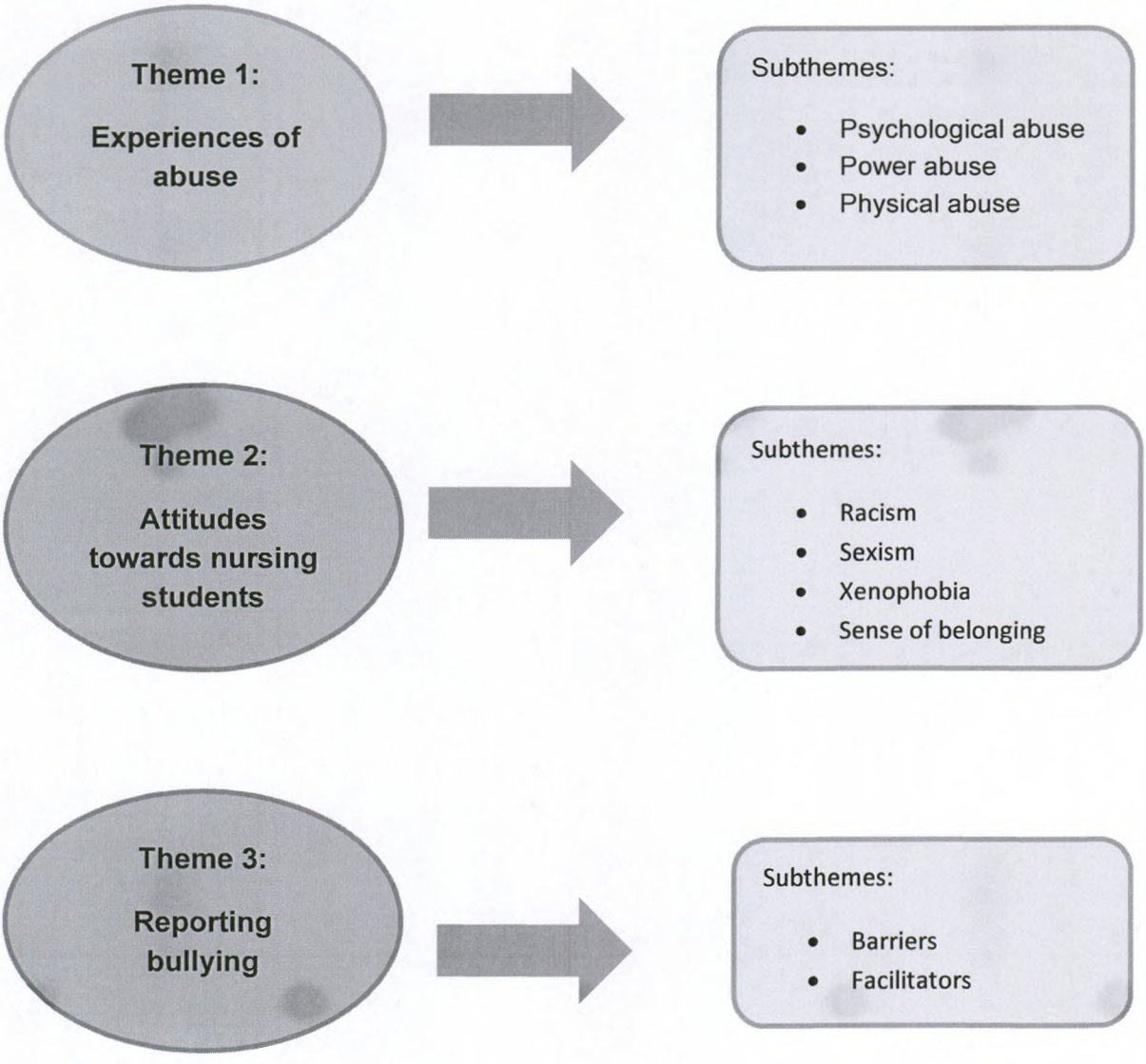

Diagram 4.1: THEMES AND SUBTHEMES

Theme 1: Experiences of abuse

This theme derived from the participants' responses to question 1 and 2 and was related to their experiences of abuse. The subthemes: psychological, power and physical abuse were the pertinent areas reported on by the participants.

The participants used words and phrases such as "*overpowering, oppression, having no choice, abuse* and *force"* to describe the meanings they attach to bullying.

"I think I consider bullying as overpowering somebody...Because people they have that tendency to abuse students or mishandle them or do whatever they want to do. Over-delegate or whatever" (P2).

A participant also mentioned that that she/he was forced to do nursing interventions outside her/his scope of practice:

"My opinion, bullying is when you are being oppressed, like, they don't give you a choice, they don't give you a choice to do what you want to do. They force you to do something that you don't want to do. That is bullying for me…..I am an EN (enrolled nurse) by the way, in fact me working with a ventilated patient is above my scope of practice" (P4)

"Well I think it is if maybe somebody is like undermining you or trying to force you to do something that you don't really want or don't understand or pushing you in the wrong direction…..But if you refuse then they will call your CF (Clinical Facilitator) *and threaten you that they're going to phone the college that you are not like; they will discontinue your course or something" (P6).*

"Bullying for me it can be someone who wants something from you, forcing you to give it back to that person" (P15).

The participants reported on their experiences and used words like *"shouting at me"* and *"making belittling remarks"* in front of patients and visitors when they have done something wrong. This in turn leads to loss of trust in that specific staff member on the part of the onlookers. There were reports regarding the use of different languages, especially Afrikaans, which is used during hand-over of patients to the next shift that comes on duty.

"Treatment that we get in the hospital which is actually not satisfactory, for example,

like I said earlier on, doctors who wrote a prescription in Afrikaans……I was working in the paediatric ward. So, there was a teething ointment that has to be applied on the babies' gums. So, luckily the mother was there, I asked her will you please give it to the baby, then she immediately grabbed it and applied it and I said, no, not there. Luckily she applied it already; okay she knows where to apply it. If it was me truly speaking, I was going to apply on the eyes, because of that Afrikaans words that was written there" (P1).

"The other thing is like; I'm not being racist, but language use, because in some other wards where you go, they will give hand over in Afrikaans" (P5).

"…..she followed, then she shouted and shouted and shouted…" (P11).

"…and then the word…., it's a big insult. You know. Gatvol…..If I translate it in my language, I won't even speak it, I wouldn't even say that to people, like somebody, you know, you make me gatvol" (P12).

Some participants experienced the bullying as traumatic and emotionally painful, as is evidenced by the descriptions of their experiences.

"She was just like, I mean, you don't know, you cannot do this, you cannot, she was just going on and on and you know, I walked away, I was in so much tears and I was like, why you always treating me like this?" (P8)

"…. we know you mos dom, we already find it we already used it then you like when then the doctors will laugh at you they make a joke of you that they know you will take forever we send someone clever and get it" (P15).

The participants reported that another aspect of bullying that they had experienced is over-delegation of duties, threats, and working in a hostile environment where they are forced to do things that they do not want to do or even forced to perform duties that is not within their scope of practice according to Regulation 2598 of the South African Nursing Council. Reports of *"unfair treatment", "oppression"* and working in a *"hostile environment"* were shared by many of the participants.

Even though psychological abuse is the most prevalent, physical abuse was also reported by participants. Others reported that their health and safety was put at risk which gave them the feeling of not being cared for by their superiors.

"But for some of the students that they don't know Afrikaans, they will get stuff thrown at them…..like theatre equipment" (P1).

"Then she said just update the board and I did not know if, what was I supposed to do. Another one was throwing files" (P2).

"Ja, so I had to go and look for the mask, I have to go to the waste, luckily there is a truck mos that collecting, so the truck was not yet there. Then I ask the guy who was working for the truck, I have to open everything. I'm putting myself at risk with my pregnancy, then we go and open and put back the plastic, because this thing has been parked. We just put on mask and gloves just for me to find the mask, like luckily enough I did find the mask then I took the mask then I go and wash it, then I send it to CSSD and I told her that I did find the mask…..We just throw everything here and then just took the file, I went to submit the file for the patient, that every time after the [inaudible] of the patient, of the deceased, we just go to her check if all the things are done properly, just throw the file at me…..I can say that, like, she pointed her finger on my forehead. Yes……Yes, she did, she did, you know, I was so so so angry" (P12).

"…and I told the sister, "No I'm not going to go to sacrifice my health like that, no I don't know I wasn't taking blood to test if I got any cancer before, I don't know if the theatres is going to expose what I have already to, that is why they did blood tests first and I had to sign a warning….." (P13).

"With the matrons especially, we have one particular matron, she's the night matron, she's for ever, she sometimes gets physical with other people……...So, the other day she walked in on us, we were sitting with this other lady, she punched the lady's shoulder, like so bad" (P14).

Theme 2: Attitudes towards nursing students

The subthemes that emerged from the participants' responses are racism, sexism, xenophobia, and a sense of belonging. Many of the participants felt as if they were discriminated against due to the colour of their skin, stating that the doctors preferred doing rounds with white nurses. According to Participant 1, the doctors prefer the white nurses because they are able to speak Afrikaans and some doctors even go to the extent of not greeting if it is not a white nurse. It is reported that white nursing students are also treated differently from black nursing students, in the sense that

discipline is not fairly applied across all races. The participants did not make many references to the classroom situation, however, the one participant indicated that one of the nurse educators on entering the classroom made it clear that she is already qualified and that is the students choice whether they want to listen or not.

".....most of them they don't know Afrikaans, so it becomes a problem when the doctors prescribe medication and they don't actually issue that medication or they don't actually understand at all and they don't even end up ordering that type of medication and the next thing the doctor becomes so furious, and then he becomes, it becomes unfair for black students ag black nurses and also choose the white nurses, he tends to favour white nurses more than black nurses, that is what I have noticed.....Bullying, most of the doctors they prefer white white white nurses, because of the Afrikaans when they give, when they give, request it's through uh Afrikaans, and they you'll find such doctors, they come in the ward, if they don't see a black ag a white nurse they don't greet.....or she will yell at you the worst part in front of the patient....but it's a white student come here come here, they will go to the side and speak to them the student"(P1).

One participant specifically isolated the fact that the nursing profession is dominated by females which posed a challenge for him. He stated that female nurses are more "emotionally" inclined which impacts on the way they treat other nurses, and this is also mainly the reason that male nurses attempt to escape from bedside nursing to specialities that are more male dominant like theatre or high-care units.

"What happened was, you know, this profession is female dominant.....We are not emotionally, like if you do something to me now, as a male, by tomorrow probably I would have forgotten about it and then it is out of my system. I even forgot that you did that. But with females, if you make one mistake, oh, they will make you crazy....." (P7).

"Well, if you are in EN, I believe that by that time, especially if you study with [name], you should know that is the procedure. But it is like I am asking for something impossible. They will do it probably once or twice and never report it. I will need to go back and see if it had subsided or what. But that is how it happens. But if, what is funny is, maybe a BC 1 (Bridging Course First Year Student), *who is a female, would ask for the same thing, it gets done. But when I ask for it as a male, I do not if they are attacking me, the character me, or they are attacking the gender.....then you start*

wondering, is it because I am a male, is it because, is it my character, what I am doing to these people that they treat me this way…..Let us say that you truly did something wrong. If a female does the same thing. In a week or two, ah, it is okay tjommie, it is fine, it is over. But with you, oh, they will hold a grudge. You see, you should not be here" (P7).

Two participants highlighted xenophobia which is the fear or dislike of foreigners. Participant 8 specifically mentioned that other languages, in this case Zulu, were used during handover of patients even though the registered nurse knew that she did not understand Zulu.

"I'm a Nigerian….. So and when it was time to, I mean, for the handover, she was saying it in Zulu" (P8).

"From my point of view I can see sometimes there is a bit of xenophobia, not like on television where they hang each other….. but there is a bit of a resistance to whatever you say, and it's going to take time for me to trust you maybe before I'll start complying to whatever you are saying…..Especially, I'm not being racist or anything, but the black people as well, you can see a bit of Xenophobia even sometimes in class" (P9).

Participants also reported that they were treated in a way that was unacceptable, specifically stating that they were not treated as human beings. They did not feel accepted as part of the team, felt isolated, and feared asking for assistance. Amongst some of the causes that contributed to the lack of a sense of belonging was not being orientated to the units, people speaking in languages other than the accepted language (English), and being shouted at.

"But the way that the sister was dealing with me it was just unacceptable. I was not happy…..because as students we go through a lot of pressure in different wards, but that day, it was the worse day of my nursing career" (P2).

"They don't treat students, agency staff as part of the team. They will make you feel isolated; they will make you feel that you don't know anything…..What quality of nursing are you providing to the poor patient, because you are just working for the sake of let the shift finish……These days, I don't see people being orientated. You need to know where stock room is and the doctor will be coming, wanting to do this procedure, the shift leader will be shouting at you forgetting that you were not

orientated" (P3).

"Like, they don't feel welcome, because they don't understand what they are saying, yet they want to be part of the team, but they can't be part of the team, because of the language…..I was there physically, but I didn't even know what they were saying….." (P5).

"I felt like okay this is student we don't have uhm what nobody consider us like, I can't say human beings but nobody considers us like an individual that makes a change somewhere" (P13).

"You know our CF, for my side, when I report to the CF they are there for us, so if someone it is like I am reporting something to my mother and she is not takes doing anything, will another person care if my mother didn't care enough to stand up for me? They are there for us as students, so if the CF didn't do anything what's another person going to do?" (P15).

One participant had this to say about the actual classroom setting: *"The teaching situation. The one part that I don't like the most is some of the lecturers when they walk into class, before they give you a lecture, the first thing they'd say is, I have my epaulettes, so it's your choice, it's either you listen or you don't. What you do is entirely up to you; yes I already have my epaulettes. For me that's a sign that says, I don't care what you do. They actually don't want to be here. Yea, so that is the worst" (P14).*

Theme 3: Reporting bullying

The subthemes derived from this theme are related to the barriers and facilitators of reporting bullying. Eight of the participants stated that they felt confident in reporting their bullying experiences but not without experiencing some barriers. Participants reported that even though they reported it, nothing is done to the situation, and stated that that it is just the "culture" of that unit. Other participants stated that they didn't feel comfortable reporting their experiences. They felt afraid that their studies might be affected if they did and would rather just keep quiet for the sake of completing their studies.

Participant 14 was of the opinion that it is the norm for students to be treated in that manner; that bullying has not been managed effectively up until now, and did not

believe that it would be managed effectively in the future.

"Yes, because I think I am confident enough and I can stand up for myself....but I felt I was treated unfairly.....I went there. I reported the matter. I was very emotional that day....So she was surprised and she said next time I should not just keep quiet and let the day run without, if I am unhappy about something and then that is how and then the sister, the unit manager said she will not take sides and she spoke and said she cannot allow that because in the meeting where they have, where they give feedback to the matrons everyday students, the unit manager for the students will talk about experience that day. Students have in different units and if it is a negative experience, obviously it is going to affect that they do not allocate students in the unit. It is going to give a unit as casualty a bad name and she cannot allow that to happen" (P2).

"I do report.....If I am not being called, to say come and let's solve the problem that means nothing is being done about it" (P3).

"I personally, if I'm bullied, I wouldn't be afraid to verbalise, but I think in some other people's situations they're afraid to be victimised or maybe that stigma that you told on this, like maybe I tell on a manager, that you know this person she doesn't treat me nicely, one two three, one two three, then bad things start to happen" (P11).

"At time I wanted to leave, you know, I called, there is this counsellor for us, ICAS (Independent Counselling and Advisory Services), *they wanted to, but they didn't help me much because they wanted to find out the situation where I'm working, how they can assist me, I tell them, I tell them about my patient, then the situation that I'm working in, they were more touched than I am, like, so it means that I have to counsel them, so each and every time when I have a problem, then my seniors are like, just go to ICAS, and I'm like, it's not helping, I'm not getting any help from them.....the matron come to the unit manager during hand over to everybody and talk, but you see, these people now, this one is everywhere, they can't talk directly, when they come they come and you did something I'll come and generalise. I'm supposed to call you straight that [name] you did one two three, right and don't do one two three" (P12)*

Participants verbalised that they were uncomfortable and afraid to report bullying because of being a student and wanting to finish their studies.

"I was uncomfortable. I wanted to, but I was afraid, because of my position……Because I am a student and another , they were all managers, they all knew like, according to me , they all know that [name] policies they must all speak in English, but, it was like I'm not even there" (P5)

"That's why, most of the time, even if they bully you, you will just try to cooperate so that at least you are in in training, you can just finish the course. And just go with the flow….. Because of you are afraid that, especially from my experience as a student, you are more scared of your studies like, they are going to take your studies away from you. So you just carry on being abused in the ward. Just for the sake of having your studies to get through" (P6).

"I never reported it anyway because, where would I reported it….. and I didn't want to come to the college it will go over and I feared it would affect my studies" (P13).

"It's not really as easy for students to do, we have to go as well via our CF's and when you tell your CF that this is what I've experienced, then she'll tell you, we tried, we tried talking to this person, we tried working on that, but nothing has been done until now. I mean, taking it further it won't help. It means actually they did try. So it's just the culture of the unit…..even if you report it, some days, no, there is nothing we can do about it, we, you get instances where even your CF can't help you, because it is something that the unit manager herself has battled to handle herself, like for a very long time. So it's like the norm in that ward that the students get treated in that manner" (P14).

4.4 Discussion of the Findings

The identified themes were experiences of abuse, attitudes towards nursing students and reporting of bullying. Bullying was described by words like being *"oppressed"* or being *"forced"* to do something. All participants reported experiences of bullying mainly in the clinical field in one form or another with psychological abuse as the most prevalent.

The findings indicate that psychological abuse is very prevalent, which is supported by Di Martino (2002) in a study titled *"Workplace violence in the health sector"*, who conducted country case studies in South Africa, amongst other countries, and included staff from all major disciplines of the health sector, found that amongst the different types of violence; psychological violence is the most widespread with verbal

abuse being the main problem. The findings from Di Martino's (2002) study showed that 60.1 percent of employees experienced psychological violence. The findings of this study is in agreement with Di Martino's (2002) findings of psychological violence and is evident in the majority of participants reporting on their experiences of verbal abuse.

The Chartered Institute of Personnel Development (CIPD) identified four groups of negative behaviours which are regularly linked to bullying, one of which is personal insults like humiliation, mockery or belittling comments (Tehrani, 2005). Bentley et al. (2009) indicates that undermining and belittlement are the most damaging to the people on the receiving end and impacts negatively on their ability to effectively cope with bullying. The risk of bullying in the health sector is specifically high and is said to be part of practice because of the close contact with people who are experiencing distress, and bullying is seen as a part of the job that one cannot escape from (Di Martino, 2002). One participant reported on being called *"dom"*. As is expected being belittled can create a sense of fear in a person when they want to contact the doctor to confirm a prescription that is not understandable to them. In turn this can lead to medico-legal risks.

A participant felt that some medical practitioners make "a joke of you" and laugh at your expense. A study conducted in Egypt (2012-2013) among 722 nursing students on the *Perceptions of student nurses' bullying behaviours and coping strategies in the clinical setting* revealed that 33.7 % of nursing students perceived that inappropriate jokes were made about them in the clinical setting (Mabrouk Abd El Rahman, 2014).

Two of the negative behaviours that are linked to bullying as identified by the CIPD are intimidation and work related harassment. Threats, psychological intimidation and exploitation of power and position are examples of intimidation, and work overload is an example of work related harassment (Tehrani, 2005). In this study some of the participants reported that they are allocated too many patients to care for during their shift or even allocated work that is not within their Scope of practice to perform. It was reported that the registered nurses over delegate to the students and then only allocate themselves a small number of duties or patients for the shift. This indicates the inappropriate use of their power and position.

Compared to the amount of responses regarding psychological abuse, it is evident

that physical abuse does not happen that often. This is supported by Di Martino (2002: 5) who states that, "Psychological violence is more prevalent than physical violence". The participants felt that their health was put in danger when they were asked to perform duties that are not usually required by a nurse to do before they have received adequate training or screening to do so. Tehrani (2005) indicates that bullying can have an impact not only on the target, but on the individual bystanders and the organisation leading to absenteeism, increased staff turnover, decrease in productivity, increased costs related to litigation, and a loss of staff and productivity amongst many others.

Compared to other racial groups, black employees reported more bullying. Di Martino (2002: 12) highlights that racism or racial harassment is any action or conduct based "on race, colour, language, national origin, religion, association with a minority, birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work". In this study there was evidence that some doctors even write prescriptions in Afrikaans which can lead to medico-legal risks in the unit even though the business language of the country and the language policy of the Healthcare Group is English. Xenophobia can be defined as hatred against people from another country (Oxford, 2007). The presence of xenophobia and racism indicates that there is still a troublesome relationship between different racial and ethnic groups, which stems from the apartheid era in South Africa (Di Martino, 2002).

One male nursing student reported experiencing sexism which is the judgement of somebody based on their sex (Oxford, 2007). This experience could be related to males being the minority in a female dominant profession. It is stated by Eriksen and Einarsen (2004) in a study regarding gender minority of Norwegian assistant nurses, that the quantity of males exposed to bullying during a period of 6 months was greater than double (10.2 %) of that reported by females (4.3 %). However, it was only one male that reported on this experience during data collection for this study.

In a study done by Thomas and Burk (2009) titled: *Junior nursing students' experiences of vertical violence during clinical rotations* indicated that nursing students are constantly faced with a range of injustices from other staff members such as being ignored and belittled, untruthfully blamed for happenings, humiliated in front of others, and being made to feel unwanted as a team member. These type of contraventions has led to the belief that even though nursing is a caring profession,

the people providing the care, are not as caring as they should be, and it is often said that nurses "eat their young" (Thomas et al., 2009). Hence, an increase in absenteeism, high staff turnover, increased sick leave, poor motivation and decreased productivity as well as dissatisfaction in the workplace. This ultimately results in a decline in the quality of care and impacts negatively on the reputation of the health care institution (Di Martino, 2002).

The first two themes, experiences of abuse and attitudes towards nursing students, are supported by a study done by de Villiers et al. (2014) on the perceptions and experiences of pre-registration nursing students in a nursing education institution in the Western Cape regarding violence which revealed that nurses generally felt that violence was an on-going problem. Types of violence reported were grouped into different categories (de Villiers et al., 2014) of which physical fights, racial tension, discrimination, lack of supervision, feeling unsafe and rudeness were also experienced by the participants in this study in one form or another.

Bullying goes under-reported in South Africa, specifically psychological violence (Di Martino, 2002). The majority of cases that are reported are not solved satisfactorily, nothing is done to correct the behaviour of the perpetrator and the victims' feel dissatisfied with how the whole process is managed (Di Martino, 2002). Carter, Thompson, Crampton, Morrow, Burford, Gray and Illing (2009) state that even though bullying is so rife and harmful to employees, it is still under-reported. In addition, the same authors argue that the eradication of bullying in the workplace will depend on understanding the reason behind victims not reporting this problem. Furthermore Carter et al (2009) conclude that healthcare professionals have a duty to report any behaviour that can be classified as bullying to ensure a safe working environment and quality nursing care. The same authors also identified that staff is of the opinion that they would be victimised if they did report bullying, and that there is lack of faith that the problem will be addressed appropriately (Carter et al., 2009).

The participants stated that they felt that bullying was just part of the "culture" of the units they worked in, and that the unit managers and clinical facilitators could not always manage their concerns related to bullying because of this "culture", or even due to having more personal relationships with the culprits. This is supported by two studies which state that if bullying continuously occurs in the workplace without intervention, it actually will become the norm and can continue indefinitely (Branch et

al., 2007; Hoel & Beale, 2006). According to Condon (2014) the concern is if nursing students are exposed to bullying as part of the norm of the units, they in turn might adopt the same practice in the future and this might be difficult to escape from once it is embedded in their daily work activities (Condon, 2014). Students feared reporting bullying because it might affect their studies. This is supported by Carter et al. (2013) who found that staff showed scepticism regarding reporting of bullying because of a lack of confidence that the policy would be implemented effectively to deal with their concerns and fears of being victimised. Responses from employers, when bullying is reported, have proven over and over to be inadequate to deal with the problem of bullying (Bentley et al., 2009). This indicates that there is lack of trust from staff members in the effective management of bullying. This could also be the reason why so many incidences of bullying go unreported.

It is important to note that these nursing students are the future of the nursing profession, and if bullying is taking place this can result in a more severe lack of human resources than what is already being experienced. Students need to be taught how to effectively manage the stressors that accompany teaching and learning. Fostering civility on the part of the nurse educators can assist students in coping with these stressors, so creating a teaching and learning environment which will help students excel in their studies.

4.5 Main Findings

The main findings according to the thematic content analysis was that nursing students had similar ideas of what they consider as bullying, using words like being "oppressed" or being "forced" to do something. The participants reported their experiences when asked what they consider as bullying. The first theme derived from the participants related to having been bullied in one form or another, was that psychological abuse was the most prevalent. Power abuse and physical abuse, however, were also experienced by the participants.

The second theme was related to attitudes towards nursing students. Participants reported racism, specifically stating that white nurses were preferred over other racial groups and that the use of Afrikaans in the clinical areas was very prevalent. Sexism was also reported by a male participant who felt that females are too emotional and treat males differently than what they treat their fellow female colleagues, which causes male nurses to flee to disciplines which are more male dominant.

Xenophobia is another sub-theme that was reported. Participants reported that nursing staff use African languages not understood by foreign nursing students, and that even though the nursing staff know that these nursing students do not speak those languages, they still continue communicating in those languages.

These nursing students felt that they were not part of the team and that there was no sense of belonging in the units where they have had these experiences. According to Kolanko, Clark, Heinrich, Olive, Serembus and Sifford (2006), problematic relationships amongst staff and students lead to poor work performance, errors and accidents, and ultimately affect attrition and throughput rates as well (Hutchinson, 2009). The researcher supports the viewpoints of these authors.

The third theme derived from the data is related to the reporting of bullying. Participants reported that some of them felt comfortable enough to report on these experiences where as others did not feel comfortable reporting it. In some cases when it was reported, the problem was sorted out in the best interest of the nursing students, but in majority of the cases, the nursing students reported and nothing was done to solve the problem. The participants who did not report it felt that they did not want anything to affect their studies or to be victimised. They seemed content with their decision as long as it meant that their studies were not affected in a negative way. It is evident that there were some facilitators and barriers that impact negatively on the reporting of bullying.

4.6 Summary

The findings in this chapter were presented according to themes and sub-themes derived from face to face interviews held with the participants. Supporting and contesting literature related to the research questions was also discussed

The final chapter will complete the research report with a summary of the main findings, a discussion of the limitations of the study, and recommendations made for nursing education, research, and nursing practice.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter of the research reports on the conclusions and limitations of the study, and recommendations for nursing education, research and nursing practice are made.

5.2 Conclusions

It is evident from the interviews conducted with second year students in the Bridging Course for Enrolled Nurses leading to registration as a general nurse, that they experienced workplace violence in the form of bullying, mostly in the clinical setting and to a lesser degree in the educational (college) situation.

Bullying has diverse negative effects in the teaching and learning landscapes and therefore needs to be prevented and managed effectively. It is emotionally painful and hurtful as well as humiliating for nursing students to experience bullying.

Students are reluctant to report bullying because of fear for reprisal, and they are willing to endure the bullying and its negative effects for the sake of completing their studies.

5.3 Limitations

Grove et al. (2013) defines limitations as constraints that limit a research study which can have an impact on whether findings can be generalized, or not.

Only participants that were registered for the Bridging Course for Enrolled Nurses leading to registration as a second year general nurse at this private nursing education institution were included in this study; therefore the findings cannot be generalised to include nursing students registered for the same course at other private or public nursing education institutions.

The research study was of a qualitative, descriptive design and even though the researcher transcribed the interviews verbatim, there is still a possibility that the interpretation of the data might differ from what can be conceived of as the true meaning. However, the researcher is of the opinion that supporting evidence from the literature study has revealed that the themes and sub-themes derived from the

data are authentic and can well be the true reflection of what was meant in the in-depth face to face interviews.

Data was collected by interviews only, and therefore no triangulation took place. Information collected through questionnaires, interviewing of other key informants and obtaining statistics from occupational health nurse practitioners, in service, could have added richer information to the study.

5.4 Recommendations

5.4.1 Recommendations for nursing education

The elimination of bullying in nursing education should start by ensuring that all stakeholders know what behaviours constitute bullying and which behaviours will not be tolerated in the teaching and learning environment, whether it is at a private nursing education institution or in the clinical setting.

Even though the private hospital group have a policy in place, many of the participants were not even aware that such a policy exists. As part of the employee wellness programme for this private hospital group, there is a confidential service available where any form of discrimination and harassment can be reported, however, this service is unknown to many of the employees and students, hence it is underutilised. Di Martino (2002) found that in South Africa, most health care facilities do not have adequate policies in place or do not disseminate these policies to the health care workers of their institution.

Nurse educators and nursing students should be educated with regards to this phenomenon. This can be done by ensuring that nurse educators and nursing students are orientated with regards to the policy related to bullying and other reporting services available to them. They should be made aware of their rights to a safe working environment and their right for protection and confidentiality when reporting these experiences of bullying. Positive attitudes about reporting must be created amongst all staff members. Policy guidelines must be strictly adhered to. When the policy states "zero-tolerance", then that should be implemented when bullying is observed or reported. This will give nursing students and other staff members a sense of comfort that if/when they experience bullying that their problem will be dealt with in the correct manner.

Nurse educators should advocate for the student nurse's human rights and dignity and should take on an active role through positive role modelling. Nurse educators should take the lead in setting up a task team that includes all stakeholders who will develop a prevention and management plan.

Nursing students should be provided with a platform which allows them to raise their concerns or experiences with regards to bullying, freely and without any objection. This platform can be in the form of listening forums/open forum meetings with other members of the management team, anonymous surveys at regular intervals, or allocating an anti-bullying representative per unit that will be responsible for a regular in-service session regarding bullying, keeping the staff and students informed, and allowing them to utilize them as representatives when reporting bullying.

5.4.2 Recommendations for nursing research

Further research should be done that includes all levels of nursing students both in the private and public health sectors. Even though bullying in not a new phenomenon, the number of studies in nursing education in the South African context are minimal and need further exploration.

Studies that specifically look at racial issues, language usage, and xenophobia can add to the body of knowledge of the diverse groups in health care settings in South Africa.

5.4.3 Recommendations for nursing practice

Education should be provided for all staff members of the health care facility related to reporting structures, training in communication, stress management and conflict management. This can commence with a detailed orientation programme which focuses on workplace violence with regular short programmes to reinforce the information.

Guidelines should be drawn up for managers, health care staff, medical practitioners and any other relevant stakeholders with regards to the effective management of bullying, at their level of employment.

Health care professionals should play an active role in ensuring harmony in the workplace. This will entail the prompt identification of bullying in any form and taking steps to solve the problem and prevent any future events of bullying. The consistent

and fair implementation of the bullying policy can be effective in creating a culture of "zero-tolerance" which can ultimately positively impact on staff turnover, productivity and patient care.

5.5 In Conclusions

The findings of this study support what is already known about bullying, which is not a new phenomenon in the nursing field. The responses from the participants, however, underline just how serious this problem actually is. Nursing education should be a joyful experience for nursing students, and they should be cared for during this time to assist them to develop to their fullest potential in this profession. Nursing is after all a caring profession, and where better to start caring, than with the registered nurses of the future.

The researcher, as an educator in an institution of learning, has noticed and experienced many situations in the last year that can be classified as bullying in this work setting. To be able to effectively manage bullying, information and knowledge are needed. Thus the researcher wanted to investigate what the nursing students consider bullying to be and what experiences they have had of bullying during their education experience.

5.6 Researchers' Reflection on the Experience

Reflection is the process of thoughtful stimulation, allowing a person to think further about a specific experience or situation, and the researcher appreciates using this opportunity to share her experiences with the readers of this report.

Even though the researcher witnessed many situations which can be classified as bullying before commencing on this research journey, those situations were only the tip of the iceberg. During the process of data collection, she dealt first hand with the emotions and fears experienced by the participants. The humiliation and abuse that they have to endure on a daily basis is enough to make any person loose courage and hope of achieving a nursing qualification.

These students come with their own life problems and some even walk miles, daily, to reach their place of work or nursing education institution and endure days being hungry and worrying about how they will care for their families. Despite all these difficulties, these students stay strong and pick themselves up and accept whatever is thrown at them for the sake of becoming a registered nurse. I felt empathy with the

students for all their trials, yet happy about their going above and beyond to ensure their goals of becoming a registered nurse.

The researcher wants to remind nurse educators and education institutions in South Africa that everybody has problems, but it is how you deal with them that makes the difference in the end. This journey has proven to be invaluable to me in my professional and personal development.

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ANNEXURE 1.1: INVITATION TO PARTICIPATE IN THE RESEARCH STUDY

Good day.

My name is Lize van Niekerk. I am currently doing a Master of Science Degree in Nursing Education at the University of Witwatersrand. I am required to conduct a research study as part of the course requirements.

Research is a process to learn the answer to a question. In this study I want to learn about the meaning students nurses attached to bulling, the experiences that nursing students have of bullying in the clinical and academic settings and how comfortable nursing students feel about reporting of bullying. Bullying in nursing has been researched as is evident from the literature. However, bullying among nursing students in the private nursing education institution has not been investigated.

I hereby invite you to participate in this research study.

If you are interested and willing to participate in the study please call me to make an appointment for the interview on 082 228 7040 or 011 628 7631.

Thank you for your time and consideration.

Lize van Niekerk
082 228 7040
011 628 7631

ANNEXURE 1.2: INFORMATION LETTER ON THE STUDY

Good day.

Thank you for showing interest in participating in this research study in which I want to learn about the meaning students nurses attached to bulling, the experiences that nursing students have of bullying in the clinical and academic settings and how comfortable nursing students feel about reporting of bullying.

An in depth face to face interview will be scheduled with you **(approximately 30-45 minutes)** in which three (3) main questions will be asked. These interviews will be digitally recorded with your consent. Your participation in this research study will not affect your academic results or work situation. There will be no risks attached to participating in this study. Your participation is voluntary and you can decide to withdraw from participating at any time without any penalty. Confidentiality and anonymity will be ensured, as the researcher will use pseudonyms or numbers for reporting the findings. If a quote is used from the digital recording, this will be done anonymously. There will be no direct benefit to you, but the findings of the study will be made available to you once it is complete.

In the event that the interview triggers any trauma or emotional distress, please feel free to inform me so that the counsellor (Mrs. Annalie van den Heever at 011 488 4061 Annalie.vandenheever@wits.ac.za) can be contacted for your assistance in this regard.

Please feel free to ask me any questions for clarity purposes and should you agree to participate in this study please sign the attached consent forms.

Thank you for your time and consideration.

Lize van Niekerk
082 228 7040/011 628 7631

Human Research Ethics Committee (Medical) contact details:

Chairperson: peter.cleaton-jone1@wits.ac.za

Administrators: Ms. Zanele Ndlovu, Mr. Rhulani Mkansi, Mr. Lebo Moeng

Contact details: 011 717 2700,011 717 2656, 011 717 1234,011 717 1252

Email: HREC-Medical.ResearchOffice@wits.ac.za

ANNEXURE 2: CONSENT FORM

I have been given the information letter on the study NURSING STUDENTS' EXPERIENCES OF BULLYING IN A PRIVATE NURSING EDUCATION INSTITUTION. I have read and understood the contents of the information letter. I have been informed regarding the purpose of this study. I give consent willingly to participate in this study, which aims to investigate the experiences of nursing students of bullying in the clinical and academic setting.

Should I agree to participate in the study, I understand that I will be interviewed for approximately 30-45 minutes. I am aware that this participation in this study is voluntary and that I can withdraw from participation at any stage without any consequences to myself. I understand that if a direct quote is used from anything that was said in the unstructured interview, that this will be done anonymously. I am aware that I can request a copy of the research findings on completion of the study.

Signature of participant: _____

Date signed: _____

ANNEXURE 3: CONSENT FOR DIGITAL RECORDING OF THE INTERVIEW

I, ...have consented to be a participant in the study being conducted by Mrs. Lize van Niekerk. I have been given the information document on the study and have read and understood the information document.

I have been asked to give my consent to the interview being digitally recorded to aid accurate collection and analysis of information. I also understand that if I decide not the consent to the interview being digitally recorded that I will be excluded from the study.

I give my consent for the interview being digitally recorded ☐

I do not consent to the interview being digitally recorded ☐

.....

Signature of participant

.....

Date

ANNEXURE 4: INTERVIEW GUIDE

The following questions will be asked:

Question 1: What do you consider as bullying?

Question 2: Tell me about your experience with bullying in the teaching and learning situation

Question 3: How comfortable/secure do you feel about reporting bullying?

Probes:

- Please explain the nature and extent of the bullying.
- Do you believe that the policy is effectively applied and/or implemented?
- What recommendation do you have to improve the effective implementation of the policy?

ANNEXURE 5: DEMOGRAPHIC INFORMATION

Please complete/circle the following:

Age: _____

Sex: Male/Female

Married: Yes/No

Years of experience in nursing: _____

ANNEXURE 6: APPROVAL OF TITLE

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

17 May 2016
Person No: 751470
PAG

Mrs L Van Niekerk
53 Twelfth Avenue
Edenvale
1609
South Africa

Dear Mrs Van Niekerk

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Nursing students' experiences of bullying in a Private Nursing Education Institution* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

ANNEXURE 7: HREC (MEDICAL) CLEARANCE CERTIFICATE

R14/49 Ms Lize van Niekerk

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160372

NAME: (Principal Investigator)	Ms Lize van Niekerk
DEPARTMENT:	Nursing Education Netcare Education Gauteng South West
PROJECT TITLE:	Nursing Students' Experiences of Bullying in a Private Nursing Education Institution
DATE CONSIDERED:	01/04/2016
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Ms Agnes Huiskamp
APPROVED BY:	Professor P. Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	23/05/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/2nd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated,from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review in March and will therefore be due in the month of March each year.

Principal Investigator Signature

Date 26/5/2016

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE 8: RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2016-0024

Ms L van Niekerk

E mail: Lize.vanniekerk@netcare.co.za

Dear Ms Van Niekerk

RE: NURSING STUDENTS' EXPERIENCES OF BULLYING IN A PRIVATE NURSING EDUCATION INSTITUTION

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

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

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

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

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

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

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

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