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Bullying and violence prevention programmes in nursing: integrative literature review

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BULLYING AND VIOLENCE PREVENTION PROGRAMMES IN NURSING: INTEGRATIVE LITERATURE REVIEW

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

Johannesburg, 2018

DECLARATION

I, Esther Caroline Nalumansi, declare that this research report (Human Research Ethics Clearance Number **W-CJ-160622-2**) is my own work. It is being submitted for the degree of Master of Science in Nursing in the University of the Witwatersrand, Johannesburg. It has not been previously submitted for any degree or examination at this or any other university.



.....

Signed at Johannesburg

On the 08 day of June, 2018

DEDICATION

I dedicate this work to my family, for it is

through them that I have come to understand the true meaning of human kindness

ABSTRACT

Background: Several studies have highlighted workplace bullying in the healthcare sector, especially its prevalence among nursing employees. Despite the recommendations by previous studies for control measures to be instituted, bullying and violence remain a major challenge in the nursing sector.

Aim: The aim of the study is to identify and critically evaluate articles from scientific nursing publications, identified in specific databases, as to what makes bullying and violence prevention programmes for nurses effective. This is to gain a better understanding of the problem, and to see how it has been addressed in the past 5 years. The findings will serve to inform future interventions to reduce workplace bullying among nurses.

Methodology: An integrative literature review framework was employed. Thirty-one (31) articles identified from Cochrane library, EBSCO host (CINAHL, ERIC and MEDLINE), PubMed, Wiley Online Library and Psych Info were included in this review.

Results: The following characteristics, which make bullying and violence prevention programmes, were identified: *leaders' involvement, empowerment programmes and institutionalisation of bullying prevention policies.*

Recommendations: To incorporate evidence based training and techniques timeously and consistently within the undergraduate and orientation programmes as well as conducting more studies within South Africa to evaluate the effectiveness of the intervention strategies mentioned in literature.

Keywords: bullying, prevention, effectiveness, nursing

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1. CHAPTER ONE: ORIENTATION TO THE STUDY

1.1. Introduction and Background

According to Murray (2009), bullying is defined as any kind of recurring maltreatment in which the injured person experiences verbal insults, threats, shameful or terrifying behaviour that affects his or her job performance and puts the health and safety of the sufferer in danger. Bullying is also sometimes described as a form of aggressive behaviour, whereby aggression is repeated and there is an imbalance of power making it difficult for the victim to defend him or herself (Cowie et al. 2002). Spector et al. (2014:73) maintain that, "Bullying is a repeated pattern of physical and/or psychological violence over time that can be directed at one or more individuals." Moreover, Bowllan (2015) states that the term 'bullying' tends to be interchangeably used with horizontal violence, lateral violence and harassment. Several authors further caution that it is increasingly becoming a problem that can no longer be ignored due to its negative impact on the nursing profession (Ariza-Montes et al. 2013; Hall, Dollard, & Coward 2010; Murray 2009).

A study conducted by Steinman (2003:1), in South Africa, examined the level of general "workplace violence in the health sector" and highlighted that brutality in the workplace included bullying. The study reported there was increasing awareness about workplace bullying in South Africa, but the country lacked adequate research on the subject to address the problem. Steinman continued that there were several job categories affected by workplace bullying and that the nursing profession emerged as the one most at risk. The author cited the following pre-disposing factors: working in accident and emergency units and mental health settings, huge numbers of dissatisfied clients, introduction of community based care and a paternalistic nursing management style (Steinman, 2003).

While some problems experienced within the nursing profession, such as attrition and increased absenteeism, receive worthwhile attention, the issue of bullying is hardly documented (Namie, 2007). In her research, Namie (2007) highlighted that nurses commonly experienced psychological violence, where physicians perceived themselves in a more positive light compared to nurses and often humiliated and undermined their qualifications. Thus, Steinman (2003:36) concluded that "The situation is such that there is already a shortage of healthcare workers in this country and if workplace violence and other factors undermining employee safety and satisfaction are not addressed immediately, South Africa may well find itself in the same situation as Zimbabwe where the health services in that neighboring state had collapsed."

1.1.1. Common types of bullying

Common types of bullying behaviours that have been identified from literature include; overt (easily identified) behaviours such as name calling, persistent criticism; gossiping; shouting; intimidation; blaming; sabotage; undermining; bickering and scape-goating. (Gilbert et al 2016; Sanner-Stiehr 2015).Covert behaviours are more frequent, subtle and gradual and these include ; eye-rolling; failure to respect privacy; withholding information; unfair delegation; ignoring; sighing; making faces behind one's back and micromanaging. (Gilbert et al 2016; Sanner-Stiehr 2015; Gillepsie 2015)

1.1.2. Most at risk of being bullied

Newly licensed registered nurses have been identified as a high group to being bullied as well as nursing students in clinical areas (Spence 2012; Gillipsie 2015; Gilbert 2016).

1.2. Consequences of bullying

Workplace bullying can have implications on both the workplace and the victims, as illustrated in the ensuing subsections.

1.2.1. Consequences in the workplace

The International Center for Human Resource in Nursing (ICHRN 2007) reports that workplace bullying causes harmful effects on health care organisations and the health structure as a whole. The effects of the workplace bullying should be prioritised, especially due to growing concerns about poor professional practice environments. Such environments are said to lead to problems in keeping and enlisting nurses, thereby promoting nursing shortage and eventually, a decline in quality of services provided to patients (ICHRN 2007). Moreover, there are bigger costs to employers and the health structure, due to high absenteeism and sick leave, poor job execution and loss of quality, creative problem-solving capacity, and departing of staff from the institution. ICHRN (2007) lists more problems at organisation level that are associated with bullying in the nursing profession, including decline in the quality of staff relations, poor team spirit, higher stress levels and tension related sicknesses and low job satisfaction. A study by McNamara (2012) showed hospital administrators linked bullying behaviour to adverse events that included medical mistakes, compromises safety of sick people and reduced standard of care. The respondents in her study mentioned that patients often experienced prolonged pain, incorrect diagnosis, incorrect treatment and sometimes death because of poor job performance due to the effects of being bullied. This indicates bullying extends beyond the nursing profession.

1.2.2. Consequences to the individual

The phenomenon of bullying has also been linked to psychological and physical reactions at the individual level. Examples include anxiety, depression, sleeplessness, an increase in absence from work and threats to leave the profession, feeling distressed, embarrassed, regretful, full of fury, terror, incapacitated and self-condemnation (Clarke et al. 2012; ICHRN 2007; Rocker 2008); these can result into a low of self-esteem, which not only place the nurse in danger, but the sick people as well (ICHRN 2007). As a result of the negative consequences

on the well-being of nurses, and by extension, their performance (Ariza-Montes et al. 2013; Hall, Dollard & Coward 2010), it is important to explore the phenomenon of bullying in the nursing profession. Cullinan (2006) states that the South African health system, being primarily nurse driven, needs to explore issues that influence this important human resource.

1.3. Recommendations for avoiding and managing bullying among nurses

A study done by Stagg (2010) identified cognitive rehearsal of responses to common bullying behaviour for staff nurses as the best workplace bullying management programme. Steinman (2003) made several recommendations on what the victims, the perpetrators and the institution as a whole could do to prevent and manage bullying in the workplace, including training in workplace violence, interpersonal communication, relationships and teamwork; other recommendations mentioned were commitment to developing an anti-violence policy, to which staff needed to adhere. The need to be protected by the policy, as well as an anti-violence programme, and reporting procedures should be drawn up by management of the institution in consultation with staff members, with debriefing of the victims and rehabilitation of the perpetrators. Steinman (2003:55) added, "There should be an investigation, action and feedback once there has been a reported incident of bullying." Further action at national and organisational level should include the organisation of a national health summit on workplace violence for all unions and stakeholders and the establishment of a health forum against workplace violence.

Dimarino (2011) suggests other ways to address bullying, include teaching nurses about prevalent forms of nurse-to-nurse violence, approaches for handling unprofessional behaviour, nursing management having a 'zero–tolerance' culture that includes clear and concise behavioural expectations and repercussions for employees who exhibit inappropriate behaviour. Townsend (2016) recommended managers need skills-based training that includes

communication, relationship building and collaboration. Stanton (2015) reported that implementing a lateral violence policy is not effective on its own, as other interventions such as an audit and feedback process should be done simultaneously. (Engelbrecht et al. 2017) emphasise that intra-professional violence should be addressed in the educational and clinical environments role modelling by the nurse educators and being taught professional ethics.

1.4. Problem statement

Cunniff and Mostert (2012) and Steinman (2003) previously highlighted workplace bullying in the healthcare sector, particularly its prevalence among certain employees in South Africa. Despite the recommendations by these studies for control measures to be instituted, bullying and violence in the workplace remain a major challenge in the South African nursing sector. In fact, the researcher observed there was no clear policy on the prevention and management of bullying at the nursing institution where she works and has identified anecdotal incidences of bullying that resulted in some nurses leaving the institution. Left unaddressed, bullying can be very costly to institutions. Poor patient care and lack of success in meeting patient safety benchmarks due to bullying can result in discontentment from patients, decreased financial remunerations which negatively affects the institution as well as affecting the accreditation of the institution. (Townsend 2016).According to Steinman (2003), workplace bullying affects the nurses' performance and health leading to increased absenteeism and high staff turnover. As it costs between R25 000-R45 000 to replace a professional worker in South Africa, not to mention severance packages, early retirement and legal costs, the phenomenon of workplace bullying and violence can no longer be ignored. This review aims to identify and critically assess the effectiveness of workplace bullying and violence prevention programmes for nurses, as described in the literature, to establish effective strategies that may be implemented into the local nursing environment.

1.5. Justification of the study

A previous systematic review by Stagg (2010) identified best practices for preventing and managing workplace bullying among staff nurses, and found that the best practice to influence people's behaviour and stop workplace bullying includes cognitive rehearsal of responses to common bullying behaviours. This study will use an integrated literature review to give a broader perspective of the topic and will draw from both qualitative and quantitative studies conducted from 2011 to date, thereby adding to the current body of knowledge and identifying areas for future research.

1.6. Aim of the Review

The focus of the review was to identify and critically evaluate scientific publications, in specific databases in the field of nursing, regarding what makes bullying and violence prevention programmes for nurses effective, and to acquire a better comprehension of the bullying issue and how it has been addressed in the last 5 years.

1.7. Research question

What makes bullying and violence prevention programmes effective in preventing and managing workplace bullying and violence amongst nurses?

1.8. Objectives of the study

This study was guided by two objectives:

a) To review available literature on effective bullying and violence prevention programmes in preventing and managing bullying and violence amongst nurses.
b) To describe the characteristics that makes programmes effective in the management and prevention of bullying in the nursing profession.

1.9. Definitions

The following terms will apply in this study:

Bullying – Bullying is a repeated pattern of physical and/or psychological violence over time that can be directed at one or more individuals **(**Spector et al. 2014). This study refers to workplace bullying being defined as the persistent, degrading and oppression of individuals through brutal words and cruel acts that gradually undermine confidence and self-esteem. (Stagg 2010)

Prevention –The Merriam Webster (2018) dictionary defines it as the act or practice of keeping something from happening, in this context keeping bullying from happening.

Nursing – The English Oxford Dictionary (2018) defines nursing as the profession or practice of providing care for the sick and infirm.

Effectiveness – The English Oxford Dictionary (2018) definition is the extent to which something is successful in producing a desired result. In this case, the desired result is being successful in preventing and managing bullying amongst nurses in the workplace, thus reducing bullying incidences and the risk of occurrences within the nursing environment. Interventions aimed at preventing and managing workplace bullying would be deemed to be effective when they manage to reduce bullying incidences an example being cognitive rehearsal intervention as it reduced bullying 100%. (Stagg 2013).

Programme - The English Oxford Dictionary (2018) defines this as a plan of action to accomplish a specified end, in this case preventing and managing bullying. In this review, a programme refers to an intervention, workshop, and educational programme that is effective in reducing bullying behaviours in the workplace. (Stagg 2013)

Cognitive rehearsal – An evidence based approach that utilizes effective communication to address lateral violence and it reduced bullying behaviours by 100%. (Griffin 2004; Stagg 2013).

1.10. Research methodology

This review employed an integrative literature review, using Whittmore and Knafl (2005) as a framework, and described in more detail in Chapter 2.

1.11. Conclusion

A summary of the research study has been provided in this chapter. The problem statement, justification, aim and objectives of the study have been delineated. In this research, all the variables and terms were defined theoretically and operationally to clarify their meanings and purpose. The following chapters will discuss the integrative literature review methodology using Whitemore and Knafl's (2005) integrative review stages as a framework in detail.

2. CHAPTER TWO: RESEARCH METHOD

2.1. Introduction

This chapter delineates the integrative research methodology as it is used in this review. It defines and differentiates the methodology from other review methods and explains the five stages of the Whittmore and Knafl (2005) framework for the integrated review.

2.2. Study design and method

A research design is a blueprint for expanding power to influence elements that could interfere with a study's suitable result (Burns & Grove 2013). The authors add that research methods are the processes a researcher follows when conducting the specific steps of the research design. An integrative literature review method was chosen for this study as it enabled the researcher to use both theoretical and empirical literature, giving a wider pool of studies to be explored and included in the study, which is required to obtain to gain a complete understanding of the topic under review (Whittemore & Knafl 2005). This research approach was appropriate as it decreased potential bias that the researcher might have had towards the topic.

2.3.Types of reviews

Whittmore and Knafl (2005) report that evidence–based techniques motivations have grown in demand for and the production of all types of reviews of the literature, which comprises of integrative, systematic, meta-analyses and qualitative reviews. They stated that the integrated review method is the only strategy that combines different methodologies. The identified types of reviews mentioned by the authors' state that the individual technique has a unique focus, sampling frame and type of analysis.

2.3.1. Systematic reviews

Burns and Grove (2013:28) define a review that is systematic as a "structured, comprehensive synthesis of quantitative studies in a particular healthcare area to determine the best research evidence available for expert clinicians to use to promote evidence-based practice." The authors continue that systematic reviews are conducted to synthesise research evidence from numerous, high quality quantitative studies with similar methodologies. Cartwright (2012) stated that such reviews have replaced traditional narrative reviews and expert commentaries. Systematic reviews are a way of summarising research evidence and are based on peer-reviewed protocols, and as such, can be replicated if needed.

2.3.2. Meta- analysis

Meta-analysis is a type of review that numerically shares the results from previous, similar studies into a single quantitative analysis and gives one of the most notable levels of verification for intervention in an organisation (Conn & Rantz, 2003 cited in Burns & Grove 2009). The review requires a specific clinical question, well-defined methods and a thorough literature search.

2.3.3. Qualitative reviews

Numerous methods have been refined to review qualitative research namely, meta-synthesis, meta-studies, formal grounded theory and meta-ethnography, which integrates results of single qualitative articles into a new theory on the occurrence being, studied (Whittmore & Knafl 2005). The authors add that although incorporating evidence from various qualitative primary studies is challenging, these procedures have the potential to expand the universality of qualitative research.

Burns and Grove (2013) state that integrative reviews identify, analyse and synthesise research results from both quantitative and qualitative literature to determine the present day information (what is known and not known) in a specific area. The method is so broad that it includes both theoretical and empirical literature (Whittmore & Knafl 2005).

2.3.4. The integrated literature review

An integrative literature review is a non-experimental design in which data regarding a particular area is objectively assessed then summarised and conclusions drawn. It consists of a systematic search, categorisation and analysis of quantitative and/or qualitative of past studies on the subject of interest (Kpodo, 2015). Whittmore and Knafl (2005:546) define an integrative literature review "as a specific method that summarises past empirical and theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem." Russel (2005) mentions several benefits to the scholarly reviewer when using an integrative literature review, which include assessing the power of the scientific proof, determining gaps in present day research, determining the need for future research, joining between related areas of work, determining central issues in an area, developing a question for research, determining a theoretical framework and enquiring which research methods have been utilized triumphantly. Systematic processes used in the integrative review are followed piously. (Russel 2005) The integrative literature review was best suited for this study not only because of the abovementioned benefits, but also because it will decrease potential bias that the researcher might have towards the topic and the ability to answer the research question.

2.4. Stages of the integrative literature review

According to Russel (2005:1), when a body of knowledge is being evaluated using the integrative review technique, there are commonly four questions being answered:

- "What is known?"
- "What is the quality of what is known?"
- "What should be known?"
- "What is the next step for research or practice?"

The author continues that through the integrative review process, the present condition of information is assessed and the standard is evaluated so that future directions for research studies are clearer. There are five stages formulated in the integrative review process, and using Whittmore and Knafl's (2005) framework as a guide for this study, these stages include:

- Problem identification
- Data collection or literature search
- Evaluation of data
- Data analysis and
- Interpretation and presentation of results

(Russel 2005; Whittmore & Knafl 2005).

Whittmore & Knafl (2005) state that reviews are taken as research of research, hence meets the same quality as empirical research in methodological rigour. The Table (2.1) below shows an overview integrative review process.

Table 2.1 : Whittemore and Knafl (2005) integrative review process

No.	Stages	Description
1	Problem identification stage	Proposal writing stage
2	Literature search/ review stage	Described under the Search strategy below.
3	Data evaluation stage	Conducted using Johns Hopkins Evidence-Based Nursing Evidence and Quality Evaluation tools attached as Annexures C, D and E.
4	Data analysis stage	Described under data analysis below
	• Data Reduction	
	• Data display	
	• Data Comparison	
	• Conclusion drawing	
	• Verification	
5	Presentation	Research report writing

2.4.1. Problem identification

This is the first stage of the integrative process. It is a clear identification of the problem and the purpose that the study is addressing (Whittmore & Knafl 2005). Burns and Grove (2013) explain it as concerning area, where there is a gap in knowledge needed for nursing practice, and identifies a population and often a setting for the study, therefore making the way for variables to be identified and defined thus facilitating all other stages of the review (Whittmore and Knafl (2005). Research problems are usually drawn from the casual observations or empirical world, deductions from theory, related literature reviews, current and political issues, personal interests, replication of previous studies and contradictory research results (Burns &

Grove 2013). Kpodo (2015) mentions that a preliminary literature review assists the researcher to further formulate the topic and refine the research question.

Cooper (1988) noted that the problem identification procedure involves expansion of theoretical and functional statements of variables being investigated. The author suggests if operational definitions are too narrow, the quality of the findings can be impaired and if too broad, important study details may be overlooked and result in incorrect interpretation of results. The researcher must be careful to balance the operational definitions and review methods. The research question in this study was drawn from anecdotal evidence of bullying in the clinical area where the researcher works; there was no clear policy on bullying at the institution. The bullying resulted in some nurses leaving the institution. The research question was further refined from the preliminary literature search when a previous systematic review study by Stagg (2010) identified best practices for preventing and managing workplace bullying among staff. This review aims to give an update on information available since 2010.

The research question in this study is:

What makes bullying and violence prevention programmes effective in preventing and managing workplace bullying and violence amongst nurses?

Once the research question was clearly defined, the researcher determined which articles were to be included or excluded. The inclusion criteria were based on the title, purpose, research question and characteristics of the study, thus, articles that did not meet the criteria were removed from the review.

The inclusion criteria for this review were:

- Studies published between January 2011 and July 2017.
- Studies should have met at least three of the search terms.
- Only articles published in English were considered.

- Primary and secondary articles published in Cochrane library, EBSCO host (CINAHL, ERIC, and MEDLINE), PubMed, Wiley online and Psych info were included.
- An ancestry search of included articles reference lists was conducted.

2.4.2. Data collection

The second stage in the integrated review process is the data collection, or literature search phase. Data refers to the information accessed from the articles that address the research question. A well-defined literature search is vital in this process for enhancing rigour and reducing the incidence of errors. In an integrative review, the search should include both qualitative and quantitative studies using a computerised search, as it is the easiest method to use (Whittmore and Knafl (2005). The authors add that conducting a comprehensive search of databases using all combinations of search terms on the topic as well as describing the accessible population is essential. Russel (2005) describes the population was literature and not as individuals or groups.

In this review, qualitative and quantitative articles published between 2011 January and 2017 July were searched, using a computerised search, from the following databases: *Cochrane* library, *EBSCOhost* (*CINAHL; ERIC* and *MEDLINE*), *PubMed*, *Wiley* online library and *Psych info* databases.

A combination of the six key terms were used to search the above listed databases, *bullying/ violence, prevention/control/management, nursing,* with the search conducted using the Boolean operator 'AND,' that is:

Table 2.2: Search terms

a)	Bullying	AND	Prevention	AND	Nursing
b)	Bullying	AND	Control	AND	Nursing
c)	Bullying	AND	Management	AND	Nursing
d)	Violence	AND	Prevention	AND	Nursing
e)	Violence	AND	Control	AND	Nursing
f)	Violence	AND	Management	AND	Nursing

The search strategy was expanded in order to get more articles, as well as including effectiveness of the programme based on the research question as well as to leave an audit trail as search terms are not the same. A combination of 11 key terms (bullying/violence/effectiveness/program/intervention/workshop/educational programme/approach/strategy/nursing) was used to conduct the search using Boolean operator 'AND' as shown below:

Table 2.3: Search terms

a.	Bullying	AND	Effectiveness	AND	Programme
b.	Violence	AND	Effectiveness	AND	Programme
c.	Bullying	AND	Nursing	AND	Intervention
d.	Bullying	AND	Nursing	AND	Workshop
e.	Bullying	AND	Nursing	AND	Educational Programme
f.	Bullying	AND	Nursing	AND	Approach
g.	Bullying	AND	Nursing	AND	Strategy
h.	Violence	AND	Nursing	AND	Intervention
i.	Violence	AND	Nursing	AND	Workshop
j.	Violence	AND	Nursing	AND	Educational Programme
k.	Violence	AND	Nursing	AND	Approach
l.	Violence	AND	Nursing	AND	Strategy

2.4.3. Evaluation of data

The third stage in the integrated review process is the evaluation phase. This is where the researcher critically determines whether the data is unworthy of staying in the study (Russel 2005).The one threat to validity in this stage is the tendency to assess research that agrees with the researcher's view positively, and negatively to those studies that do not. The author suggested one approach to overcome this is to use a methodologic evaluation list however there is no universally accepted model. Inclusion of articles was based on the inclusion criteria identified in this document, done by two reviewers, the researcher and the supervisor. In this review, the included articles were evaluated using the John Hopkins Nursing Evidence-Based Practice quality evaluation tool as detailed in Annexures D and E. Permission to use this tool

was granted (see Annexure A). Information needed from the included articles to answer the research question was extracted and the quality of the articles and their level of evidence were assessed.

2.4.4. Data analysis (According to Table 2.1)

Analysis and interpretation of the data are incorporated in this stage of the integrated review process. Cooper (1988), as cited in Russel (2005:550), this stage is seen as "reducing the separate data points collected by the inquirer into a unified statement about the research problem." Whittemore and Knafl (2005) add that data analysis requires data from the empirical form to be organized, arranged, categorised and outlined into a unified and comprehensive conclusion about the phenomenon. The aim is to give a thorough and unbiased interpretation and find innovative ways to synthesise the evidence. This stage is complex and there are several threats to validity if there is no adherence to the details. Method of analysis should be delineated prior to the study. (Whittmore & Knafl 2005).

A thematic analysis was used in this review to analyse data and involved constant data comparison in which data was converted to themes, patterns and relationships (Whittmore & Knafl 2005). The thematic analysis used in this study comprised five stages, namely data reduction, data display, data comparison, drawing conclusion and verification. These stages will be discussed below.

2.4.5. Data reduction

Data reduction involves categorising the data into various sub groups based on identified characteristics: type of design, date of publication, sample characteristics and context. It is then extracted and coded into feasible structure that is a data matrix. This makes it easy to compare articles (Whittmore & Knafl 2005). In this review, data was reduced into design categories

(quantitative, qualitative and mixed methods), as illustrated on the data matrix in the tables in the next chapter.

2.4.5.1.Data display

Data is displayed on a data matrix for easy visualization of patterns, similarities and themes. See (Table 3.1 and 3.2)

2.4.5.2. Data comparison

Data comparison involves examining the displayed data in order to determine themes, patterns and relationships. Concept mapping was used in this review to include identified variables, patterns or themes (Whittmore & Knafl 2005).

2.4.5.3. Conclusion drawing and verification

This is the final stage. Raw data that related directly to the research question was removed and. Patterns were identified and clustered into themes. Sub-themes derived were compared with the data displayed on the matrix. The themes and sub-themes were considered by the researcher and applied to broader levels of concept. Conclusions were then drawn from the data set to confirm if they correlated with the primary source of information to ensure inclusiveness and accuracy of interpretations. Recommendations are made for practice and further study. In this study, patterns identified were sorted into themes for critical data comparison. Sub–themes were compared with the data displayed on the matrix. The researcher together with the supervisor

2.4.5.4. Interpretation and presentation of results

In this stage conclusions are drawn from the analysed data. This involved analysed data being synthesised into a new viewpoint about the phenomenon being studied. It is an important stage as it allows the research question to be answered and fulfils the aim of the review. Factors that make bullying and violence programmes effective in preventing and managing workplace, bullying and violence amongst nurses were described.

2.5. Document analysis and sample

The study population is peer-reviewed literature, published between 2011 and 2017, on bullying and violence prevention programmes for nurses.

2.5.1 Inclusion criteria

- Articles that have been published between January 2011 and July 2017.
- Articles that have met at least three of the key terms.
- Only articles published in English were considered.
- Primary and secondary articles published in Cochrane library, EBSCO host (CINAHL, ERIC and MEDLINE), PubMed, Wiley Online library, and Psych info were included.
- An ancestry search of included articles reference lists was conducted.

2.6. Validity and reliability

Burns and Grove (2013:197) define validity as "a measure of accuracy of a claim." Burns and Grove (2013) further mention that validity gives a major basis for making decisions about which findings are adequate and well-founded enough to add to the evidence base for practice (Burns & Grove 2013). Russel (2005) suggested four ways of strengthening validity of the study are; conducting an exhaustive data collection strategy; clearly describing the data to be collected such as sources, years and keywords; presenting all selection biases and summarizing demographics of the subjects included in the study. To prove validity a tool must speak to the data being collected. "A measure is reliable if it gives the same result each time the same situation or factor is measured."(Burns& Grove 2013:197). In this review, permission (see Annexure A) was granted to use the *John Hopkins Evidence-Based Practice quality assessment tools* (see also Annexure B), a validated tool, to extract information from the included articles. The VHA office of the nursing service in the United States of America (2016) has used the John Hopkins assessment tools in several research projects. The nursing the tool comprises:

- The article number
- Author(s) and publication date
- Evidence type
- Sample size and setting
- Study findings
- Limitations as well as
- Evidence level and quality.

The following considerations applied for the study to continue and ensure it remained authentic:

- The research proposal was reviewed by the Department of Nursing Education at the University of the Witwatersrand to assess the feasibility of the study.
- The Johns Hopkins Evidence-Based Nursing data collection tool was used to extract information from the included articles (Annexure B).
- Inclusion of articles was based on the inclusion criteria identified in this document, done by two reviewers, the researcher and the supervisor.
- Studies that did not meet the inclusion criteria were removed.
- The supervisor served as a co-reviewer/coder to limit individual bias
- When conflict arose between the two reviewers on an aspect of the review, a pre-identified third party was consulted to resolve the conflict.
- Files were created for abstracts reviewed, full texts retrieved on printed paper and articles included or excluded.

2.7. Ethical considerations

Certain ethical requirements were taken into consideration for the research study to proceed to ensure the research remained authentic, valid and reliable.

- The research proposal was peer reviewed for input from the Nursing Department of Education, Therapeutic School of Sciences, Faculty of Health Sciences, and University of Witwatersrand.
- Approval was obtained from the Faculty of Health Sciences Postgraduate Research committee, University of Witwatersrand.
- Ethical clearance waiver with reference number (W-CJ-160622-2) was acquired from University of Witwatersrand Human Research Ethics Committee (medical) for review (Annexure F).
- Permission was acquired for the use of the John Hopkins Nursing Evidence-based Practice Model and tools (Annexure A).
- All articles used in the integrative review were checked against checklists (Annexure B, C, D, and E) for validity, reliability and authenticity.
- An experienced co-reviewer was used to maintain rigour and ensure high quality. No conflict arose between the researcher and the co-reviewer. This allowed the research to be of a high quality and rigorous throughout the review process.
- All articles used were handled with respect and integrity and all copyright issues were observed.

2.8. Conclusion

This chapter has described the integrative research methodology, as it was used, in detail and differentiated the methodology from other review methods whilst explaining the five stages of Whittmore and Knafl's (2005) framework of the integrative review. The ethical steps to ensure the research remained authentic, valid and reliable were adhered to and explained. The next chapter discusses the process of data collection and inclusion of studies.

3. CHAPTER THREE: DATA COLLECTION AND INCLUSION OF STUDIES

3.1. Introduction

This chapter describes in detail the ancestry search and the literature search process, which includes:

- Types of papers
- Evidence grading
- Quality assessment process
- Extracted information from the included articles
- Inclusion and exclusion process.

3.2. Search terms

See Table 2.3

3.2.1. Computerized Search

There was a data search conducted, titles were scanned for relevance. Abstracts for the relevant titles were read, relevant articles were then downloaded. There was a discussion between researcher and co-researcher and full articles were included. The results of the search process are summarised below in Table (3.1) and Figure (3.1), as well as the second search process summarised in table (3.2) and Figure (3.2)

Table 3.1: Search strategy of initial search

Database	Data search	Titles scanned	Number of abstracts read	Studies included	Date retrieved
COCHRANE LIBRARY	Bullying, Prevention, Nursing	0	0	0	12.11.2016
	Bullying, Control, Nursing	0	0	0	12.11.2016
	Bullying, Management, Nursing	0	0	0	12.11.2016
	Violence, Prevention, Nursing	0	0	0	12.11.2016
	Violence, Control, Nursing	0	0	0	12.11.2016
	Violence, Management, Nursing	0	0	0	12.11.2016
TOTAL		**0**	**0**	**0**	**0**
EBSCO HOST Consisting of: CINAHL; MEDLINE ERIC	Bullying, Prevention, Nursing	97	45	24	12.11.2016
	Bullying, Control, Nursing	96	71	25	12.11.2016
	Bullying, Management, Nursing	64	38	26	12.11.2016
	Violence, Prevention, Nursing	261	242	19	12.11.2016
	Violence, Control, Nursing	216	213	3	12.11.2016
	Violence, Management, Nursing	112	107	5	14.11.2016
TOTAL		**846**	**716**	**102**	
PUBMED	Bullying, Prevention, Nursing	138	90	48	14.11.2016
	Bullying, Control, Nursing	40	37	3	14.11.2016
	Bullying, Management, Nursing	147	140	7	14.11.2016
	Violence, Prevention, Nursing	534	513	21	01.12.2016
	Violence, Control, Nursing	499	495	4	01.12.2016
	Violence, Management, Nursing	580	565	15	01.12.2016
TOTAL		**1938**	**1840**	**98**	
WILEY ONLINE	Bullying, Prevention, Nursing	2	1	1	03.01.2017
	Bullying, Control, Nursing	22	13	9	03.01.2017
	Bullying, Management, Nursing	0	0	0	03.01.2017
	Violence, Prevention, Nursing	60	45	15	03.01.2017
	Violence, Control, Nursing	0	0	0	03.01.2017
	Violence, Management, Nursing	3	0	0	03.01.2017
TOTAL		**87**	**59**	**25**	
PSYCH INFO	Bullying, Prevention, Nursing	31	27	4	03.01.2017
	Bullying, Control, Nursing	9	0	0	03.01.2017
	Bullying, Management, Nursing	34	20	14	03.01.2017
	Violence, Nursing	136	135	1	03.01.2017
	Violence	24	20	4	03.01.2017
	Violence, Management,	20	0	0	03.01.2017
TOTAL		254	202	23	
SUM TOTAL		3125	2817	**248**	

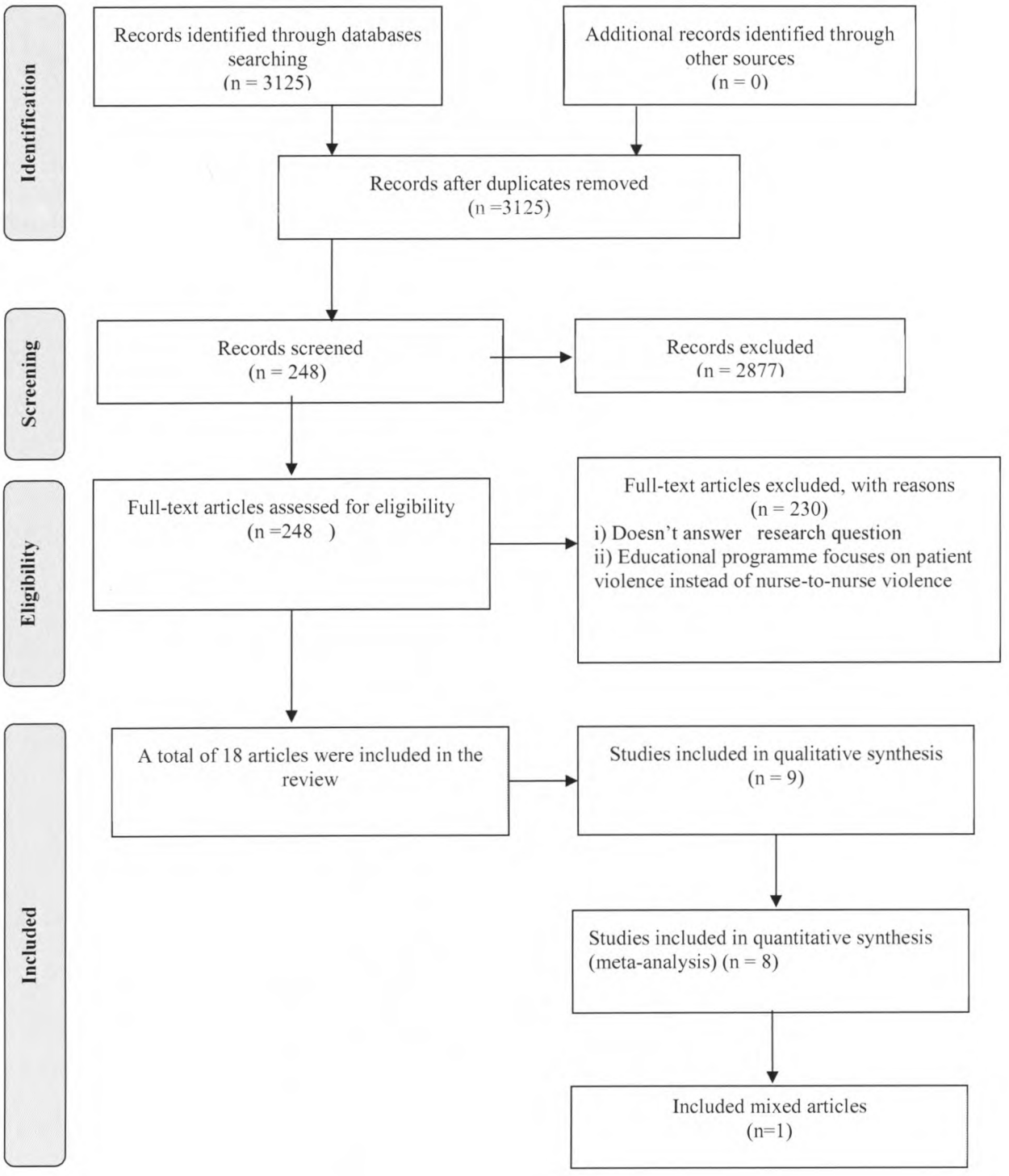

Figure 3:1: Summary of the initial search strategy from Table 3.1

Table 3.2: Secondary search terms

Database	Key words combined	Studies identified	Number of abstracts read	Studies included	Date retrieved
COCHRANE LIBRARY	Bullying, Effectiveness, Programme	3	0	0	29.08.2017
	Violence, Effectiveness, Programme	6	0	0	29.08.2017
	Bullying, Nursing, Intervention	1	1	0	29.08.2017
	Bullying, Nursing, Workshop	0	0	0	29.08.2017
	Bullying, Nursing, Educational programme	1	0	0	29.08.2017
	Bullying, Nursing, Approach	0	0	0	29.08.2017
	Bullying, Nursing, Strategy	0	0	0	29.08.2017
	Violence, Nursing, Intervention	2	0	0	29.08.2017
	Violence, Nursing, Workshop	0	0	0	29.08.2017
	Violence, Nursing, Educational programme	8	0	0	29.08.2017
	Violence, Nursing, Approach	1	0	0	29.08.2017
	Violence, Nursing, Strategy	1	0	0	29.08.2017
TOTAL		**23**	**1**	**0**	
EBSCO HOST Consisting of: CINAHL;MEDLINE ERIC	Violence, Effectiveness, Programme	1	0	0	29.08.2017
	Bullying, Nursing, Intervention	3	0	0	29.08.2017
	Bullying, Nursing, Workshop	53	51	2	29.08.2017
	Bullying, Nursing, Educational programme	14	11	3	29.08.2017
	Bullying, Nursing, Approach	6	3	3	29.08.2017
	Bullying, Nursing, Strategy	47	46	1	29.08.2017
	Violence, Nursing, Intervention	46	42	2	31.08.2017
	Violence, Nursing, Workshop	115	110	5	31.08.2017
	Violence, Nursing, Educational programme	5	4	0	31.08.2017
	Violence, Nursing, Approach	3	3	4	31.08.2017
	Violence, Nursing, Strategy	102	98	3	31.08.2017
TOTAL		**395**	**368**	**23**	

Table 3.2: Secondary search terms (b)

Database	Key words combined	Studies identified	Number of abstracts read	Studies included	Date retrieved
PUBMED	Bullying, Effectiveness, Programme	57	53	4	31.08.2017
	Violence, Effectiveness, Programme	253	252	1	31.08.2017
	Bullying, , Nursing, Intervention	54	53	1	31.08.2017
	Bullying, Nursing, Workshop	107	105	2	31.08.2017
	Bullying, Nursing, Educational programme	4	0	0	31.08.2017
	Bullying, Nursing, Approach	30	0	0	31.08.2017
	Bullying, Nursing, Strategy	17	0	0	31.08.2017
	Violence, Nursing, Intervention	64	0	0	31.08.2017
	Violence, Nursing, Workshop	2	0	0	31.08.2017
	Violence, Nursing, Educational programme	2	0	0	31.08.2017
	Violence, Nursing, Approach	58	0	0	31.08.2017
	Violence, Nursing, Strategy	13	11	2	31.08.2017
TOTAL		**661**	**474**	**10**	
WILEY ONLINE	Bullying, Effectiveness, Programme	0	0	0	01.09.2017
	Violence, Effectiveness, Programme	0	0	0	01.09.2017
	Bullying, Nursing, Intervention	11	1	1	01.09.2017
	Bullying, , Nursing, Workshop	1	1	1	01.09.2017
	Bullying, , Nursing, Educational programme	98	0	0	01.09.2017
	Bullying, Nursing, Approach	108	0	0	01.09.2017
	Bullying, Nursing, Strategy	360	357	3	01.09.2017
	Violence, Nursing, Intervention	72	0	0	01.09.2017
	Violence, Nursing, Workshop	91	0	0	01.09.2017
	Violence, Nursing, Educational programme	348	0	0	01.09.2017
	Violence, Nursing, Approach	38	0	0	01.09.2017
	Violence, Nursing, Strategy	32	0	0	01.09.2017
TOTAL		**1159**	**359**	**5**	

Table 3.2: Secondary search terms (c)

PSYCH INFO	Bullying, Effectiveness, Programme	3	0	0	01.09.2017
	Violence, Effectiveness, Programme	4	0	0	01.09.2017
	Bullying, Nursing, Intervention	17	16	2	01.09.2017
	Bullying, Nursing, Workshop	3	2	1	01.09.2017
	Bullying, Nursing, Educational program	8	0	0	01.09.2017
	Bullying, Nursing, Approach	34	0	0	01.09.2017
	Bullying, , Nursing, Strategy	45	41	4	01.09.2017
	Violence, Nursing, Intervention	66	65	1	01.09.2017
	Violence, Nursing, Workshop	6	0	0	01.09.2017
	Violence, Nursing, Educational programme	14	13	1	01.09.2017
	Violence, Nursing, Approach	40	38	2	01.09.2017
	Violence, Nursing, Strategy	37	0	1	01.09.2017
TOTAL		**277**	**175**	**12**	
SUM TOTAL		**2515**	**1377**	**50**	

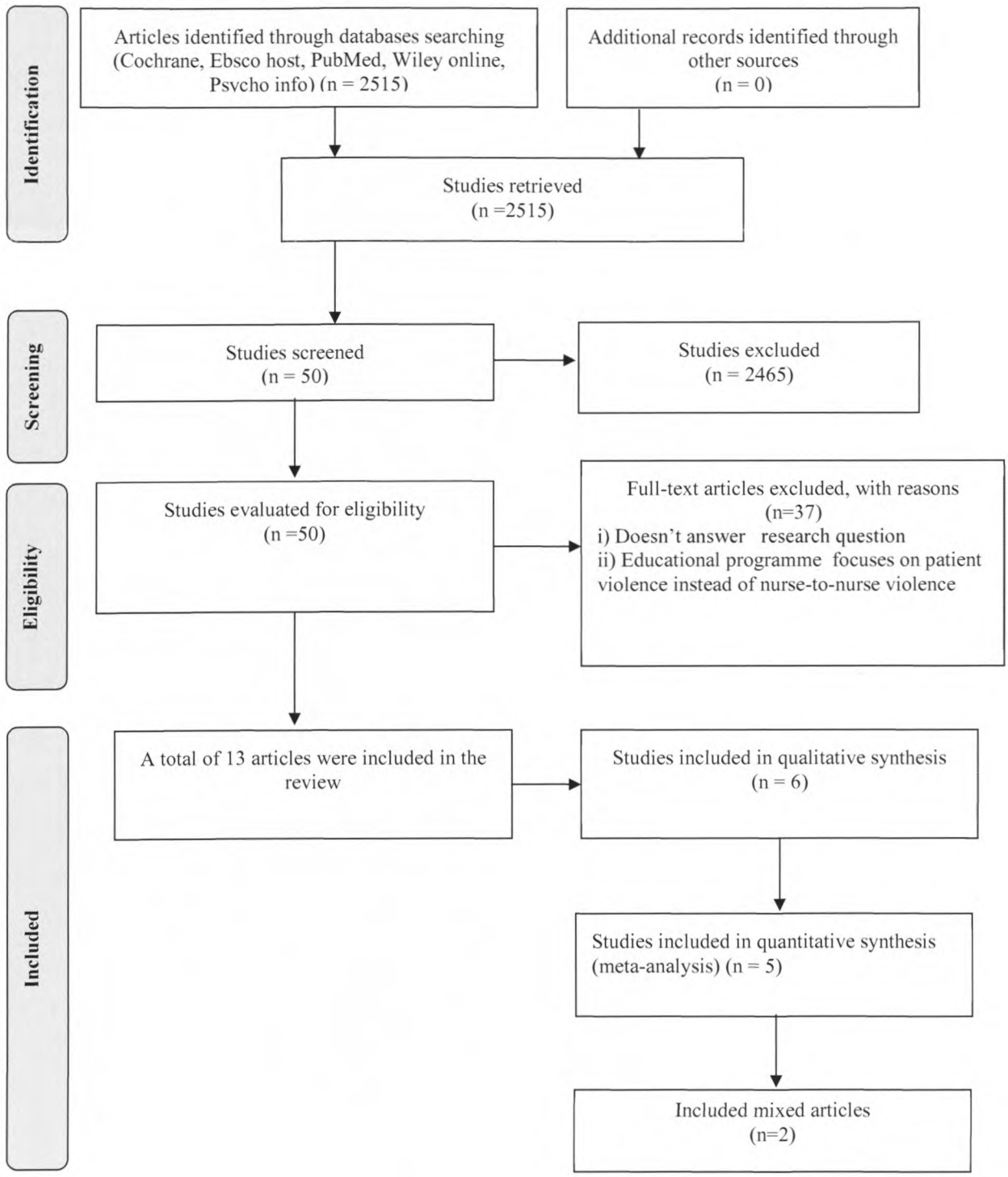

Figure 3:2: Summary of the secondary search strategy from Table 3.2

3.2.2. The inclusion and exclusion process

Two hundred and ninety eight (298) studies from the first and second search strategy were scrutinised by two independent reviewers (the student and supervisor) in the first inclusion and exclusion meeting that was held. The abstracts of the studies included were scrutinised against the inclusion criteria. After the exclusion meeting, consensus was reached on 49 articles for the preliminary inclusion, which were further evaluated using the John Hopkins Appraisal Tool and Evidence Level and Quality Guide (See Annexure C), and 31 articles were included from the first and second search strategy.

3.2.3. Description and evaluation of studies included

The data matrix consisted of 13 quantitative studies, 15 qualitative studies and three mixed method studies and all were evaluated and ranked according to the Johns Hopkins Evidence Level and Quality Tool Guide (See Annexure C). The tool ranked the studies from "Level 1 (experimental, randomised control trials, with or without meta-analysis); Level 2 (quasi–experimental articles); Level 3 (Non–experimental and qualitative studies)." The quality in the tool guide classified studies into (A) high quality, (B) good quality, (C) low quality or major flaws. A Johns Hopkins non-research evidence appraisal tool was intended for the reports, but was not used in this review.

3.2.4. Ancestry search

An ancestry search was conducted on the studies. This involved scanning the reference list of the studies to see if there were citations from these that meet the inclusion criteria of the study. These studies are termed the ancestors of the included studies. In this search, no studies were retrieved. They did not fit the inclusion criteria of this study.

3.2.5. Reasons for exclusion

Apart from not meeting the inclusion criteria, the main reason for excluding the articles was if the programme in the studies focused on bullying and violence from patients and visitors instead of nurse-to-nurse bullying and it did not answer the evidence-based practice question.

3.2.6. Analysis

Data analysis was carried out using Whittemore and Knafl's (2005) thematic analysis process. This process is divided in five phases, namely data reduction, data display, data comparison, drawing of conclusions and verification.

- Data reduction involves categorising the data into various sub-groups based on identified characteristics: type of design, date of publication, sample characteristics and context.
- Data is displayed on a data matrix for easy management.
- Data comparison involves examining the displayed data in order to determine themes, patterns and relationships.
- Data comparison involves the use of concept mapping to include identified variables, patterns or themes.
- In the conclusion and verification phase, data analysis is completed, conclusions are drawn from the themes identified and are described.
- The conclusions are then verified with the data set to confirm if they correlate. Recommendations are made for practice and further study.

3.3. Data matrix

3.3.1. Quantitative articles

Quantitative articles will be summarised in Table 3.3; qualitative articles summarised in Table 3.4 and mixed method articles in Table 3.5

Table 3.3: Quantitative articles

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
1.	Bortoluzzi, Caporale & Palese (2014:643)	Cross sectional study design,	Empirical study of 175 nurses in Northern Italy from various hospitals.	"A participative leadership style adopted by the nurse manager allows for the reduction of tensions in nurse working teams."	• Sample size constrained, selection bias • Cross- sectional study design was used instead of a longitudinal study design all variables were measured and tested in the different models	IIB
2.	Ceravolo, Schwartz Foltz-Ramos, et-al. 2012:599)	Workshop intervention study	203 workshops for 4000 practicing nurses in New York in 3 years	"Educational workshops that enhanced awareness of lateral violence and improved assertive communication resulted in a better working environment, reduction in turnover and vacancy rates, and reduced incidence of lateral violence"	• Lower response rate on the post-surveys	IIB
3.	Chipps & McRury (2012:94)	Quasi-experimental pilot study pre-test-post-test comparison	16 nurses in two rehabilitation units	"The development of an educational programme and use of a registered nurse educator in a group setting is an effective method for addressing workplace bullying"	• Small sample size • There was no control group and workplace bullying was not calculated overtime.	IIB
4.	Dalby & Herrick (2014:344)	A one-time pre-test–post-test evaluation de sign	29 nurses took part in a pre-test, and 25 participated in the post-test, in Midwestern United States	• "Positive trends were related to the decreasing frequency of lateral violence behaviours experienced and observed after the intervention". • "Participants were better able to identify causes of lateral violence in their work units, suggesting the educational intervention was successful in creating a healthier work environment and de- creasing the incidence of lateral violence behaviours"	• Sample size was small • Results cannot be generalized • Restricted one-time after intervention assessment makes evaluation of the long-term effect difficult.	**IIB**

Table 3:3: Quantitative articles (b)

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
5.	Gilbert, Hudson, & Strider (2016:10).	A none-experimental, descriptive, causal comparative, correlational design via an anonymous Web-based survey was used	A convenience sample comprising of nurse managers throughout the United States, 380 responded	• "Targeted and ongoing education for nurse managers and other frontline nurse leaders related to what bullying looks like and the importance of preventing and eliminating all forms of incivility (overt and covert) • The development of clear expectations regarding professionalism and civility • Holding nurse managers accountable for ensuring respectful behaviours and a just culture; • Partnerships between nursing leadership, hospital administration, and human resource colleagues to set, and most importantly, uphold, "zero tolerance" policies • Peer (manager-to-manager) coaching."	• The vast majority of respondents in the study were from academic medical centres, so results can only be generalised to academic medical centres but not necessarily to non-academic medical centres • 89.9% of the participants were female, making the results generalisable to female nurse managers but not necessarily to their male counterparts • 68.4% of the respondents were from Magnet facilities, therefore, the results are more generalisable to Magnet facilities than non-Magnet facilities.	IIIB
6.	Kaiser (2017:110).	A survey	237 staff nurses from acute care and continuing care settings	• "Transformational leadership style had the strongest correlation with low incivility between staff nurses. Leadership is not a definitive factor of incivility, but leader behaviours impact on the level of incivility between staff nurses". • "The relationship between leaders and staff and empowerment of staff have the strongest impact on nurse incivility."	• Both constructs of leadership and incivility are subjective • The survey method is based strictly on respondent perception and may not accurately gauge the true levels of incivility and leadership styles on the nursing unit. • Measurement tool not developed as extensive testing for psychometric properties was not performed.	IIIB
7.	Laschinger, Wong & Grau (2012:1274).	Cross-sectional survey design	342 recent degree holders working in acute care hospitals in Ontario, Canada	"The results suggest that efforts should be made to assist nurse managers in developing and implementing authentic leadership practices as part of a strategy for eliminating workplace bullying and burnout in nursing work environments".	i) The results of this study must be interpreted carefully given the restrictions of cross-sectional study design, which prevent the ability to make statements of cause and effect.	IIIB

Table 3:3: Quantitative articles (c)

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
8.	Ley (2015:11)	Prospective, quasi-experimental study used a pre-test-post-test control group design.	47 perinatal registered nurses practicing in acute care settings.	• "Results show that nurses knowledge of BHLV(bullying, harassment and lateral violence) behaviours and strategies for reducing the BHLV behaviours were significantly increased after the intervention" • "There is a need for evidence-based educational pathways toward the prevention or correction of this phenomenon".	• Geographical homogeneity and tightly controlled nursing experience level of the target population that limit generalisability to the larger population of interest. • Selection bias could be problematic as the most motivated nurses may make up the largest component of the sample. • Other issues related to bias might have occurred if subjects talked or conferred with each other about their participation and shared their answers on the tools between administrations.	IIB
9.	Mallette, Duff Mcphee, Pollex & Wood (2017:44)	Experimental effectiveness study used a pre-test-post-test control group design.	164 student nurses	"Findings from this study suggest that learning through the self-directed e-learning module followed with practice in a virtual world is an effective way of acquiring knowledge, skills and abilities to better address horizontal violence".	(Abstract)	IIB
10.	Sanderson (2013:viii)	Quality improvement study	"227 Mental Health Nursing Service staff from various fields of study"	"These findings support continued use of assertiveness training with role-play as an effective approach for improving civility in a culturally diverse MH nursing staff".	• Results cannot be generalised. • It was a retrospective study, the results contributed only to a correlational relationship and not a predictive relationship.	IIIB
11.	Sanner-Stiehr & Ward-Smith (2015:1)	Experimental, randomised cluster design study	"88 nursing students: 41 from the trial group and 47 from the control group."	i) "Results indicate that a cognitive behavioural rehearsal intervention can increase nursing students' self-efficacy to respond to lateral violence prior to entry to the nursing workplace, where it is likely to be encountered".	i) Only 78 were available to complete the follow-up instrument from the initial total of 88.	IB

Table 3:3: Quantitative articles (d)

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
12.	Stagg, Sheridan, Jones & Speroni (2011:395)	"Descriptive, quasi-experiment. Study had three components: Pilot survey testing, survey administration and an intervention with a pre – and post-test study design"	62 staff nurses on medical and surgical units	• "After the cognitive rehearsal programme, nurses' knowledge of workplace bullying management significantly increased." • "Nurses were more likely to report that they had observed bullying and had bullied others." • Nurses felt more adequately prepared to handle workplace bullying". • "Results of the research support the provision of a workplace bullying management programme for nurses and the need for a specific policy on workplace bullying".	• Small sample size of medical and surgical nurses expanded chances of making a type II error. • Small sample size therefore results cannot be generalised to other populations. • Calculations were obtained from the use of self–report survey.	IIB
13	Stagg, Sheridan, Jones & Speroni (2013)	Non-experimental pilot study	"15 medical and surgical nurses who participated in the cognitive rehearsal training programme"	• "40% of the nurses reported a decrease in bullying behaviours in the past 6 months. • A common theme of increased awareness of bullying behaviours emerged, which included the participants' own actions as well as those of others. 70% of the nurses reported changing their own behaviours following the course." • "When asked to provide recommendations to reduce workplace bullying, staff education regarding bullying was a common theme."	• "This study was not designed with the thoroughness of a qualitative study. The study analysis relied mainly on quantitative procedures. • Results cannot be generalised. • The frequency of bullying witnessed by the nurses was not quantified. • The convenience sample made the researchers question whether the study participants' experiences differed from those who did not participate in the programme. • Participants may have had difficulty recalling bullying experiences and responses during the past 6 months."	IIIB

3.3.2. Qualitative articles

Table 3.4: Qualitative articles

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
1.	Blando Ridenour, Hartley & Casteel (2017:9)	Semi structured Interviews in two focus groups	27 attendees from different organisations were represented: 13 in one focus group and 14 in the other.	• "Seven themes were identified as major barriers to effective implementation of workplace violence programme: lack of action despite reporting; varying perceptions of violence; bullying; profit–driven management models; lack of management accountability; a focus on customer service; weak social service and law enforcement." • "Many barriers to effective implementation of workplace violence programmes are within the programme itself and/or related to broader healthcare industry and societal issues. Creative innovations to support communication, management support and public policy can address challenges to effective implementation of WPV programmes and improve workplace violence prevention programmes."	• Lack of randomisation among the focus group members were not randomised that could result in reporting bias. • All focus group participants were experienced professionals who belonged to a union therefore their comments may not be representative of nurses and allied health professionals at large.	IIIB
2.	Egues & Leinung, (2014:240)	Intervention study	230 minority nursing students within a multicultural environment	• "Nurse Educators can help influence anti-bullying awareness through workshops integrated into their programme of study. This innovative curriculum strategy demonstrates nurse educator commitment to anti-bullying that is focused on guiding and promoting the advocacy of educational, leadership, and professional opportunities and skills growth for minority nursing student scholars".	• Small sample size. • Results cannot be generalised. • One-time post intervention assessment limits long-term evaluation.	IIIB
3.	Evans & Curtis (2011:654)	Intervention study	20 senior nursing students registered in the Spring 2011 Nursing Leadership course.	• "Student responses to this virtual approach teaching method were positive. Based on survey results, 72% of respondents indicated they were more comfortable exploring conflict in the virtual environment than they would have been if the scenarios had been conducted face-to-face." • "Exposure to conflict management within Second Life provided an opportunity for students to explore and respond to complex scenarios in a safe, nonthreatening environment." • "Approaching conflict management in this manner allowed faculty to create an environment and scenarios that were specific to the nursing profession while providing the opportunity for students and faculty to discuss students' concerns about engaging in conflict openly."	• Due to an initial lack of buy-in, faculty members were not as prepared as needed on the first day of simulations, which created frustration for students looking to their clinical faculty member for guidance. • This project was implemented during the last semester of students' senior year.	IIIB

Table 3:4: Qualitative articles (b)

SN	Author& date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
4.	Gillespie et al. (2017:17)	Non–experimental, descriptive design	10 faculty members at three universities across five academic campuses.	• "It was critiqued by an advisory board and deemed relevant, clear, simple and non-ambiguous." • ii) "Programme had value to faculty members and students" • "findings from the pilot implementation of the bullying educational programme indicate the need to incorporate the programme into additional nursing courses" • "The incorporation may permit the programme content to be addressed multiple times over three years of study, as well as potentially mitigate the problem of faculty members who are not available during the subsequent years."	• Results cannot be generalised	IIIB
5.	Gillespie et al. (2015:1)	Qualitative descriptive design	Eight nursing students at two college campuses of a university	• "Role play simulation was an effective and active learning strategy in education to diffuse bullying in nursing practice." • To enhance the learning experience further, adequate briefing instructions, opportunity to opt out and comprehensive debriefing is essential.	• Small sample size and participants drawn from the same university. • Results cannot be generalised	IIIB
6.	Johnson, (2015:2384)	"Critical and Foucauldian discourse analysis of semi-structured interviews with nursing unit managers and documents from hospital systems where they worked".	Purposive sample of 15 managers from seven different hospitals in USA.	• "The effective prevention of workplace bullying will require departmental and organisational initiatives." • "Leaders in all types of organisations can use the results of this study to examine their organisations' discourses of workplace bullying prevention to determine where change is needed."	• Results cannot be generalised • Examined only formal organisational documents, (i.e. policies) and discussions with managers in an artificial setting (i.e. interviews). Analysis of informal documents such as internal memos or emails, or observations of informal, natural discussions among members of an organisation may add deeper insight into organisational and managerial discourses of workplace bullying prevention.	IIIB

Table 3:4: Qualitative articles (c)

SN	Author & date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
7.	Johnson, et al. (2015:460).	Descriptive, qualitative study using discourse analysis	Purposive and snowball sampling was used to recruit 15 hospital nursing managers located in urban, suburban, and rural settings	• "Findings suggest that organisations that are serious about addressing workplace bullying need to draft, and actively disseminate, coherent policies that can be clearly understood and uniformly implemented by managers." • "To effectively address bullying, organisations need to clarify how they want nursing managers to address bullying and should offer them support and guidance through this often difficult process." • "Organisations also need to create opportunities for everyone to openly discuss the problem of workplace bullying, thereby creating a culture in which it is acknowledged and addressed." • "Organisations that are serious about addressing workplace bullying need to offer ongoing educational opportunities for management and staff, as well as periodical reminders of policies."	This study was conducted in a specific geographic region of the United States, which limits its generalisability	IIIB
8.	Johnson et al. (2015:271)	Descriptive qualitative study	Purposive sampling of 15 managers in the United States	• "Mediation and confrontation are two strategies commonly suggested in the nursing literature as appropriate responses to bullying". • "To manage workplace bullying effectively, managers need to engage in ongoing dialogue with staff about bullying." • "Finally, staff nurses can assist managers' efforts to deal with bullying by providing appropriate documentation of behaviours and by not excusing or normalising these behaviours".	• "The sample was homogeneous in ethnicity and gender, and was drawn from a limited geographic area. • Although data saturation was achieved, samples with a more diverse representation, and from other geographic areas, may uncover additional discourses of bullying."	IIIB
9.	Lux, Hutcheso, & Peden (2012: 236)	Qualitative descriptive study	nine staff nurses from three hospital systems in central Ohio	• "Participants' described a deliberate approach that included delaying confrontation, approaching the colleague calmly and acknowledging the colleague's point of view when managing conflict." • "Using a deliberate approach, the confrontation was delayed unless it was connected to a patient safety issue." • "Active listening was used to assure that the perpetrator's concerns were heard during conflict resolution"	• "Participants only participated in a single interview. Multiple interviews may have led to further description of the phenomenon. • Participants had been in practice for a number of years. Seasoned nurses may describe successful management of disruptive behaviours differently from less experienced nurses."	IIIB

Table 3:4: Qualitative articles (d)

SN	Author and date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & Quality
10	Lux, Hutcheson, & Peden (2014:37)	Qualitative descriptive study	Nine staff nurses in acute care settings in the United States	• "Staff nurses recommended educational strategies that focused on communication skills for professional practice. These included learning how to communicate with hostile individuals, and giving and receiving constructive criticism". • "Communication training as an important educational topic for nurses, emphasising teaching assertive communication, teamwork and self-reflection". • "Journaling, as a teaching strategy, could be used to help nurses and students reflect on disruptive behaviour situations as well as provide documentation of events in real time."	• "Participants only participated in a single interview. Multiple interviews may have led to further description of the phenomenon."	IIIB
11	Skarbek, Johnson, & Dawson (2015: 495).	Phenomenological qualitative study	The participants were six nursing managers (5females,1male) who were employed in four urban hospitals and one sub- urban hospital in the Midwestern and North-eastern regions of the United States	• "Institution-wide ''mandatory programmes' were not deemed effective. Instead, nurse manager-initiated interventions on a unit level, in collaboration with institutional and administrative support, were perceived to be effective methods to address workplace bullying among registered nurses." • "RNs at all levels of the hierarchy must first acknowledge that workplace bullying exists. Managers and administrators must support victims of bullying and find ways to prevent this insidious behaviour from occurring."	Results cannot be generalised	IIIB
12	Soncrant (2015)	Intervention study	Six graduate students and two clinical supervisors in healthcare settings	• "87, 5% found the presentation 'very effective' in raising levels of awareness and recognition of workplace bullying of nurses."	• Small sample size • Results cannot be generalised	IIIB
13	St-Pierre, (2012)	Used principles of critical nursing ethnography, data, qualitative study	"Twenty-three semi-structured interviews were done in both a university- affiliated psychiatric hospital and a community hospital located in a large metropolitan city in Ontario."	Several strategies were described by managers including: • "Coaching individuals so they feel capable of addressing the issue themselves". • "Acting as mediator, and disciplining employees whose actions warrant harsh consequences." • "Conclusions drawn from the study suggest that aggression management is not solely the responsibility of managers but must involve several actors including the aggressive individual, peers, human resources department, and unions."	Results cannot be generalised	IIIB

Table 3:4: Qualitative articles (e)

SN	Author and date	Evidence type	Sample size & Sample setting	Study findings that help answer the research question	Limitations	Evidence level & quality
14	Strandmark, & Rahm, (2014:66)	Community based participatory approach. Qualitative grounded theory methodology used.	"26 nurses working in two geriatric wards at nursing homes in two municipalities and one geriatric psychiatric ward at a hospital engaged in focus groups and three female immediate supervisors were interviewed across the three workplaces."	i) "Focus group interviews indicated that those best positioned to prevent and combat bullying were the immediate supervisors, in collaboration with co-workers and upper management". ii) "The goal of zero tolerance toward bullying can be achieved if all concerned work together, using a humanistic value system, an open workplace atmosphere, group collaboration and conflict resolution". iii) "Focus group interviews at the fourth meeting, after the implementation, showed that employees were then more aware of bullying problems, the atmosphere at the workplace improved, the collaboration between and within the group was stronger and the supervisor worked continuously to prevent and combat bullying, using the humanistic values suggested." iv) "The anti-bullying programme implementation in the workplace achieved some success, but the intervention process is ongoing."	Results cannot be generalized	IIIB
15	Ulrich et al. (2017:203)	Qualitative exploratory design	333 nursing students from 05 college campuses of three universities completed a reflection worksheet.	i)"Role play simulation was a highly effective pedagogy, allowing participants to feel emotions they might experience should they encounter bullying in future eliciting learning at both the cognitive and affective domains."	i)lack of geographical variability in the participating nursing schools ii) Students' knowledge and experiences with bullying were not measured. Their backgrounds could have had an impact on their participation and engagement in role-play simulation, ultimately affecting their affective responses documented of the reflection sheets.	IIIB

Table 3.5: Mixed method article

SN	Author and date	Evidence type	Sample Size and Sample setting	Study findings that help answer the research question	Limitations	Evidence level & quality
1.	Brann (2016:85)	"First a pre/post-test survey design was employed to assess awareness and knowledge, followed by a focus group discussion to evaluate online course design"	"55 nursing students in a Bachelor of Science programme at a mid–Atlantic university"	• "Course participation increased awareness of workplace violence. Qualitative data from the focus groups reinforced the quantitative findings". • "Participants strongly recommended including the National Institute for Occupational Safety and Health (NIOSH) workplace violence prevention for nurse's online course in nursing curriculums. Incorporating the course early in the nursing educational experience would better prepare students to deal with workplace violence when they enter healthcare professions."	• Students completed the course at their own pace, there is no way of knowing if other information may have influenced the participants (other training). • Follow-up may have enhanced retention of information. • Small sample size is a limitation for generalisability.	IIIB
2.	Rouse & Al-Maqbali (2014:192).	"Qualitative content analysis was conducted first, followed by a quantitative descriptive analysis."	1526 nurses from 22 hospitals in Oman	• "The participants stressed that nurse manager feedback should be shared privately and framed in a positive and constructive tone. Active listening, team collaboration and the avoidance of discrimination/favouritism were also emphasised".	• "Restricted to nursing professionals in Oman. • The study used one open- ended and nondirective question to measure a nurse's perceptions of the essential communication skills of nurse managers. Participants who responded to this question may have had higher levels of dissatisfaction with their nurse managers, resulting in more negative comments".	IIIB
3.	Schaefer (2014:vii)	Mixed method intervention trial	Small size of senior, Baccalaureate nursing students from a nursing college randomly assigned into two groups.	"Education focusing on recognising covert forms of negative behaviour and the continued need to report them, if incorporated into nursing education curriculum may help break the cycle of violence identified as 'eating our young'."	• Small convenience sample from one college of nursing. • The responses to the quantitative questions relied on behavioural coding of observations by the nursing students. • The instrument was a newly developed tool with limited reliability and validity.	IB,IIIB

3.4. Conclusion

The chapter has described the literature search process that was conducted in detail, including the description process of the included and excluded articles in the review, the types of papers, evidence grading and quality assessment process, and the extracted information from the included articles was displayed on the data matrix. The following chapter analyses the data collected from the articles using the Whitmore and Knafl (2005) thematic analysis.

4. CHAPTER FOUR: DATA ANALYIS

This chapter describes the first three stages of the thematic analysis of data extracted and displayed in the data matrix in Chapter 3, that is data reduction, display and comparison, and the evidence level of the studies are rated using the John Hopkins Research Evidence Level and Quality Tool (Annexure C).

4.1. Data Reduction and Display

The data was reduced into quantitative, qualitative and mixed methods, as described from the search strategy and data matrix in Chapter 3.

4.2. Distribution of Studies Included

Most of the studies that were published regarding bullying prevention were from various places of United States of America, and the following describes the distribution in detail. The table below gives an overview of the following:

- The country where the included studies were published.
- The year the study was done.
- Number of authors who conducted the study.
- Institutions that were involved during the conduction of the study.
- The journal in which the study was published.

Table 4.1: Distribution of Studies Included

Number Article	Country of Publication	Year of publication	Number of authors	Institutional Collaborations	Journal Published
1	USA	2012	4	1	Nursing management
2	USA	2014	2	1	Nursing Forum
3	USA	2015	4	1	Nursing administration
4	USA	2017	1	1	Nursing management
5	USA	2017	5	4	Research brief from Nursing Education
6	USA	2015	5	3	Manuscript from Nursing Education Journal
7	USA	2011	2	1	Nursing Education
8	USA	2015	1	1	Doctoral dissertation
9	USA	2011	5	1	Nurse leadership
10	USA	2015	1	1	Advanced nursing
11	USA	2015	3	3	Nursing administration
12	UK	2012	3	2	Internal Journal of Nursing Studies
13	USA	2015	4	4	Manuscript
14	USA	2017	4	2	Nursing Education and Practice
15	Italy	2014	3	1	Nursing management
16	USA	2017	1	1	Doctoral dissertation
17	UK	2013	4	1	Workplace health and safety
18	USA	2016	3	1	Nursing administration
19	UK	2011	4	1	Continuing education in nursing
20	Sweden	2014	2	1	Scandinavian Journal of Public Health
21	USA	2015	5	1	Nursing forum
22	UK	2012	1	1	Healthcare manager
23	USA	2014	3	1	Nursing education
24	USA	2011	3	1	Issues in mental health nursing
25	USA	2013	1	1	Doctoral Dissertation
26	USA	2012	1	1	Journal for nurses in staff development
27	USA	2014	1	1	Dissertation
28	USA	2017	2	2	Journal of Safety Research
29	USA	2015	2	1	Journal of Nursing Education
30	USA	2014	2	1	Journal of Continuing Education in Nursing
31	USA	2014	2	2	Journal of Nursing Management

4.2.1. Distribution of publications by year

Figure 4.1 below shows that the most of the studies were published in 2015, eight in total and only one study in 2016. In between these years, the numbers fluctuated.

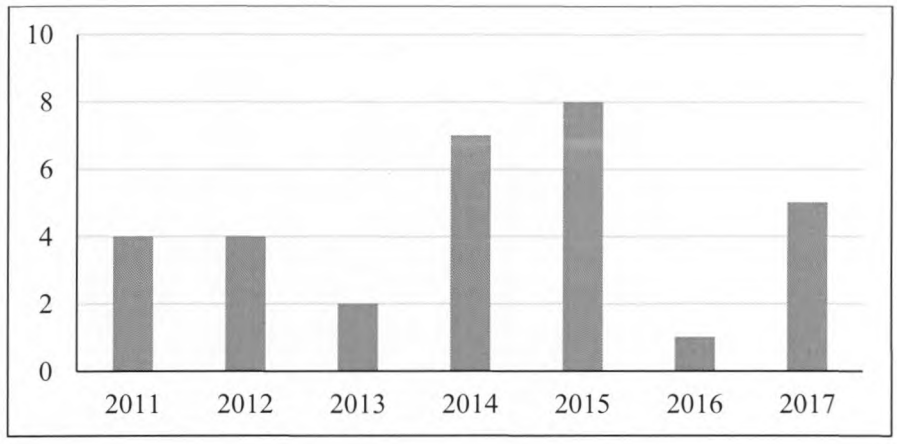

Figure 4:1: Yearly Distribution of studies

4.2.2. Geographical distribution of articles included in the review

Figure (4.2) below shows the United States of America published 26 of the 31 included studies.

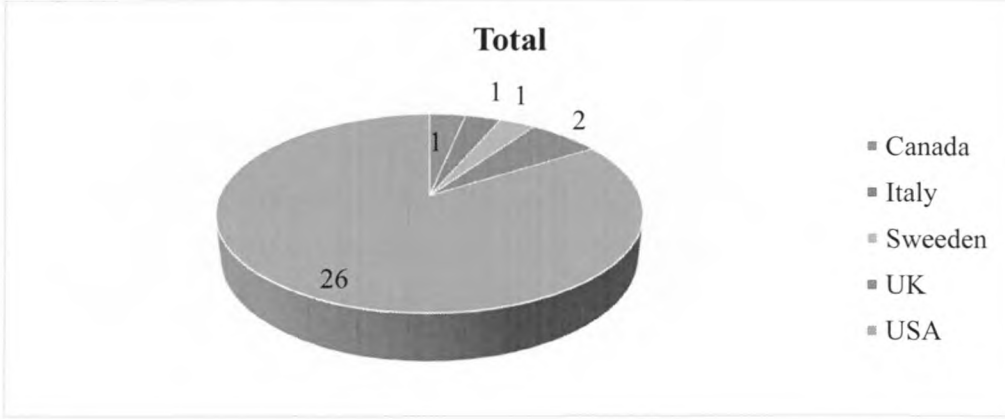

Figure 4:2: Country of published studies

Number of authors

Figure 4.3 below shows the number of authors on a published study. Eight studies were published by one author, seven studies were published two authors, six studies were published by three and four authors and four articles were published by five authors.

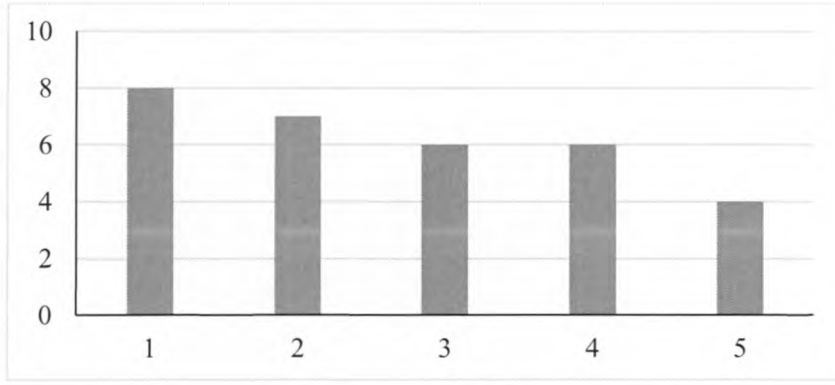

Figure 4:3: Number of Authors per published study

Number of collaborations

Figure 4.4 below shows number of institutional collaborations, out of 31 studies, 23 authors were from the same institution, four authors were from two different institutions, two authors were from three different institutions and two authors from four different institutions.

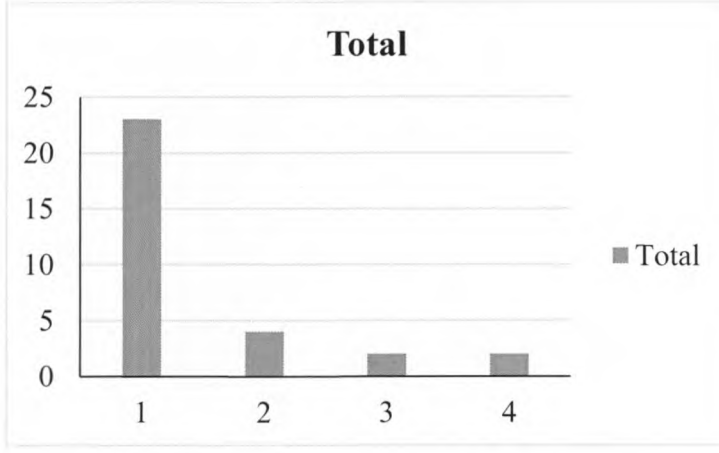

Figure 4:4: Institutional Collaborations of Included Studies

4.3. Themes and Sub-Themes

Three major themes were identified in this review: "Empowerment programmes", "Leaders' involvement" in bullying prevention programmes for nurses and "Institutionalisation of bullying prevention policies." Table (4.2 to 4.4) displays the themes and subthemes that emerged from the 31 included studies.

Note: The percentages represent the ratio of articles supporting the sub-themes out of the total number of articles included in the study.

Table 4.2: Empowerment programmes (Theme 1)

THEME 1: EMPOWERMENT PROGRAMMES 71% (n=22)		
SUB-THEMES	**SUPPORTING STATEMENTS**	**%**
Inclusion in undergraduate curriculum	• Virtual approach teaching method increased students' confidence to explore conflict in a safe environment, hence empowering them to prevent bullying (Evans &Curtis, 2011). • In cooperating educational programme on bullying into the nursing curriculum, this empowers the graduate nurses to prevent bullying (Gillespie et al., 2017). • Role play simulation on bullying prevention is an effective and active learning approach that empowers nurses to disperse bullying in nursing practice (Gillespie et al., 2015). • Role play simulation on bullying is an effective way of empowering students to identify and manage bullying in their future workplace domains (Ulrich et al., 2017). • Conflict management using virtual approach through meetings allowed for students and faculty to openly discuss students' concerns about engaging in and prevention of conflicts in the workplace (Evans & Curtis, 2011). • Incorporating workshops on bullying in nursing programmes empowers students to recognise and manage bullying behaviours effectively (Egues & Leinung, 2014). • Self-directed e-learning module with practice during simulation is an effective way of acquiring knowledge, skills and abilities to better address horizontal violence (Mallette et al., 2011). • Incorporating education highlighting subtle forms of negative behaviour and the continued need to report them into nursing education curriculum helps in breaking the cycle of violence. (Schaefer, 2014). • Educational approaches that focused on communication skills for professional practice in order to equip students to manage bullying behaviours more effectively were found to be helpful (Lux, Hutcheson & Peden, 2014) • A cognitive behavioural rehearsal intervention increases nursing students' self-efficacy to respond to lateral violence prior to entry to the nursing workplace, where it is likely to be encountered(Sanner-Stiehr, 2015).	**29%** ***(n=9)***

Table 4:2: Empowerment programmes (Theme 1) (a)

SUB-THEMES	SUPPORTING STATEMENTS	%
In-service training programmes	• Educational workshops for nurses enhanced awareness of lateral violence and improve assertive communication resulting in a better working environment and decreased incidences of nurse to nurse violence (Ceravolo et al., 2012). • Ongoing educational opportunities for nurse leaders and staff are needed in order to increase awareness around bullying behaviours (Gilbert, Hudson &Strider, 2016). • An educational programme regarding bullying and use of a registered nurse educator in a group setting is an effective method for addressing workplace bullying (Chipps & McRury, 2012). • Assertiveness training with role-play was found to be an effective approach for improving civility in a culturally diverse mental health nursing staff institution (Sanderson, 2013). • Online course developed by NIOSH for nurses with the goal of increasing awareness and educating participants about prevention techniques to promote safety was effective in preventing bullying (Brann & Hartley, 2017).There is a need for evidence-based educational pathways toward the prevention or correction of the bullying problem(Ley, 2015). • Staff education regarding bullying is important in bullying prevention in the workplace (Stagg& Sheridan, 2013). • There were encouraging trends related to the reduced frequency of lateral violence behaviours experienced observed after an educational intervention regarding bullying was implemented (Dahlby & Herrick, 2014). • Continuous educational opportunities for nurse leaders and staff as well as periodical reminders of bullying policies are effective ways of empowering staff to prevent bullying (Johnson, Boutain *et al.*, 2015). • Journaling, as a teaching strategy, is an effective way of empowering nurses to reflect on disruptive behaviour situations and managing them (Lux, Hutcheson & Peden, 2014). • Cognitive rehearsal programme increased nurses' knowledge of workplace bullying and management (Stagg et al., 2011) • A workshop presentation on bullying was found to be very effective in raising levels of awareness on bullying behaviours in the workplace (Soncrant, 2015)	**39** % (n=12)

Table 4:2: Empowerment programmes (Theme 1) (b)

SUB-THEMES	SUPPORTING STATEMENTS	%
Taking personal responsibility	• Empowering nurses to deliberately delay confrontation, approach colleague calmly and acknowledging the colleague's point of view when managing conflict was found to be helpful in preventing bullying (Lux, Hutcheson & Peden, 2012). • Bullying prevention programmes that promote active listening are effective in bullying prevention (Lux, Hutcheson & Peden, 2012). • Effective communication skills are essential in managing hostility in the workplace as they are needed especially when hostility occurs during nurse interactions (Lux, Hutcheson & Peden, 2014). • Bullying prevention programmes that assist nurses to reflect on their behaviours that encourages bullying in the workplace increases their awareness of such bullying behaviour, therefore adopting ways of preventing bullying in the workplace (Stagg Sheridan, 2013). • Empowering nurses to appropriately document behaviours helps eliminate bullying behaviours (Johnson, Boutain, *et al.*, 2015). • The individuals (bully and the victim), peers, human resources department and unions need to take responsibility for managing bullying in the workplace (St-Pierre, 2012)	**19** % (n=6)

4.3.1. Theme one: Empowerment programmes

Seventy-one percent (71%, n=22) , of included studies in this review indicated the important role education and training programmes play in raising awareness, knowledge and understanding as well as decreasing bullying incidences post the interventions, therefore empowering nurses. Dahlby (2014) states that to overcome gaps that exist in identifying and managing lateral violence in the workplace, education is needed to bridge that gap, as well as successful methods to stop the lateral violence. When education and training programmes are empowering through imparting knowledge and skills, nurses will tackle the bullying phenomenon in their workplaces more effectively. This theme was subdivided into three subthemes, namely, in-service training programmes **(39% n=12),** included in the undergraduate curriculum (**29%, n= 9)**, and taking personal responsibility (**19% n=6**).

4.3.1.1. In-service training programmes

Thirty-nine percent (39% n=12) of the included studies in this review highlighted positive results of different training programmes that managed to reduce bullying behaviours in different settings through awareness and being knowledgeable about bullying and being equipped with skills to manage bullying in the workplace, therefore empowering nurses attending these in-service programmes. The following extracts explicitly substantiate this claim.

"*Educational workshops that enhanced awareness of lateral violence and improved assertive communication resulted in a better working environment, reduction in turnover and vacancy rates, and reduced incidence of lateral violence.*" (Ceravolo et al., 2012)

"*Positive trends were related to the decreasing frequency of lateral violence behaviours experienced and observed after the intervention. Participants were better able to identify causes of lateral violence in their work units, suggesting the educational intervention was*

successful in creating a healthier work environment and decreasing the incidence of lateral violence behaviours." (Dalby, 2014)

"*Development of an educational program and use of a registered nurse educator in a group setting is an effective method for addressing workplace bullying.*" (Chipps, 2012)

"*Support continued use of assertiveness training with role-play as an effective approach for improving civility in a culturally diverse MH nursing staff.*" (Sanderson, 2013)

"*After the training program, nurses' knowledge of workplace bullying management significantly increased.*" (Stagg, 2011)

"These results indicate that a cognitive behavioural rehearsal intervention can increase nursing students' self-efficacy to respond to lateral violence prior to entry to the nursing workplace, where it is likely to be encountered." (Sanner-Stiehr, 2015)

"Increased awareness of bullying behaviours emerged, which included the participants' own actions as well as those of others; 70% of the nurses reported changing their own behaviours following the course." (Stagg & Sheridan 2013)

" *87,5% found the presentation 'very effective' in raising levels of awareness.*" (Soncrant, 2015)

Bullying prevention programmes are deemed effective when they cater for the needs of the institution and assertive communication skills have been identified as a need in order to manage bullying behaviours more effectively, as illustrated in extracts below.

"Communication was the most commonly mentioned content area, specifically learning how to communicate in difficult situations. They particularly identified learning how to communicate with hostile individuals." (Lux, 2014)

"However, to better prepare the new nurse for this environment an increased focus on nurse-to-nurse and inter-professional communication that assists in conflict management is needed." (Lux, 2014)

"Using a deliberate approach, the confrontation was delayed unless it was connected to a patient safety issue. The perpetrator was approached calmly in a private setting. Active listening was used to assure that the perpetrator's concerns were heard. This thoughtful approach ended with a discussion related to alternate ways of responding." (Lux, 2014)

"Nursing professionals said approachable and affirming behaviours are essential communication skills for nurse managers. According to Pope (2010), approachable behaviours make nurses feel comfortable asking for help or clarification." (Rouse & Al-Maqbali, 2014)

"Active listening, team collaboration and the avoidance of discrimination/favouritism." (Rouse &Al-Maqbali, 2014)

The studies resulting in this sub-theme ranged from Level 2 (evidence from quasi-experimental studies and intervention studies quantitative) to Level 3 with (from non-experimental qualitative study), with Level 3 being the majority.

4.3.1.2. Inclusion in undergraduate curriculum

New professionals tend to leave their jobs due to lateral violence (Evans, 2011). The author adds that nurse educators need to prepare students to enter hostile environments hence the need to incorporate a bullying module into the undergraduate curriculum and adjust learning strategies on conflict management, as it can be both time and practice consuming. Twenty nine percent (n=9) of the included articles highlighted this sub-theme. The following extracts

illustrate various teaching methods to equip students with skills to cope in a bullying environment.

"*Student responses to this teaching method were positive. Based on survey results, 72% of respondents indicated they were more comfortable exploring conflict in the virtual environment than they would have been if the scenarios had been conducted face-to-face.*"(Evans, 2011)

"*Role play simulation was an effective and active learning strategy to diffuse education on bullying in nursing practice.*" (Gillespie, 2015)

"*Findings from the pilot implementation of the program indicate the need to incorporate the program into additional nursing courses.*" (Ulrich, 2017)

"*Participants citing benefits from the content strongly recommended including the course in nursing curriculums.*" (Brann, 2017)

*"Nurse Educators can help influence anti-bullying awareness through workshops integrated into their program of study." (*Egues, 2014)

"Self-directed e-learning module followed with practice in a virtual world is an effective way of acquiring knowledge, skills and abilities to better address horizontal violence." (Malleate, 2011)

"Education focusing on recognising covert forms of negative behaviour and the continued need to report, if incorporated into nursing education curriculum may help break the cycle of violence identified as 'eating our young." (Schaefer, 2014)

The studies resulting in this sub-theme ranged from Levels 2 to 3 (evidence from quasi-experimental to non-experimental studies)

4.3.1.3. Taking personal responsibility

Sixteen percent (16% n=5) of the included studies mention that it takes a collective team effort from an institution for bullying behaviours to be eradicated, as everyone has a role to play, including the victim, thus empowering the victim to take personal responsibility when managing bullying behaviours in the workplace instead of leaving management to handle it, as clearly illustrated in the following extracts.

"*Aggression management is not solely the responsibility of managers but must involve several actors including the aggressive individual, peers, human resources department, and unions.*" (St-Pierre, 2012)

"Providing *appropriate documentation of behaviours and by not excusing or normalising these behaviours.*" (Johnson, Boutain, *et al.*, 2015)

The studies resulting in this sub-theme ranged from Level 1 (evidence from experimental studies and intervention studies quantitative) to Level 3 with (from non-experimental qualitative study), with Level 3 being the majority.

Table 4.3: Leader's involvement (Theme 2)

THEME 2 : LEADERS'S INVOLVEMENT 29% (n=9)		
SUB-THEMES	**SUPPORTING STATEMENTS**	%
Leader's role	• Managers should be involved in the implementation of bullying prevention policies and programmes (Johnson, Doris Boutain, *et al.*, 2015). • To manage workplace bullying effectively, managers need to interact continuously in a dialogue with staff about bullying (Johnson et al., 2015a). • Nurse manager-initiated bullying prevention interventions at unit level were effective (Skarbek, Johnson & Dawson, 2015). • Managers should coach nurses so they feel confident of confronting the bullying problem themselves (St-Pierre, 2012). • Managers should act as mediators and discipline bullying perpetrators to prevent bullying (St-Pierre, 2012). • Nurse managers are in the best position to combat bullying (Strandmark & Rahm, 2014). • Nurse managers need to give feedback regarding employee's mistakes to employees privately and framed in a positive and constructive tone(Rouse & Al-Maqbali, 2014).	13% (n=4)
Leadership style	• A leadership style that is participative utilized by the nurse manager permits for the reduction of tensions in nurse working teams (Bortoluzzi, Caporale & Palese, 2014). • A leadership style that is transformative, had the strongest link with low incivility between staff nurses (Kaiser, 2017). • Authentic leadership practices promote elimination of workplace bullying (Laschinger, Wong & Grau, 2012).	10% (n=3)
Skills and support for managers	• Strategies that should be used to prevent and eliminate nurse-to-nurse bullying include peer (manager to manager) coaching (Gilbert, Hudson & Strider, 2016). • Innovative ways to support communication, leadership support and public policy can address bullying issues and improve workplace violence prevention programmes (Blando et al., 2015). • There should be ongoing education for nurse managers and other frontline nurse leaders related to what bullying is, and the importance of preventing and eliminating all forms of incivility (overt and covert) (Gilbert *et al.*, 2016). • Managers should be able to debrief about their own struggles related to managing bullying (St-Pierre, 2012). • Nurse managers should be assisted in developing and implementing authentic leadership practices as part of a strategy for eliminating workplace bullying(Laschinger, Wong & Grau, 2012).	10% (n=3)

4.3.2. Theme two: Leaders' involvement

Twenty-nine percent (29% n=9) of the studies highlighted the importance of leaders' involvement on the effectiveness of bullying prevention programmes (Johnson et al 2015; St-Pierre 2012; Strandmark 2014 & Skarbek 2015). Leadership style and skills exhibited by nurse managers in organisations have great influence on combating bullying in the workplace and therefore have an indirect impact on the implementation of bullying and prevention programmes. A study conducted by Spence (2012) found that nurse managers played a pivotal role in representing the standards for acceptable behaviour and strengthening the role of leadership in creating a positive surrounding that does not tolerate bullying. Blando *et al.* (2015) stated that problems to implementation of workplace violence prevention programmes are within the programme itself or related to the wider healthcare industry and societal issues. Lack of leaders' involvement was an example of one of the issues in this review. Successful approaches for avoiding bullying depend on the quality of working environments that are created by managers (Spence *et al.* 2012). Three sub-themes were combined to form the theme "leaders' involvement," and they include leaders' role (13% n=4), leadership style (10 % n=3) and skills and support for managers (10 % n=3).

4.3.2.1. Leader's role

The leader's role was identified in 13% (n=4) of the studies included in this review. Strider *et al.* (2016) mention that bullying behaviours tend to thrive in surroundings that enable them and nurse managers should be held accountable for ensuring respectful behaviour and a just culture. The studies in this review emphasise that nurse managers are important key players in the prevention and elimination of bullying in nursing. The institution needs to outline what is expected of the nurse managers when managing bullying incidences in order to respond accordingly, as illustrated in the following extracts:

"To effectively address workplace bullying, organisations need to make sure that managers have a clear, consistent idea of what constitutes bullying behaviour, that managers understand how they are expected to respond to bullying and that they have assistance in applying this understanding to specific situations" (Johnson *et al.* 2015).

"Managers need to engage in ongoing dialogue with staff about bullying. These conversations should centre on finding a shared understanding of what constitutes bullying, what managers can and cannot do to respond to bullying, and what role staff nurses should play in responding to bullying incidents. In addition, when bullying occurs, managers need to make sure that incidents are fully resolved in a manner that supports the target" (Johnson *et al.* 2015).

Skarbek (2015) found that interventions initiated by nurse managers were more effective than institutional programmes as managers tend to emulate what is expected based on how they conduct themselves in the unit. This is illustrated by in the extract below.

"*Institution–wide mandatory programs were deemed not effective. Instead, nurse managers initiated interventions on a unit level, in collaboration with institutional and administrative support, were perceived to be effective methods to address workplace bullying among registered nurses"(*Skarbek *et al.* 2015).

Skarbek et al (2015) concur with St-Pierre (2012) on emphasising the importance of managers being visible in the unit in order to address some of the issues timeously.

Other responsibilities on how managers are expected to respond to bullying incidences include being supportive and giving feedback to the victims, as illustrated by this extract:

"Several strategies were described by managers including coaching individuals so they feel capable of addressing the issue themselves, acting as mediator to allow both sides to openly and respectfully talk about the issue, and disciplining employees whose actions warrant harsh consequences." (St-Pierre, 2012).

"Six of the participants believed that their nurse managers were not supportive of their complaints about DB on their units. They believed their nurse managers would listen to their concerns but did not follow through with actions to resolve the situation. Ultimately, they believed the lack of management support allowed for the perpetuation of a tradition of DB" (Lux, 2014).

The studies resulting in this sub-theme were all Level 3 (evidence from non–experimental, qualitative studies).

4.3.2.2. Leadership style

"Leaders are compelling role models, and their actions communicate messages as to what is considered acceptable behaviour" (Kaiser, 2017:111), thus setting the tone of the organisational culture. The author adds that the power of leaders to influence the work environment is well documented. Ten percent (10% n=3) of the 31 included studies confirm there is a relationship between the type of leadership style managers' use on their subordinates and the occurrence/reduction of bullying behaviours in the nursing environments. The authors mention how different leadership styles, namely participative, transformational and authentic, reduce the onset of bullying, as illustrated in the following extracts:

"A participative leadership style adopted by the nurse manager allows for the reduction of tensions in nurse working teams." (Bortoluzzi *et al.* 2014)

"Participative decision-making (PDM), which reflected the nurse manager's ability to listen to suggestions coming from nurses and to involve them in the decision-making process, seemed to reduce the risk of mobbing." (Bortoluzzi *et al.* 2014)

"Transformational leadership was the least frequently reported style, yet had the strongest impact on attenuating nurse to nurse incivility." (Kaiser, 2017)

"Authentic leadership was an important factor influencing nursing retention outcomes by decreasing the likelihood of bullying and burnout, thereby improving new nurses' job satisfaction and lowering turnover intentions." (Laschinger, 2012)

The studies resulting in this sub-theme were all Levels 2 and 3 (evidence from quantitative cross–sectional survey designs).

4.3.2.3. Skills and support for managers

Ten percent (10% n=3) of the 31 included studies in this review highlighted the need for managers to have their own form of support, as much as they are expected to support their subordinates, as they may not have the skills to identify or respond to bullying incidences, as illustrated in the following extracts:

"*Although nurse managers are well positioned to prevent and eliminate nurse-to-nurse bullying, they may not recognise it and often lack the skills and support necessary to address it."* (Strider *et al.* 2016)

"*Because nurse executives are accountable for nurse manager growth and development, they are responsible for ensuring that nurse managers are provided with the tools they need to recognise and respond to bullying behaviours. Therefore, they should prioritise education so that nurse managers are able to identify the behaviours and support to ensure that they are able to act upon them accordingly."* (Strider *et al.* 2016)

"Easy solutions may not be readily apparent. However, creative innovations to support communication, management support, and public policy can address these issues and improve workplace violence prevention programs." (Blando *et al.* 2015)

"*Participants also talked about the emotional time commitment and emotional strain of having to deal with workplace aggression. They stressed the importance of being able to debrief, especially when not feeling good about a situation."* (St-Pierre, 2012).

The studies resulting in this sub-theme were all Level 3 (evidence from non–experimental, qualitative studies).

4.3.3. Theme three: Institutionalization of bullying prevention policies

Bullying and violence prevention programmes need to be accepted by the entire institution, from executive to the ground floor, in order to be effective. Twenty three percent emphasised how information that is conveyed in anti-bullying policies needs to be clear, unambiguous and specific, as well as the importance of it being explicitly communicated on all nursing levels to increase awareness (Johnson *et al.*, 2015; Gilbert *et al.*, 2016; Stagg, 2011). This theme was further divided into two sub-themes namely, included in the institutional policy **(16%, n=5)** and transparency **(10%, n=3).**

Table 4.4: Institutionalisation of bullying prevention policies (Theme three)

INSTITUTIONALISATION OF BULLYING PREVENTION POLICIES 23% (n=7)		
SUB-THEMES	**SUPPORTING STATEMENTS**	%
Inclusion in institutional policy	• Bullying prevention programmes that build partnerships between nursing leadership, hospital administration and human resources effectively prevent and eliminate nurse-to-nurse bullying (Gilbert, Hudson & Strider, 2016). • Institutional policy on bullying promotes effectiveness of bullying prevention programmes (Blando et al., 2015). • Departmental and organisational initiatives to prevent bullying effectively prevent workplace bullying (Johnson, 2015). • Institutional policies that uphold, "zero tolerance" regarding bullying are effective in preventing bullying (Gilbert, Hudson & Strider, 2016). • Institutional policy on bullying should be communicated to all stakeholders to promote awareness of the policy (Johnson, Boutain, *et al.*, 2015). • There should be a specific policy on bullying in the workplace (Stagg et al., 2011). • Institutional policy should clarify nursing managers' role in addressing bullying (Johnson, Boutain, *et al.*, 2015).	16% (n=5)
Policy implementation	• Organisations need to draft, and actively disseminate, coherent bullying prevention policies that can be clearly understood and uniformly implemented by managers. (Johnson, Boutain, *et al.*, 2015) • Bullying prevention programmes that promote an open workplace atmosphere, which includes collaboration between employees, nurse management and hospital administration, facilitates the implementation of bullying prevention programmes (Strandmark & Rahm, 2014). • Programmes that promote open relationship between leaders and staff have a positive impact on the reduction of nurse incivility (Kaiser, 2017). • Managers need to interact verbally continuously with staff about bullying in order to effectively manage workplace bullying (Johnson, Boutain, *et al.*, 2015). • Organisations that make opportunities for everyone to openly communicate the problem of workplace bullying promotes a free atmosphere in which bullying is acknowledged and addressed (Johnson, Boutain, *et al.*, 2015). • A workplace atmosphere where co-workers communicate openly, gives the group safety to openly discuss a bullying problem (Strandmark & Rahm, 2014).	10% (n=3)

4.3.3.1. Inclusion in the institutional policy

Sixteen percent (16% n=5) of the 31 included studies in this review highlighted the importance of an institution accepting bullying prevention programmes and incorporating them within the hospital policy.

"*Partnerships between nursing leadership, hospital administration and human resource colleagues to set, and most importantly uphold "zero tolerance" policies.*" (*Gilbert et al.*, 2016)

"*Organisations that are serious about addressing workplace bullying need to offer ongoing educational opportunities for management and staff, as well as periodical reminders of policies.*" (Johnson *et al.* 2015)

"Results of the research support the provision of a workplace bullying management programme for nurses and the need for a specific policy on workplace bullying." (Stagg, 2011)

The studies resulting in this sub-theme were all Level 3 (evidence from non–experimental studies).

4.3.3.2. Policy implementation

Effective communication is required when bullying prevention policies are to be implemented, which includes explicitly circulating information regarding bullying to other nursing staff to promote awareness, as illustrated in the extracts of ten percent (10% n=3) of the 31 included studies in this review.

"The relationship between leaders and staff and empowerment of staff have the strongest impact on nurse incivility." (Kaiser, 2017)

"*The findings suggest that organisations that are serious about addressing workplace bullying need to draft, and actively disseminate, coherent policies that can be clearly understood and uniformly implemented by managers.*" (Johnson *et al.*, 2015)

Policies regarding bullying need to be clear on the institution's definition of what bullying behaviours are and how to respond, so they can be dealt with accordingly, and the organisation needs to discuss bullying with staff openly, as well as reinforcing the existence of and making them aware of such policies. The following extracts give a clear picture of this:

"Unclear policy language can also offer insufficient guidance to managers, resulting in differential enforcement of policies." (Johnson *et al.,* 2015)

"Managers (n = 10) also said they had difficulties disciplining staff when the policies did not clearly define bullying or when bullying involved subtle behaviours, such as ''eye rolling or making faces,'' which were not covered by the policies." (Johnson *et al.,* 2015)

"The policies discussed in the study included code of conduct, harassment and violence in the workplace. No specific workplace bullying policy was in place. Many study participants were unaware of the appropriate policy to follow when reporting workplace bullying." (Stagg, 2011)

"To effectively address bullying, organisations need to clarify how they want NMs to address bullying and should offer them support and guidance through this often difficult process" (Johnson *et al.,* 2015).

"A unique finding of this study was that while the NMs said they expect staff to actively confront co-workers, who violate behavioural standards, and they will take action only if these efforts are not successful, this expectation was not evident in the policies. This suggests that NMs either are not aware of the policies, or are interpreting them differently. It also suggests that these organisations are not reinforcing the policies and may not be serious about addressing workplace bullying." (Johnson *et al.,* 2015)

One study places emphasis on keeping workplace atmosphere open and less restricted to encourage workers to participate more positively at work, as explicitly shown in this extract:

"Not everyone was capable of telling a co-worker that they do not accept insulting behaviour however, continuous attention to the issue is helpful. People discuss things. When issues are brought to everyone's attention, they are easier to keep in mind. If you never talk about something, it disappears. If no one brings it up, it will not be dealt with." (Strandmark & Rahm, 2014)

Studies resulting in this sub-theme range from Level 2 (evidence from quasi-experimental studies) to Level 3 (evidence from non–experimental studies).

4.4. Conclusion

The themes emerging from the literature on characteristics that make bullying and violence prevention programmes have been described in this chapter. The following chapter will discuss the results of this review, make recommendations and draw conclusions from it.

5. CHAPTER FIVE: DISCUSSION AND INTERPRETATION, RECOMMENDATIONS AND CONCLUSION

5.1. Introduction

This chapter provides a discussion based on the findings and explores possible meanings to the findings in this integrative literature review. This includes summaries of the findings, and how there alignment with the research objectives. Limitations of, as well as recommendations from the study are provided. The aim of this integrated review was to identify and critically evaluate scientific publications, in specific databases in the field of nursing, regarding what makes bullying and violence prevention programmes for nurses effective. The study was conducted with the research question in mind.

5.2. Discussion and interpretation

5.2.1. Review and critical analyses of included studies

The articles included in this study are of mixed quality. The quantitative studies reviewed range from Level 1B, which is (experimental randomised control trials) of good quality, to Levels 2B and 3B (quasi-experimental and non-experimental studies) of good quality (Sanner-Stiehr, 2015; Stagg, 2013). Qualitative studies were all Level 3B (non-experimental) with good quality. Although the quality of the qualitative studies was good, the strength of the level evidence was weak. This finding supports the general notion that nursing research is mostly qualitative with weak evidence (Burns &Grove 2013). There were more qualitative studies, than quantitative studies, 15 and 13 respectively, which could be because when researching the topic of bullying, qualitative methodology may be more appropriate. The mixed method studies ranged from Levels 1B to 3B, with good quality, although it was challenging to use the John Hopkins Appraisal Tool Guide as it did not allow for the evaluation of mixed method studies. The tool is better suited for studies that are either quantitative or qualitative in nature, not both;

these articles were however helpful in describing characteristics that make bullying and prevention programmes effective. The mixed method articles were evaluated looking at the methodologies individually.

It is encouraging to note an increase, since 2015, in the number of studies being published on programmes to address bullying in nursing. A number of institutional collaborations were also noted to have taken place, and this could assist in having institutional collaborations within South Africa to evaluate the intervention strategies for efficacy that have been suggested in literature from other countries. This could also indicate that the issue of bullying is increasing or awareness of it is on the rise.

5.2.2. Description of characteristics that make bullying and violence prevention programmes effective in the management and prevention of bullying in the nursing profession based on available literature.

One of the objectives of this study was to describe characteristics that make bullying and violence prevention programmes effective, based on studies conducted in the previous five years. These characteristics are discussed below within the context of the identified themes.

5.2.2.1. Empowerment programmes

Timeous introduction of a bullying module to undergraduates is another characteristic that makes prevention programmes successful, as it increases awareness of bullying amongst nursing students early into their training and equips them with communication and assertiveness skills required for dealing with bullying incidences. These skills are necessary for them to combat the bullying they face in their clinical placements.

Different styles of teaching have been identified as being effective in promoting effective learning, and include virtual approach teaching methods, such as role-play, self-directed e-learning modules combined with simulation and cognitive behavioural rehearsal intervention

(Egues and Leinung, 2014;Evans and Curtis, 2011; Mallette *et al.*, 2011; Sanner-Stiehr, 2015; Ulrich *et al.*, 2017).

There is increased emphasis on timing of training occurring early in either an undergraduate programme or new employees association with an institution. The need to update awareness and skills continuously was known before but now receives greater emphasis, as most included studies highlighted that new staff members are vulnerable to being victims of bullying and turnover rates are the highest during this time. A change has been noted in the mode of delivery of these courses. The emergence of simulation in healthcare training has been used to good effect in programmes designed to address bullying and violence in nursing. When bullying is not tolerated by the emerging nursing profession, only then will it start moving away from being viewed as an oppressed profession, according to literature, and the new era of nursing students will be empowered (Kaiser 2017; Loven-Skolnik 2013).

Ongoing in-service programmes should include a bullying module, as it is effective in decreasing bullying behaviours and increasing awareness about the matter, however, being consistent is key in achieving this. Once the nurse professionals have been equipped with knowledge and skills on how to manage bullying behaviours, they are empowered to take personal responsibility when bullying incidences occur before escalating the matter to management. The acquired skills that can be used include using effective communication skills to diffuse tension during a conflict, to journaling the bullying incidences as they occur, in order to give proof once they report the matter to management (Johnson et al 2015(b); Lux et al 2014). All stakeholders, namely, individuals (bully and the victim), peers, Human Resources department and unions have a role to play in effectively managing bullying (St-Pierre, 2012). Loven-Skolnik (2013) found that few hospitals included education on managing workplace behaviours in their orientation programmes and the effectiveness was questionable. It was also not clear from literature who is best placed to facilitate this in-service training to staff members;

special skills are required and this may well be outside the competencies of the average unit manager. This could be an area worth exploring in future research, although one study by Chipps and McRury (2012) found that a registered nurse educator in a group setting was effective in confronting bullying in the workplace.

Since the study conducted by Stagg (2010), which showed that a cognitive rehearsal response programme was the most effective in combating bullying behaviours, more educational strategies have been developed and have shown to be effective. It should be noted that most of them still need to be evaluated to measure true effectiveness (Brann & Hartley 2017; Ceravolo *et al.*, 2012; Chipps & Mcury 2012;Loven –Skolnik 2013) Sanderson 2013; Stagg 2011 et al ; Stagg et al 2013).

To date the cognitive rehearsal programme intervention is still considered the most effective as it showed 100% efficacy in managing bullying behaviours in spite of several other interventions (Stagg 2013). Other programmes do serve to raise awareness, increase understanding and equip personnel with skills to manage bullying behaviours, however they need to be attended on an ongoing basis, instead of just as a once off during orientation, to ensure lasting effect and as an effort to change workplace culture if the organisation is serious about 'zero tolerance' on bullying. The few empirical studies that have been conducted in South Africa indicate there is a high rate of workplace bullying amongst nurses (Steinman 2003; Samuels 2015). It is interesting to note there was only one study, by Borcheds (2015), which evaluated workplace violence and found staff education to be most effective in combating bullying in the workplace (Borcheds, 2015). More of these studies need to be conducted although this was not the focus of this study.

5.2.2.2. Leaders' involvement

An effective programme should include a section within bullying and violence prevention programmes that encourages involvement from nurse leaders, as this is one of the

characteristics of a successful prevention programme. Their role is vital in influencing adherence to the programme and role modelling acceptable behaviour within the workplace. Their roles need to be clearly defined and they need training to equip them with skills and support so they can respond appropriately to bullying incidences that tend to occur. Another characteristic that is effective is leadership styles, which have been identified in literature to be effective in promoting civility; these include participative, transformational and authentic leadership practices. These leadership styles utilise input from personnel during the decision-making processes, resulting in a reduction of tension in nursing teams (Bortoluzzi et al 2014; Kaiser 2017; Wong et al 2012). A study by Loven- Skolnik (2013), not from the reviewed data, found that nurse leaders play a pivotal role as guardians and have responsibility for implementing policies that are intended to create safe working environments, free from bullying. However, they fail to do so, as Loven-Skolnik states, *"Nurse Leaders fail to implement, support, and enforce known workplace violence interventions regardless of recommendations found in literature, media publications, and agency regulations"* (Loven-Skolnik, 2013:7). The findings of this review further support those of Loven-Skolnik (2013) in that transformational leadership style is effective in bringing the required change in the clinical culture because it is non-authoritative and encourages active participation from subordinates. Ineffective leadership with unclear roles and goals results in poor communication and toxic clinical environments. It can be safely deduced that the style of leadership produces success in reduction of bullying incidences. Loven-Skolnik (2013) continues that in order for bullying behaviours to be effectively managed, people need to be held accountable. As accountability comes from the top, an improved organisational culture is needed and leaders need to commit to alter thinking and the reduction of workplace violence. Contrary to the findings of this review, Loven-Skolnik (2013) reported that workplace violence education was optional and management skills were not a required competency. The

findings of this review strongly recommend courses to enhance management skills, but to date this has not been implemented or assessed for efficacy.

5.2.2.3. Institutionalisation of bullying prevention policies

Another characteristic that ensures the success of bullying and violence prevention programmes is "top down" support, which includes the executives and management of organisations down to the nurses in the wards. This includes not only incorporating the anti-bullying policy into the institutions' policy, but also disseminating the anti-bullying policy actively and not just on paper but by talking about the policy within the different levels among the nursing professionals so as to increase awareness regarding the matter, therefore making communication vital in achieving this.

The anti-bullying policy should include channels to be followed once an incident has been reported and emphasising giving feedback regarding the reported bullying, including giving consequences to those who are guilty and support to the victims, so personnel do not perceive that nothing is being done. Loven-Skolnik (2013) found reporting without follow up is pointless and this is what makes prevention programmes ineffective as personnel feel that nothing comes out of it. The author adds that workplace violence behaviour continues to go underreported due to fears of retaliation or an attitude that little has changed, so why report. Thus, the importance to report, track and record bullying incidences is vital. Nurse leaders, as participants in one study by Loven –Skolnik (2013), reported nothing would change given inconsistent compliance practices and disappointing follow-up methods with reported offenders.

Findings in this review are contradicted by Loven-Skolnik (2013), as the author found zero tolerance policies were in name only, and that it would take more than just policies to solve the problem given the severity and effect workplace violence had on relationships, culture and leadership. The author reported that tolerance of bad behaviour was socialised and considered

normal, therefore eradication of bullying behaviours was impossible. The author added passive dissemination of policies was an ineffective means of implementation, a finding similar to that in a study conducted by Coursey (2013). Given the authors findings, active dissemination of information regarding bullying is essential and includes talking about it and calling the problem by name instead of turning a blind eye.

Rayan (2016:47) reported there is a necessity to reinforce and revive workplace violence prevention policies because bullying continues to exist and the author provided five steps to developing an effective policy, namely "describing the context of the problem, identifying policy goals and options, weighing policy alternatives, highlighting the recommended solutions, and providing a strategy for implementation and evaluation". Workplace violence policy is complex and needs a task team, with the help of health professional organisations, to achieve intended goals long term. (Rayan, 2016).

In summary, from literature it shows there is increased knowledge on what bullying is and its implications on the workforce, and this is not new information. There have been several developments in creating evidence-based techniques to prevent and manage bulling, which this review has added to the body of knowledge since the study done by Stagg (2010), as well as making several recommendations on how to manage the ongoing bullying issue effectively. However, the struggle of nurse leaders having to participate actively and being involved in managing bullying behaviours continues.

5.3. Limitations of study

Limitations to this review and its findings are described below.

5.3.1. Scope of databases

The search strategy used the following databases: Cochrane library, EBSCO host (CINAHL, ERIC and MEDLINE), PubMed, Wiley Online library and Psych info. There is a possibility articles in other databases could have the potential of influencing the findings in this review.

5.3.2. Language

Only studies published in English were considered. There might be some articles published in other languages that could have potentially influenced the findings in this review which were not included.

5.3.3. The Evaluation tool

The John Hopkins Evidence Level and Quality Guide had a noted limitation as it did not allow for the evaluation of mixed method studies accommodating quantitative or qualitative studies only. This limitation could have potentially affected the quality and level of the mixed method studies in this review.

5.4. Conclusion

Available literature, which was discussed in detail in this chapter, has been reviewed on what makes bullying and violence prevention programmes effective in preventing and managing bullying and violence amongst nurses in this review, as well as describing the characteristics that make prevention programmes effective. The research question has been answered and the study objectives met.

This chapter has discussed the findings from the review in detail, explored the limitations, recommendations are given below and conclusion given.

5.5. Recommendations

5.5.1. Anti- bullying Policy

Development of anti-bullying policies should involve all stakeholders, namely nurse educators, nurse executives, representative unions and nurses of all categories in the wards. This is important to ensure relevance of the policy and to increase the likelihood of acceptance and implementation thereof.

5.5.2. Nursing education

It is recommended that nursing educators incorporate a bullying module highlighting what bullying is, how it can be identified in the workplace and management thereof as well as using different teaching modalities within the undergraduate curriculum that have been identified in literature.

5.5.3. Clinical practice

It is also recommended to incorporate evidence-based training and techniques within the orientation programme, as well as part of in-service programme, and attendance should be continuous to increase awareness.

5.5.4. Nursing Administration

It is recommended that nurse managers receive adequate training on identifying and managing bullying behaviours effectively and training on effective leadership styles in order to reduce tension within nursing teams, as well as be given support when struggling in order to be actively involved within the bullying and violence prevention programmes.

5.5.5. Research

It is recommended more collaborative studies to be conducted within South Africa to explore and compare the effectiveness of the intervention strategies mentioned in literature.

5.6. Summary

Bullying and prevention programmes can be effective in managing bullying in the workplace provided all stakeholders are on the same page by having a zero tolerance attitude, as well as playing their part as nurse educators, nurse executives, nurse leaders and nurses in all categories to enforce change. Until there is willingness from within the nursing profession and its hierarchy to commit and act for change, by utilising the recommendations and plans available from literature to eradicate bullying, behaviours will remain empty rhetoric and bullying will continue to exist.

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ANNEXURE A: PERMISSION TO USE JOHNS HOPKINS EVIDENCE BASED PRACTICE QUALITY ASSESSMENT TOOLS.

Log in • Register

JOHNS HOPKINS MEDICINE

IJHN Learning System

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Home › Johns Hopkins Nursing Evidence-Based Practice Model and Tools

Johns Hopkins Nursing Evidence-Based Practice Model and Tools

Thank you for submitting the requested information. You now have permission to use the JHN EBP model and tools.

Click here to download the tools. Reminder: You may not modify the model or the tools. All reference to source forms should include "©The Johns Hopkins Hospital/The Johns Hopkins University."

We offer an excellent online course about our model/tools. It is an engaging online experience, containing interactive elements, self-checks, instructional videos, and demonstrations of how to put EBP into use. The course follows the EBP process from beginning to end and provides guidance to the learner on how to proceed, using the tools that are part of the Johns Hopkins Nursing EBP model. Take a **sneak peek of the course**.

Click here for more information about our online course. Group rates available, email ijhn@jhmi.edu to inquire.

Do you prefer hands-on learning? We are offering a 5-day intensive Boot Camp where you will learn and master the entire EBP process from beginning to end. Take advantage of our retreat-type setting to focus on your project, collaborate with peers, and get the expertise and assistance from our faculty. Click here to learn more about EBP Boot Camp.

Go back to the form

The Institute for Johns Hopkins Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

ANNEXURE B: JOHNS HOPKINS INDIVIDUAL EVIDENCE SUMMARY TOOL

Johns Hopkins Nursing Evidence-Based Practice
Appendix G: Individual Evidence Summary Tool

EBP Question:

Date:

Article #	Author & Date	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence Level & Quality
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			
			☐ N/A			

Attach a reference list with full citations of articles reviewed for this EBP question.

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ANNEXURE C: ANNEXURE C: JONHS HOPKINS EVIDENCE LEVEL AND QUALITY

Johns Hopkins Nursing Evidence-Based Practice
Appendix C: Evidence Level and Quality Guide

Evidence Levels	Quality Guides
Level I Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis	**A** **High quality:** Consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence
Level II Quasi-experimental study Systematic review of a combination of RCTs and quasi-experimental, or quasi-experimental studies only, with or without meta-analysis	**B** **Good quality:** Reasonably consistent results; sufficient sample size for the study design; some control, fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence
Level III Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental studies, or non-experimental studies only, with or without meta-analysis Qualitative study or systematic review with or without a meta-synthesis	**C** **Low quality or major flaws:** Little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn

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ANNEXURE D: JOHNS HOPKINS RESEARCH EVIDENCE APPRAISAL TOOL

Johns Hopkins Nursing Evidence-Based Practice
Appendix E: Research Evidence Appraisal Tool

Evidence Level and Quality:_____

Article Title:		Number:		
Author(s):		Publication Date:		
Journal:				
Setting:	Sample (Composition & size):			
Does this evidence address my EBP question?	☐Yes	☐No Do not proceed with appraisal of this evidence		
Level of Evidence (Study Design)				
A. Is this a report of a single research study? ***If No, go to B.***			☐Yes	☐No
1. Was there manipulation of an independent variable?			☐Yes	☐No
2. Was there a control group?			☐Yes	☐No
3. Were study participants randomly assigned to the intervention and control groups?			☐Yes	☐No
If Yes to all three, this is a Randomized Controlled Trial (RCT) or Experimental Study →	☐ LEVEL I			
If Yes to #1 and #2 and No to #3, OR Yes to #1 and No to #2 and #3, this is Quasi Experimental (some degree of investigator control, some manipulation of an independent variable, lacks random assignment to groups, may have a control group) →	☐ LEVEL II			
If No to #1, #2, and #3, this is Non-Experimental (no manipulation of independent variable, can be descriptive, comparative, or correlational, often uses secondary data) **or Qualitative** (exploratory in nature such as interviews or focus groups, a starting point for studies for which little research currently exists, has small sample sizes, may use results to design empirical studies) →	☐ LEVEL III			
NEXT, COMPLETE THE BOTTOM SECTION ON THE FOLLOWING PAGE, "STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION"				

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ANNEXURE E: JOHNS HOPKINS NON-RESEARCH EVIDENCE APPRAISAL TOOL

Johns Hopkins Nursing Evidence-Based Practice
Appendix F: Non-Research Evidence Appraisal Tool

Evidence Level & Quality:_____

Article Title:		Number:
Author(s):		Publication Date:
Journal:		
Does this evidence address the EBP question?	☐Yes	☐No Do not proceed with appraisal of this evidence

☐ **Clinical Practice Guidelines:** Systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel. **LEVEL IV**

☐ **Consensus or Position Statement:** Systematically developed recommendations based on research and nationally recognized expert opinion that guides members of a professional organization in decision-making for an issue of concern. **LEVEL IV**

• Are the types of evidence included identified?	☐Yes	☐No
• Were appropriate stakeholders involved in the development of recommendations?	☐Yes	☐No
• Are groups to which recommendations apply and do not apply clearly stated?	☐Yes	☐No
• Have potential biases been eliminated?	☐Yes	☐No
• Were recommendations valid (reproducible search, expert consensus, independent review, current, and level of supporting evidence identified for each recommendation)?	☐Yes	☐No
• Were the recommendations supported by evidence?	☐Yes	☐No
• Are recommendations clear?	☐Yes	☐No

☐ **Literature Review:** Summary of published literature without systematic appraisal of evidence quality or strength. **LEVEL V**

• Is subject matter to be reviewed clearly stated?	☐Yes	☐No
• Is relevant, up-to-date literature included in the review (most sources within last 5 years or classic)?	☐Yes	☐No
• Is there a meaningful analysis of the conclusions in the literature?	☐Yes	☐No
• Are gaps in the literature identified?	☐Yes	☐No
• Are recommendations made for future practice or study?	☐Yes	☐No

☐ **Expert Opinion:** Opinion of one or more individuals based on clinical expertise. **LEVEL V**

• Has the individual published or presented on the topic?	☐Yes	☐No
• Is author's opinion based on scientific evidence?	☐Yes	☐No
• Is the author's opinion clearly stated?	☐Yes	☐No
• Are potential biases acknowledged?	☐Yes	☐No

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ANNEXURE F: ETHICS CLEARANCE CERTIFICATE

Human Research Ethics Committee (Medical)

Research Office Secretariat: Senate House Room SH10005, 10th floor. Tel +27 (0)11-717-1252
Medical School Secretariat: P V Tobias Health Sciences Building, 2nd floor
Tel +27 (0)11-717-2700 / 1234 / 1252 / 2656
Private Bag 3, Wits 2050, www.wits.ac.za. Fax +27 (0)11-717-1265
South African National Health Research Ethics Council registration: REC-250208-04
United States Office of Human Research Protections registration: FWA00000715 IRB00001223

Ref: W-CJ-160622-2 22/06/2016

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator: **Miss Nalumansi Esther (student no 1166473)**

Project title: **Effectiveness of bullying and violence prevention programs in nursing: integrated literature review.**

Reason: This is a review of information in the public domain. There are no human participants.

UNIVERSITY OF THE WITWATERSRAND
PROF PE CLEATON-JONES
HREC (MEDICAL)
2016 -06- 22
JOHANNESBURG

Professor Peter Cleaton-Jones

Chair: Human Research Ethics Committee (Medical)

Copy – HREC (Medical) Secretariat: Zanele Ndlovu, Rhulani Mkansi.

ANNEXURE G: APPROVAL OF RESEARCH 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

06 January 2017
Person No: 0502885M
PAG

Miss EC Nalumansi
Private Bag X7
Randburg
2125
South Africa

Dear Miss Nalumansi

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *Bullying and violence programs in nursing: Integrated literature* 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