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How does workplace bullying influence nurses' abilities to provide patient care? A nurse perspective

Colleen V. Anusiewicz PhD, BSN, RN, Postdoctoral Research Fellow[1] | Nataliya V. Ivankova PhD, MPH, Professor[2] | Pauline A. Swiger PhD, RN, CNL, CMSRN, LTC, AN, Adjunct Faculty, Lieutenant Colonel, US Army Nurse Corps[1] | Gordon L. Gillespie PhD, RN, PHCNS-BC, CEN, CCRN, CPEN, FAEN, Professor & Associate Dean of Research[3] | Peng Li PhD, Biostatistician[1] | Patricia A. Patrician PhD, RN, FAAN, Professor & Rachel Z. Booth Endowed Chair in Nursing[1]

[1]The University of Alabama at Birmingham School of Nursing, Birmingham, AL, USA

[2]The University of Alabama at Birmingham School of Health Professions, Birmingham, AL, USA

[3]University of Cincinnati - College of Nursing, Cincinnati, OH, USA

Correspondence
Colleen V. Anusiewicz, The University of Alabama at Birmingham School of Nursing, Birmingham, Alabama, USA.
Email: cva94@nursing.upenn.edu; canusiewicz@yahoo.com

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Abstract

Aims and objectives: To explore how workplace bullying influences nurses' abilities to provide patient care.

Background: Nurses' experiences of workplace bullying undermine nursing work environments and potentially threaten patient care. Although there is a link between nurses' experiences of workplace bullying and poor patient care, additional exploration is necessary as current evidence remains underdeveloped and inconclusive.

Design: Qualitative descriptive study.

Methods: Fifteen inpatient staff nurses who have experienced workplace bullying while working in one hospital located in the southern region of the USA participated in individual, semi-structured interviews. Inductive thematic analysis was used to analyse interview transcripts in NVivo 12 software. The COREQ checklist for qualitative studies has been used in reporting this study.

Results: Three themes, and respective subthemes, were generated from data analysis: (a) workplace bullying as part of the nursing work environment, (b) workplace bullying's influence on nurses and (c) workplace bullying's influence on patient care. Workplace bullying was perceived to be inherent in the nursing work environment; nurses felt that they were targets of workplace bullying because (a) they were new nurses, (b) there was an abuse of power, or (c) the nature of the work occasioned it. Nurses were mentally and emotionally influenced by the bullying. Some nurses perceived that workplace bullying did influence their ability to provide patient care; however, others did not.

Conclusions: Organisations must support new nurses and manage relational attributes of the nursing work environment to reduce workplace bullying. Nursing leaders should receive education on fostering and sustaining favourable nursing work environments and be held accountable for behavioural expectations of the organisation.

Relevance to clinical practice: Understanding how nurses perceive the work environment to influence their experiences of workplace bullying informs the development of organisational interventions to reduce the behaviour. Furthermore, exploring how nurses' experiences of workplace bullying influences their abilities to provide patient care increases our understanding of workplace bullying implications.

KEYWORDS
Bullying, nurses, patient care, workplace

1 | INTRODUCTION

Workplace bullying (WPB) is conceptually defined as any negative behaviour, exhibited by an individual or group with either perceived or actual power, that is repeatedly and persistently directed towards another individual, who has difficulty defending himself or herself against the behaviour, for a prolonged time frame (i.e. at least six months) (Anusiewicz, Shirey, & Patrician, 2019; Nielsen & Einarsen, 2018). Despite increased awareness and efforts to reduce the behaviour, WPB remains an issue nurses regularly experience internationally (Crawford et al., 2019; Thompson, 2013). Over the past 30 years (Meissner, 1999; Sauer, 2012), research on WPB in the nursing profession has rapidly evolved due to the potential implications for nursing, patient and healthcare organisational outcomes.

What does this paper contribute to the wider global clinical community?

- Organisational interventions to decrease the prevalence of nurses experiencing WPB should be acutely focused on educating nursing leaders (i.e. preceptors, charge nurses, ANMs, nurse managers) and nurses with more experience about behavioural expectations and their influential role in creating and sustaining a culture of safety within the nursing work environment.
- The influence WPB has on nurses' abilities to provide patient care varies, underscoring the desire and commitment nurses have to providing high-quality, safe patient care.

1.1 | Background

Although WPB has long been understood in terms of oppressed group behaviour, this conceptualisation fails to acknowledge potential issues in the nursing work environment that may influence why WPB continues to occur (Hutchinson, Vickers, Jackson, & Wilkes, 2006). Described as the organisational characteristics that either "enhance or attenuate a nurse's ability to practice nursing skilfully and deliver high quality care" (Swiger et al., 2017, p. 76), the nursing work environment is the context in which all nursing processes take place (Swiger, 2017). Thus, the nursing work environment has a key role in providing the foundation necessary for positive nurse, patient and healthcare organisational outcomes (Aiken et al., 2011; Lake, 2019; Laschinger, 2014; Wei et al., 2018). However, WPB threatens the favourability of the nursing work environment.

Additionally, with the demand for high-quality, safe patient care, understanding how nurses' experiences of WPB influence nurses' abilities to provide patient care has garnered attention from researchers, nursing and healthcare leadership, and organisations including The Joint Commission (TJC, 2008, 2016) and the American Nurses Association (2015). Due to the poor nursing outcomes associated with WPB (e.g. poor mental and physical health, job dissatisfaction, turnover, decreased communication among healthcare workers, altered thinking and concentration) (Hutchinson & Jackson, 2013; Sauer & McCoy, 2017), it follows then that there is a link between nurse-reported WPB and poor patient care (Houck & Colbert, 2017). However, empirical evidence to support this link is limited and remains inconclusive (Houck & Colbert, 2017). Because nurses are at increased risk for experiencing WPB (Gillespie, Grubb, Brown, Boesch, & Ulrich, 2017; Purpora et al., 2012) and are valuable informants of healthcare quality and safety (McHugh & Stimpfel, 2012), obtaining nurses' perspectives is beneficial to further understanding how nurses' experiences of WPB may influence patient care. Therefore, the purpose of this study was to explore how WPB influences nurses' abilities to provide patient care. To provide context, attributes of the nursing work environment were explored to determine how the environment may influence nurses' experiences of WPB. The following research questions guided data collection and analysis: What attributes of the nursing work environment influence nurses' experiences of WPB? How do nurses perceive that WPB influences their mental, physical and emotional well-being? How do nurses perceive that experiencing WPB influences their ability to provide patient care?

1.2 | Conceptual framework

Donabedian's (1966) structure, process and outcome framework, which is widely used to inform and evaluate efforts to improve quality of care (Gallagher & Rowell, 2003; Swiger, 2017), guided this study.

Donabedian proposed using a triad of categories, which includes structure, process and outcome, to evaluate healthcare quality (Ayanian & Markel, 2016; Donabedian, 1966). "Structure" is defined as the settings, provider qualifications and administrative systems through which patient care occurs; "process" includes the components of patient care delivered, specifically what is actually done in giving and receiving care; and "outcome" focuses on patient recovery, restoration of function and survival (Ayanian & Markel, 2016). According to Donabedian's (1966) framework, structure influences processes, which influences outcomes. In this study, "structure" was conceptualised as the nursing work environment because it is the context in which all nursing processes occur. Neither "process" nor "outcomes" were directly explored in this study; however, and in line with the framework, it would follow that WPB occurring within the nursing work environment would influence nurses' abilities to provide patient care, which would influence "processes," and in turn, would influence patient "outcomes."

2 | METHODS

Reported here are the findings from the qualitative study strand of a larger concurrent, mixed-methods study seeking to explore nurse-reported WPB in the southern region of the USA. A qualitative, descriptive approach was chosen because it is appropriate for exploration and involves remaining close to the data with limited researcher interpretation (Sandelowski, 2000). Thus, the approach captures the perspective of the participant, providing understanding of the meaning the participant gives to a phenomenon or event, such as WPB (Sandelowski, 2000). The consolidated criteria for reporting qualitative studies (COREQ) (Tong et al., 2007) has been used in reporting this study (Supplementary File 1).

2.1 | Sampling and recruitment

One large academic medical centre located in an urban setting in the southern region of the USA was selected for recruitment based on established stakeholder relationships, stakeholder interest in the study and the research team's access to the nurses working at the hospital. Specific study eligibility criteria included: (a) being a full-time inpatient staff nurse working at the study hospital when the bullying experience occurred, (b) being bullied by another nurse or healthcare worker at study hospital and (c) experiencing behaviours that align with the definition of nurse-reported WPB used for this study. Purposive sampling (Bradshaw, Atkinson, & Doody, 2017) was used to recruit nurses who met study criteria and had experienced WPB within the past year. The sample size for this study was based on data saturation (Bradshaw et al., 2017; LoBiondo-Wood & Haber, 2014). Thus, the research team aimed to collect detailed contextual and exhaustive descriptions and participant quotes (i.e. "rich, thick" descriptions) that would provide ample information to answer research questions (Fusch & Ness, 2015; Lincoln & Guba, 1985). Our target sample was 15 to 20 nurses.

2.2 | Data collection

Following Institutional Review Board approval, inpatient staff nurses were recruited to participate in individual interviews using a recruitment email disseminated in November 2019 by the hospital's Director of the Center for Nursing Excellence. The recruitment email included the principal investigator's (PI) credentials and interest in conducting the study, the study purpose, participant eligibility information and the PI's contact information. Prior to the conduction of this study, the PI had received previous qualitative research education and training. Interview data were collected between November 2019–March 2020. Nurses who were interested in participating in the study were able to reach out to the PI for further information regarding the study. The PI screened each nurse to determine whether they met study eligibility, and if so, individual interviews were scheduled. Due to the sensitivity of the research topic, importance of maintaining participant confidentiality and input from stakeholders, individual interviews were determined to be the most appropriate form of qualitative data collection (Mack et al., 2005; Sagoe, 2012). Individual, semi-structured interviews lasting approximately 45 min to 1 hr were conducted in-person with only the PI at the nurse's preferred location, date and time to reduce nurse participant burden and assure confidentiality. Each nurse was asked for a preferred pseudonym that would be used throughout the interview, analysis and dissemination of findings. Prior to beginning the interview, each nurse was asked to complete a demographic questionnaire. After interview completion, nurses were compensated with a $25 VISA gift card for their contributions to the study.

Development of the interview questions was informed by the study purpose; research questions; current nursing literature; and Donabedian's (1966) structure, process, outcome framework. To determine attributes of the nursing work environment that were perceived to influence nurses' experiences of WPB, questions and probes were developed to obtain descriptions of (a) the relationships among nurses and healthcare workers, and (b) how the nurses felt valued and supported by the hospital and led by their nursing administration, including their nurse manager. A broader question was also developed to determine whether there were any additional characteristics of the nurse's unit that were perceived to create an environment that influenced the nurse's experiences of WPB. Next, because research suggests that patient outcomes are negatively affected by nurses' experiences of WPB due to the personal impacts of WPB on nurses, questions and probes were developed to capture the nurses' WPB experiences and how the experiences influenced the nurses' physical, mental and emotional being. These questions served to provide the link between nurses' experiences of WPB and if or how their ability to provide patient care was influenced. After discussing how the nurses were personally influenced by their WPB experiences, a broad question was then developed to determine

TABLE 1 Sample interview questions

Workplace bullying as part of the nursing work environment	1. How do you think you are valued as a nurse at the hospital? 2. How would you describe your nurse manager's ability to lead and support the nursing staff? 3. How would you describe the collaboration or relationships between nurses on your unit? 4. What characteristics of your unit or work environment do you perceive to foster workplace bullying?
Workplace bullying's influence on nurses	1. How has/did workplace bullying affect you personally? 2. How has/did workplace bullying affect your mental health? 3. How has/did workplace bullying affect your physical health?
Workplace bullying's influence on patient care	1. How do you think that your experiences of workplace bullying affect/affected your ability to provide patient care? 2. How does workplace bullying influence the quality of care you provide/provided to your patients? Why do you think it does or does not affect the quality of care? 3. How does workplace bullying influence the overall safety of your patients? Why do you think it does or does not affect patient safety? 4. How, if at all, does being bullied distract you from your work? 5. How does being bullied potentially affect your willingness to ask questions about your patients or nursing care tasks? 6. How, if at all, does being bullied affect your ability to think clearly at work

whether nurse participants perceived WPB to influence their patient care. This question was important to ask first so that the nurse participants could explain their own perception of how WPB influences their ability to provide patient care without the assumption that there is a negative relationship. Then, additional probes were developed to further determine how the quality of care and patient's safety were influenced. The chronological order of the interview questions and probes was guided by the conceptual framework.

Prior to interviews, two pilot interviews were conducted with inpatient staff nurses working at the study hospital to further inform the interview guide. Pilot interview transcripts were reviewed with the expert methodologist on the study to incorporate appropriate adjustments to the interview guide to ensure the questions and probes would provide "rich, thick" descriptions that would sufficiently address the study purpose. Additionally, members of the research team who provided content expertise reviewed the interview questions and probes to further ensure their appropriateness. Table 1 includes a sample of the interview questions and probes.

2.3 | Data analysis

Nurses' interviews were audio-recorded and transcribed verbatim by a professional transcription company. Transcripts were verified for accuracy and uploaded for analysis into NVivo 12 software. Data were analysed iteratively with data collection using an inductive thematic analysis approach consistent with steps outlined by Guest, MacQueen, and Namey (2012). All analysis was conducted by the PI with guidance and oversight from the expert methodologist and content experts. First, all transcripts were actively read and verified to facilitate data immersion and familiarity. Second, transcripts were coded line-by-line using the open coding technique to generate initial subthemes. Third, subthemes were further grouped into overarching themes. Finally, the themes and subthemes were presented to the research team for further refinement to ensure that the themes and subthemes were informative and representative of the textual data.

2.4 | Establishing trustworthiness

Strategies to ensure study rigour followed criteria outlined by Lincoln and Guba (1985) (i.e. credibility, dependability, transferability and confirmability). Member checking of transcripts helped to ensure there was no misinterpretation of what nurse participants shared during their interviews (Maxwell, 2012). To facilitate the member checking process, the study PI developed and provided summaries of each interview to the respective participant for their review. Researcher bias was identified through reflexive journaling and discussion with the research team, who represented differing professional backgrounds and expertise. Additionally, an audit trail inclusive of all analytic procedures was kept and used to facilitate discussion with the research team and expert methodologist. Emergent codes and themes were also regularly discussed with select committee members. Lastly, information regarding the study population has been provided, allowing readers to determine the extent to which their situation aligns with the research context, and thus, whether the findings can be transferred (Merriam & Tisdell, 2015).

3 | RESULTS

Fifteen nurses who met inclusion criteria were interviewed; the nurse demographics are found in Table 2. Only female nurses participated in this study, and over half (60%) of the nurses held a bachelor's degree. Nurses had worked as a registered nurse for a median of 4.5 years (range = < 1 to 36); however, nine nurses had worked for less than one year when they experienced WPB. All nurses were working full-time (36 hr/week) and were providing direct patient care when they experienced WPB. Although all nurses were employed at the same large, academic medical centre, they represented various units. Most nurses were moderately satisfied with their job but intended to leave within the next 6 to 12 months. Summaries of WPB experiences for each nurse participant are provided in Table 3. Three themes, and related subthemes, emerged from the data analysis: 1)

TABLE 2 Demographics and questionnaire summary of all participants (N = 15)

Question	*n* (%) or Median (Range)
Gender	
Female	15 (100.00)
Age	34 (22–58)
Race	
White	7 (46.67)
Black or African American	2 (13.33)
American Indian or Alaska Native	1 (6.67)
Asian/Pacific Islander	4 (26.66)
Other	1 (6.67)
Education level	
Associate degree	3 (20.00)
Bachelor's degree	9 (60.00)
Graduate (master, DNP, PhD)	3 (20.00)
Years as an RN	4.5 (<1–36)
Unit type	
Medical	2 (13.33)
Surgical	1 (6.67)
Medical/surgical	4 (26.66)
Intensive care	5 (33.34)
OR/recovery room	1 (6.67)
Psychiatry	2 (13.33)
Shift type	
Day	7 (46.67)
Night	6 (40.00)
Combination	2 (13.33)
Shift length	
12 hr	15 (100.00)
Hours/week	36 (36–40)
Overtime/week	5 (0–24)
Job satisfaction	
Very dissatisfied	3 (20.00)
Moderately dissatisfied	4 (26.66)
Moderately satisfied	7 (46.67)
Very satisfied	1 (6.67)
Intent to leave	
Yes, within the next 6–12 months	10 (66.67)
No plans within the next year	5 (33.33)
Quality of care	
Poor	0 (0.00)
Fair	3 (20.00)
Good	10 (66.67)
Excellent	2 (13.33)
Recommend hospital	
No	1 (6.67)
Yes	14 (93.33)

WPB as part of the nursing work environment, 2) WPB's influence on nurses and 3) WPB's influence on patient care. Table 4 presents the themes, related subthemes and illustrative nurse quotes.

3.1 | Theme 1: Workplace bullying as part of the nursing work environment

Workplace bullying was perceived to be inherent in the unit's nursing work environment; nurses felt that they were targets of WPB because (a) they were a new nurse, (b) there was an abuse of power, or (c) the nature of the work occasioned it. All three reasons led to feelings of frustration as the nurses realised WPB was an accepted norm within their work environment. Ultimately, the nurses reasoned that for the bullying to stop, they had to "take it" until they gained more nursing experience, were promoted to a leadership role or leave the unit altogether.

3.1.1 | Being a new nurse

The nurses expressed that being a new nurse in an established nursing work environment was a primary reason they perceived to experience WPB. Being new mainly meant the nurse was new to the nursing profession ($N = 9$), but in some cases, it meant being new to the unit ($N = 2$). New nurses shared that they were frequently bullied by their preceptors or other nurses with more clinical experience during their orientation period or shortly after orientation completion. Some nurses described their preceptors as disengaged, gossipy or belittling and explained that the preceptors rushed them when providing care. Others commented that the nurses with more clinical experience would be hyper-focused on their work, intentionally looking to find something wrong to purposefully get them in trouble. The nurses also described situations of feeling hazed or drowning in their work without receiving help, even upon request. Betty shared, *"I was bullied every day because the nurses saw me drown in my work as a new nurse [and] chose to ignore me and gossip rather than help me."* Although age discrimination was perceived to cause WPB in some of the nurses' experiences, the nurses primarily attributed the bullying to being new to the profession, having to earn the respect from the more experienced nurses. Darcy explained, *"[It's] the experienced* versus *the inexperienced nurse… it's almost a ranking atmosphere…[bullying] is like a part of the workplace, and you just gotta get your rank. You'll be here for a couple a years, and then you'll be all right kinda thing."* Essentially, the nurses expressed needing to earn their place on the unit, which was achieved primarily through struggling to perform patient care. The struggling often occurred until the nurses either gained more experience themselves or were promoted to a leadership role on the unit. Rose, who was bullied by receiving unfair patient assignments, explained, *"After a while with the assistant nurse manager [the bully], that kind of died off because after I had gained enough experience—you could give me whatever [patient assignment], and it's fine at this point, but as a new nurse, that was really horrible."* The nurses expressed frustration with the

TABLE 3 Brief bullying descriptions of nurse participants

Betty was a new nurse who was bullied primarily by her nurse manager during her orientation period. After requesting an extension to her orientation, Betty noticed she was starting to be mistreated.
Sarah was a new nurse who was bullied by two nurses on her unit. The first nurse was well-known for having a constant attitude and belittling other nurses. The other, a circulating nurse, would ridicule Sarah for differences in approaches to patient care.
Polly was verbally harassed by her nurse manager in a private room on the unit with the door locked. Shortly afterwards, the nurse manager removed Polly as a charge nurse.
April was a new nurse who explained her relationships with the other nurses as "hostile" and said that they would "snap" at her. After confronting her bully about a medication that was left out, the bully said to April, "You better watch your back around here."
Jessica, a new nurse, was bullied by two circulating nurses who were good friends. These nurses were hyper-focused on Jessica's work performance and would purposefully look for something Jessica did wrong and escalate the situation to the nurse manager without discussing them with Jessica first.
Tina was bullied by her preceptor during her orientation and simultaneously undermined by her assistant nurse manager (ANM) and nurse manager. The bullies threatened that if Tina reported the bullying, she would be fired for improper patient documentation, which Tina states is a fabrication of the truth.
Alice was a charge nurse who asked a staff nurse to admit a patient. The staff nurse ignored Alice's request and later reported Alice to the nurse manager, CNO and HR for embarrassing her. Her claims dismissed, the staff nurse filed a lawsuit against Alice and reported her to the state Board of Nursing.
Melissa was a new nurse. Her first preceptor was disengaged and did not adequately orient her. After advocating for a change in preceptor, Melissa was then bullied by her new preceptor and gossiped about by other nurses on the unit for being behind in her nursing skillsets.
Lee was an ANM who was treated unequally by her new nurse manager. Lee was instructed to do tasks outside of her nursing role (e.g. cleaning bedside commodes) and was repeatedly tricked and wrongly accused of actions she did not do in an attempt to fire her.
Suzanne was an experienced nurse but new to the unit. A clique on the unit would spread gossip and rumours about Suzanne regarding her physical appearance and personal life.
Darcy was a new nurse who quickly learned that if you are new, you must struggle first to earn your rank on the unit. Senior nurses would either not help or begrudgingly help Darcy with patient care. Darcy explained there was no teamwork on the unit.
Rose was a new nurse who was bullied by her ANM and a more senior nurse. The ANM would repeatedly give Rose unfair patient assignments that were unsafe due to the high acuity. Rose described the other nurse as a "blatant" bully, who would "insult" and "intimidate" any new nurse.
Candy was a new nurse who reported being bullied via email and in-person by her nurse manager. The nurse manager would publicly scold and belittle her (and other nurses) for asking questions/for help, creating a culture of fear.
Beth was primarily bullied by an ANM, who was known for making new nurses feel incompetent. For over a year, the ANM would bully Beth through unfair patient assignments every time she came to work. This lasted until Beth could clinically handle the workload and gained seniority status. Now, Beth witnesses the ANM doing the same to other new nurses.
Gwen was a new nurse who reported being bullied by a senior nurse on the unit after a discrepancy with a patient. In addition to gossiping and spreading rumours, the senior nurse would refuse to communicate with Gwen, even regarding patient care. This behaviour has lasted for a year despite HR involvement.

process of having to earn respect through struggling with patient care or workload and talked about the importance of teamwork in nursing and the desire for their preceptors or the more experienced nurses to remember what it was like to be new to the profession: *"I feel like in nursing, if you don't have teamwork, there's no nursing. You can't really work as a nurse if you don't have a good team to support you"* (Sarah).

3.1.2 | Abuse of power

The nurses noted that the bully was able to acquire and subsequently abuse power that was obtained either through their formal leadership role on the unit (e.g. nurse manager, assistant nurse manager [ANM] or charge nurse), informally based on the years of nursing experience they had, or by being a *"favorite."* Over half of the nurses identified the bully as a nurse in a leadership role. Being in leadership was perceived by the nurses to create feelings of entitlement, which resulted in *"power trips."* Polly shared, *"Nursing leaders can become power hungry [and] let the position justify negative behavior."* However, if the bully did not hold a formal leadership role, they typically had more nursing experience. The more years of nursing experience the bully had, the more clinical expertise they gained and the greater were their informal power and authority on the unit. Jessica explained, *"They know they are valued employees due to their experience so they aren't necessarily worried about any real repercussions from the nurse managers, should the bullied nurse report it."*

Lastly, the nurses explained that if the bully was not in a leadership role themselves or had more nursing experience, they were often favoured by nursing management. Favouritism allowed for the bullying behaviour to remain unchallenged on units and created a culture of acceptance within the nursing work environment. Rose shared, *"My preceptor told me, 'Don't bother saying anything because she's [the bully] a pet. She's a favorite, and nothing will get done. It'll just make you look bad, so just don't say anything. Just suck it up and take it.'"* Indeed, "taking it" was how Rose and many of the new nurses decided to handle the bullying, as they either waited until they gained more nursing experience or obtained a leadership role themselves, or in some situations, transferred units in hopes that the bullying would not occur in the new unit.

TABLE 4 Results of data analysis: qualitative themes, subthemes and illustrative quotes

Themes	Subthemes	Illustrative Quotes
WPB as part of the nursing work environment	*Being a new nurse*	• "It was very civil, but it was let's just let our young person drown over here because she's gotta figure it out on her own. It's not supposed to be that way. You're supposed to work together as a group to build that nurse's confidence and also provide good patient care." **(April)**
		• "I have heard of instances where they have targeted one or two other people, but I think that once they see something that you do wrong, the kinda just keep tabs on you. Then it's the same people that they keep writing [you] up essentially, and I am unfortunately one of those people." **(Sarah)**
	Abuse of power	• "I think the manager had a soft spot for the two people who were the main bullies." **(Rose)**
		• "I think sometimes who you know might influence what position you get or what behavior is excused." **(Polly)**
	Nature of the work	• "I believe that the type of work that we do is a very high stress job. The stakes are very high and there is a lot of responsibilities that are expected of us. I believe that that in itself is what causes so much stress that it develops in a pattern of bullying." **(Sarah)**
		• "I think it's just the demands, the emotional and physical and mental demands that nurses face because, physically, you're on your feet for 12 hr a day, pretty much, and there were times I wasn't even able to go to the bathroom, let alone eat, but we're expected to know a whole lot and not make mistakes. Then, like I said, the emotional thing. You can get attached to a patient, and something happens with them, or you have a patient that just treats you like crap, and you're supposed to just take it…It's a hard profession. I love it still, but it's a hard profession." **(Candy)**
WPB's influence on nurses	*Self-doubt*	• "I didn't even have a lot of direct contact with her, but it was still enough. She would make just nurses feel very inadequate, like during report, like they didn't do their job or nurses would be—so many of my coworkers on nights, they would end up crying during report. Just make you feel like you didn't do your job." **(Suzanne)**
		• "Now, it just makes me so mad because once you develop as a nurse and you understand all the roles that you play and the importance of being able to trust your coworkers, being able to trust your higher ups, the fact that there is a wedge in that and we can't run like a well-oiled machine, and you've got nurses doubting themselves—I feel like 9 times out of 10, if you're a nurse, it's'cause you were called to be a nurse. To have somebody doubt the calling that God's put on your life is extremely infuriating to me. The fact that we feel like we can't do anything about it makes it all the worse." **(Beth)**
	Feelings of defenselessness	• "I felt like I was in a hopeless, helpless position." **(Polly)**
		• "There's actually only two people that I've had problems with. Sometimes that's all you need, really. One person's a lot sometimes." **(Sarah)**
	Emotional distress	• "I felt like I was an outsider, and no one liked me, and so no one really cared if I was hurting, and no one really cared about me." **(Betty)**
		• "Lack of confidence and I was just crying all the time at home, and I really felt like there was somethin' wrong with me. I wasn't a good nurse. I wasn't smart." **(Melissa)**
WPB's influence on patient care	*My patient is the priority*	• "I still do everything I can for my patients, regardless of what anyone thinks. To me, nursing, it's about having the team and in the end, it's really about the patient. For me, my patients are everything. If I have a patient, I'm gonna do my best to make them comfortable, and happy, and just in no pain
		• and just try to make their experience as pleasant as possible. I don't care what anyone else thinks." **(Sarah)**
		• "I don't think it did affect me. I'm focused when I'm doing patient care. I don't think that really affected me." **(Alice)**
	Bullying influences patient care	• "There's been several times, literally several times, that we've had to do trend trackers because of issues, safety issues, that have happened with nurses and patients because the nurse is scared to go and get help." **(Beth)**
		• "I think that the fact that she won't communicate with me or give me shift report or listen to my shift report…that's the problem." **(Gwen)**

3.1.3 | Nature of the work

The nurses expressed that the high stress and demanding nature of nursing work influenced their experiences of WPB. Stress typically resulted from the *"busy flow on the unit"* (Tina) or the patient population. The stress, demands and patient needs increased frustration among nurses and other members of the healthcare team. Sarah shared, *"I believe that the type of work that we [nurses] do is a very high stress job. The stakes are very high and there is a lot of responsibilities that are expected of us. I believe that that in itself is what causes so much stress that it develops in[to] a pattern of bullying."* Other nurses discussed the emotional and physical demands of their patients and trying to meet their patients' needs while simultaneously suppressing their own. After putting aside their own needs over time, however, nurses began to experience frustration and emotional and physical exhaustion, heightening the tensions among the nurses and healthcare team, often resulting in WPB. *"We have a very difficult patient population, and because of that, you never know what you're gonna come in and have, and it's stressful. It's just there is a lot of stress"* (Katie). Although the nurses enjoyed their work and caring for patients, they discussed how the stress of their *"specialised"* and *"very difficult"* patient population (Beth) was worsened by the fast pace and high demands of their workload and environment.

3.2 | Theme 2: Workplace bullying's influence on nurses

Each nurse discussed how experiencing WPB influenced their mental and emotional well-being (i.e. self-doubt, feelings of defenselessness and emotional distress); however, none felt the bullying influenced them physically. How the bullying influenced the nurses depended largely on the repetitiveness of the behaviour and the lack of support they perceived to have on their unit to successfully stand up for themselves.

3.2.1 | Self-doubt

Self-doubt was commonly discussed by the nurses as a result of experiencing WPB. Particularly, self-doubt was expressed by new nurses who felt ridiculed by their preceptors for being too slow or as a result of the bully being hyper-focused on the patient care provided by the nurse. The continued criticism, harsh comments regarding their work performance and other bullying tactics decreased the nurses' self-confidence, leaving them with feelings of incompetence, which they already struggled with because they were new to the profession. In some situations, the WPB led nurses to question their self-worth: *"When you have somebody's life in your hands and you're made to feel incompetent and not good enough to be there, I think that probably is one of worst feelings in the world"* (Beth). Ultimately, the self-doubt led nurses to question their nursing abilities in providing patient care or their choice of nursing as a career. Betty shared, *"It made me doubt myself. It made me wonder if I was really in the right field…made me feel like I wasn't good enough. I wasn't meant to be a nurse. I was stupid."*

3.2.2 | Feelings of defenselessness

For various reasons, nurses expressed feelings of defenselessness while experiencing WPB. Nurses knew that their bullies were experienced nurses who brought much clinical expertise to the unit and often held leadership roles because of how long they had been working as nurses on the unit. In several situations, it was explained how everyone on the unit knew who the "bully" or "bullies" were and who the "target" was. However, due to the bullies' position on the unit, the behaviours remained unopposed. This allowed for a culture of silence or acceptance to be formed on units. Jessica stated, *"They're [the bullies are] so highly regarded on the unit. They're very experienced, and they are great nurses. I will say that. They both hold charge nurse positions or ANM positions so they're my higher ups. I feel like I don't really have a say in this kinda stuff."* Nurses also mentioned that because the bully and the other nurses working on the unit had previously established relationships and they were the new nurse, they felt they lacked the necessary support to effectively defend themselves. Nurses perceived that too much was against them to successfully contest their situation. Sarah said, *"I felt like everybody knew each other already. They've been working with each other for years and I'm this new person."* The feelings of defenselessness caused many nurses to leave their current nursing job because they felt leaving was the only way to escape the bullying.

3.2.3 | Emotional distress

Although the nurses did not identify any physical impacts that resulted from experiencing WPB, they did express a wide variety of mental and emotional health effects that influenced their well-being. These effects ranged from *"crying quite a bit"* (Suzanne), to varying levels of anxiety, to symptoms of post-traumatic stress disorder and seeking out clinical support. The extent to which nurses were affected mentally or emotionally depended on a few aspects of their situation, including the frequency of the bullying and whether the nurse had any additional support on the unit. Jessica stated, *"It hasn't affected me so much that I feel out of sorts or that I can't control myself in the environment. I have instances where I've just left work and cried in my car."*

As the bullying continued, nurses explained how they noticed they were not themselves anymore. Sometimes, these feelings led nurses to seek clinical help and support, or at least consider it:

> I had gone through the first 25 years of my life never having an issue, high school, college, no issue. Then I get up here for less than a year, and I'm wigging out…I actually did end up going— I just went to an urgent

> care because I was sick of feeling that way. I was sick of feeling down and freaking out and worrying all the time. They did put me on Zoloft for a little while.
>
> (April)

Nurses noted that it was not so much the bullying behaviours they experienced that wore them down mentally or emotionally, but rather the repetitiveness of the bullying experiences. There was a difference between experiencing a bullying behaviour every now and then versus every time the nurse came to work. Lee explained, *"When you constantly deal with little stuff like that every day, you start to get anxious about goin' to work because you don't know who gonna come at you that day."* For most of the nurses, every day they worked, they were bullied to some degree. The consistency of the bullying behaviours eventually caused nurses to feel, as Alice described, *"emotionally wiped."*

3.3 | Theme 3: Workplace bullying's influence on patient care

The nurses were divided on whether they perceived experiencing WPB to influence their ability to provide patient care. While several nurses expressed that their patients were the priority, others could not deny that, because the bullying influenced them personally, created distraction or decreased their willingness to ask questions or for help, their ability to provide patient care was subsequently influenced negatively. These nurses did not want their patient care to be impacted but they could not keep the bullying experiences from interfering with how they provided care.

3.3.1 | My patient is the priority

Several nurses declared that patient care came first; this was the one thing these nurses strived to protect. Although the nurses did not hide how experiencing WPB influenced them personally, whether through self-doubt, feelings of defenselessness or emotional distress, several were adamant that patient care was their highest priority. The nurses described pushing aside their feelings and what was occurring on the unit to ensure their patient was not impacted negatively. Patient care was important to the nurses, who felt a duty to provide that care as best they could: *"Our patients are our focus…I think my focus and my heart is not to—my intentions are never to harm patients, even though my emotions are hurt. I couldn't do that"* (Polly).

However, the nurses expressed that although they would not allow their WPB experiences to impact their patient care, they were more likely to avoid asking the bully questions regarding patient care or for help due to frequent pushback (i.e. being mocked for asking a stupid question, eye rolling, sighing). The nurses acknowledged that they see how this could hinder patient care but explained developing relationships with other nurses on the unit who they felt comfortable asking questions or for help. The nurses' strong resolve to do what was right by the patient ultimately prevailed as they pushed aside their own feelings and frustrations to do what they needed to appropriately care for their patients. Darcy shared:

> I just feel like I'm looked at differently and that if I ask for help, it's like, "Oh, you should know that already, and you don't, and that's a big deal." You gotta learn You don't learn unless you ask. It's made me more timid to ask for help, and I'm very selective on who I do ask for help. I know that sounds like a huge safety issue for patients, but I make sure that I'm asking someone I know that knows their stuff and will come and help me

Like Darcy, many nurses had a very practical attitude when discussing how they addressed WPB and patient care. The nurses were dogged in ensuring that patients received the care they needed, even if it meant having to be uncomfortable so they could ask the bully their question or for help. Despite their resolve, the nurses did not conceal that it was difficult to face their bully as it often caused undue stress and anxiety. Yet as patient advocates, the nurses were determined to take the actions necessary to prioritise the patient and their care.

3.3.2 | Bullying influences patient care

Although many nurses were resolute that their patients were the priority, others expressed that experiencing WPB did negatively affect their ability to provide patient care, whether it be the quality of care or in some cases, the patient's safety. These nurses expressed that the bullying distracted them, which consequently interfered with their patient care. For example, April shared, *"Overall, the patient care did go down with me because I was constantly nervous on the job. I didn't need to be nervous because of the people I worked with and how they treated me'cause I was already nervous enough being a new nurse."* Ultimately, the nurses felt they could not sufficiently deliver the care they desired to provide because of what was occurring outside of the patient's room and the varying ways the bullying influenced them personally or their work performance. Several nurses were keenly aware of how they were not able to provide the care they knew they could provide had they not been dealing with WPB. Beth explained:

> I feel like me personally, I give the best care to my patients when I'm calm and my head isn't worried about what is gonna happen with this person [the bully]… My dad used to come home from school and his dad would spank him and then ask him what he did wrong. That's what this is like. "I know I've done somethin' wrong, and I know I'm gonna get in trouble for it," so

> your mind isn't there focused on the patient and what they need. Patients can feel that disconnect.

Like others, Melissa felt her decreased willingness to ask questions regarding patient care was the main reason her patient care was negatively influenced: *"My preceptor, she literally told me, 'There is a such thing as asking dumb questions,"cause I would ask her a lot of questions, and she told me that, and I was like—started keeping my mouth shut after that."*

How patient care was influenced, in part, depended on the type of bullying the nurses experienced. For example, Rose explained that when she started her first nursing job, she was bullied through unmanageable workloads, that is patient assignments; she received the highest acuity patients every time she worked with one particular ANM, who was in charge of patient assignments. This ultimately influenced her ability to provide good patient care: *"As a brand-new nurse, given the kind of patient load that I was expected to care for from this particular person, that absolutely affected the quality of care…I knew that when I showed up and she was there, I knew I'd be getting them both, which was not safe because of the acuity of it"* (Rose).

Interestingly, some nurses were more apt to allow the quality of their care to diminish as a result of experiencing WPB rather than allowing the safety of their patients to be compromised. To the nurses, quality of care encompassed being there for the patient or having the ability to spend time with them. Nurses explained that although quality of care is an important aspect of caring for a patient, it was not as crucial as the patient's safety:

> If I'm just trying to hold it together, and I can't ask a question, then I felt like there were times when I wasn't completely sure about what I was doing, and I was afraid to ask; although, when it comes to patient safety, then I'm pretty much like I will take the risk of looking stupid in asking a question versus hurting a patient." (Candy)

Additionally, some new nurses were told they were too slow or could not be on the unit after a certain time and therefore needed to hurry up and finish. This caused the nurses to feel rushed while at work, which negatively influenced the patient's safety and quality of care. Tina shared, *"I don't stay in the room because I hear her [preceptor] saying you're just too slow. I do a real quick assessment. Yeah. I'll probably miss something because I'm going too fast because I don't want anybody to think I'm too slow."* The new nurses were frustrated because they wanted to learn and perform the patient care tasks correctly but felt they could not do so because of the reprimands by their bullies who were their preceptors or nurse managers.

4 | DISCUSSION

Using Donabedian's (1966) structure, process and outcome framework as guidance, the purpose of this study was to explore how nurse-reported WPB influences nurses' abilities to provide patient care. Drawing on the perspectives provided by nurses during the interviews, the nurses perceived their experiences of WPB to occur in their nursing work environment because they were new nurses, there was an abuse of power, and due to the demanding, stressful nature of the work of nursing. The new nurses perceived that they were more susceptible to being bullied because they had lower levels of established organisational support and there was a lack of appropriate leadership and management to help mitigate their situations. Existing literature states that new nurses are especially vulnerable to experiencing WPB (Beecroft, Dorey, & Wenten, 2008; Sauer, 2012) due to their more junior status within the organisational hierarchy (Rush et al., 2014). The hierarchy in health care has been identified as a primary reason WPB occurs in nursing work environments as it creates power differentials among healthcare workers, which if left unchecked, as was commonly experienced by the nurses in this study, can lead to opportunities for an abuse of power and, subsequently, increases the likelihood for WPB to occur. In addition to the hierarchical structure, WPB often occurs due to the complex and demanding nature of healthcare work. This finding is in line with the work environment hypothesis and job demands–resources model (Bakker & Demerouti, 2007), which both underscore that the characteristics of jobs and work environments are important determinants in workers' health, well-being and attitudes towards their work (Broeck, Baillien, & Witte, 2011; Hauge, Skogstad, & Einarsen, 2007). Stressful and chaotic work environments or jobs that are characterised by high demands (e.g. workload and role conflict) and a lack of job resources (e.g. social support and work autonomy) can give rise to behaviours such as WPB.

According to Donabedian's (1966) framework, good structure should promote good processes, which should promote good outcomes. Workplace bullying occurring within the nursing work environment jeopardises this flow and hinders healthcare quality. Although the findings from this study are not generalisable, they indicate that the orientation period and role of nursing leaders and nurses with more experience can be relational attributes of the nursing work environment that influence nurses' experiences of WPB. Therefore, it is important to develop organisational-level strategies that provide support to new nurses and also educate preceptors, nurses in leadership roles and nurses with more experience regarding the influence they have in creating and sustaining a favourable nursing work environment. These efforts could improve the structure of healthcare organisations which in turn can improve subsequent processes and outcomes.

The influence WPB had on nurses' abilities to provide patient care was perceived differently among the nurses who participated in this study. By some, WPB was thought to influence patient care through its negative effects on nurses' mental and emotional well-being (i.e. self-doubt, feelings of defenselessness and emotional distress) or through creating distractions while at work and decreasing the nurses' willingness to ask questions or for help regarding patient care. Yet although several nurses perceived their WPB experiences to negatively influence their ability to provide patient care, others expressed that patients were their highest priority and, therefore, perceived no influence. This finding contradicts most research in

this area where the consensus is that nurses' experiences of WPB negatively influence patient outcomes and/or patient care (Houck & Colbert, 2017).

Differing bullying severities and duration of exposure, perpetrators, organisational support levels and relational aspects of the nurses' bullying narratives should be considered as likely influencers of nurses' WPB experiences and how WPB may influence patient care. Additionally, perhaps the divergent perceptions among nurses relate to individual factors including levels of resiliency, emotional intelligence or self-efficacy, which were not explored in the interviews. These factors have been empirically shown to have a mediating role in the relationship between WPB and an individual's health (Anasori, Bayighomog, & Tanova, 2020; Fida, Laschinger, & Leiter, 2018; Hutchinson & Hurley, 2013; Meseguer-de-Pedro et al., 2019). Thus, a nurse's ability to provide patient care may not be influenced despite experiencing WPB due to such individual factors. Based on the findings from this study, the influence of WPB on nurses' abilities to provide patient care may not be as straightforward as generally understood.

4.1 | Limitations

This study has several limitations. First, according to the definition of WPB, the bullying behaviours must typically occur for at least six months (Nielsen, 2009). However, not all nurses in this study experienced WPB for a full six months. The time frame of bullying exposure remains a debate among researchers (Nielsen, 2009). Further, although many nurses were currently experiencing WPB at the time of the interview, a few had previously experienced WPB and were now removed from the situation. This may introduce recall bias due to memory disintegration (Schat et al., 2006). Second, this study only considered the perspectives from 15 nurses working in one hospital located in the southern region of the USA. Therefore, and in line with qualitative research, the findings from this study cannot be generalised to other populations. Additionally, not exploring the perspectives of the patients that these nurses cared for potentially limits a more comprehensive understanding of how nurses' experiences of WPB influence their ability to provide patient care from the patient's perspective. However, obtaining the patient's perspective was not the aim of this study. Last, due to the nature of qualitative research, there is a potential for bias in the qualitative result interpretation (Merriam & Tisdell, 2015); however, the descriptive research design used involves remaining close to the data and emphasises minimal levels of interpretation.

4.2 | Future research

Based on findings from this study, future research should be conducted to further determine attributes of the nursing work environment that may influence nurses' experiences of WPB. Additionally, because some nurses in this study did not perceive WPB to influence their ability to provide patient care, more research is needed to further understand the influence of WPB on patient care. Research exploring individual nurse factors (e.g. resiliency, emotional intelligence or self-efficacy) may provide explanations for why there was a divide in perception for how WPB influences nurses' abilities to provide patient care. Finally, because the nurses who participated in this study were all female, future work should include male nurses, who also experience disruptive workplace behaviours perpetuated by nurse co-workers (Kronsberg, Bouret, & Brett, 2018).

4.3 | Relevance to clinical practice

Nurses continue to experience WPB in healthcare organisations (Crawford, 2019). Through obtaining nurses' perspectives, the findings from this study suggest the need for healthcare organisations and nursing leaders to place increasing focus on relational attributes of the nursing work environment to reduce WPB behaviours. Additionally, it is important to educate nurses with formal or informal power, whether through their nursing role (i.e. preceptors, charge nurses, ANMs, nurse managers) or more years of experience, about the behavioural expectations of the organisation and the influence they have in fostering and sustaining a favourable nursing work environment. Also, because being a new nurse in an established nursing work environment was a primary reason nurse participants perceived to experience WPB, nurses in formal and informal leadership roles should maintain realistic expectations regarding the level of expertise among new nurses (e.g. include Dr. Patricia Benner's From Novice to Expert Theory in continuing education or training). Additionally, to ensure new nurses are appropriately assigned patients based on acuity, nursing leaders and healthcare organisations should consider implementing unit-based standards that align with the experience and expertise of new nurses that reflect a gradual and fair increase in patient acuity workloads. Further, although continued exploration of how nurses' experiences of WPB influence their ability to provide patient care is necessary, the findings provide additional understanding of the potentially far-reaching implications nurse-reported WPB has on patient care and patient outcomes.

5 | CONCLUSION

This qualitative study explored how nurses' experiences of WPB, occurring within the nursing work environment, may influence their abilities to provide patient care. The nurses perceived WPB as an inherent characteristic of the nursing work environment because they were targets of bullying for reasons they could not readily change (i.e. being a new nurse, an abuse of power by formal and informal nursing leaders, or due to the nature of the work). Although several nurses perceived WPB did negatively influence their abilities to provide patient care, others, and in contrast to what is widely

understood, did not, primarily because nurses tended to place the patients' well-being above their own.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTION

Study conception and design; data acquisition; data analysis and interpretation; manuscript drafting and revision; final approval of the version; participation in the work to take public responsibility for appropriate portions of the content; agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: all authors. **Colleen V. Anusiewicz**, PhD, RN, University of Alabama at Birmingham. As first author and Principal Investigator (PI) of the study, Dr. Anusiewicz contributed largely to all the aspects of study conduction and writing of the subsequent manuscript. **Nataliya V. Ivankova**, PhD, MPH, University of Alabama at Birmingham. Dr. Ivankova was the expert mixed methodologist on the study and significantly guided and provided instruction to the PI (first author) throughout study conduction and the preparation of the manuscript. Dr. Ivankova met bimonthly (at minimum) with the PI throughout the conduction of the study. **Pauline A. Swiger**, PhD, RN, CNL, CMSRN, LTC, AN, U.S. Army Nursing Corps, University of Alabama at Birmingham. Dr. Swiger contributed to the conception and design of the study, helped refine the subthemes and themes generated from data analysis, had discussion with PI about potential biases and was involved in the drafting and revising of the manuscript. **Gordon L. Gillespie**, PhD, RN, PHCNS-BC, CEN, CCRN, CPEN, FAEN, University of Cincinnati. Dr. Gillespie contributed to the conception and design of the study, helped refine the subthemes and themes generated from data analysis, had discussion with PI about potential biases and was involved in the drafting and revising of the manuscript. **Peng Li**, PhD, University of Alabama at Birmingham. Dr. Li contributed to the conception of the study and was involved in the drafting and revising of the manuscript. **Patricia A. Patrician**, PhD, RN, FAAN, University of Alabama at Birmingham. Dr. Patrician contributed to the conception and design of the study, acquisition of data, and the analysis and interpretation of data; helped refine the subthemes and themes generated from data analysis; frequently discussed the study and potential biases throughout study conduction with the PI; and was actively involved in the drafting and revising of the manuscript.

ORCID

Colleen V. Anusiewicz https://orcid.org/0000-0002-0833-1934

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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