

EXPLORING THE MODERATING EFFECT OF A CARING WORK
ENVIRONMENT ON THE RELATIONSHIP BETWEEN WORKPLACE
MISTREATMENT AND NURSES' ABILITY TO PROVIDE PATIENT CARE

by

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This dissertation was prepared under the direction of the candidate's dissertation advisor, Dr. Patricia Liehr, the Christine E. Lynn College of Nursing, and has been approved by the members of her supervisory committee. It was submitted to the faculty of the Christine E. Lynn College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

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Workplace mistreatment (bullying, horizontal violence, and incivility) has been shown to impact nurses' work satisfaction, job turnover, and physical and mental health. However, there are limited studies that examine its effect on patient outcomes. A correlational descriptive study of 79 acute care nurses was used to test a social justice model for examining the relationship between workplace mistreatment, quantified as threats to dimensions of nurses' well-being (health, personal security, reasoning, respect, attachment, and self-determination), and nurses' ability to provide quality patient care. In addition, this study considered the moderating effect of caring work environment among co-workers on nurses' ability to provide quality patient care in the face of workplace mistreatment. Stories of workplace mistreatment were collected anonymously and analyzed for alignment with threats to six dimensions of well-being. Ability to provide patient care was measured using the Healthcare Productivity Survey and a caring work environment was measured via the Culture of Companionate Love scale.

The results demonstrated that threats to all six dimensions of well-being described by Powers and Faden (2006) were expressed in nurses' stories of workplace mistreatment. Furthermore, 87% reported a decrease in ability to provide patient care after an incident of workplace mistreatment. Yet frequency of threatened dimensions did not have a significant relationship with ability to provide patient care. Moreover, there was a significant moderator effect of the caring work environment on the relationship between number of threatened dimensions of well-being and ability to provide quality patient care. Nurses in high caring environments loss less ability to provide care than nurses in low caring environments when one to three dimensions of well-being were threatened. However, this relationship reversed when four or more dimensions were threatened. Implications include further research on the relationship between workplace mistreatment and nurse well-being and changing practice to include fostering a caring work environment in healthcare facilities.

DEDICATION

“But thanks be to God, who gives us the victory through our Lord Jesus Christ. Therefore, my beloved brothers, be steadfast, immovable, always abounding in the work of the Lord, knowing that in the Lord your labor is not in vain” (1 Cor. 15:57-58 English Standard Version).

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CHAPTER 1. INTRODUCTION

Phenomenon of Interest

Workplace mistreatment, an umbrella term used to identify various forms of interpersonal abuse demonstrated among co-workers, is a common problem that can have serious consequences for individuals and organizations. Consequences for the individual include mental and physical health problems, impaired sleep, depression, and post-traumatic stress disorder (PTSD) (Erikson et al., 2009; Nielsen & Einarsen, 2012; Spence Laschinger & Nosko, 2015; Vessey, Demarco, Gaffney, & Budin, 2009). Consequences for organizations include staff turnover and decreased productivity (Hutton & Gates, 2008; Lewis & Malecha, 2011; Read & Laschinger, 2013; Rodwell, Demir, & Steane, 2013; Simons, 2008). According to the Workplace Bullying Institute (WBI, 2017), 27% of Americans have experienced abusive behavior at work. The incidence of workplace mistreatment is even higher among nurses, with reports ranging as high as 77.6% (Spence Laschinger, Leiter, Day, & Gilin, 2009).

Forms of workplace mistreatment described in the literature include incivility, bullying, horizontal violence, and lateral violence. Though all of these terms represent unprofessional behaviors, there are some distinctions made between terms. Workplace incivility (WI) embodies a wide continuum of behaviors from something as subtle as ignoring a person to outright physical abuse (Andersson & Pearson, 1999; Clark, Landrum, & Nguyen, 2013). Bullying involves purposeful targeting of an individual, from managers or staff members, with the behavior repeated over time (Einarsen, Hoel,

& Notelaers, 2009; WBI, 2017). Horizontal violence and lateral violence (HV/LV) can include bullying and/or incivility but are specific to mistreatment between colleagues on the same hierarchical level (Longo & Sherman, 2007). The term workplace mistreatment is used in this study as an inclusive linguistic approach, enabling description of a broad range of participant experiences (Spence Laschinger, 2014). Regardless of the descriptive terms used, targets of workplace mistreatment may be subject to negative behavior, such as verbal abuse, or they may be prevented from achieving rewarding experiences, such as career advancement (Yang, Caughlin, Gazica, Truxillo, & Spector, 2014).

Problem Statement

Workplace mistreatment has been shown to impact nurses' work satisfaction (Clark et al., 2013; Hamblin et al., 2015), turnover (Clark et al., 2013; Spence Laschinger, 2014; Spence Laschinger, Leiter et al., 2009), and physical and mental health (Longo & Sherman, 2007; Vessey et al., 2009). While there have been several studies published on the effect of workplace mistreatment on nurses and organizations, including impact on financial outcomes (Hutton & Gates, 2008), there are limited studies that examine the relationship between workplace mistreatment and patient outcomes (Spence Laschinger, 2014). Direct assessment of this relationship is challenging because it can be difficult to acquire the detailed hospital data needed to enable valid assessment. However, examining the relationship between threats to nurses' well-being from workplace mistreatment and nurses' ability to provide quality patient care moves the researcher one step closer to making the mistreatment-patient outcome connection.

Purpose of the Study

The purpose of this study was to explore the relationship between workplace

mistreatment and nurses' ability to provide quality patient care in the acute care setting, while considering the moderating effects of a caring environment in the workplace. Powers and Faden's (2006) theory of social justice as human well-being was used as a theoretical framework.

Theoretical Framework

Social justice has been defined as "full participation in society and the balancing of benefits and burdens by all citizens resulting in equitable living and a just ordering of society" (Buettner-Schmidt & Lobo, 2012, p. 95). Buettner-Schmidt and Lobo (2012) pointed to violence in the workplace and workers' rights as areas of application of social justice in nursing. Social justice has been a highly regarded standard in nursing since the start of the profession (Thorne, 2014) and is "fundamental to the discipline of nursing" (American Association of Colleges of Nursing [AACN], 2008, p. 4). In fact, the theme of social justice can be found in several nursing theories, including those that do not articulate it specifically (Thorne, 2014). Though nurses are aware of their commitment ensuring social justice for the general public, they have done a poor job of addressing social injustices within their own work environment and recognizing barriers that prohibit them from upholding professional duties (Brown & Reimer-Kirkham, 2014). When nurses are unable to practice to their full capability due to workplace mistreatment that threatens their well-being, they may be denying others their right to quality and safe healthcare by not performing their professional duties.

Powers and Faden's Theory of Social Justice

Powers and Faden (2006) view social justice as freedom to achieve human well-being represented as six core dimensions of well-being: health, personal security,

reasoning, respect, attachment, and self-determination. According to Powers and Faden's theory, in order to live a decent life, a human must maintain adequate levels of each of these dimensions. Additionally, the dimensions can influence each other; therefore, a deficiency in one component may lead to deficiencies in others. Powers and Faden have addressed the importance of human well-being, indicating that "social justice is concerned with human well-being" (p. 15), and the six dimensions of well-being "offer different lenses through which the justice of political structures, social practices, and institutions can be assessed" (p. 15).

The Powers and Faden (2006) theory was used to study the relationship between workplace mistreatment, quantified as threats to dimensions of nurse well-being, and nurses' ability to provide quality patient care. Providing patient care is a complex responsibility that requires cognitive and interpersonal skills as well as the need to concentrate (Potter, Perry, & Stockert, 2013). Experiencing workplace mistreatment from physicians, administrators, or co-workers can interfere with a nurse's well-being, and thus impact ability to provide quality patient care (Walrath, Dang, & Nyberg, 2010). Compromising ability to provide quality patient care may lead to errors and poor patient outcomes (Longo, 2010; Rosenstein & O'Daniel, 2005). Therefore, studying threats to nurse well-being connected with the ability to provide quality patient care provides an avenue for approaching patient outcomes in future research.

Further, this study incorporated examination of the moderating effect of a caring work environment on the relationship between threats to well-being induced by workplace mistreatment and ability to provide quality patient care. If a caring environment with colleagues moderates the relationship between workplace mistreatment

and nurses' ability to provide quality patient care, there will be foundational evidence supporting cultivation of a caring environment for practicing nurses.

Roach's Six Cs and a Caring Environment

A caring environment may moderate the effect of workplace mistreatment. Roach (2002) recognized "...caregivers themselves must be cared for, the environment within which they practice must enable them to care and their lives as professionals must somehow be integrated with who they are and wish to be as human persons" (p. 137). According to Roach's theory, the Human Act of Caring, one cares because one is human. Roach identified six elements of caring that depict qualities foundational to caring (p. 43). These elements are known as the six Cs and include compassion, competence, confidence, conscience, commitment, and comportment (Roach, 2002).

Compassion is connecting in full presence to another's pain. Competence is having the skills and knowledge to perform within your scope of practice. Confidence refers to building trust, creating a context where information is believable. Conscience is caring guided by morals and ethical codes, to do what is best for the other. Commitment is standing by the other through the length of the relationship, no matter how difficult. Comportment is showing respect through speech, body language, and dress. From Roach's (2002) theory of caring outlined by the six Cs, the pivotal dimension of compassion was emphasized in this dissertation to characterize the core of caring, essential to the context where a caring environment can occur.

Research Questions and Hypotheses

The overall research questions focused on the relationship between workplace mistreatment, quantified as threats to nurse well-being (health, personal security,

reasoning, respect, attachment, and self-determination), and nurses' ability to provide quality patient care. In addition, this study considered the moderating effect of a caring environment expressed through compassion between colleagues.

The specific research questions and, when appropriate, corresponding hypotheses were as follows.

- A. How do nurses' stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?
- B. How does the number of threatened dimensions of well-being relate to nurses' ability to provide quality patient care?

Hypothesis 1: An increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

- C. How does a caring work environment (compassion) moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

Hypothesis 2: A workplace caring environment (compassion) will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care (see Figure 1).

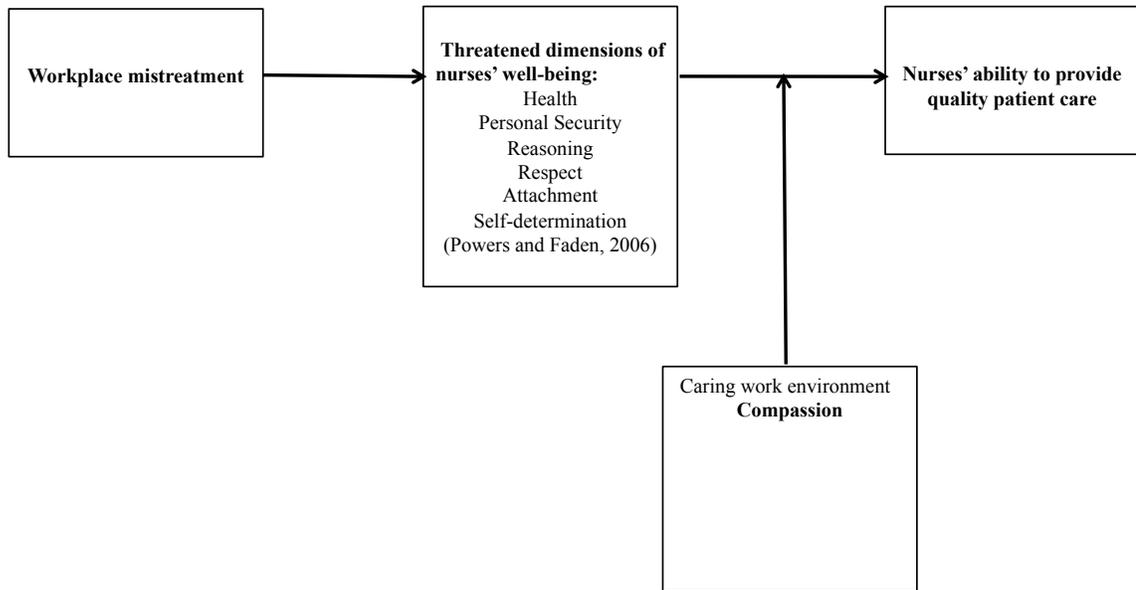


Figure 1. The relationship between workplace mistreatment, threatened dimensions of nurses' well-being, and nurses ability to provide patient care, with caring work environment (compassion) as a moderator.

Definition of Terms

Conceptual Definitions

For the purposes of this study the following conceptual definitions were used:

1. Workplace mistreatment is defined as an umbrella term that describes "... an interpersonal situation under which at least one member initiates counternormative negative actions or stops normative positive actions toward another member in the same workplace" (Yang et al., 2014, p. 315).
2. Threats to well-being are defined as circumstances occurring during workplace mistreatment that thwart achievement of one or more of the six dimensions of well-being as defined by Powers and Faden (2006). A definition of each dimension follows:

- a. Health is a moral concern for human flourishing observed through physical, psychological, and biological functioning.
 - b. Personal security is freedom from actual or feared threats of physical or psychological abuse.
 - c. Reasoning is a diverse set of capabilities essential for understanding the real world, including the ability to analyze, imagine, and respond appropriately based on empirical evidence.
 - d. Respect is regard for another human as equal, having worth and value. Self-respect requires seeing self as equal, having worth and value.
 - e. Attachment is the ability to connect with other people. It allows one to create a sense of fellow-feeling and communal solidarity.
 - f. Self-determination is the ability to live life according to one's own choices and efforts, without being forced to comply with the plans of another.
3. Ability to provide quality patient care is defined as the capacity to administer care that is safe, competent, and compassionate (Gillespie, Gates, & Succop, 2010).
 4. A caring environment is defined as a workplace context consistent with the six Cs of caring as described by Roach (2002), with an emphasis on compassion.

Operational Definitions

For the purpose of this study the following operational definitions were used:

1. Workplace mistreatment was operationalized through the collection of stories describing an incident of interpersonal mistreatment between hospital

employees obtained from participants who have been the recipient of negative behaviors in the workplace.

2. Threats to well-being were operationalized through analysis of collected stories describing workplace mistreatment by calculating the number of threatened dimensions of well-being that align with six dimensions of well-being (health, respect, reasoning, personal security, attachment, and self-determination) proposed by Powers and Faden (2006) in their theory of social justice.
3. Ability to provide quality patient care will be operationalized using the Healthcare Productivity Survey© (Gillespie et al., 2010). See Appendix A for permission to use the tool from the author, Gordon Gillespie, PhD.
4. A caring workplace environment was operationalized using the culture of companionate love scale (Barsade & O'Neill, 2014). Currently there is no tool available to directly measure Roach's (2002) theory. The culture of companionate love scale captures the overall essence of a caring environment with strong emphasis on the compassion dimension of Roach's theory. The scale specifically addresses workplace affection, compassion, caring, and tenderness. See Appendix B for permission to use the instrument, which was obtained from the author.

Summary

Workplace mistreatment has been a significant issue in the general public and more so in nursing. Consequences of workplace mistreatment include stress, illness, absenteeism, job dissatisfaction, and turnover. Examining workplace mistreatment

through a social justice theory calls attention to this problem as a human rights issue. This study explored the relationship between threats to the well-being of nurses as defined through a social justice theory and ability to provide quality patient care. It also examined how caring in the workplace, captured through compassion, moderates this relationship. If workplace mistreatment affects nurses' ability to provide quality care, it is no longer a contained phenomenon but now a human rights issue for the patient as well as the nurse. Further, if a caring environment can moderate the relationship between threats to well-being and ability to provide quality patient care, there is foundational evidence guiding the development of an intervention for enhancing caring in the workplace that can be tested to determine effects on patient outcomes in future research.

CHAPTER 2. LITERATURE REVIEW

Chapter 2 presents a review of the literature on workplace mistreatment; a description of the theoretical frameworks, including Powers and Faden's (2006) theory of social justice and Roach's (2002) theory, the Human Act of Caring, described in the six Cs of caring; and compassion in the workplace. The chapter is divided into the following sections: types of workplace mistreatment; workplace mistreatment and impact on individuals as a social justice issue that affects well-being (Powers & Faden, 2006); impact of workplace mistreatment on patient outcomes; Roach's (2002) theory, the Human Act of Caring; and the impact of compassion in the workplace.

Types of Workplace Mistreatment

There is overlap in the language used to describe workplace mistreatment and, oftentimes, terms are used interchangeably within the same article or as subsets of each other (Dellasega, 2009; Hutchinson, 2013; Lee, Bernstein, Lee, & Nokes, 2014). In fact, Vessey, DeMarco, and DiFazio (2010) noted a lack of continuity in the defining of the terms bullying, harassment, and horizontal violence (BHHV) and bundled them together, defining BHHV as "offensive, abusive, intimidating, or insulting behaviors that cause ... distress to the recipient" (p. 136). A brief discussion of the types of workplace mistreatment follows.

Workplace Incivility

Workplace incivility (WI) covers a wide scope of workplace mistreatment behavior, from eye rolling to outright aggression. Andersson and Pearson (1999) defined

WI as “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others” (p. 457). The authors stressed that the intent to do harm may exist but does not have to; i.e., the perpetrator may be ignorant of social graces, may be lapsing in judgment at the moment, or may be misinterpreting the situation. It also tends to be less intense than other forms of aggression, such as threats or physical violence. The major concern with this behavior is the potential for escalation of the negative behavior as the involved parties continue to interact (Andersson & Pearson, 1999).

Clark et al. (2013) took a more critical stance in a discussion of WI. The authors defined incivility as “rude or disruptive behavior often resulting in psychological or physiological distress for the people involved and, if left unaddressed, may progress into threatening situations or result in temporary or permanent illness or injury” (p. 11). This definition incorporates the impact on the recipient. It is not clear if intentionality is a factor, thus distinguishing Clark et al.’s (2013) definition from Andersson and Pearson’s (1999). Clark’s model, the Continuum of Incivility (Clark, Barbosa-Leiker, Gill, & Nguyen, 2015), illustrates a broader range of behaviors than Andersson and Pearson (1999), encompassing relatively harmless infractions, such as distractions or annoyances, all the way to physical violence at the opposite end of the continuum. Behaviors labeled in the model include “non-verbals (eye rolling), sarcasm, bullying, racial/ethnic slurs, intimidation, mobbing, and physical violence” (p. 309). Andersson and Pearson (1999) and Clark (2013) agree that there is a potential for escalation in behaviors with each

subsequent act of incivility; thus, addressing infractions early may prevent more severe problems down the road.

Workplace Bullying

In contrast to the unclear intentionality of WI, workplace bullying (WB) involves purposeful targeting of an individual with the aggressive behavior repeated over time (WBI, 2017). In an integrative review, Bartlett and Bartlett (2011) defined workplace bullying as negative acts (that can be physical, verbal, or psychological) repeated over time by an instigator toward a target where an instigator/target power imbalance exists, whether true or perceived. Vessey et al. (2010) also discussed a power differential that distinguishes bullying from other forms of workplace mistreatment but does not consider repetition a necessary component.

Horizontal Violence and Lateral Violence

Horizontal violence (HV) connotes workplace mistreatment in which the people involved are hierarchical equals in the organization (Longo & Sherman, 2007). Therefore, if the conflict is between colleagues of a different profession (like a physician and a nurse) or hierarchical level in the organization (such as an administrator and a nurse), it is not considered HV. Horizontal violence was first described in the nursing literature in Roberts's (1983) sentinel article. Roberts (2015) revisited the topic in a literature review more than 30 years later and used the term lateral violence (LV). To that end, in this paper HV and LV are considered synonyms. Roberts' view of HV/LV incorporated the antecedent, oppressed group behavior; a concept derived from the works of Freire (1970).

Freire (1970) postulated that when a more powerful group dominates members of a particular culture, they display “oppressed group behavior” (p. 47). The oppressed group members begin to take on characteristics of the dominant group. They eventually place a higher value on the attributes of the dominant group and reject their own culture’s norms. As the process continues, the oppressed group members begin to experience self-loathing and poor self-esteem. This creates a dynamic in which one’s peers are an embodiment of the hated characteristics in oneself. The frustrated oppressed individual cannot retaliate against their oppressors and begin to take out their aggression on less threatening targets, their equals. Roberts (1983) posited medicine’s authority over nursing has led to nurses becoming an oppressed group, while Farrell (2001) extended this to organizational hierarchy and gender. Nursing’s lack of leadership in healthcare and reluctance to participate in professional organizations have been cited as characteristics of oppressed group behavior (Roberts, 1983). Divisiveness and lack of cohesion in nursing are manifestations of HV/LV resulting from belonging to an oppressed group (Roberts, 1983).

Longo and Sherman (2007) described HV/LV as “an act of aggression that’s perpetrated by one colleague toward another colleague” (p. 35), with behavioral displays of HV/LV that can include overt or covert verbal, emotional, or physical abuse. This range of behaviors appears to fit on the Continuum of Incivility, with the added component that the perpetrator and target are on the same level, most likely two nurses. However, Clark et al.’s (2015) Continuum of Incivility model does not capture passive-aggressive or covert behaviors like withholding information or career sabotage (blocking career advancement), where the concept of HV/LV does (Longo & Newman, 2014).

Saltzberg (2011) suggested that the culture of nursing perpetuates HV/LV and that it does not start upon joining the workforce but rather during the nursing education experience. Tales of *nurses eating their young* and first or secondhand experience with HV/LV as students set the mold for the perpetuation of HV/LV in one's professional life. Frequently, nursing students are encouraged to conform to the way things are instead of questioning if there is a better way. This social reproduction of oppression and mistreatment (Phillips, 2014) lays fertile ground for future perpetrators and victims of HV/LV. This may explain how HV/LV has continued to be an issue in nursing despite years of discussion and research on the topic.

In summary, workplace mistreatment goes by several names, including WI, WB, and HV/LV, to name a few. There can be confusion in identifying a form of mistreatment because the terms are not defined consistently in the literature. The term workplace mistreatment is used in this dissertation in order to capture all the forms of negative workplace behavior nurses experience from colleagues and gain an understanding of how it affects ability to provide quality patient care. While healthcare facilities cannot ignore overt physical violence amongst employees as it is illegal, acts of WI, WB, and HV/LV persist in other ways (such as eye rolling, ignoring co-workers, gossip, etc.) and frequently hospital administrators do not acknowledge or address them. In order to change this, there must be a shift in the culture of healthcare so that workplace mistreatment is given the consideration it warrants. Framing workplace mistreatment as a social justice issue may draw the attention of key stakeholders, such as administration, governmental agencies, and the public to facilitate this culture shift.

Social Justice and Powers and Faden's Model

In their theory of social justice, Powers and Faden (2006) view social justice as achieving human well-being. Powers and Faden asserted that social justice results from careful attention to obstacles to well-being, rather than identifiable principles. The nature of relationships, particularly surrounding lack of respect and support for capacities to fulfill the attachment and self-determination dimensions of well-being, is the focus of the theory of social justice, rather than assessment of distributive shares. Workplace mistreatment can be viewed as a threat to the well-being of nurses and, as such, is a social injustice.

Powers and Faden's (2006) theory includes a model with six dimensions of well-being, which are health, personal security, respect, attachment, self-determination, and reasoning. People must maintain adequate levels of each dimension in order to live a bare minimum quality of life. A serious deficiency in one or more dimensions prevents an individual from experiencing an equitable level of well-being and, therefore, may be considered a social injustice. The authors recognized that the six dimensions influence each other; a deficiency in one dimension may lead to deficiencies in other dimensions (Powers & Faden, 2006). Powers and Faden stated, "The job of justice, positively stated, is the task of securing a sufficient level of each dimension for each individual, insofar as possible" (p. 16). Research related to workplace mistreatment for each dimension was explored in order to determine if a link between workplace mistreatment and threats to social justice expressed as impaired well-being is supported in the literature .

Impact of Workplace Mistreatment on the Six Dimensions of Well-being

Health

According to Powers and Faden (2006), health is more than the absence of disease, but is a moral concern for human flourishing observed through physical, psychological, and biological functioning. The authors contend that the absence of health is more than impaired function, but also includes experiencing pain, premature mortality, and preventable morbidity (Powers & Faden, 2006). Health represents the sustainment of human existence across the lifespan. Workplace mistreatment has been shown to negatively impact various aspects of physical and psychological health (Longo & Sherman, 2007; Vessey et al., 2010), and research demonstrates outcomes, including headaches, gastrointestinal symptoms, stress, anxiety, depression, mood swings, irritability, difficulty concentrating, and altered sleep patterns (Spence Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013; Nielsen & Einarsen, 2012; Owayolu, Owayolu, & Karadag, 2014; Vessey et al., 2010; Vessey et al., 2009). Furthermore, workplace mistreatment has been linked to post-traumatic stress disorder (MacIntosh, Wuest, Gray, & Cronkhite, 2010; Nielsen & Einarsen, 2012; Spence Laschinger & Nosko, 2015) and suicidal ideation (Nielsen, Nielsen, Notelaers, & Einarsen, 2015).

In a descriptive study of 303 registered nurses, including a subsample of staff nurses ($N = 220$), 90% ($N = 191$) of the staff nurses surveyed reported stress levels as moderate or severe after experiencing workplace mistreatment (Vessey et al., 2009). The researchers developed a 30-item survey for the study that was made available on the Internet. Psychometrics of the instrument were not reported. Specific symptoms named in relation to the workplace mistreatment experience included anxiety (95%, $N = 181$),

stress headaches or GI symptoms (72%, $N = 137$), irritability (61%, $N = 116$), depression (56%, $N = 107$), loss of concentration (48%, $N = 92$), and change in sleep patterns (42%, $N = 80$).

Nielsen and Einarsen (2012) performed two meta-analyses to examine outcomes for victims of workplace mistreatment. The first of these included 66 samples from eight cross-sectional studies for a total sample size of 77,721 respondents. The participants were representative of multiple countries, including those in Scandinavia, Europe, and North America. Job titles of the participants were not reported. All of the studies obtained data from victim self-report of experiences. The results of the meta-analysis indicated a positive association between workplace mistreatment and mental health problems in general ($p < .001$) and the sub-categories of anxiety ($p < .001$) and depression ($p < .001$). Furthermore, they found post-traumatic stress ($p < .001$), general strain ($p < .001$), somatization ($p < .001$), and physical health problems were positively ($p < .001$) associated with workplace mistreatment. Relationships in this research ranged from .18 (physical health problems) to .34 (depression). In a second meta-analysis, Nielsen and Einarsen included 25 longitudinal studies of workplace mistreatment outcomes. All of the studies came from Scandinavian countries. Results demonstrated a significant positive relationship between workplace mistreatment presence at baseline and both absenteeism ($r = .12, p < .001$) and mental health problems ($r = .20, p < .001$) at follow-up.

Spence Laschinger et al. (2013) examined the relationship between workplace mistreatment (from supervisors, physicians, and co-workers) and mental health of new graduate nurses ($N = 272$). The researchers combined three standardized questionnaires into a survey: The Workplace Incivility Scale [WIS] (Cortina, Magley, Williams, &

Langhout, 2001), the Psychological Capital Questionnaire (Luthans, Vogelgesang, & Lester, 2006), and the Mental Health Inventory [MHI-5] (Veit & Ware, 1983); all used Likert scales and had acceptable Cronbach's alpha reliability, ranging from .68 to .91 (Spence Laschinger et al., 2013). The results indicated workplace mistreatment was significantly related to poor mental health ($p < .05$) of new graduate nurses, with mistreatment from co-workers having the strongest correlation ($r = .36, p < .05$) (Spence Laschinger et al., 2013).

Symptoms of a more serious mental health problem, post-traumatic stress disorder (PTSD), were also found to have a positive correlation with workplace mistreatment (Spence Laschinger & Nosko, 2015). Spence Laschinger and Nosko (2015) administered the Negative Acts Questionnaire – Revised (NAQ-R), and primary care PTSD screen (PC-PTSD) to hospital nurses ($N = 875$) to examine the relationship between workplace mistreatment exposure and PTSD in nurses. The results showed workplace mistreatment was significantly related to PTSD symptomology in new nurses ($r = 0.55, p < .05$) and experienced nurses ($r = 0.60, p < .05$).

Targets of workplace mistreatment exhibit a multitude of physical and mental health symptoms, ranging from mild to severe. Threat to the first well-being dimension, health, sets the victim up for deficiencies in the remaining dimensions. If the victim is a nurse providing patient care, this may affect the care the patient receives and therefore patient well-being in the dimensions of health and personal security could be impacted as well.

Personal Security

Safety is a fundamental human need (Powers & Faden, 2006). Personal security

refers to freedom from actual or feared threats of physical or psychological abuse in one's surroundings, leading to feeling unsafe (Powers & Faden, 2006). Victims of workplace mistreatment are often made to feel unsafe, either from an immediate physical threat or from anticipation of long-term consequences, such as loss of job or reputation (Vessey et al., 2010; Walrath et al., 2010). Verbal assaults, aggressive facial expressions (such as staring), and isolating behaviors that are indicative of workplace mistreatment intimidate victims and make them feel afraid, threatened, and insecure (Hutchinson, 2013; Hutchinson, Vickers, Wilkes, & Jackson, 2010). Behaviors indicative of workplace mistreatment often take the form of attacks on professional skills and cause victims to question their own competency and feel intimidated to perform nursing skills in front of others (Hutchinson et al., 2010). As a result, the victims are made to believe they are unsafe in the clinical area and other aspects of well-being, such as reasoning, self-respect, and self-determination, can be threatened.

Walrath et al. (2010) conducted a qualitative study of hospital RNs' ($N = 96$) experience with workplace mistreatment using focus groups ranging in size from 7 to 14 RNs. The sample included nurse administrators, advance practice nurses, and staff nurses. Negative behaviors described by participants were categorized on a continuum from low to high intensity as incivility, psychological aggression, and violence. Participants described intimidation and exclusion by certain colleagues, feeling as though their practice was being policed, or worrying that a medical error would make them the subject of gossiping. Participants also expressed the concern that negative behaviors are a distraction and may impact patient safety and decrease the quality of care they deliver (Walrath et al., 2010).

Respect

Respect involves regarding an individual as equal, having worth and value, and can be demonstrated through respect from others, respect towards others, and respect for self. According to the American Nurses Association Code of Ethics, “the nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (Fowler, 2015, p. 1). This provision highlights the need for nurses to refrain from participating in harassment and intimidation in all relationships and to be proactive in preventing harm (Fowler, 2015). In terms of well-being, respect from others and self-respect represent a significant part of the Powers and Faden’s (2006) theory. The authors stated that a lack of respect from others occurs when people experience discrimination based on being judged for being of an inferior social status (Powers & Faden, 2006). Self-respect is threatened as a result of social oppression unless extreme efforts are put forth to change this dynamic (Powers & Faden, 2006).

If respect entails treating others as moral equals (Powers & Faden, 2006), displaying a lack of respect is at the core of workplace mistreatment. Research demonstrates verbal abuse, belittlement, and spreading of rumors in the workplace can all lead to feelings of shame, humiliation, and damage to one’s professional reputation (Felblinger, 2008; Hutchinson et al., 2010; Simons & Sauer, 2013). These behaviors have the potential to elicit a self-blame or self-attack mode, or loss of self-respect, or loss of respect for others (Felblinger, 2008; Walrafen, Brewer, & Mulvenon, 2012), all of which perpetuate the cycle of mistreatment.

Walrafen et al. (2012) employed a mixed-method design to explore nurses’ experience with workplace mistreatment. The researchers created a 9-item Horizontal

Violence Behavior Survey based on the nursing literature and feedback from seven experts in the field (Walrafen et al., 2012). The sample of nurses from a multi-institutional healthcare system ($N = 227$) were asked to choose one or more of the following answers for each item: *experienced*, *witnessed*, *neither experienced nor witnessed*. Psychometrics of the instrument were not reported. For the qualitative portion, three open-ended questions were asked and analyzed using a descriptive analytical technique. The authors did not provide the exact wording of the open-ended questions.

For quantitative results, Walrafen et al. (2012) reported the top three categories of negative behaviors experienced by a majority of the participants were covert or overt affronts (58.3%), nonverbal negative innuendos (54.1%), and back-stabbing (53.4%). Behaviors described in the open-ended questions included verbally dismissive or demeaning remarks, slander, degradation, taunting, and refusing to help colleagues. The researchers acknowledged the use of their own tool as a potential weakness of the study.

Simons and Sauer (2013) conducted a qualitative study to explore nurses' experience with workplace mistreatment and the coping strategies they used to address it. The purposive sample ($N = 18$) consisted of nurses currently working who self-identified as being targets of workplace mistreatment. Interviews were conducted away from the work setting. A content analysis revealed a variety of negative behaviors, with being yelled at the most often reported. Participants described feeling humiliated, embarrassed, and disrespected. Others described feeling "pecked at" and tortured. Many expressed a desire to quit their position at some point.

Attachment

Powers and Faden (2006) identified the ability to form bonds with others as a

central dimension to well-being. The bonds can range from intimate expressions of friendship and love to a sense of solidarity or community demonstrating attunement to others and their needs. Though respect is needed for attachment, a deeper emotional connection distinguishes attachment from respect.

Victims of workplace mistreatment are often subject to isolation, exclusion (Hutchinson, Vickers, Wilkes, & Jackson, 2010), and social withdrawal (Felblinger, 2008), and demonstrate decreased attachment to the organization through cynicism toward work colleagues and intention to leave (Spence Laschinger, Finegan, & Wilk, 2009). Victims of workplace mistreatment have reported impaired communication, such as being ignored when requesting help, which leads to a sense of isolation in the work environment (Walrafen et al., 2012). Nurses, particularly those working in hospital environments, need to be able to collaborate with colleague in order to communicate information (Purpora & Blegen, 2015), such as patient status; to ask questions from more experienced colleagues when they do not have enough knowledge on a topic; or even to ask for assistance during emergencies or crises. Workplace mistreatment impairs attachments with co-workers and disrupts peer communication (Walrafen et al., 2012), thus interfering with the process of delivering high-quality and safe care. A deficiency in attachment can put one at risk for making errors and eventually impact the other dimensions of well-being, such as respect, due to damage to one's professional reputation.

Self-determination

According to Powers and Faden (2006), living a self-determined life is “living one's life from the inside, according to one's own inclinations and values” (p. 26). This

includes where and how someone chooses to earn a living. Workplace mistreatment may interfere with opportunities for advancement and promotion and the associated salary increases. This occurs by denying victims opportunities for professional development, such as excluding them from educational programs or committee work, thus preventing them from reaching their full career potential (Hutchinson et al., 2010; Walrafen et al., 2012). In some instances, workplace mistreatment can make it intolerable for the victim to continue employment at their current job and resignation is their only option. Victims may not only leave their current position but change professions altogether (Johnson & Rea, 2009; Nielsen & Einarsen, 2012; Vessey et al., 2009; Vogelpohl, Rice, Edwards, & Bork, 2013). The ramifications from loss of job, career, and financial security are certainly a threat to well-being and can affect the other dimensions, such as personal security and health.

At times more than one dimension of well-being is described in a study.

Hutchinson et al. (2010) conducted a three part mixed-method study to explore the nature of workplace mistreatment in the Australian nursing environment. The sample ($N = 26$) consisted of nurses who experienced workplace mistreatment. Individual interviews were held, recorded, and transcribed. Data were analyzed using a constant comparative method, coded, and categories identified. Three categories of workplace mistreatment were reported: personal attack, erosion of professional competence and reputation, and attack through work roles and tasks. The results of this study indicated damage to multiple dimensions of well-being. Participants reported isolation and exclusion with behaviors such as being ignored or excluded from conversation (attachment dimension). Intimidation and threats were another pattern that emerged, with examples given such as

raising voices or hands, destroying personal property, or physical aggression like pushing (personal security dimension). Another form of workplace mistreatment was belittlement and humiliation (respect dimension), such as name-calling. Limiting career opportunities, such as excluding from educational or promotion opportunities (self-determination dimension), was another category of workplace mistreatment that the participants reported.

Reasoning

According to Powers and Faden (2006), reasoning embodies cognitive abilities such as learning, executive functioning, making logical connections, and detecting errors.. The authors discussed two types of reasoning: theoretical and practical (Powers & Faden, 2006). Theoretical reasoning includes basic intellectual skills and habits needed to understand the natural world using evidence and reflection. Practical reasoning involves conceptualizing how to live, based on values and desires, and being able to deliberate with others to achieve goals. Both types of reasoning contribute to beliefs about the natural and social world that contribute to the arrival at practical conclusions (Powers & Faden, 2006). Reasoning is essential for both critical thinking and decision-making. Nurses are expected to use critical thinking to integrate objective data with subjective data obtained from assessment of the patient and to incorporate knowledge from the biological, physical, behavioral, and social sciences to achieve the best outcomes for patients (American Nurses Association, 2015).

One way in which reasoning may be conceptualized is through an examination of nurse productivity, which requires a demonstration of cognitive tasks and demands. Three studies found in the literature demonstrate a relationship between workplace

mistreatment and productivity (Berry, Gillespie, Gates, & Schafer, 2012; Hutton & Gates, 2008; Lewis & Malecha, 2011).

Two of these studies (Hutton & Gates, 2008; Lewis & Malecha, 2011) used the Work Limitations Questionnaire [WLQ] (Lerner et al., 2001) in combination with a workplace mistreatment measure to investigate this relationship. The WLQ, a 25-item questionnaire, measures productivity by the degree of interference one experiences in performing work functions. Four elements of productivity are included in the instrument: time management, physical demands, mental-interpersonal demands, and output demands. Lerner et al. (2001), the instrument's authors, reported Cronbach alphas of ≥ 0.90 and positive correlations with health status and self-reported work productivity ($p \leq 0.05$).

Hutton and Gates (2008) examined workplace mistreatment experienced by direct healthcare staff in a hospital in the Midwest. Participants ($N = 184$) responded to the WLQ and the Incivility in Healthcare Survey (IHS). The IHS consists of 41 items rating frequency of incivility on a Likert-type scale. The instrument is divided into five subscales, which measure incivility from general environment, direct care staff, direct supervisors, physicians, and patients. The internal consistency of the IHS measured by Cronbach's alpha was determined to be 0.942. Results showed correlations between workplace mistreatment from direct supervisors and productivity ($r = 0.284, p = .000$) and workplace mistreatment from patients and productivity ($r = 0.204, p = .006$). Mistreatment from physicians and from other direct care staff members did not have a significant relationship with productivity.

Lewis and Melcha (2011) explored the relationship between workplace mistreatment and productivity in a sample of registered nurses ($N = 659$) from the state of Texas. A correlational, comparative, and predictive model design was used. Standard work environments were compared to healthy work environments, with hospitals designated Magnet or Pathway to Excellence categorized as healthy work environments. Surveys including the WLQ (Lerner et al., 2001) and the Nursing Incivility Scale [NIS] (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010) were mailed to the participants. The NIS measures source specific (coworkers, supervisor, physicians, patients/visitors, and the general environment) mistreatment. This 43-item instrument has demonstrated reliability, with internal consistency alpha ranging from .88 to .94 for each of the subscales.

Lewis and Malecha (2011) found the nurses working in healthy work environments had lower WPI scores than those in standard environments ($p < .001$) in all subscales except the patient/visitor scale. The WLQ productivity loss scores were calculated to an estimated mean loss in productivity of 20% in those experiencing workplace mistreatment, regardless of the hospital environment where a nurse worked. Results also showed significant correlations between environment, nurse, supervisor, and patient/visitor and the time management, mental/interpersonal skill demands, and output demands subscales relationships in the study ranged from $r = -.195, p < .000$ to $r = -.319, p < .000$. This negative relationship indicates that the higher the incivility, the lower the productivity. The physical demands subscale of the WLQ did not have correlation with workplace mistreatment.

Berry et al. (2012) examined the relationship between workplace mistreatment and productivity using the Healthcare Productivity Survey [HPS] (Gillespie et al., 2010). The participants received a postcard mailing and accessed a questionnaire via the Internet. The sample ($N = 197$) consisted mostly of White females less than 30 years of age. Almost half of the respondents reported being the target of WPB (44.7%, $N = 88$). The main perpetrators of WPB were staff nurses (44%, $N = 88$), followed by nurses in leadership positions (19%, $N = 38$), and the lowest by physicians (6%, $N = 12$). Of those that reported being a victim of a WPB event, 46.7% ($N = 92$) reported a decrease in ability to provide patient care, 23.9% ($N = 47$) reported no change, and 29.4% ($N = 56$) reported increased productivity. Differential findings related to subscales were not reported.

The results of these studies illustrate the impact of workplace mistreatment on victims' ability to meet cognitive demands of the nursing role, crucial for patient care, as well as to reflect and critically assess current situations that may be limiting their ability to achieve goals or act on their own behalf. Threats to the dimension of reasoning may bleed into other dimensions. For example, a loss of self-respect and self-determination may occur if the victim is unable to perform his or her job responsibilities safely and subsequently garners a bad work reputation, harms a patient, or is subject to discipline from superiors in the workplace.

Available research supports the concern that workplace mistreatment may threaten all dimensions of human well-being outlined in Power and Faden's (2006) theory. Therefore, it is possible that workplace mistreatment can be viewed as a social injustice that impacts the well-being of nurses. This, then, has the potential to indirectly

effect the well-being of patients who are being cared for by nurses who cannot perform their professional duties to their full potential due to sequelae of mistreatment.

Workplace Mistreatment and Patient Outcomes

A search of the literature revealed few studies examining the link between workplace mistreatment experienced by direct care nurses and patient outcomes. A discussion on these studies follows.

One study examined the impact of workplace mistreatment in the perioperative department. Smith (2011) examined the frequency of occurrence of five surgical never events (medical errors that result in death or catastrophic injury) as a proxy measurement of patient outcomes. The sample consisted of perioperative registered nurses ($N = 853$) who were invited to complete to an electronic survey, which included 11 questions adapted from the Workplace Bullying Inventory [WBI] (Hutchinson et al., 2008) plus one question added for the study. The additional question, created by the author, asked participants to rank how often they thought that workplace mistreatment in the perioperative workplace affected surgical never events which were listed. Responses ranged from 1 = Never to 5 = Always. Results indicated a significant relationship between workplace mistreatment and perceived errors such as surgery on the wrong patient ($p < .001$), surgery on the wrong site ($p < .001$), wrong surgical procedure ($p < .001$), retained surgical items ($p < .001$), and intraoperative or immediate post-operative death of a healthy patient ($p < .001$) (Smith, 2011). A limit of the study is lack of validity and reliability testing on this final question created by Smith (2011). Participants were asked their perception of the link between workplace mistreatment and never events;

however the researchers did not report if the participants actually witnessed these events or if it was personal opinion.

Reynolds, Kelly, and Singh-Carlson (2014) examined the prevalence and influence of HV in the perinatal department. Nurses working in the perinatal area ($N = 63$) responded to a survey consisting of 19 items, scored on a Likert scale. Six items related to experiencing or witnessing HV in the past 12 months, six to being mentally or physically affected by HV in the past 12 months, six to the type of healthcare provider perpetrating the behavior, and one item referred to a poor patient outcome or near miss occurring because of negative workplace behaviors. The researchers reported a correlation between nurses experiencing workplace mistreatment and poor patient outcomes and near misses. Participants who reported that there had been a bad patient outcome had a significantly higher mean score on the witnessed subscale ($M = 28.16$, $SD = 3.88$) compared with those who did not report a bad patient outcome [$M = 22.41$, $SD = 6.65$, $t(58) = 2.86$, $p = .005$]. While respondents who reported a bad patient outcome also had a higher mean affected subscale score ($M = 19.33$, $SD = 6.74$) compared with those who did not report a bad patient outcome [$M = 16.08$, $SD = 6.87$, $t(59) = 1.47$, $p = .14$], the difference in means was not statistically significant. Total overall hostility scale mean scores were also higher for those who reported a bad patient outcome ($M = 47.50$, $SD = 8.73$) compared with those who did not report a bad patient outcome [$p = 38.45$, $SD = 12.27$, $t(58) = 2.40$, $p = .02$]. For the six survey items related to HV, experiencing and witnessing HV were combined; therefore it was not possible to determine whether or not the participants directly experienced the workplace mistreatment. This is a limitation of the study.

Spence Laschinger (2014) examined the relationship between workplace mistreatment and patient care quality. Nurses living in Ontario, Canada ($N = 336$) responded to a questionnaire mailed to their homes. Workplace mistreatment behaviors were assessed through the Negative Acts Questionnaire Revised [NAQ-R] (Einarsen et al., 2009), which measures bullying, and Workplace Incivility Scale (Cortina et al., 2001), which measures incivility. Patient safety risk was assessed through ranking five items scored on a Likert scale as to whether the participant agreed or disagreed with the statement. Spence Laschinger (2014) created the items based on a review of the literature. To assess perception of patient care quality, participants were asked to rate, on a scale ranging from 1 (poor) to 4 (excellent), the quality of care of their unit. Finally, nurse-assessed adverse events were measured through a scale consisting of five items that assessed participants' perceptions of the frequency of common adverse patient outcomes over the past year (medication errors, nosocomial infections, falls, work-related injury, and patient complaints) on a scale from 1 = never to 4 = frequently. The results indicated workplace mistreatment from colleagues, physicians, and supervisors (including those considered subtle) have significant direct and indirect effects on nurse-assessed adverse events ($R^2 = 0.03-0.06$) and perceptions of patient care quality ($R^2 = 0.04-0.07$) through perceptions of increased patient safety risk (Spence Laschinger, 2014).

Purpora, Belgen, and Stotts (2015) examined the relationship between HV and patient outcomes through a survey of registered nurses ($N = 175$) working in California. The researchers used a questionnaire made of items from a combination of tools used in previous studies, including the NAQ-R (to measure workplace mistreatment), Nurse Rated Quality of Care, Nurse Staffing and the Quality of Care Questionnaire, and

Hospital Survey on Patient Safety Culture (to measure patient outcomes). The authors reported Cronbach's alpha values for the 21-item NAQ-R, quality of care scale, and the error and adverse events scale were 0.87-0.92.

Participants were instructed to rate items based on events that may have happened to either the nurse or a patient in the last six months. Results indicated an inverse relationship between workplace mistreatment and the quality of patient care ($r = -0.469$; $p < 0.01$). For every one unit increase in NAQ-R score, there was a corresponding 0.672 decrease in the quality of patient care score, controlling for the other variables ($p < 0.05$). Additionally, there was a positive correlation between HV and errors and adverse events ($r = 0.442$; $p < 0.01$). For every one unit increase in NAQ-R score, there was a corresponding 0.428 increase in errors and adverse events score, controlling for the other variables ($p < 0.05$). A limit of the study is the authors did not provide detailed information on the actual items used, so it is unclear what kinds of events the participants were reporting.

Of the studies described here all of them were quantitative, three took place in the United States and one in Canada. The studies all used a similar method in that nurses were instructed to rate on a Likert scale the degree to which they have witnessed or experienced workplace mistreatment and their perception of patient safety or care quality in their area. While these studies provide some insight into the relationship between workplace mistreatment and patient outcomes, they have limitations often associated with study methods (e.g., failure to distinguish witnessing versus experiencing mistreatment; failure to document reliability and validity of instruments). Therefore, there is a need for a different approach to investigating this relationship between workplace mistreatment

and patient outcomes. It is difficult to measure a direct relationship between workplace mistreatment of the nurse and outcomes for the patient due to the complexity of healthcare and number of factors that affect clinical outcomes. However, measuring nurses' ability to provide quality patient care provides the opportunity to infer a relationship. If the nurse reports her ability to provide quality patient care is impaired after workplace mistreatment occurs, it follows that patient outcomes would suffer.

Workplace Mistreatment and Nurses' Ability to Provide Quality Care

Measuring nurses' ability to provide patient care after a negative experience provides a bridge from nurse well-being to patient well-being. This can be measured through the HPS (Gillespie et al., 2010). The HPS was developed to measure the change in nurse productivity following stressful work events. There are three studies (Berry et al., 2012; Gates, Gillespie, & Succop, 2011; Gillespie et al., 2010) published using this instrument: first to test its psychometrics (Gillespie et al., 2010), then a study of workplace violence (WPV) perpetrated by patients and visitors toward nursing staff (Gates et al., 2011), and the most recent on workplace bullying of novice nurses (Berry et al., 2012), described earlier in this chapter (see under Reasoning subheading).

Productivity is understood to mean the ability to perform job activities. This is easily measured in certain professions where production is a concrete concept, such as sales or factory work. However, in nursing, productivity includes things like providing safe and high quality direct patient care, while being compassionate in care delivery (Gillespie et al., 2010).

The HPS is a two-part instrument (see Appendix C). The first part is a free-writing exercise that instructs the respondent to tell about an episode of being a

workplace mistreatment target within the last 30 days. The second part is a 29-item survey, divided into four subscales: cognitive, workload, support and communication, and competent and safe care. Items were created based on the primary author's (Gillespie) knowledge of the roles and responsibilities of nurses, gleaned from his clinical experience (Gillespie et al., 2010). Participants are to rate their ability to perform particular nursing functions after the negative incident as compared to before the incident. Responses are on a Likert scale ranging from -2 to +2, with the negative scale indicating they were less able, zero indicating no change, and the positive scale indicating they were better able to perform job functions. Scores are added with a possible total ranging from -58 to +58, with a negative score indicating a loss in productivity, zero indicating no change in productivity, and a positive score indicating an increase in productivity.

Psychometrics of the instrument were derived through a survey mailed to a national sample of 3,000 emergency room nurses holding a membership in the Emergency Nurses Association [ENA] (Gillespie et al., 2010). Inclusion criteria were working as a nurse in the emergency department and having a U.S. mailing address. There were 220 usable surveys returned, for an 8.2% response rate, enough to achieve a power of .85. Content validity, factor analysis, and test-retest reliability were conducted. After factor analysis, 6 of 36 items were deleted. For test-retest reliability, the authors computed Pearson's correlation coefficient and found a strong and significant correlation ($r = .801, p < .001$). The authors acknowledged a study limitation in that the sample consisted of mostly White females, all of who worked in the emergency room, and thus the psychometric of the HPS instrument should be tested in other populations. Another

possible limitation of the study is that respondents were basing responses on events that happened as long as 30 days in the past and may have had difficulty remembering with accuracy.

Gates et al. (2011) examined the relationship between exposure to WPV and nurses' ability to provide quality patient care. Emergency room nurses ($N = 238$) responded to a four-section survey consisting of a written narrative of an incident of WV, the HPS, the Impact of Events Scale - Revised, and demographic information (Berry et al., 2012; Gates et al., 2011). The results indicated that 37% of participants had a negative total productivity score, indicating a decrease in productivity after the incident.

The HPS has been used to examine the relationship of workplace mistreatment and work productivity in novice nurses (Berry et al., 2012). Participants ($N = 197$) responded to a postcard mailing and accessed the questionnaire via the Internet. The majority of participants were White females under 30 years of age. More than half of the respondents reported being the target of workplace mistreatment (58.4%, $N = 115$). The main perpetrators of workplace mistreatment were staff nurses (44%, $N = 88$) followed by nurse leaders (19%, $N = 38$). Almost half of the participants who reported being a victim of a workplace mistreatment event, 46.7% ($N = 92$), reported a decrease in healthcare productivity; 29.4 % ($N = 56$) reported increased productivity; and 23.9% ($N = 47$) reported no change. The authors did not report performing a power analysis but did cite small sample size as a limitation. The homogeneity of the sample makes it difficult to generalize the results. Additionally, there is the risk of selection bias, as those who experience workplace mistreatment may be more likely to fill out a survey or write a story on that topic.

In all three studies, sample homogeneity is a limitation; most participants were White females, and the authors recommend future research using the HPS with a heterogeneous sample to increase generalizability of the results. Inclusion criteria were limited to nurses working in the emergency department or novice nurses. The current study included all acute care nurses regardless of years of experience or department. Additionally, none of the previous studies had analyzed the stories of workplace mistreatment. The written narratives had only been used as a memory trigger to aid the participant in answering the survey items. In the current study, participants' stories were analyzed for alignment with the six dimensions of well-being (health, personal security, respect, attachment, self-determination, and reasoning) as described by Powers and Faden's (2006) theory of social justice. This provided a deeper understanding of the relationship between mistreatment-related threats to nurses' well-being as associated with the ability to provide quality care.

Roach's Theory the Human Act of Caring

Roach's (2002) theory, the Human Act of Caring, was selected as the caring framework for this study for its simplicity, straight forwardness, and ease of application embodied in the description of the components of caring, known as Roach's six Cs (Myers, 2013). The six Cs epitomize the act of caring and, as such, the National Health Service (NHS, 2016) in England has adopted a modified version of the six Cs as the nursing strategy and vision for the country as has Scripps Mercy Hospital in San Diego, California and Martin Memorial Health Systems' hospitals in Martin county, Florida (Myers, 2013).

According to Roach's (2002) theory, the Human Act of Caring, one cares because one is human. Roach identified six elements of caring, germane to nursing care (p. 43). These elements are known as the six Cs and include compassion, competence, confidence, conscience, commitment, and comportment (Roach, 2002). Compassion is connecting in full presence, to another's pain. Competence is having the skills and knowledge to perform within your scope of practice. Confidence refers to building trust, creating a context where information is believable. Conscience is caring guided by morals and ethical codes, to do what is best for the other. Commitment is standing by the other through the length of the relationship, no matter how difficult. Comportment is showing respect through speech, body language, and dress. Roach's theory of caring can be used to conceptualize a safe, healthy, and caring environment for nurses and patients.

Myers (2013) recommended future research of Roach's (2002) six Cs, writing:

It would seem logical that nurses who were exposed to the demonstration of the six Cs by other nurses would be more likely and willing to express these six Cs to patients and their families. A pilot project could be put into effect in designated workplaces, and a nurse educator be available to teach and demonstrate the theory, ensure that staff were fluent in their understanding of Roach's Cs and rewarded for progress in this area...." (Myers, 2013, p. 412)

Myers (2013) suggestion underscores the appropriateness of the use of Roach's (2002) theory as the caring framework in this study.

Compassion in the Workplace

A search of the literature did not reveal a tool to specifically measure the presence of Roach's (2002) six Cs. However, Barsade and O'Neill (2014), who come from the

business world, have developed a measure, the Culture of Companionate Love scale, which captures the essence of caring as described by Roach (2002), particularly the compassion dimension of the 6 Cs. The scale measures the frequency of affection, compassion, caring, and tenderness for others exhibited by colleagues in the workplace. The scale includes four items measured on a 1–5 Likert scale (1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often). Participants are asked, “To what degree do other employees in your (division/organization) express the following emotions (affection, caring, compassion and tenderness) at work?” The authors reported a Cronbach alpha of .73 (Barsade & O’Neill, 2014), which is acceptable for a newly developed instrument (Tappen, 2011).

In a longitudinal study, companionate love in the workplace was examined in relation to employee outcomes, such as emotional exhaustion and job satisfaction, and the “cascading effects on patients and their families” (Barsade & O’Neill, 2014, p. 558). The authors selected the long-term care environment for the study setting citing, “Perhaps no industry has supported the importance of companionate love for its employees as much as the healthcare industry, which includes organizations providing long-term patient care” (Barsade & O’Neill, 2014, p. 558). This impression regarding the healthcare industry’s intent to promote companionate love is in direct contrast to the focus of this dissertation. The contrast highlights a disconnect between what is being experienced within the nursing profession and how the profession may be viewed by others not directly involved in healthcare settings. It is interesting to consider Barsade and O’Neill’s (2014) findings in light of their impression about the healthcare industry.

The sample included employees in various clinical and non-clinical job roles ($N = 185$), patients ($N = 108$), and patients' family members ($N = 42$) in a long-term care facility (LTC) (Barsade & O'Neill, 2014). Data were collected at two intervals. Results of the study indicated a positive relationship between a culture of companionate love (as defined as perception of caring, compassion, tenderness, and affection by colleagues in the workplace) and both teamwork ($r = .51, p < .05$) and employee satisfaction ($r = .56, p < .01$). At the same time, there was a negative relationship between a culture of companionate love and employee absenteeism ($r = -.21, p < .05$) and emotional exhaustion ($r = -.40, p < .01$). In regards to patient outcomes, a culture of companionate love was positively correlated with LTC patients' pleasant mood ($r = .46, p < .05$), satisfaction ($r = .60, p < .01$), quality of life ($r = .57, p < .05$), and health (as measured by fewer transfers from the LTC to the emergency room) ($r = 1.61, p < .05$). Patient families' ratings of the culture of companionate love had a positive and significant relationship with family member satisfaction ($r = .41, p < .001$) and a willingness to recommend the facility to other people ($r = .49, p < .01$).

Summary

Despite evidence of the negative effects of workplace mistreatment on the victims and the organizations where they work, workplace mistreatment remains a problem in many industries, including healthcare. The literature provides evidence that workplace mistreatment can threaten the six dimensions of well-being outlined in Powers and Faden's (2006) theory of social justice. There is limited research available in the literature that demonstrates the relationship between workplace mistreatment of nurses and patient outcomes. Exploring the connection among effects of workplace

mistreatment, nurses' dimensions of well-being and ability to provide quality patient care provide a new substratum of this phenomenon to be investigated. Hutchinson, Jackson, Haigh, and Hayter (2013) suggested "extending scholarship into new areas will help ensure we do not become desensitized to what is an unacceptable yet common feature of nursing" (p. 904). Victims and organizations have tolerated this negative behavior to their detriment and at the risk of patients' well-being. Viewing workplace mistreatment from the perspective of threatened nurse well-being and impaired ability to provide quality patient care may bring a new sense of urgency and inspire leadership to put policies and training into place to address it from a perspective of a culture change rather than an individual change.

Furthermore, Barsade and O'Neil (2014) queried companionate love, found it, and linked it to employee as well as patient/family outcomes. This positive perspective warranted consideration as the findings from the current study took shape. Barsade and O'Neil's study not only demonstrated healthcare workers' experiences in a culture of companionate love significantly correlate to their level of workplace engagement and withdrawal, but also showed the consequences of a culture of compassion extend to patients and even to their families. If compassion in the workplace can mitigate emotional exhaustion and increased absenteeism, perhaps it can moderate the effects of workplace mistreatment on nurses' ability to perform their professional duties and to provide quality patient care. Fostering a climate of compassion in the workplace may be a viable option for organizations to utilize in preventing and ameliorating the effects of workplace mistreatment among hospital employees.

CHAPTER 3. RESEARCH METHODOLOGY

Chapter 3 explains the methodology for this study of the relationship between workplace mistreatment, nurses' ability to provide quality patient care, and a caring work environment characterized by compassion. The chapter is divided into the following sections: (1) research design; (2) research questions and hypotheses; (3) measures, including reliability and validity; (4) ethical considerations, including protection of human subjects; (5) sampling, recruitment, and setting; (6) data collection protocol; (7) data analysis; (8) limitations of the research plan; (9) timeline; and (10) summary.

Research Design

In this exploratory study, a descriptive correlational design was used to examine the relationship between workplace mistreatment, nurses' ability to provide quality patient care, and a caring work environment, characterized by compassion.

Research Questions and Hypotheses

The overall research questions focus on the relationship between workplace mistreatment, quantified as threats to dimensions of nurses' well-being (health, personal security, reasoning, respect, attachment, and self determination) and nurses' ability to provide quality patient care. In addition, this study considered the moderating effect of caring work environment compassion among co-workers on nurses' ability to provide quality patient care in the face of workplace mistreatment.

The specific research questions and, when appropriate, corresponding hypotheses were:

- A. How do nurses' stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?
- B. How does the number of threatened dimensions of well-being relate to nurses' ability to provide quality patient care?

Hypothesis 1: An increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

- C. How does a caring work environment (compassion) moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

Hypothesis 2: A caring work environment (compassion) will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care.

Measures

Demographic Data

Participant characteristics of age, educational level, nursing specialty, race, number of years working as a nurse, number of years working in their current role, and sex were captured in survey format (see Appendix D for demographic questionnaire).

Workplace Mistreatment

Data on workplace mistreatment were collected through part one of the Healthcare Productivity Survey [HPS] (Gillespie et al., 2010) via written narratives about the participants' experiences of workplace mistreatment. This served two functions. First,

narratives were examined for alignment of stories of mistreatment with threats to the six dimensions of well-being, addressing the first research question. Secondly, the stories activated a memory of a recent (within the last 30 days) experience with workplace mistreatment. Narratives can serve to help the writer make sense of a specific life experience (Casey et al., 2016); writing about an incident of workplace mistreatment for this study may be a first step toward making sense of the experience. It also serves to ground the participant in the memory of the event and facilitates consideration of the quality of care they provided following the workplace mistreatment incident. Responses to questions on ability to provide quality patient care, as described in the next section, were based on the account of workplace mistreatment discussed in the written narrative.

Ability to Provide Quality Patient Care

Part two of the HPS (Gillespie et al., 2010) was used to measure the participant's ability to provide quality nursing care after an incident of workplace mistreatment. Part two of the HPS is a 29-item survey, which measures change in productivity before and after an incident of workplace mistreatment. The respondent is instructed to rate if their work productivity increased, decreased, or stayed the same after experiencing workplace violence (or mistreatment in the case of this current study) in comparison to before the incident. Productivity is understood to mean the ability to perform job activities. The researchers created the survey items based on the knowledge of the roles and responsibilities of nurses from the primary researcher's clinical experience. Participants in this study were instructed to respond to the survey based on the incident contained in the written narrative as discussed previously.

Survey items in the HPS are divided into four subscales: cognitive demands, handle/manage workload, support and communication with patients and visitors, and safety and competency. Items are rated on a Likert scale ranging from -2 to +2, with the negative rating indicating a perceived decreased ability and a positive rating indicating an increased ability to perform work activities after the incident compared to before the incident. A zero can be selected to indicate no change in ability to provide quality patient care for an item. The scores are then added to yield a subscale score and a total score. Total scores could range from -58 to +58; a score below zero indicates decreased ability to provide patient care compared to ability prior to the incident, zero indicates no change, and a positive score indicates an increase in ability to provide patient care.

The HPS was first developed to measure the change in nurse productivity following an incident of workplace violence (WPV). Psychometric evaluation for the tool was performed with a sample of emergency room nurses ($N = 220$) who had experienced WPV (Gillespie et al., 2010). Mean age of participants was 43.7 years (42.3–45.1, 95% CI). The majority of participants were female (86.1%), White (91%), and had bachelor's degrees (55.4%).

Content validity, factor analysis, and test-retest reliability were conducted (Gillespie et al., 2010). A content validity index was administered to assess agreement/disagreement of ten experts (nurses and physicians) in emergency care with a range of agreement from 80 to 100% for each item; therefore, no changes were made to the instrument. After factor analysis, 6 of 35 items were deleted. A Pearson's correlation coefficient was computed for test-retest reliability, using an alpha level of .05 to determine statistical significance, and WPV was found to have a strong and significant correlation

($r = .801, p < .001$) with ability to provide quality patient care. Internal consistency was estimated by calculating Cronbach's alpha for the entire HPS scale and each HPS subscale, and the authors reported strong internal consistency reliability for each HPS subscale (0.871–0.945).

Caring Work Environment

A search of the literature did not reveal a tool to specifically measure the presence of Roach's (2002) six Cs. The culture of companionate love scale (Barsade & O'Neill, 2014), a newly developed measure, captures the essence of caring as described by Roach (2002), with strong emphasis on the compassion dimension of the six Cs. The scale specifically addresses workplace affection, compassion, caring, and tenderness for others. The scale includes four items measured on a 1–5 Likert-type scale (1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often). Participants are asked, "To what degree do other employees in your (division/organization) express the following emotions (affection, caring, compassion and tenderness) at work?" It is short and therefore uses little of the participant's time. The authors reported a Cronbach alpha of .73 (Barsade & O'Neill, 2014), which is acceptable for a newly developed instrument (Tappen, 2011). See Appendix E for the Culture of Companionate Love scale.

Ethical Considerations

Prior to initiation of the study, approval from the Institutional Review Board (IRB) of Florida Atlantic University was obtained (Appendix F). The electronic survey was made available through SurveyMonkey (2017). Volunteers interested in participating in the study clicked a hyperlink provided in a post on the allnurses.com website. Clicking on the survey and proceeding to answer the questions after reading the consent paragraph

implied consent. The first screen of the survey contained questions to determine if inclusion criteria were met. Potential risks and benefits for participating were also provided electronically before the participants continued to the survey. Participants were instructed that they could withdraw from the study at any time. The researcher was available by phone, if needed, to provide a description of the study, the purpose, and the procedure, and to answer any questions that participants had. Participants were assured of anonymity as the computer connections were secured and encrypted and there was no identifying information provided during data collection.

A risk of the study was experiencing stress due to recalling memories of mistreatment. If at any time a participant felt uncomfortable, they could stop answering questions at their will. All participants are nurses currently employed in the hospital setting and therefore are likely to have access to an Employee Assistance Program (EAP). Participants were instructed to contact their facility's EAP or a mental health counselor of their choosing should they need help managing the stress study participation precipitated. It is unknown if participants benefited directly from the study; however they could see the opportunity to express thoughts and feelings regarding a stressful incident as helpful and the study contributes to the knowledge of workplace mistreatment and nurses' ability to provide patient care.

Written narratives and surveys contained no information that would identify the participants. If a participant mistakenly disclosed identifiable information, it was replaced with pseudo names and places. Data were stored in a locked cabinet and a password-protected computer that only researchers working directly on the project could access. Data will be destroyed five years after completion of the study.

Sampling

The population of interest was hospital employed nurses who were providing direct patient care during the time of the workplace mistreatment. The study used a convenience sample of registered nurses. Inclusion criteria required that participants be registered nurses aged 18 or older; employed in the hospital setting in acute or sub-acute areas; providing direct patient care; able to read, write, and understand English; and subject of a workplace mistreatment event within 30 days prior to responding to the study. An exclusion criterion was working as an advanced practice nurse.

Power analysis was calculated using both the Pearson's correlation and the moderator data analysis approaches to ensure the correct number of participants was recruited. Power analysis for a Pearson correlation was conducted in G*Power to determine a sufficient sample size with an alpha of 0.05, a power of 0.80, a medium effect size ($p = .3$), and one tail (Faul et al., 2013). Based on the aforementioned assumptions, the desired sample size is 64. An a priori power analysis using G*Power 3.0 for a multiple regression with two predictors was conducted to determine a sufficient sample size using an alpha of 0.05, a power of 0.80, and a medium effect size ($f^2 = 0.15$) (Faul, Erdfelder, Buchner, & Lang, 2013) for the moderator analysis. Based on these assumptions, the desired sample size is 68. Therefore, for this study the goal sample size was 68.

Recruitment

Participants were recruited in phases to ensure an adequate number of responses was reached; all phases included snowball sampling technique. The study was announced on the allnurses (n.d.) website and the hyperlink to the survey was included in the

announcement. This website was selected because according to the administrators of this website, “allnurses is the leading social-networking site for nurses and nursing students. People from all over the World come to allnurses to communicate and discuss nursing, jobs, schools, NCLEX, careers, and so much more” (allnurses. n.d.). At the time of this writing, the number of registered accounts on the site is over 983,000. Members of the allnurses.com site have the ability to share postings with others. Therefore, snowball sampling was appropriate in this phase. The process for recruiting survey participants required by the allnurses.com website is as follows:

1. Post research request to a forum on the website and label the topic as “research.”
2. An online survey tool such as Survey Monkey must be used.
3. Once the research request is posted, it is reviewed by staff and made public after final approval. (See Appendix G for a screenshot research request.)

After the minimum number of responses (68) was not reached within 30 days of posting the survey link, phase two was implemented.

Phase II: Announcements of the study including a hyperlink to the survey were made available through the researcher’s social media accounts including Twitter, LinkedIn, and Facebook.

Phase III: Announcement of the study including a hyperlink to the survey was sent via blast email to nursing students at the Christine E. Lynn College of Nursing at Florida Atlantic University.

Setting

Data was collected via electronic survey available on the Internet.

Data Collection Protocol

Data were collected by electronic survey hosted by SurveyMonkey (2017). The participants were anonymous as there would be no identifying information on the survey. SurveyMonkey is a secured site and only the researcher had access to the account on SurveyMonkey. Names of parties involved and institutions were not included in the data. The researcher enabled the SSL encryption feature to protect data transmitted between the respondent's computer and the SurveyMonkey servers. IP addresses were masked from the researcher to ensure there was no way to trace information back to the participant's computer.

Total time to complete the instruments was approximately 25 - 35 minutes:

- Demographic questionnaire: 3 minutes
- Written narrative: 5-15 minutes
- 29-item productivity survey: 12-15 minutes
- 4-item companionate love survey: 2 minutes

The participants were asked to write about an episode of workplace mistreatment from a colleague that occurred in the last 30 days using the following instructions:

Please think about a recent experience with workplace mistreatment (otherwise known as incivility, bullying, or horizontal violence) that caused you stress. Tell me what happened; what you thought about it, what you felt about it; how it affected your life; and how you managed it. You do not need to worry about style, grammar, or spelling. Feel free to express any and all emotions or thoughts that you have. Limit your writing to 15 minutes or less. All of your writing will be kept anonymous. Do not include any identifying information.

Once the participant decided the narrative was complete, he/she clicked the “next” button to go to the next part of the survey and answer the 29 items related to patient care, based on the story just written. The 29 items are spread out over three electronic pages to make the survey appearance more pleasing and seem less overwhelming (SurveyMonkey, 2017). The participant clicked the “next” button and the Culture of Companionate Love scale then followed. The demographics questionnaire followed the companionate love scale. Once the survey was ended, either due to the participant discontinuing or all of the questionnaires completed, a screen appeared thanking the respondent for their participation.

Data Analysis

Descriptive statistics were calculated to capture participant demographics. The specific research questions and the data analyses each were:

A. How do nurses’ stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?

This research question was analyzed using a qualitative analysis method. Narratives were read and re-read by the researcher so the researcher was immersed in the data. Using the directed content analysis described by Hsieh and Shannon (2005), stories of workplace mistreatment were evaluated to determine which of the six categories provided by the social justice as well-being model and noted: health, personal security, reasoning, respect, attachment, and self-determination. The total number of threatened dimensions of well-being was calculated for each story. To enhance trustworthiness of the results peer debriefing was used and an experienced researcher read 20% of the narratives to determine inter-rater agreement.

B. How does the number of threatened dimensions of well-being relate to nurses' ability to provide quality patient care?

Hypothesis 1: An increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

To investigate this research question, a Pearson product-moment r correlation was conducted to assess the relationship between the number of threatened dimensions of well-being and HPS total score (representing nurses' ability to provide quality patient care). Pearson r correlation is a bivariate measure of association (strength and direction) of the relationship between two variables. Given that all variables were continuous (interval/ratio data) and the hypotheses sought to assess the relationships, Pearson r correlations were the appropriate bivariate statistic (Statistics Solutions, 2017a).

C. How does a caring work environment (compassion) moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

Hypothesis 2: A caring work environment (compassion) will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care (see Figure 2).

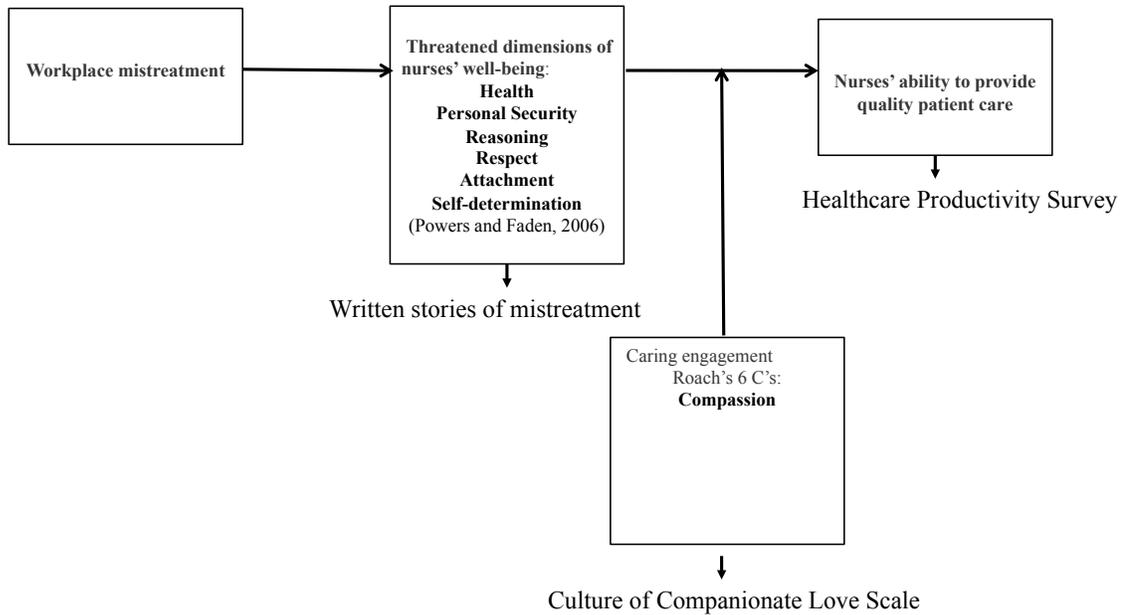


Figure 2. Diagram representing the study's concepts and their corresponding measures.

To examine this research question, a Baron and Kenny (1986) moderation analysis was conducted to assess a caring work environment (compassion) as a moderator of the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care (Statistics Solutions, 2017b). To examine for moderation, a multiple linear regression was conducted. The independent variables of the regression were number of threatened dimensions of well-being, a caring work environment (moderator) as measured by the Culture Of Companionate Love Scale, and the interaction between number of threatened dimensions of well-being and a caring work environment (compassion). Multiplying independent variable and moderator together after both have been centered to have a mean of 0 created the interaction. The dependent variable of the regression was nurses' ability to provide quality patient care. If the interaction is significant, then moderation is supported (Baron & Kenny, 1986; Statistics Solutions, 2017b).

Limitations of the Research Plan

A limitation to this research plan is potential for participant bias as participants who are more sensitive to workplace mistreatment are likely to complete the study disproportionately compared with potential participants who are not as sensitive to workplace mistreatment. Furthermore, there was no control over the amount of time participants took to write their stories. Therefore, capturing expression of threats to dimensions of well-being was limited by the length of time participants elected to spend on the story. Additionally, participants may have over- or under-reported the effect that workplace mistreatment had on their work productivity.

Timeline

The study timeline is outlined in Table 1.

Table 1

Study Timeline

Action	Time Frame
Data collection	11/28/2016 to 3/22/2017
Data analysis	3/28/2017 to 5/28/2017
Chapters 4 and 5 written	5/29/2017 to 9/25/2017

Summary

This study investigated the relationship between workplace mistreatment and nurses' ability to provide quality patient care in the hospital setting. The six dimensions of well-being, as described by Powers and Faden (2006) in their theory of social justice, was used to quantify impact of workplace mistreatment on the study participants. The

study also examined the role of a caring work environment expressed through compassion as a moderator on this relationship.

CHAPTER 4. STUDY FINDINGS

The purpose of this study was to explore the relationship between workplace mistreatment, nurses' ability to provide quality patient care, and a caring work environment. This chapter presents the participant demographics and addresses findings related to each of the research questions. Findings include samples of participants' narratives that reflect threatened dimensions of well-being and results of the quantitative data analysis. Qualitative data were analyzed using directed content analysis and quantitative data were analyzed using SPSS version 24.0.

Sample Size and Demographics

This section presents the results of the descriptive analyses, including percentages and frequencies for demographic information, participant qualities, and job titles of perpetrators identified by the participants. Nurses were recruited via the internet in three phases: (1) an announcement posted on the allnurses.com website, (2) a link to the survey posted on the researcher's social media pages, and (3) a blast email sent to students enrolled in courses at the Christine E. Lynn College of Nursing. Due to the nature of this recruitment strategy, it was not possible to calculate a response rate as it was unknown how many people saw the study announcement. Registered nurses who were providing direct patient care in a hospital setting and had experienced workplace mistreatment within 30 days of answering the survey were the population of interest. Once IRB approval was obtained, recruitment was performed in three phases, all of which included snowball technique. All questionnaires included in the study were recreated on the

SurveyMonkey (2017) website and the survey was accessible via a URL link. The survey remained open on SurveyMonkey until the sample size reached or exceeded enough usable responses to achieve sufficient power. In phase one, the study announcement including the link for SurveyMonkey was posted on the website, www.allnurses.com. After 30 days, phase two began and the researcher posted the announcement and link on personal social media websites, including Facebook, LinkedIn, and Twitter. An amendment to the recruitment method was added to the IRB package (Appendix H) after it was determined the sample was not large enough and a third phase was instituted. In phase three, a blast email containing the study announcement and SurveyMonkey link was sent to the students enrolled in courses at the Christine E. Lynn College of Nursing at Florida Atlantic University. The same URL was advertised during all three phases of recruitment; therefore, it was impossible to know to which advertisement the participant responded. The entire recruitment lasted four months.

Part one of the Healthcare Productivity Survey (HPS) structures story collection as a foundation for the quantitative survey components in part two.

Since these stories were an essential component of the survey process, quantitative data were only considered when a story of mistreatment was available. In the quantitative component, nurses recorded their ability to provide quality patient care following the mistreatment incident described in their story. In addition, participants rated the level of caring in their work environment on the Culture of Companionate Love scale. Demographic information was the last element of data collection.

Seventy-nine nurses (12.7% male, 87.3% female) participated in the study. Six hundred and twenty respondents opened the survey link, with 44% ($N = 273$) of these

individuals meeting the inclusion criteria. Participants ($N = 84$) who answered both the Healthcare Productivity Survey (HPS) and Culture of Compassionate Love scale were identified as complete by SurveyMonkey. The stories of these 84 participants were evaluated for inclusion, based on pre-established criteria. Participants whose stories did not adhere to the researcher's criteria (such as reporting an incident that was greater than 30 days old, witness accounts of workplace mistreatment, or non-staff members as perpetrators) were not included in the final analysis, leaving 79 participants, for a completion rate of 29%.

The majority (83.5%) of participants were Caucasian; other participants' races included African American (5%), Asian (5%), Hispanic (3%), multiple ethnicity or other (3%), and one participant chose not to answer. Of the participants who reported their highest level of education ($N = 74$), 5 (6.3%) had a Diploma in Nursing, 15 (19%) had an ADN, and 40 (50.6%) had completed a BSN. Nine participants (11.4%) reported holding a Master's degree, either in nursing ($N = 5$) or outside of nursing ($N = 4$). The age of participants ranged from 23 to 67 years old ($M = 42$, $SD = 11.9$). Most of the participants ($N = 19$) live in the Southeastern United States. Participants' length of time working as a nurse ranged from less than one year ($N = 5$) to 43 years ($M = 13$, $SD = 12$). Participants' tenure at their current job ranged from 3 months to 30 years ($M = 5.8$, $SD = 6.8$). Several nursing specialties were represented in the sample, with emergency department ($N = 13$) and medical/surgical ($N = 13$) nurses making up the largest groups in the study. See Table 2 for a complete list of the sample's demographic data.

Table 2

Sample Demographic Descriptive Statistics

Characteristic	<i>N</i>	%
Sex		
Male	10	12.7
Female	69	87.3
Race		
Asian/Pacific Islander	4	5.1
Black/African American	4	5.1
Hispanic	2	2.5
White/Caucasian	66	83.5
Multiple ethnicity/other	2	2.5
Not answered	1	1.3
Level of Education		
Diploma in Nursing	5	6.3
Associate's Degree Nursing	15	19
Bachelor's Degree Nursing	40	50.6
Bachelor's outside of nursing	5	6.3
MSN	5	6.3
MS outside of nursing	4	5.1
Unanswered	5	6.3
Region		
New England	5	6.3
Middle Atlantic	14	17.7
East North Central	9	11.4
West North Central	5	6.3
South Atlantic	19	24.1
East South Central	4	5.1
West South Central	4	5.1
Mountain	1	1.3
Pacific	8	10.1

Table 2 (cont.)

Characteristic	<i>N</i>	%
Countries outside United States		
Australia	6	7.6
Germany	1	1.3
Ireland	2	2.5
United Kingdom	1	1.3
Specialty		
Critical care	8	10.1
Emergency/trauma	13	16.5
Geriatrics	6	7.6
Hospice	1	1.3
Management	1	1.3
Medical/surgical	13	16.5
OR/PACU ¹	7	8.9
Oncology	3	3.8
Pediatrics/PICU ²	2	2.5
Psychiatry	5	6.3
Rehab	2	2.5
Telemetry/PCU ³	6	7.6
OB/L&D ⁴	3	3.8
Other	9	11.4

Note. ¹PACU = post anesthesia care unit
²PICU = pediatric intensive care unit
³PCU = progressive care unit
⁴L&D = labor and delivery

Most participants identified a staff nurse ($N = 37$) or nurse manager ($N = 11$) as the perpetrator of workplace mistreatment (see Table 3). Twenty-two participants selected “other” for the perpetrator’s job role. Included in these were respiratory therapists, nurse practitioners, and risk managers.

Table 3

Role of Perpetrator

Role	<i>N</i>	%
Physician	6	7.6
Nurse manager	11	13.9
Nurse	37	46.8
UAP ¹	3	3.8
Other	22	27.8

Note. ¹UAP = unlicensed assistive personnel

Research Questions and Hypotheses

The overall research questions focused on the relationship between workplace mistreatment, quantified as threats to nurse well-being (health, personal security, reasoning, respect, attachment, and self-determination), and nurses' ability to provide quality patient care. In addition, this study considered the moderating effect of a caring environment expressed through compassion.

The specific research questions and, when appropriate, corresponding hypotheses were:

- A. How do nurses' stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?
- B. How does the number of threatened dimensions of well-being relate to nurses' ability to provide quality patient care?

Hypothesis 1: An increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

C. How does a caring work environment (compassion) moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

Hypothesis 2: A caring work environment (compassion) will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care.

Research Findings

Findings related to each research question are reported.

Research Question A

This question asked: How do nurses' stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?

Participants were instructed to describe an incident in the last 30 days in which they experienced workplace mistreatment. These narratives were read and re-read by the researcher until the researcher was immersed in the data. Using the directed content analysis described by Hsieh and Shanon (2005), stories of workplace mistreatment were analyzed for alignment with the six dimensions of well-being provided by Powers and Faden's (2006) social justice theory. The dimensions include health, personal security, reasoning, respect, attachment, and self-determination. Definitions provided by Powers and Faden (2006) were used to determine alignment. The total numbers of threatened dimensions of well-being were calculated for each story. Each dimension was marked as

present if it was expressed one or more times; a dimension was not counted more than once per story regardless of whether it was discussed multiple times in the same story.

To enhance trustworthiness of the results, peer debriefing was used and an experienced researcher read 20% of the narratives to determine inter-rater agreement. When discrepancies or differences arose, there were discussions and reference back to the definitions of the six dimensions until the researchers reached agreement. There was discussion of key phrases or characteristics of stories that represented threatened dimensions of well-being, thereby creating coding schema that enabled consistent grouping of narrative data segments. For instance, mention of loss of sleep or increased stress was categorized as a threat to the health dimension. Statements of feeling incompetent or unable think were categorized as a threat to reasoning. Participant statements expressing fear of physical assault or actions leading to loss of employment were considered to be expressing a threat to personal security.

Frequencies for the number of threatened dimensions of well-being found in the participants' narratives are presented in Table 4. Almost every narrative (95%) described a threat to the "respect" dimension of well-being. On the other hand, threats to the dimension of personal security appeared least often (9%).

Table 5 reports the definition of each dimension of well-being and two exemplar quotes coded as a threat to the corresponding dimension.

Table 4

Frequencies of Threatened Dimensions of Well-being

Dimension	<i>N</i>
Health	22
Security	7
Reasoning	9
Respect	75
Attachment	37
Self-determination	22

Table 5

Dimension of Well-being Definitions and Exemplars

Dimension of Well-being	Definition	Exemplars of Threats to Dimension
Health	A moral concern for human flourishing observed through physical, psychological, and biological functioning.	<p>“These incidents have affected my emotional and physical well-being. I am constantly bothered by it, causing a lot of inner stress. I have lost 8 pounds in 2 weeks, no appetite.”</p> <p>“Through this I’ve felt some anger, sadness and now I’m just numb that this is still happening in nursing after all these years.”</p>
Personal Security	The freedom from actual or feared threats of physical or psychological abuse.	<p>“...the others on nights are great but everyone is afraid of these two.”</p> <p>“I could see her doing something very bad someday when she snaps.”</p>
Reasoning	A diverse set of capabilities essential for understanding the real world, including the ability to analyze, imagine and respond appropriately based on empirical evidence.	<p>“I felt humiliated and incompetent. ...I felt like I could not manage the tasks I needed to complete.”</p> <p>“I’m a basket case and it’s affecting patient care.”</p>

Table 5 (cont.)

Dimension of Well-being	Definition	Exemplars of Threats to Dimension
Respect	Regard for another human as equal, having worth and value. Self-respect requires seeing self as equal, having worth and value.	<p>“While asking questions about orders, I was told that I was too stupid to work at Wal-Mart.”</p> <p>“I stayed overtime to help the next shift. One of the nurses then told the charge nurse we might as well have the sloth from <i>Zootopia</i> stay to help.”</p>
Attachment	The ability to connect with other people. It allows one to create a sense of fellow-feeling and communal solidarity.	<p>“...management use their power to belittle/undermine/ a divide us as a group.”</p> <p>“Staff talk to each other [in] cliques but very mean to others that are not part of the group.”</p>
Self-determination	The ability to live life according to one’s own choices and efforts, without being forced to comply with the plans of another.	<p>“Several older nurses including myself forced to quit or leave. Called [us] the AARP group in meetings.”</p> <p>“I’m currently looking for another position somewhere else and probably part time. I don't think I can put up with this at the age of 62 from 30-something [year-old] nurses at this point in my life and career.”</p>

Research Question B and Hypothesis 1

This question asked: How does the number of threatened dimensions of well-being relate to nurses’ ability to provide quality patient care? Hypothesis 1: Increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

The corresponding hypothesis was: An increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

There are six dimensions of well-being in Powers and Faden’s (2006) theory of social justice. Qualitative analysis of the narratives revealed participants experienced a range of one to five threatened dimensions ($M = 2.18$, $SD = 1.19$). Ability to provide

quality patient care was measured by the Healthcare Productivity Survey (HPS). The HPS contains 29 statements to be rated on a scale of -2 to +2. The possible survey total ranges from -58 to +58. A negative total score indicates there was a decrease in ability to provide quality patient care; zero indicates there was no change in ability to provide quality patient care; and a positive number indicates there was an increase in ability to provide quality patient care after the incident described in the story about workplace mistreatment. In the current study, alpha reliability of the HPS was .97, with a range of .87 to .96 for the four subscales. Most of the nurses in this study ($N = 69$, 87%) reported a decrease in ability to provide quality patient care following the incident of mistreatment described in the story, one reported no change, and the remaining ($N = 10$, 12%) reported an increase. Mean scores of the four subscales were as follows: cognitive demands ($M = -4.79$, $SD = 3.70$), handle/manage workload ($M = -4.51$, $SD = 4.22$), support and communication with patients and visitors ($M = -2.53$, $SD = 4.51$), safety and competency ($M = -3.52$, $SD = 6.73$), indicating ability to provide quality patient care decreased in all four areas (see Table 6).

To investigate this research question, a Pearson product-moment r correlation was calculated to assess the relationship between number of threatened dimensions of well-being and nurses' ability to provide quality patient care after an event of workplace mistreatment as measured with the Healthcare Productivity Survey (HPS). There was not a significant relationship found between number of threatened dimensions of well-being and HPS total scores ($p = .321$); therefore, hypothesis 1 was not supported (see Table 7).

Table 6

HPS Scored by Subscale and Total

HPS Scale	<i>N</i>	Minimum	Maximum	<i>M</i>	<i>SD</i>
Cognitive demands	79	-10	8	-4.79	3.70
Handle/manage workload	79	-12	7	-4.51	4.22
Support and communication with patients and visitors	79	-12	12	-2.53	4.51
Safety and competency	79	-20	8	-3.52	6.73
Total	79	-58	31	-16.33	18.31

Table 7

Correlation between Number of Threatened Dimensions of Well-being and Nurses' Ability to Provide quality Patient Care

Variables		HPS Total Score	Total Number of Dimensions
HPS score	Pearson Correlation	1	-.113
	Sig. (2-tailed)		.321
	<i>N</i>	79	79
Number of dimensions	Pearson Correlation	-.113	1
	Sig. (2-tailed)	.321	
	<i>N</i>	79	79

Additional analyses performed. To investigate the combined predictive ability of the threatened dimensions of well-being on nurses' ability to provide quality patient care, a multiple linear regression was conducted. The dimensions of personal security and respect were not included in this model due to frequencies related to these dimensions: 75 of 79 reported experiencing threats to the respect dimension and only 7 people reported

threats to the personal security dimension. As can be seen in Table 8, the inclusions of the remaining four dimensions (health, personal security, attachment, and self-determination) statistically predicted HPS score [$F(4,74) = 2.82, R^2 = .132, p = .031$], with 13.2% of the total variability of HPS score being accounted for. However, out of this set of predictors only health ($p = .005$) and attachment ($p = .035$) accounted for a significant proportion of unique variance. Nurses who reported having threats to the health dimension of well-being reported less of a decline in ability to provide patient care compared to nurses reporting threats to the other dimensions. Whereas those who reported threats to the attachment dimension of well-being reported having the greatest decrease in ability to provide patient care compared to nurses reporting threats to the other dimensions of well-being. Table 9 reports descriptive statistics for the HPS measure for each well-being dimension distinguishing HPS scores for those who expressed and those who did not express threats to each dimension of well-being.

Table 8

Multiple Linear Regression Results for Dimensions Predicting HPS Score

Dimension	<i>B</i>	<i>SD</i>	β	<i>t</i>	<i>p</i>
Intercept	-14.0	2.9		-4.8	
Health	12.5	4.7	0.3	2.6	0.005*
Reasoning	-2.3	6.4	0.0	-0.4	0.361
Attachment	-7.7	4.2	-0.2	-1.8	0.035*
Self Determination	-7.1	4.8	-0.2	-1.5	0.073

Note. [$F(4,74) = 2.82, R^2 = .132, p = .031$], * $p < .05$

Table 9

Mean HPS Score for Those Who Mentioned vs. Those Who Did Not Mention Threats

Dimension	N	Not Expressed		Expressed	
		M	SD	M	SD
Health	22	-18.6	19.3	-10.5	14.2
Security	7	-15.9	18.3	-21.1	18.8
Reasoning	9	-16.3	17.9	-16.8	22.7
Respect	75	-7.25	19.7	-16.8	18.3
Attachment	37	-12.8	17.6	-20.3	18.5
Self-Determination	22	-14.6	17.2	-16.3	18.3

Research Question C and Hypothesis 2

This question asked: How does a caring work environment moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

The corresponding hypothesis was: A caring work environment will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care.

Caring work environment was operationalized by the Culture of Companionate Love scale (Barsade & O'Neill, 2014). Participants were instructed to rate the frequency of their coworkers' expression of affection, caring, compassion, and tenderness on a scale from 1 to 5 (never to very often, respectively). Alpha reliability for this instrument in the current study was .84 and mean score was 2.89 ($SD = .83$). To examine research question C, moderation analysis (Baron & Kenny, 1986) was conducted to assess the impact of a caring work environment (compassion) as a moderator of the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care.

To examine for moderation, a multiple linear regression was conducted. The independent variables of the regression were number of threatened dimensions of well-being, a caring work environment (moderator), and the interaction between number of threatened dimensions of well-being and a caring work environment (compassion). Multiplying independent variable and moderator together after both have been centered to have a mean of zero created the interaction. The dependent variable of the regression was nurses' ability to provide quality patient care. There was a statistically significant interaction between caring work environment (compassion) and the frequency of threatened dimensions of well-being on predicting ability to provide patient care (see Table 10).

Table 10

Multiple Linear Regression Results for Caring Work Environment Moderating Number of Dimensions in Predicting Productivity

Model	Predictors	<i>B</i>	<i>SE</i>	β	<i>t</i>	<i>p</i>
Restricted	Intercept	-21.92	8.51		-2.58	0.012
	Total Dimension	-1.68	1.74	-0.11	-0.96	0.339
	Caring Environment	3.20	2.50	0.14	1.28	0.204
Full	Intercept	-60.18	17.49		-3.44	0.001
	Total Dimension	14.33	6.67	0.93	2.15	0.035
	Caring Environment	16.14	5.75	0.73	2.81	0.006
	Caring Environment*Dimension	-5.43	2.19	-1.20	-2.48	0.015**

Note. [$F(1,75) = 6.15, \Delta R^2 = .073, p = .015$] for full model, ** $p < .05$

Mean scores from the Culture of Companionate Love scale were grouped as low, moderate, or high, as part of the moderator analysis. While all three groups had a diminished ability to provide patient care after workplace mistreatment occurred, the

degree to which their ability changed was different depending on level of caring work environment and number of threatened dimensions of well-being. Participants reporting high levels of a caring work environment had less change to their ability to provide patient care than the moderate or low caring work environment groups when they had three or less threatened dimensions of well-being (HPS score = -3 to -18). However, with four or more threatened dimensions of well-being reported in their stories, ability to provide patient care declined more in the high and moderate caring working environment group (HPS score = -25 and 20.4, respectively) than in the low (HPS score = -10.5). Participants who reported having low levels of a caring work environment had the greatest decrease in ability to provide patient care (HPS score = -30) overall. Yet, in the low caring environment group, ability to provide quality patient care was less impacted by an increasing number of threatened dimensions of well-being. Participants who reported a moderate caring work environment did not vary widely in ability to provide patient care in respect to number of threatened dimensions of well-being (HPS score = -15 to -20) (see Figure 3). Data were further analyzed to determine if the participants in the low, moderate, and high caring working environment groups had shared characteristics. Cross tabulations with chi-square analysis were performed for participants' demographic characteristics of age, sex, and nursing specialty relative to low, medium, or high levels of caring work environment, and there were no statistically significant differences.

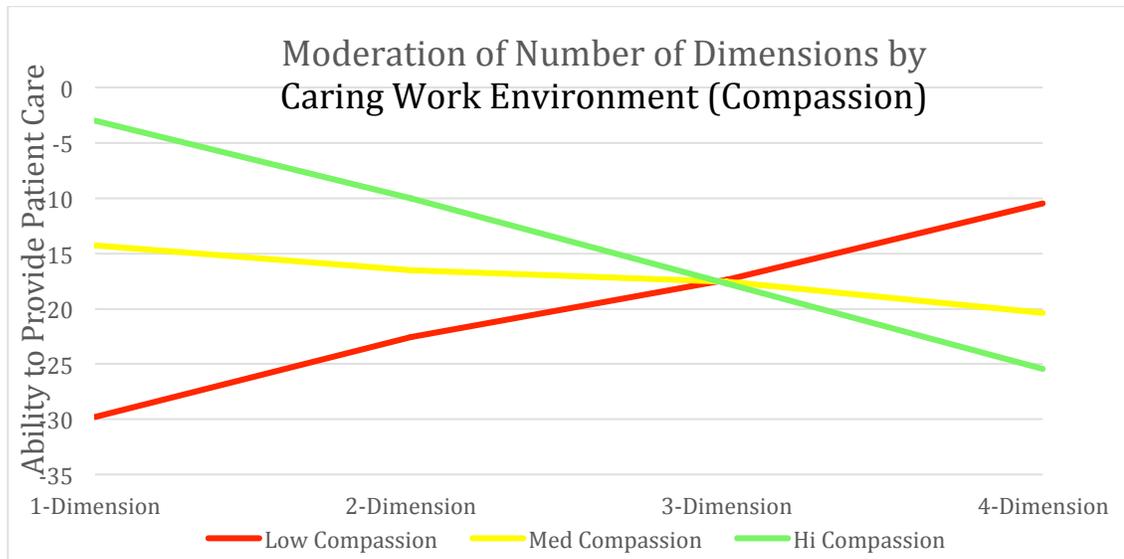


Figure 3. Moderation of caring work environment on overall ability to provide patient care predicted by reported number of dimensions.

Summary

The results of this study were presented in Chapter 4. The six dimensions of well-being described by Powers and Faden (2006) did align with nurses' stories of workplace mistreatment. Furthermore, frequency of threatened dimensions did not have a significant relationship with ability to provide patient care; the findings of the study did not support Hypothesis 1. However, there was a significant moderator effect of the caring work environment on the relationship between number of threatened dimensions of well-being and ability to provide quality patient care, as stated in Hypothesis 2. Implications of these finding are discussed in Chapter 5.

CHAPTER 5. SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

This chapter discusses the findings of this research study and includes implications for nursing practice and research. The discussion is organized by research questions and their corresponding hypotheses. The purpose of this study was to examine the relationship between workplace mistreatment and nurses' ability to provide quality patient care in the hospital environment and to explore nurses' perceived level of caring in the work environment as a moderator of this relationship. The study employed both qualitative and quantitative methods to answer the research questions.

Introduction

Patient outcomes and satisfaction have received ever-increasing attention in the last several years due to publications such "To Err is Human" (Committee on Quality of Health Care in America, Kohn, Corrigan, Donaldson, & Institute of Medicine, 2000) and ties to reimbursement since the Patient Protection and Affordable Care Act of 2010 (2010) came into legislation. It is understood that workplace mistreatment not only affects the victim's physical and mental health and job satisfaction, but also affects the organization through decreased company loyalty and work productivity (Einarsen et al., 2009; Gillespie et al., 2010; Longo, 2007; Longo & Sherman, 2007; Purpora & Blegen, 2015; Spence Laschinger, Leiter et al., 2009; Wright & Khatri, 2015). In the healthcare setting, work productivity translates to providing quality patient care, which actuates patient outcomes and patient satisfaction (Gillespie et al., 2010). If workplace mistreatment negatively impacts productivity as stated previously, a work environment

free of workplace mistreatment may lend itself to quality patient care, positive patient outcomes, and high patient satisfaction. For example, Barsade and O'Neill (2014) found a caring work environment had a positive correlation to resident and family satisfaction in long-term care and an inverse relationship to transfers to the emergency room. The difficulty lies in determining how workplace mistreatment of healthcare workers affects the patient. As of now, there is limited research available on the topic (Spence Laschinger, 2014).

Discussion

The results of the qualitative data analysis show that the six dimensions of well-being as defined by Powers and Faden (2006) aligned with stories of mistreatment. However, there was not a significant relationship between frequency of threatened dimensions of well-being and ability to provide quality patient care. At the same time, expressions of threats to the health and attachment dimensions of well-being were significant predictors of ability to provide patient care. The results also indicate that a caring work environment had a significant moderating effect on the relationship between workplace mistreatment and ability to provide quality patient care. A discussion of these results is presented as related to participant demographics and each research question. Each question is noted, followed by a discussion that contextualizes the findings with extant literature.

Findings Related to Demographic Data

Seventy-nine participants completed surveys that met the inclusion criteria. The majority of these participants were Caucasian (83.5%) and female (87.3%), which is a common issue in nursing research. While this may be seen as a limitation of the study in

terms of generalizability, it is close to the makeup of the nursing workforce (National Council of State Boards of Nursing [NCSBN], 2017) and therefore is a logical result. Moreover, NCSBN (2015) reported in the United States 80.5% of registered nurses identify as Caucasian and 92% as female. The current study had a slightly higher percentage of males than that of the workforce. The current sample's age ranged from 23 to 67 years old and the mean age (42 years old) was younger than the national average of 48 (NCSBN, 2017). This may be the result of advertising an electronic survey on a web-based message board and on social media, which younger people are more likely to feel comfortable using. Sending surveys by mail in addition to providing electronic surveys could be one way to address this. In order to gain a more varied perspective, future research studies could focus recruitment strategies or inclusion criteria toward participants who are male and/or belong to groups underrepresented in the nursing profession.

Discussion of Findings Related to Research Questions and Their Corresponding Hypotheses

Research Question A

This question was: How do nurses' stories of workplace mistreatment align with the six dimensions of well-being (health, personal security, reasoning, respect, attachment, and self-determination) articulated in the theory of social justice (Powers & Faden, 2006)?

Powers and Faden (2006) theorized there are six dimensions of well-being: health, personal security, respect, reasoning, attachment, and self-determination. In order to attain well-being, an individual must maintain adequate levels of each dimension and

social justice is defined as having the opportunity to fulfill these adequate levels. Conversely, disrupting attainment of one or more of these dimensions of well-being is an injustice. When workplace mistreatment threatens nurses' well-being, it is a plausible assumption that their ability to provide quality patient care will suffer as well. Workplace mistreatment of nurses can become a social justice issue for both the victim and the patient, dependent on their care. This is a particularly important issue in nursing research, as social justice is a core value of the nursing profession (AACN, 2008). Therefore, Powers and Faden's (2006) theory of social justice as well-being was selected as the theoretical framework for the study.

To answer research question A, stories of workplace mistreatment collected using the HPS were analyzed and coded for expression of threats to the six dimensions of well-being. Previous researchers utilizing the HPS captured participants' narratives solely to prompt a memory of workplace mistreatment (Berry et al., 2012) or workplace violence (Gates et al., 2011; Gillespie et al., 2010) to set the stage for measuring ability to care for patients. The prior studies did not analyze stories nor did they report qualitative results, making this paper a unique contribution to the literature.

Analysis of the narratives collected in the current study indicates nurses' stories of workplace mistreatment do align with the six dimensions of well-being posited by Powers and Faden (2006). Similar to previous studies of victims' experiences of workplace mistreatment (Hutchinson et al., 2010; Lewis & Malecha, 2011; Simons & Sauer, 2013; Spence Laschinger et al., 2013; Vogelpohl et al., 2013; Walrath et al., 2010), threats to well-being (health, personal security, respect, reasoning, attachment, and self-determination) were expressed in the current sample's stories of mistreatment.

Furthermore, threats to every dimension of well-being were expressed in this sample. Therefore, using this social justice lens to view workplace mistreatment is appropriate (Moffa & Longo, 2016), and the findings suggest the validity of the social justice – workplace mistreatment connection.

Almost every participant's story (74 of 79) expressed a threat to the dimension of respect. This is not surprising as disrespect of the individual is inherent in mistreatment (Andersson & Pearson, 1999; Leiter, 2013; Powers & Faden, 2006). The four participants whose stories did not express a threat to the respect dimension lacked sufficient detail to determine whether or not the participant experienced disrespect. Threats to the dimension personal security appeared in seven participants' stories, making personal security the least expressed of the six dimensions of well-being. This finding is consistent with previous studies, where direct personal threats and physical violence are the least common type of workplace mistreatment reported by participants (Longo, 2007; Spiri, Brantley, & McGuire, 2016; Wright & Khatri, 2015). A possible explanation for this could be that perpetrators are aware that these types of infractions are easier to recognize and have legal implications, which could jeopardize the perpetrator's employment or other areas of life. Alternatively, it may be that mistreatment in the workplace tends toward non-physical, given that the workplace is a public setting and healthcare professionals accept certain standards of behavior for the workplace setting. This is a potential area of focus for future research especially since the finding corroborates that of other researchers.

Research Question B and Hypothesis 1

This question was: How does the number of threatened dimensions of well-being relate to nurses' ability to provide quality patient care?

The corresponding hypothesis was: Increased number of threatened dimensions of well-being will correlate with decreased ability to provide quality patient care.

The number of threatened dimensions of well-being per participant was calculated based on the results of the qualitative analysis of the participants' narratives. The results reveal a range of one to five threatened dimensions in an individual story. Ability to provide quality patient care was measured by the HPS. The possible survey total ranged from -58 to +58, with a negative score indicating there was a decrease in ability to provide quality patient care, zero indicating there was no change in ability, and a positive number indicating there was an increase in ability to provide quality patient care after the incident described in the story about workplace mistreatment.

Most of the nurses in this study (87%) reported a decrease in ability to provide quality patient care, one reported no change, and the remaining nurses (12%) reported an increase in ability to provide patient care. These results differ somewhat from prior studies (Berry et al., 2012; Gillespie et al., 2010) using the HPS to measure nurse productivity of novice nurses after an incident of workplace mistreatment or workplace violence. Berry et al. (2012) found that less than half (46.7%) reported decreased ability to provide patient care. No change was reported by 23.9%, while 29.4% of participants reported an increase in productivity after an incident of workplace mistreatment. Berry et al. included witnesses of workplace mistreatment in their study and this could be an explanation for the difference in results between the two studies. Witnessing workplace

mistreatment, while potentially disruptive and stressful, is not a direct threat to one's personhood (Totterdell, Hershcovis, Niven, Reich, & Stride, 2012). Conversely, actual victims have a personal stake in the interaction, at a minimum their respect, and possibly more.

It is not clear why some participants scored lower on the HPS than others. It was hypothesized that the number of threatened dimensions of well-being would correlate with nurses' ability to provide quality patient care after an incident of workplace mistreatment. However, Pearson product-moment r correlation assessing the relationship between number of threatened dimensions of well-being and HPS total score did not show a significant relationship. Therefore, hypothesis 1 was not supported. A possible reason for this is the limited variance in number of threatened dimensions of well-being in the current sample. As seen in Table 11, most of the participants (67%) expressed one or two threatened dimensions of well-being, only three participants expressed five threatened dimensions of well-being, and none of the participants expressed zero or six threatened dimensions of well-being. A future study with a larger sample size may offer a greater variance and provide a clearer picture of this relationship. Analyzing the correlation of various combinations of threatened dimensions of well-being and HPS score was considered; however, this would require a larger sample size to sufficiently power the study, and this possibility provides direction for future research.

Table 11

Frequency of Threatened Dimensions Expressed in Participants' Narratives

Possible Number of Threatened Dimensions	Actual Number of Threatened Dimensions	Percent
0	0	0
1	29	36.7
2	24	30.4
3	12	15.2
4	11	13.9
5	3	3.8
6	0	0
Total	79	100.0

Extended analysis about relationship of threats to individual dimensions and ability to provide quality patient care. Additional analysis was performed to determine if expression of threats to specific dimensions of well-being predicted ability to provide quality patient care after an incident of workplace mistreatment. A multiple linear regression was conducted to address this inquiry. The dimensions of personal security and respect were not included in this model due to their maximum and minimum frequencies related to these dimensions; that is, 75 of 79 reported experiencing threats to respect and 7 reported threats to personal security.

The results reveal expression of threats to the health dimension and expression of threats to the attachment dimension were significant predictors of ability to provide care after an incident of workplace mistreatment. As reported earlier, most participants reported a decrease in the ability to provide patient care. However, participants ($N = 22$) who expressed threats to health (such as insomnia, depression, or stress) reported a less

severe decline in ability to provide patient care following the mistreatment incident. Specifically, the mean scores for the HPS were -10.5 for those expressing threats to health as opposed -18.6 for those who did not express threats to health ($p < .05$). It is unclear as to why this would occur and it is an area for future research. One possible explanation is those participants reporting a threat to the health dimension used a different coping mechanism than those who did not report it and this helped them retain more of their ability to provide quality patient care. Prior research (Leijten et al., 2014; Letvak & Buck, 2008; Pereira et al., 2017) indicated a significant negative relationship between mental and physical health problems and work productivity. However, there were no studies found that compared these to the other dimensions of well-being; therefore, it is difficult to determine if this finding is unique or not. It is also possible participants expressing threats to the health dimension were experiencing ongoing health issues, and a single incident of mistreatment would not change their ability to provide patient care.

Of all the dimensions of well-being, expression of threats to the attachment dimension ($N = 37$) significantly predicted greatest decline in ability to provide quality patient care (HPS score = -20.3) compared to those who did not express threats to attachment (HPS score = -12.8, $p < .05$). Stories coded as expressing threats to attachment included descriptions of being left out of a group by co-workers, lack of greetings or acknowledgement, and formation of cliques on the unit. These activities have been described as workplace ostracism in the literature, and have been identified as potentially more harmful than overt acts of workplace mistreatment (O'Reilly, Robinson, Berdahl, & Banki, 2015). Ostracism can be acutely painful because it violates a basic

human need to belong, and in evolutionary terms threatens one's survival (Ferris, Chen, & Lim, 2017). In a study of employees from various industries ($N = 146$), O'Reilly et al. (2015) found a stronger negative correlation between ostracism and self-esteem, well-being, and commitment to the organization than overt mistreatment. Yet, ostracism is generally viewed as more acceptable than other forms of mistreatment (O'Reilly et al., 2015). This invalidation of the victim's negative reaction to ostracism may worsen the victim's already painful experience (O'Reilly et al., 2015).

Since ostracism is the absence of performing an action, it is difficult for organizations to prevent and control (Robinson, O'Reilly, & Wang, 2013); overt harassment can be identified and documented, whereas failing to make someone feel welcome is difficult to identify or to prove. Furthermore, it has been shown to indirectly influence workplace engagement and performance (Gkorezis, Panagiotou, & Theodorou, 2016; Leung, Wu, Chen, & Young, 2011). For example, Gkorezis et al. (2016) reported a positive relationship between nurses' experience of ostracism and their silence regarding patient safety concerns. The authors found test scores demonstrating ostracism were negatively correlated with identifying with the organization. When nurses did not feel a sense of belonging, they were less likely to report concerns regarding patient care and more likely to withhold suggestions and concerns. Based on these findings and the current study's findings regarding attachment, fostering collegial relationships in healthcare workers is critical to quality patient care and patient safety.

Research Question C and Hypothesis 2

This question was: How does a caring work environment moderate the relationship between threatened dimensions of well-being and nurses' ability to provide quality patient care?

The corresponding hypothesis was: A caring work environment will moderate the relationship between the number of threatened dimensions of well-being and the ability to provide quality patient care.

Caring work environment was operationalized by the Culture of Companionate Love scale (Barsade & O'Neill, 2014). Participants rated the frequency of their coworkers' expression of affection, caring, compassion, and tenderness on a scale from 1 to 5 (never to very often, respectively). In the moderator analysis, mean scores of the Culture of Companionate Love scale were divided into low, moderate, and high level groups. These groups were derived from the participants' total scores, with the average scores of 1-2 assigned to the low caring group, 3 to the moderate caring group, and 4-5 to the high caring group. All three groups reported an average decrease in ability to provide quality care after an incident of workplace mistreatment. However, the degree to which the nurses' ability declined was different depending on whether they belonged to the low, moderate, or high caring work environment group. These levels can be viewed as a continuum going from weak to strong caring environments (Barsade & O'Neill, 2014) as opposed to whether caring exists or does not. It is possible for an incident of workplace mistreatment to occur in a relatively strong caring work environment; they are not mutually exclusive.

Specifically, those participants who reported a high caring work environment reported the least decline in the ability to provide patient care (HPS score = -3 to -18) when experiencing from one, two, or three threatened dimensions. The moderate caring environment group had HPS mean scores from -14 to -18 for one to three threatened dimensions. Comparatively, the low caring environment group experienced the greatest decline in ability to provide patient care, with mean HPS scores from -30 to -18 as the number of threatened dimensions increased from one to three. This analysis demonstrates a caring work environment does moderate the relationship between workplace mistreatment and nurses' ability to provide quality patient care and, therefore, hypothesis 2 is supported. Moreover, this aligns with prior research on the effects of compassion in the workplace (Chu, 2016; Lilius et al., 2008; Purpora & Blegen, 2015; Sloan, 2012). For example, Lilius et al. (2008) found increased positive emotions and decreased negative emotions, and a positive relationship with affective organizational commitment in hospital workers who reported receiving compassion from colleagues. The authors concluded from the findings that compassion from co-workers may have a significant impact on attitudes toward work and performance and health related outcomes. Similarly, Sloan (2012) found coworker support moderated the negative relationship between mistreatment from a supervisor and job satisfaction and the positive relationship between mistreatment and psychological distress.

Purpora et al. (2015) found participants' scores on the Negative Acts Questionnaire-Revised (measuring workplace mistreatment) were inversely related to scores on the Nurse-Rated Quality of Care scale. However, supportive peer relationships mitigated the effects of workplace mistreatment on quality of patient care given by

victims of workplace mistreatment. Chu (2016) found compassion from colleagues heightened nurses' positive moods, which led to better job performance. Receiving compassion from co-workers also improved organizational citizenship behaviors. The authors posited receiving compassion after a painful incident, like workplace mistreatment, can ameliorate the negative effects of the experience.

While a caring work environment or support from peers may mitigate effects of workplace mistreatment, it changes once four or more dimensions are threatened. In the current study, at the point of four threatened dimensions, the trend reversed and those in the low caring group had the least decline in ability to provide patient care (-10.5). Unexpectedly, nurses in the high caring group had the steepest decline in ability to provide patient care (HPS score = -25.5), while the moderate group (HPS score = -20.4) stayed in the middle of the two groups. In fact, the moderate caring group had little fluctuation in ability to provide patient care as the number of threatened dimensions increased. Based on these results, it would appear working in a high caring environment preserves the ability to provide patient care after an incident of workplace mistreatment – that is until the nurse's well-being is severely threatened. In other words, for nurses experiencing threats to several dimensions of well-being, a high caring work environment becomes somewhat of a liability and a low caring environment somehow becomes a buffer. In contrast, nurses in the low caring environment had a positive relationship between number of threatened dimensions and HPS scores; their ability to provide care declined less as number of threatened dimensions increased.

One explanation for this reversal is that nurses working in a moderate to high caring work environment are more likely to feel safe to be their true selves and thus be

less guarded emotionally. This sense of safety in demonstrating one's true self to others may lead to viewing attacks as personal and therefore more meaningful. Ford, Myrden, and Kelloway (2016) found a similar relationship between work engagement and the effects of workplace mistreatment on victims' outcomes. Ford et al. studied adults from various industries ($N = 492$) who had experienced workplace mistreatment and found those who were characterized as the high engagement group were more likely to be angry after an incident of workplace mistreatment than those in the low engagement group. The authors suggested that those in the low engagement group were either already withdrawn and protect themselves by holding back their authentic self or are so accustomed to workplace mistreatment their sense of self is too diminished to be angered by a personal attack. In a similar vein, nurses acclimated to working in a low caring environment are less vulnerable to threats to multiple dimensions of well-being and are able to persevere regardless.

Limitations

The following limitations were noted in the study: sample size, self-selection bias, and convenience sampling. Although the sample size was relatively small, it was adequate to achieve power. However, a larger sample would have been conducive to analyzing the effects of threats to different combinations of dimensions on nurses' ability to provide patient care, as opposed to only the frequency of dimensions as in the current study. Self-selection bias is another limitation of the current study. The nurses who choose to participate in a study on workplace mistreatment may be different than those who do not choose to participate, such as being more sensitive to negative behaviors and therefore more likely to be affected by workplace mistreatment. Additionally participants

may have reported erroneous scores on the HPS items, for better or worse, as a way to cope with the negative incident; in other words, rating ability to provide patient care after the incident worse than it actually was in order to garner attention for the issue.

Conversely, participants may report increased productivity to demonstrate the perpetrator did not get the better of them. This is a limitation for most studies relying on participant self-report. A future study examining objective data, such as auditing patients' charts from the shift in question, could be helpful in determining if the nurse in fact delivered the same level of care. However, this could be a challenge logistically. One would have to determine how to measure level of care provided from the patient perspective.

Furthermore, it would require giving up participant anonymity to determine which patients were cared for on a given shift. Finally, it may be difficult to secure hospital approval for this sort of investigation; administrators may be hesitant to endorse an investigation that may shed an unfavorable light on quality of care. Finally, as discussed earlier in the paper, the use of a convenience sample recruited from the Internet could miss data on nurses who do not use social media or are not comfortable using a computer for electronic surveys.

Implications

Research

The analysis of stories of mistreatment was a novel approach extending methods used in the previously conducted research using the HPS (Berry et al., 2012; Gates et al., 2011; Gillespie et al., 2010). This approach relied heavily on the qualitative analysis of story data, and trustworthiness criteria were employed to affirm the qualitative findings. The length of the stories of mistreatment ranged from 6 words ("frustration, anger,

disappointment, hurt, unsupported, excluded”) to 1,034 words, and the stories were included as long as there was an indication of mistreatment experience. It may be useful to set a minimum and maximum limit of words used to describe the mistreatment incident in future research. While both qualitative and quantitative designs were used in this study it did not use the traditional mixed-methods approach. A future study with a true mixed-method design and analyses exploring inferences and meta-inferences may shed more light on the relationship between threats to nurse well-being and ability to provide quality patient care (Chiang-Hanisko, Newman, Dyess, Piyakong, & Liehr, 2016).

An exploration of which combinations of threatened dimensions of well-being have a negative relationship with nurses’ ability to provide quality patient care would take this research a step further. In this particular study, the sample was too small to conduct such an analysis. There was no incentive offered to participants, other than the opportunity to share their story and add to the body of nursing research. This may be a reason for the small sample size. Over 600 individuals opened the survey and started completing the questionnaires. However, the final sample yielded 79 nurses because the majority of surveys were left incomplete. A future study using a gift card incentive for completion of all parts of the survey could increase the number of usable datasets.

Practice

The results of this study demonstrate, as in previous studies (Berry et al., 2012; Gates et al., 2011), that workplace mistreatment has an effect on nurses’ ability to provide quality patient care. Workplace mistreatment is not just the victim’s problem but becomes a threat to the well-being of the patients cared for by the victims. Healthcare organizations are obligated to provide a safe environment for staff and patients. This

study underscored the need for administrators in healthcare organizations to take workplace mistreatment as a serious threat to nurse well-being and a social justice issue that could threaten patient safety.

This study provided a new angle to view workplace mistreatment by using a social justice framework as a lens. A next step could be to perform a similar study using a larger sample size and inquiring of participants what they found helpful in resolving the situation of workplace mistreatment. Developing interventions to prevent and address mistreatment in the workplace would be the ultimate goal. While there have been some studies, there is a paucity of literature on the topic of interventions to temper and eliminate workplace mistreatment. Most of the research available puts the responsibility on the victim, such as assertiveness training and cognitive rehearsal (American Nurses Association, 2015). There are also zero-tolerance policies in place, but these have not demonstrated effective results (Hinduja, 2012). The social justice lens may provide a new approach to the problem and social justice literature could be mined for ideas as to how to address this particular social injustice. For instance, school psychology and education researchers are developing bullying prevention programs based on social justice models (Brooks, Jenkins, De Oca, & Immen, 2014; Polanin & Vera, 2013; Vanderheiden, 2013).

Another benefit of using the social justice as well-being model was that it shed light on the susceptibility of impairment to ability to provide patient care when the attachment dimension is threatened. It makes sense that threats to the attachment dimension were the most detrimental to ability to provide patient care at the same time that a caring work environment was a protectant in light of the literature on ostracism. This highlights the need to provide education on supportive workplace behaviors that

emphasize inclusion in order to prevent workplace ostracism and ameliorate effects of this and other forms of workplace mistreatment when they do occur. This need is especially urgent because ostracism can go unnoticed or unchecked and education may heighten sensitivity to the ill effects of exclusion behaviors. In addition, the moderating effect of a caring work environment on the relationship between workplace mistreatment and ability to provide patient care suggests that it is important to foster caring between employees and that caring employee relationships may translate to optimal caring for patients.

Raising awareness of this issue to the public may put more pressure on hospital administration to make cultural changes. If patients realize the relationship between the nursing care they receive and low versus high caring work environments, they may seek out those institutions deemed as high caring. This added financial incentive for hospital administrators may drive efforts toward cultivating caring work environments. One such idea is to develop a program similar to Magnet Status, such as “Caring Workplace Certified,” for organizations deemed by experts in caring theory as excellent in maintaining a caring work environment. The Watson Caring Science Institute (WCSI) Affiliate designation (Watson & Brewer, 2015; WCSI, n.d.b) is beginning to do this. As of 2015 there were 11 organizations listed as having the WCSI Affiliate designation. A facility must meet certain criteria to attain the designation, one of which includes creating a culture of caring for staff (WCSI, n.d.b). As of now the designation has been tested from the patient point of view using the Watson Caritas Patient Score® (Watson & Brewer, 2015). The Watson Caritas Co-Worker Score® is an instrument currently in development (WCSI, n.d.a) and as of this writing no studies using it were found in the

extant literature. A future study comparing the Watson Instrument to the Culture of Companionate Love scale and patient satisfaction scores may be helpful in determining the significance of caring interactions between colleagues and how these interactions affect patient care, outcomes, and satisfaction.

Summary

This research study tested a social justice theory as a framework for examining workplace mistreatment of nurses. Powers and Faden's (2006) theory of social justice allows for the examination of the interaction between the act(s) of mistreatment and the victim's well-being, and how that interaction may impair nurses' ability to provide quality patient care. Due to the difficulty in linking patient outcomes related to nurse well-being, the HPS was used to measure nurses' ability to provide quality patient care and serves as a proxy for patient outcome measurement. The results indicated all six dimensions of well-being posited by Powers and Faden were expressed by nurses experiencing workplace mistreatment. Due to the difficulty in linking patient outcomes to workplace mistreatment nurses, the HPS was used to measure nurses' ability to provide quality patient care and serves as a proxy for patient outcome measurement. The results indicated all six dimensions of well-being posited by Powers and Faden were expressed by nurses experiencing workplace mistreatment. Therefore, this empirical testing of the model supports viewing workplace mistreatment as a social injustice (Moffa & Longo, 2016) and adds to the current body of nursing knowledge.

Furthermore, the study demonstrated a caring work environment plays a role in nurses' ability to recover from threats to well-being. However, this recovery is related to the number of threatened dimensions of well-being and the level of caring. Nurses who

perceive their colleagues as highly caring are better able to retain their ability to provide quality patient care than those who perceive low and moderate caring, so long as the number of threatened dimensions is three or less. At four threatened dimensions or more, the relationship inverts. Awareness of this nuance is important when designing workplace policies to prevent and reduce effects of workplace mistreatment on nurses' ability to provide patient care. Healthcare administrators and the public at large expect direct care nurses to demonstrate compassionate and caring relationships with their patients. In order to maintain this type of relationship there needs to be an openness or willingness to be present with the patient (Brewer & Watson, 2015). This type of openness may leave the nurse vulnerable to threatened well-being and associated impaired ability to provide care (Angel & Vatney, 2017). It is therefore imperative a healthy and psychologically safe environment is provided to staff upon whom these expectations are placed (Angel & Vatney, 2017; Frankel, Haraden, Federico, & Lenoci-Edwards, 2017). Although the nursing profession was the population of interest in this study, workplace mistreatment is pervasive in many industries. This is important to recognize, considering workplace mistreatment is a social injustice regardless of how a person makes a living. Policies and interventions to prevent or alleviate workplace mistreatment and its effect on well-being can grow out of the work being done in schools and hospitals and be tailored to be delivered across settings.

APPENDICES

Appendix A. Permission to Use Healthcare Productivity Survey

9/13/2016

RE: Healthcare productivity survey - Christine Moffa

RE: Healthcare productivity survey

Gillespie, Gordon (gillesgl) [REDACTED] >

Sun 4/6/2014 9:36 AM

Inbox

To: Christine Moffa <[REDACTED]>;

Cc: Gillespie, Gordon (gillesgl) [REDACTED]

4 attachments (859 KB)

Healthcare Productivity Survey, 2009.pdf; Gates, Gillespie, Succop, 2011.pdf; Gillespie, Gates, Mentzel, Al-Natour, et al., 2013.pdf; Berry, Gillespie, Gates, et al., 2012.pdf;

Christine,

Attached is information about the survey. You may use it freely for your project online or paper format. Due to page limitations, content for the HPS in an upcoming journal was cut. Currently, there no other papers reporting findings using the instrument; although, there are several students and researchers using the instrument for their projects (primarily in Europe and Asia).

I do continue to use the instrument for studies with violence. The next paper that I publish using the HPS will likely be about 18 months out. My recommendation for the instrument is to broaden the range to be -3 to 3. It will allow for a deeper understanding of the phenomenon.

Thanks, Gordon
[REDACTED] cell

Gordon Lee Gillespie, PhD, RN, PHCNS-BC, CEN, CPEN, FAEN
Robert Wood Johnson Foundation Nurse Faculty Scholar
Assistant Professor
University of Cincinnati College of Nursing
223 Procter Hall
P.O. Box 21-0038
Cincinnati, OH 45221-0038
O: [REDACTED]
F: [REDACTED]



National Conference for Workplace Violence Prevention & Management in Healthcare Settings:
<http://nursing.uc.edu/research/funded-conferences-workshops/national-conference-for-workplace-violence-prevention/presentations.html>

From: Christine Moffa [mailto:[REDACTED]]
Sent: Saturday, April 05, 2014 15:27

<https://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMkADQ4OWM2ZTFjLW1zY2MtNDE2My1hNTdmLWE3M2M2NzZmMTYzMGYBGA...> 1/2

9/13/2016

RE: Healthcare productivity survey - Christine Moffa

To: Gillespie, Gordon (gillesgl)

Subject: Healthcare productivity survey

Dear Dr. Gillespie,

I am a doctoral student at the College of Nursing at Florida Atlantic University. My research area of interest is workplace incivility/health work environments. I am interested in using the Healthcare Productivity Survey for a pilot study this summer and I would like to ask your permission to do so.

I have found three articles on the instrument, the last of which was published in 2012. Are there any more recent studies using the tool? Are you continuing to study it?

Thank you for any information you have to offer.

Warmly,

Christine Moffa, MS, RN
PhD Student
College of Nursing Student Council Chair
GPSA Representative for the CON
Christine E. Lynn College of Nursing
Florida Atlantic University

[REDACTED]

[REDACTED]

<https://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMkADQ4OWM2ZTFjLWlZy2MtNDE2My1hNTdmLWE3M2M2NzZmTYzMgBGA...> 2/2

Appendix B. Permission to Use Culture of Companionate Love Scale

9/13/2016

Fwd: Culture of Companionate Love Scale - Christine Moffa

Fwd: Culture of Companionate Love Scale

Christine Moffa

Sat 4/30/2016 7:18 PM

To: Patricia Liehr [REDACTED]

📎 2 attachments (450 KB)

BarsadeONeill_CultureofCompanionateLove_2014.pdf; ATT00001.htm;

Great! The article is attached...

Sent from my iPhone

Begin forwarded message:

From: "Barsade, Sigal G." [REDACTED]
To: "Christine Moffa" <[REDACTED]>
Subject: RE: Culture of Companionate Love Scale

Dear Ms. Moffa,

I would be delighted to have you use the companionate love scale. It is actually embedded in the method section of the article (it is a very short – but reliable – scale), and I am also including the appendix which lays out the scale even more clearly, and includes other emotional culture scales (e.g. joy, anger, etc...) that you may find useful as well. If you use it, I would love to know the results. Best, Sigal

Sigal Barsade

Joseph Frank Bernstein Professor of Management
The Wharton School University of Pennsylvania
Suite 2000 Steinberg-Dietrich Hall Philadelphia, PA 19104

From: Christine Moffa [REDACTED]
Sent: Friday, April 29, 2016 1:09 PM
To: Barsade, Sigal G.; [REDACTED]
Subject: Culture of Companionate Love Scale

Hello,

I really enjoyed your article on companionate love in the workplace. I am writing my dissertation on workplace bullying in the acute care setting and the relationship to patient outcomes. and I would like to look at a caring environment as a moderator. I would love to see the Companionate Love Scale to see if it's a good fit for my study.

Please let me know if this is a possibility.

<https://outlook.office.com/owa/?viewmodel=ReadMessageItem&ItemID=AAMkADQ4OWM2ZTFjLWlZy2MtNDE2My1hNTdmLWE3M2M2NzZmZTYzMgBGA...> 1/2

9/13/2016

Fwd: Culture of Companionate Love Scale - Christine Moffa

Thank you!

Regards,

Christine Moffa, MS, RN

PhD Student

Christine E. Lynn College of Nursing

[REDACTED]

[REDACTED]

Appendix C. Healthcare Productivity Survey

Healthcare Productivity Survey© Gillespie, Gates, & Succop (2009)

The Healthcare Productivity Survey© was developed by Drs. Gillespie, Gates, and Succop to determine the self-perceived change in productivity following a stressful traumatic event, specifically workplace violence and providing trauma patient care.

Instrument validity was determined through 10 content experts (physicians, registered nurses) using a content validity index. Each item scored 80% or better reflecting strong content validity.

Reliability was determined with internal consistency reliability using a sample of U.S. emergency nurses. There was strong internal consistency reliability for each subscale ranging from 0.875 to 0.936. The four subscales are: cognitive demands, handle/manage workload, support and communication with patients and visitors, and safety and competency.

RECOMMENDED SURVEY INSTRUCTIONS FOR WORKPLACE VIOLENCE:

Please think about an event of workplace violence from the last 30 days. Please answer the following items as they relate to that event of **WORKPLACE VIOLENCE**. Indicate the response that best describes your ability to do the following job activities after the event of **WORKPLACE VIOLENCE** in comparison to before the event occurred.

RECOMMENDED SURVEY INSTRUCTIONS FOR TRAUMA CARE:

Please think about a trauma patient care event from the last 30 days. Please answer the following items as they relate to that event of **TRAUMA PATIENT CARE**. Indicate the response that best describes your ability to do the following job activities after providing **TRAUMA PATIENT CARE** in comparison to before the trauma patient arriving.

Each item is rated with the following Likert scale:

- 2 decreased productivity
- 1 somewhat decreased productivity
- 0 no change in productivity
- +1 somewhat increased productivity
- +2 increased productivity

SURVEY ITEMS:

1. Keep your mind on your work.
2. Think clearly when working.
3. Concentrate on your work.
4. Be attentive to details.

5. Initiate or start work activities.
6. Handle your patient load.
7. Work at your usual pace.
8. Complete your patient care on time.
9. Complete your documentation on time.
10. Coordinate/collaborate care of my patients with other employees.
11. Control your emotional reactions (examples anxiety, anger, fear, stress) while working with co-workers.
12. Provide emotional support to all patients.
13. Provide emotional support to all family members.
14. Be empathetic with patients and families.
15. Answer patient and family questions.
16. Advocate for patients' needs.
17. Provide education to patients and families on discharge/transfer from unit
18. Fully evaluate a patient's condition.
19. Monitor a patient's condition.
20. Safely administer medications (right patient, drug, route, dosage).
21. Make safe clinical decisions using critical thinking skills.
22. Perform therapeutic interventions without error or injury (examples intravenous therapy, urinary catheter insertion, restraints).
23. Be attentive to asepsis.
24. Accurately note/report results from lab/diagnostic tests.
25. Confirm patient identification before performing therapeutic interventions.
26. Make accurate and necessary entries on patients' medical records.
27. Perform clinical assessments as ordered and/or dictated by patient's condition.
28. Provide safe care for patients.
29. Provide compassionate care to patients and families.

Subscale 1 – Cognitive demands: 1-4 and 11

Subscale 2 – Handle/manage workload: 5-10

Subscale 3 – Support and communication with patients and visitors: 12-17

Subscale 4 – Safety and competency: 18-27

Questions 28 and 29 are not associated with any specific subscale.

Items should be summed to yield a subscale score and a total change in work productivity score. Scores less than 0 represent decreased work productivity. Scores greater than 0 represent increased work productivity. Scores summing to 0, indicate no change in work productivity.

The instrument may be used free of charge pending agreement of the following items:

1. Proper acknowledgement of the instrument and authors. Recommended citation:

Gillespie, G. L., Gates, D. M., & Succop, P. (2010). Psychometrics of the Healthcare Productivity Survey. *Advanced Emergency Nursing Journal*, 32(3), 258-271.
doi:10.1097/TME.0b013e3181e97510

2. Forward an electronic copy of any article published that used the Healthcare Productivity Survey.

Sincerely,

Gordon Lee Gillespie, PhD, RN
University of Cincinnati College of Nursing
P.O. Box 21-0038
Cincinnati, OH 45221-0038
[REDACTED]

SURVEY INSTRUCTIONS

Please answer the following items as they relate to the event of **workplace mistreatment** you just wrote about. Indicate the response that best describes your ability to do the following job activities after the event of **workplace mistreatment** in comparison to before the event occurred.

		Decreased ability (-2)	Somewhat decreased ability (-1)	No change in ability (0)	Somewhat increased ability (+1)	Increased ability (+2)
1	Keep your mind on your work.					
2	Think clearly when working.					
3	Concentrate on your work.					
4	Be attentive to details.					
5	Initiate or start work activities					
6	Handle your patient load.					
7	Work at your usual pace.					
8	Complete your patient care on time.					
9	Complete your documentation on time.					
10	Coordinate/collaborate care of your patients with other employees.					
11	Control your emotional reactions (such as anxiety, anger, fear, stress) while working with co-workers.					
12	Provide emotional support to all patients.					
13	Provide emotional support to all family members.					
14	Be empathetic with patients and families.					
15	Answer patient and family questions					
16	Advocate for patient needs.					
17	Provide education to patients and families on discharge/transfer from unit.					
18	Fully evaluate a patient's condition.					
19	Monitor a patient's condition.					
20	Safely administer medications.					

21	Make safe clinical decisions using critical thinking skills.					
22	Perform therapeutic interventions without error or injury (examples: intravenous therapy, urinary catheter insertion)					
23	Be attentive to asepsis.					
24	Accurately note/report results from lab/diagnostic tests.					
25	Confirm patient identification before performing therapeutic interventions.					
26	Make accurate and necessary entries on patient's medical records.					
27	Perform clinical assessments as ordered and/or dictated by patient's condition.					
28	Provide care for patients.					
29	Provide compassionate care to patients and families.					

Appendix D. Demographic Survey

Demographics

Are you male or female?

- Male
 Female

In what country do you live?

- United States
 Other (please specify)

In which region of the United States do you live?

- | | |
|--|--|
| <input type="radio"/> I reside outside of the United States. | <input type="radio"/> South Atlantic (Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida) |
| <input type="radio"/> New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut) | <input type="radio"/> East South Central (Kentucky, Tennessee, Alabama, Mississippi) |
| <input type="radio"/> Middle Atlantic (New York, New Jersey, Pennsylvania) | <input type="radio"/> West South Central (Arkansas, Louisiana, Oklahoma, Texas) |
| <input type="radio"/> East North Central (Ohio, Indiana, Illinois, Michigan, Wisconsin) | <input type="radio"/> Mountain (Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada) |
| <input type="radio"/> West North Central (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas) | <input type="radio"/> Pacific (Washington, Oregon, California, Alaska, Hawaii) |
| <input type="radio"/> Other (please specify) | |

Which race best describes you? (Please choose only one.)

- American Indian or Alaskan Native
 Asian / Pacific Islander
 Black or African American
 Hispanic
 White / Caucasian
 Multiple ethnicity / Other (please specify)

How long have you been a nurse?

Years

Months

About how long have you been in your current position?

Years

Months

What is the highest level of education you have completed?

What is your primary specialty in nursing?

Critical Care

Medical/Surgical

Psychiatry

ED/Trauma

NICU/Neonatal

Rehab

Geriatrics/LTC

OR/PACU

Telemetry/PCU

Home Health/Hospice

Oncology

Women's Health/L&D

Management

Pediatrics/PICU

Other (please specify)

What is your age?

Appendix E. Culture of Companionate Love Scale

Work Environment					
Answer the following questions as they relate to the frequency with which your co-workers express emotions on a scale of one to five.					
1 = Never to 5 = Very often					
In general, how frequently do other employees in your department express					
	(Never) 1	2	3	4	5 (Very often)
affection?	<input type="radio"/>				
caring?	<input type="radio"/>				
compassion?	<input type="radio"/>				
tenderness?	<input type="radio"/>				

Appendix F. FAU IRB Approval



Institutional Review Board
Division of Research
777 Glades Rd.
Boca Raton, FL 33431
Tel: [REDACTED]

Charles Dukes, Ed.D., Chair

DATE: November 23, 2016

TO: Patricia Liehr, PhD
FROM: Florida Atlantic University Social, Behavioral and Educational Research IRB

PROTOCOL #: 947733-1
PROTOCOL TITLE: [947733-1] Exploring the Relationship Between Workplace Mistreatment and Nurses' Ability to Provide Quality Patient Care

SUBMISSION TYPE: New Project
REVIEW CATEGORY: Exemption category # A3

ACTION: DETERMINATION OF EXEMPT STATUS
EFFECTIVE DATE: November 23, 2016

Thank you for your submission of New Project materials for this research study. The Florida Atlantic University Social, Behavioral and Educational Research IRB has determined this project is EXEMPT FROM FEDERAL REGULATIONS. Therefore, you may initiate your research study.

We will keep a copy of this correspondence on file in our office. Please keep the IRB informed of any substantive change in your procedures, so that the exemption status may be re-evaluated if needed. Substantive changes are changes that are not minor and may result in increased risk or burden or decreased benefits to participants. Please also inform our office if you encounter any problem involving human subjects while conducting your research.

If you have any questions or comments about this correspondence, please contact Ximena Levy at:

Institutional Review Board
Research Integrity/Division of Research
Florida Atlantic University
Boca Raton, FL 33431
Phone: [REDACTED]

* Please include your protocol number and title in all correspondence with this office.

**This letter has been electronically signed in accordance with all applicable regulations,
and a copy is retained within our records.**

Appendix G. Permission from Allnurses.com



261 School Ave., Suite 300
Excelsior, MN 55331

October 4, 2016

Florida Atlantic University

Institutional Review Board

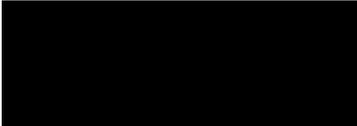
The purpose of this letter is to grant Christine Moffa a student at the Christine E. Lynn College of Nursing at Florida Atlantic University permission to conduct research with the membership of allnurses.com. The research project, Exploring the Relationship between Workplace Mistreatment and Nurses' Ability to Provide Quality Patient Care entails writing a story of workplace mistreatment and answering a survey through Survey Monkey . allnurses.com was selected because the website hosts over 900,000 members, many of whom meet the inclusion criteria for this study.

I understand that the research will take place from November 15, 2016 through November 15, 2017, with a 90 day extension upon written request.

I understand that Christine Moffa will receive informed consent from all research participants, that any data collected by Christine Moffa will be kept confidential, and that Christine Moffa will receive Florida Atlantic University's approval before she or he recruits research participants or collects data.

Upon completion of the research project, a summary of the results and final paper will be posted on [allnurses.com in the related forum to the project](#).

As the Community Manager of allnurses and authorized to act on behalf of allnurses.com on research matters, I do hereby grant permission for Christine Moffa to conduct Exploring the Relationship between Workplace Mistreatment and Nurses' Ability to Provide Quality Patient Care on allnurses.com.


Mary Watts BSN, RN / Community Manager allnurses.com

Appendix H. FAU IRB Amendment Approval



Institutional Review Board

Division of Research
777 Glades Rd.
Boca Raton, FL 33431
Tel: [REDACTED]

Charles Dukes, Ed.D., Chair

DATE: February 7, 2017

TO: Patricia Liehr, PhD
FROM: Florida Atlantic University Social, Behavioral and Educational Research IRB

IRBNET ID #: 947733-2
PROTOCOL TITLE: [947733-2] Exploring the Relationship Between Workplace Mistreatment and Nurses' Ability to Provide Quality Patient Care

SUBMISSION TYPE: Amendment/Modification
REVIEW TYPE: Administrative Review

ACTION: *Acknowledged*
EFFECTIVE DATE: February 7, 2017

Thank you for your submission of Amendment/Modification materials for this research protocol. The IRB has reviewed and acknowledged this minor change to the Exempt study.

- Additional recruitment method via SurveyMonkey link

We will keep a copy of this correspondence on file in our office. Please keep the IRB informed of any substantive changes in your procedures, so that the exemption status may be re-evaluated if needed. Substantive changes are changes that are not minor and may result in increased risk or burden or decreased benefits to participants. Please also inform our office if you encounter any problem involving human subjects while conducting your research.

If you have any questions or comments about this correspondence, please contact Danae Montgomery at:

Institutional Review Board
Research Integrity/Division of Research
Florida Atlantic University
Boca Raton, FL 33431
Phone: [REDACTED]

* Please include your protocol number and title in all correspondence with this office.

**This letter has been electronically signed in accordance with all applicable regulations,
and a copy is retained within our records.**

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