**A Study of Nurses' Experiences with Behaviors that Compromise a Healthy Work Environment in the Hospital Setting**

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## Abstract

The existence of disruptive behaviors in the hospital setting has been shown to affect the communication and collaboration between healthcare professionals. This study explored nurses' experiences with behaviors that compromise a healthy work environment. The data collection was accomplished through semi-structured interviews and review of organizational documents. The results of the analysis concluded that there existed a low incidence of disruptive behaviors in the selected organization. Themes were determined that reflected inconsistencies in the nurses' practice environment that contributed to the presence of disruptive behaviors. Inconsistency in communication and collaboration, in holding colleagues accountable, and the lack of visibility of nursing leadership were the most pervasive concerns.

Key Words: nursing, disruptive behaviors, healthy work environments, collaboration, communication, accountability, patient safety, Donabedian model

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# CHAPTER ONE-INTRODUCTION

In the healthcare environment, communication between healthcare professionals has been shown to be pivotal in the creation of a culture of patient safety (Kohn, Corrigan, & Donaldson, 2000; TJC, 2008). In their report, "To Err is Human: Building a Safer Health System," the Institute of Medicine (IOM) released data on patient deaths due to medical errors (Kohn et al., 2000). This report focused on the role of ineffective communication and collaboration between health care professionals. It triggered concerns from regulatory and professional organizations because of the validated relationship between patient outcomes and patient safety and how healthcare professionals communicate and relate to one another (AACN, 2005; TJC, 2008).

Behaviors that have been found to contribute to ineffective communication and collaboration between health care professionals have been labeled disruptive behaviors (Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005; Rosenstein & O'Daniel, 2005; TJC, 2008), incivility (Pearson, Andersson, & Wegner, 2001), vertical and horizontal violence (Embree & White, 2010), verbal abuse (Budin, Brewer, Chao, & Kovner, 2013), workplace aggression (Demir & Rodwell, 2012) , intimidation (Lamontagne, 2010), and workplace bullying (Einarsen & Skogstad, 1996; S. Johnson & Rea, 2009) . Regardless of the label, the presence of these behaviors has been shown to affect nurse retention, turnover, intent to leave their job, and potential negative effects on patient outcomes due to communication differences (Hutchinson, Jackson, Wilkes, & Vickers, 2008; S. Johnson & Rea, 2009; P. Lewis, 2009; Sofield & Salmond, 2003; TJC, 2008).

Organizations have proposed strategies to improve communication and collaboration between healthcare professionals at the point of direct patient care. Responding to the

inextricable links among quality of the work environment, nursing practice and patient care outcomes, the American Association of Critical-Care Nurses (AACN, 2005) developed standards for establishing and sustaining a healthy work environment. .

Subsequent to the release of these standards, The Joint Commission (TJC), a healthcare accrediting organization, developed standards on behaviors that compromise a culture of safety. These behaviors were labeled disruptive behaviors, which described conduct by an individual working in the organization "that intimidates others to the extent that quality and safety could be compromised" (TJC, 2008). These standards were based on the rationale that safety and quality thrive in an environment that supports teamwork and respect for others regardless of position in the hospital (TJC, 2015, p. LD-16). The standards further communicated to organizations accredited by TJC that behaviors that intimidate others and affect morale or staff turnover undermine a culture of safety and can be harmful to patient care.

**Purpose**

The primary purpose of this study is to explore how nurses working in a hospital setting describe their experiences with behaviors that compromise a healthy work environment, which is crucial to the existence of a culture of safety. This study will contribute to knowledge surrounding this topic through documentation of firsthand accounts of nurses that experienced non-collegial, non-collaborative relationships and communication in the hospital setting with their colleagues. The interviews provided the opportunity for nurses to describe a work environment that is important to the provision of safe and quality patient care and how the area in which they work measures up to these ideals.

**Significance**

This research was designed to gain an understanding of the communication that occurs in the hospital setting which influences nurses' safe provision of patient care. Interviewing staff nurses and nursing leaders captures the essence of the behaviors experienced in their own words. Studies reviewed were primarily quantitative research in which structured questionnaires and survey instruments were used as the data collection of choice, thereby limiting responses to the survey tool format (S. Johnson & Rea, 2009; Rosenstein, 2002; Smetzer & Cohen, 2005).

This study also provided insight into the responsibilities of leadership as described by nurses. It was the responsibility of organizational leadership to set the expectations for managing the behaviors and evaluate the effectiveness of the communication of these expectations. The effect on patient safety and the impact on the nursing shortage are two key reasons why the study of the presence of behaviors that compromise a healthy work environment and the potential to compromise the provision of patient care is important.

**Research Question**

The primary research question for this study is "How do nurses working in the hospital setting describe experiences with behaviors that compromise a healthy work environment?" In order to understand the context of the responses, feedback on the ideal work environment is important to the research.

**Assumptions and Limitations**

As an outsider to the organization, an assumption was that a culture of safety existed in the organization in which the research was conducted. This assumption was supported by the organization's reputation as a nationally recognized leader in establishing and

maintaining a culture of patient safety. Organizations with a positive safety culture are characterized by mutual trust, shared perceptions of the importance of safety, and confidence in the efficacy of preventive measures (Nieva & Sorra, 2003).

An assumption was also made that the staff nurses and nursing leadership interviewed confided in this researcher as an outsider to their organization. To be perceived as "safe" to the participants was important to the security of their positions in the organization in discussing the disruptive behaviors. The role of outsider could also have been a limitation evidenced by the reluctance of the nurses to participate. There was also a possibility that the organization was reluctant to share the documents requested that reflected patient and nursing outcomes.

**Definitions**

*Staff nurse*: Registered nurses functioning in nonsupervisory positions. These registered nurses provided direct patient care working under the job description defined by the organization. This category of nurses included staff nurses, charge nurses, and nurse educators. A charge nurse was a staff nurse assigned to coordinate the activities of the nursing unit on a shift-by-shift basis. Nurse educators were considered staff nurses but responsible for the training and education of staff on each nursing unit.

*Nursing Leader*: Registered nurses who either directly or indirectly supervised the staff nurse. This category of nurses included the Chief Nursing Officer (CNO), nursing directors, nurse managers, and clinical coordinators.

*Inpatient nursing unit*: A functional group of staff working together to provide care to a discrete population of patients admitted to the hospital who stay overnight for nursing and medical care. Included in the study were medical, surgical, critical care, and obstetrical

nursing care units. Nurses that worked in the emergency department and operating room were excluded based on this definition.

**Summary**

The goal of this research is to determine through interviews nurses' experiences with behaviors that compromise a healthy work environment. Determining the characteristics of the environment in which nurses provided patient care served to shed light on the perceptions of those interviewed. Chapter 2 addresses the review of theoretical literature relevant to behaviors which compromise communication and relationships in the healthcare environment and impact on nursing and patient outcomes. Chapter 3 describes the methodology used to study the research questions. A description of the selected case and sample, data collection process, and data analysis is presented. Chapter 4 presents the findings resulting from the analysis of the data and the conceptual framework developed as a result of the analysis, and Chapter 5 includes the conclusion about the study findings, limitations of the study, and recommendations for future research.

## CHAPTER TWO – REVIEW OF LITERATURE

In the healthcare environment, the communication between healthcare professionals has been shown to be pivotal in the creation of a culture of patient safety (Kohn et al., 2000; TJC, 2008). In 2000, the Institute of Medicine (IOM) released data on patient deaths due to medical errors and the role of ineffective communication and collaboration between health care professionals (Kohn et al., 2000) . The content of this report contributed to actions of regulatory, patient safety advocates and professional organizations to improve communication between healthcare professionals at the point of direct patient care (AACN, 2005; TJC, 2008).

In response to the work of the IOM (Kohn et al., 2000; Page, 2004), the American Association of Critical-Care Nurses (AACN, 2005) developed "Standards for Establishing and Sustaining Healthy Work Environments". Their goal was to provide a framework to promote competencies in communication and collaboration that would ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability. In addition to communication and collaboration, these standards focused on decision-making, staffing, recognition, and leadership. The environment in which nurses practice is an aggregate of processes and relationships characteristic of these standards (Kramer & Schmalenberg, 2008).

The goal of this review of literature is to establish the importance of studying behaviors experienced by nurses that compromise a healthy work environment and their potential effects on patient safety. This will be accomplished by a discussion of descriptions and definitions of disruptive behaviors, the consequences of these behaviors on patient and nursing outcomes, the importance of collaboration, and the role of a culture of safety.

**Disruptive Behaviors**

The focus of this research is on disruptive behaviors that contribute to poor communication and collaboration. They have been referred to in many ways: incivility, workplace bullying, horizontal and lateral violence, verbal abuse, and relational aggression. Lack of consensus in the labeling and definitions of these constructs complicates the determination of prevalence (Agervold, 2007; Einarsen, Hoel, Zapf, & Cooper, 2011; Keashly & Jagatic, 2011), and development of strategies to eliminate them from the work environment (Agervold, 2007; Bartholomew, 2006; Quine, 2001).

The proliferation of constructs and the interchangeable use also complicates identifying and building on relevant literature to come up with a common definition. For instance, intimidation is a key characteristic of the definition of disruptive behaviors as set forth by TJC but also characterizes bullying (Agervold, 2007; Bartlett & Bartlett, 2011), horizontal and lateral violence (Bartholomew, 2006; Corney, 2008), verbal abuse (Cook, Green, & Topp, 2001), and relational aggression (Dellasega, 2011).

The study of the occurrence of disruptive behaviors in the healthcare setting has gained momentum over the past decade (Longo, 2007; Pfifferling, 2008; Porto & Lauve, 2006; Reiter, Pichert, & Hickson, 2012; Rosenstein, 2011; Tubbs & Hart, 2011). Studies have been conducted to determine the prevalence experienced by health care professionals.

Rosenstein (2002, 2011) and Rosenstein and O'Daniel (2005, 2008) conducted surveys to investigate the impact of disruptive behaviors on nurse satisfaction and retention, communication defects on patient safety, and to gather perceptions of nurses and physicians about the problem. The convenience sample of nurses (72%), physicians (27%), and executive-level administrators (1%) represented all clinical service areas in hospitals from

VHA, Inc., a network of community-owned healthcare systems in the United States. The results, conclusion, and recommendations of these studies have been referenced by others' published work on disruptive behaviors (Martin & Hemphill, 2012; Reiter et al., 2012; Smetzer & Cohen, 2005; TJC, 2008).

The term *disruptive behavior* has historically been associated with physician behaviors. A review of literature from 2000 to 2008 by Saxton, Hines, and Enriquez (2009) focused on disruptive physician behaviors and physician verbal abuse in the health care setting. All 10 of the studies reviewed were descriptive in nature and used a non-experimental approach. Self-report survey tools were used to measure the prevalence of disruptive behaviors. However, no two studies used the same tool or survey items. The prevalence of disruptive behaviors was confirmed through the review of the selected research reports.

One of the studies reviewed by Saxton was that conducted by the Institute of Safe Medication Practices (Smetzer & Cohen, 2005) which reported 88% of respondents encountered condescending language or voice intonation and almost half encountered strong verbal abuse (48%) or threatening body language (43%). Even though physicians and other prescribers engaged in intimidating behaviors more frequently than pharmacists, nurses, and supervisors, intimidating behaviors were attributed to all healthcare providers.

Studies by The American College of Physician Executives (C. Johnson, 2009, November-December) and Vital Smarts and AACN (Maxfield et al., 2005) also determined a fundamental lack of respect between nurses and physicians. Whereas the data collected by the American College of Physician Executives was by means of a self-report survey, the Vital Smarts study collected data through focus groups, interviews, workplace observations,

in addition to surveys. Behaviors experienced by those participants included verbal abuse and condescending, insulting, or rude comments.

When a trend has been determined by TJC from reports of unexpected patient injury or death, a sentinel event alert is issued to accredited organizations. In response to research studies that had validated the prevalence and effects of disruptive behaviors on patient safety (Kohn et al., 2000; Rosenstein, 2002; Rosenstein & O'Daniel, 2005; Smetzer & Cohen, 2005), TJC (2008) released a sentinel event alert titled, "Behaviors that undermine a culture of safety". The content of this document focused on a review of literature on intimidating and disruptive behaviors, root causes, and contributing factors, and suggested actions to prevent or manage these behaviors in the healthcare organization environment.

The follow-up by TJC to the release of this alert was the implementation of standards aimed at the elimination of the presence of disruptive behaviors in healthcare organizations (TJC, 2009). These standards required organizations to develop a safety program that would result in a culture of safety. The meaning of or definition of disruptive behaviors and inappropriate behaviors as released by TJC were unclear to organizations resulting in the release of a follow-up publication (2009, April). Disruptive behavior according to this document was described as "conduct by an individual working in the organization that intimidates others to the extent that quality and safety could be compromised. These disruptive behaviors as determined by organizations may be verbal or non-verbal, may involve the use of rude language, may be threatening or may involve physical contact" (TJC, 2009, April, p. 10). Further guidance in this document was for organizations to define disruptive and inappropriate behaviors in terms of their own circumstances and create and implement a process for managing the behaviors. The only requirement was that it must

apply to anyone who works in the organization. This failure of TJC to standardize the definition of disruptive behaviors has contributed to the problem of lack of consensus in the labeling of behaviors that characterize not only of disruptive behaviors but also that of verbal abuse, incivility, relational aggression, bullying, and lateral or horizontal violence in the workplace.

Rosenstein (2002), as a result of his research, defined disruptive behaviors as "any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment" (p. 27). Due to the range of behaviors from the very subtle to the very severe, this definition alone could characterize other constructs. Any conduct by a team member that interferes, or has the potential to interfere with the team's ability to achieve intended outcomes, or very simply, "non-teamwork-promoting behavior" can also be considered disruptive (Reiter et al., 2012).

The literature on bullying is applicable to the discussion of differentiation between the constructs described as disruptive behavior (Einarsen et al., 2011; Keashly & Jagatic, 2011). Bullying has been termed as such by English-speaking countries, harassment by the French speaking, and mobbing by Europeans (Einarsen et al., 2011; Raynor & Hoel, 1997). In the US, there are a myriad of terms that describe the behaviors as labeled by other countries whereas the European tradition is characterized by high degree of unity in the labeling of concepts and competing terms (Einarsen et al., 2011)

The defining characteristic of bullying is related to the frequency and duration of the behaviors (Einarsen et al., 2011; Keashly & Jagatic, 2011). Bullying is a long-term process and not about single isolated events. The behaviors are repeated, persistent, and directed towards one or more individuals (Leymann, 1996).

Imbalance of power has been determined to be characteristic of disruptive behaviors (Estes, 2013). The proposition is that those in low-power positions (subordinates, entry-level employees, and women) are more vulnerable to being the target of hostile behaviors than those in higher power positions. Conversely, those in high power positions are hypothesized as more likely to be the instigator of hostile workplace behaviors. Thus, by virtue of position and the access to resources and influence that the position entails, the potential exists for the abuse of power (Katrinli, 2010). Intimidation is associated with differences of perceived power of individual positions within the organization (Lamontagne, 2010).

Despite the inferred *power over* element from the literature, it has also been shown that coworkers are frequently the source of disruptive behaviors in the workplace (Bartlett & Bartlett, 2011; Hutchinson, Vickers, Jackson, & Wilkes, 2006; Lutgen-Sandvik, 2006). Since a single event or conflict between two equally strong parties is not considered bullying, lateral violence which can be and often is a onetime occurrence would not be classified as a bullying behavior (Zapf & Gross, 2001).Yet, nursing researchers have incorporated the terms and behaviors of horizontal and lateral violence as bullying (Bigony et al., 2009).

Intentionality (intent to harm) has been included in the definition of bullying, relational aggression, and incivility (Dellasega, 2011; Keashly & Jagatic, 2011; Lutgen-Sandvik, Tracy, & Alberts, 2007; Pearson et al., 2001). There is a growing debate of whether this is valuable. Whereas incivility has been defined with an ambivalent intent to harm, bullying and relational aggression are characterized by the intent to harm. Because of the difficulty in verifying the intent, it is not an essential element of the European research on bullying (Einarsen et al., 2011) . Studies rarely measure intent; it is subjective from the

perspective of the target and relies on the contexts of duration, relationship to, and history with the perpetrator and the organizational norms (Keashly & Jagatic, 2011).

It has also been proposed that these constructs are escalated interpersonal conflicts (Andersson & Pearson, 1999; Einarsen et al., 2011; Hutchinson et al., 2008). Andersson and Pearson (1999) proposed that incivility, manifested as a low level of aggression in the workplace, can escalate into more intense forms of aggression through what they have labeled the incivility spiral. The incivility spiral starts out with a retaliatory exchange of uncivil behaviors until one party perceives that the other's behavior directly threatens his or her identity. At this point parties engage in increasingly more coercive and severe behaviors with presumably greater risk of injury. This evolving process involves an escalation of the perpetrator's behaviors from indirect and subtle behaviors to more direct psychologically aggressive acts and to ultimately severe psychological and physical violence (Einarsen et al., 2011; Gosh, Jacobs, & Reio, 2011; Hutton, 2006).

To simplify the problem of concept definition and use, this research considered the behaviors associated with bullying, incivility, horizontal and lateral violence, verbal abuse, and relational aggression as disruptive behaviors. Regardless of the terminology used, these identical phenomena are toxic to the work setting, nursing outcomes, and the safety of patient care.

**Nursing Outcomes**

The effect on nursing outcomes most notably the recruitment and retention of nurses, has been well documented in the literature as a consequence of disruptive behaviors (Bartholomew, 2006; Bigony et al., 2009; Hutchinson et al., 2006; Quine, 2001). In addition to physical effects, employee attitudes, and well-being, job satisfaction, work performance,

and perception of trust and justice are also affected. This results in an increased cost to the organization due to turnover and difficulty in recruitment of nurses (Baker, Beglinger, King, Salyards, & Thompson, 2000; Christmas, 2008).

In a publication released by the American Association of Colleges of Nursing an existing nursing shortage is projected to grow to 260,000 by 2025 ("Nursing shortage fact sheet," 2014). This is attributed to nursing school enrollments that are not growing fast enough to meet the projected demand, a shortage of nursing school faculty, aging work force, and high nurse turnover and vacancy rates. The vacancy rate that exists because of high nurse turnover results in insufficient staffing which raises the stress level of nurses, impacts job satisfaction, and drives many nurses to leave the profession. All of these effects eventually impact the quality and safety of patient care. This preexisting nursing shortage is compounded by behaviors that contribute to the nurse's intent to leave the organization.

Researchers have worked diligently to ascertain the essential characteristics of a healthy work environment in which nurses practice (AACN, 2005; ANCC, 2014; Kramer & Schmalenberg, 2008, 2002). In 1983, the Academy of Nursing Task Force on Nursing Practice in Hospitals identified characteristics in the work environment that enabled greater capacity to attract and retain nurses (Kramer & Schmalenberg, 2008).

The results of these endeavors provided a framework to promote competencies in communication and collaboration that would ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability. These combined characteristics primarily focused on communication, collegiality, and collaboration between nurses and physician; staffing as it relates to both appropriateness and quality; leadership that is supportive; and clinical autonomy and effective decision-making. It is the aggregate of

processes and relationships of these characteristics that promote a healthy work environment (Kramer & Schmalenberg, 2008).

The characteristics varied depending on job position, focus, and responsibilities (Kramer & Schmalenberg, 2008). For example, the characteristic of leadership expectations varied from the perspective of staff nurses and nursing executives. The nursing executives focus was more global concentrating on the dynamics and quality of leadership whereas the focus of the staff nurse was more specific concentrating on support from their nurse manager.

Heath, Johnson, and Blake (2004) conducted a study to validate through focus groups the findings and recommendations of literature that has been published around the topic of healthy work environments. The conclusion from this study was that nursing leaders must prioritize efforts to improve the culture of the work environment by setting the tone and establishing standards of practice. Transforming environments where negative behaviors exist, facilitating open communication, supporting the critical role of nursing leadership, and improving collaborative relationships must be a high priority in strategic planning among healthcare organizations (Heath et al., 2004).

The nursing outcome that has drawn the most interest globally is that of the intent of nurses to leave their areas of employment or nursing altogether as a result of their work environment and/or experiences with disruptive behaviors (Blake, 2012; S. Johnson & Rea, 2009; P. Lewis, 2009; Maxfield et al., 2005; Simons, 2008; Sofield & Salmond, 2003).

Factors that have been shown to increase the chance of intent to leave include the following: frequent and longer duration of the abuse (Maxfield et al., 2005); peer relationships such as bullying (Simons, 2008); manager relationship and accountability

(Blake, 2012; S. Johnson & Rea, 2009); and medical staff verbal abuse (Sofield & Salmond, 2003).

Maxfield et al. (2005) suggested that improvement in communication could not only contribute to significant reductions in errors, but also to improvement in quality of care, reduction in nursing turnover, and marked improvement in productivity. In their study, there was a strong correlation ($p<.001$) between the frequency of mistreatment and intent to quit their job as well as a strong correlation between the duration of abuse and intent to quit their job. Another significant finding of this study was that nurses and other clinical care providers who are confident in their ability to confront people when the concern is disrespect or abuse are more satisfied with their workplace ($p<.001$), and do not intend to leave their job ($p<.001$). Sofield and Salmond (2003) also found a relationship between verbal abuse and intent to leave the organization ($p<.01$) but the source of the verbal abuse was not from the nurse's peers but from the physicians in this study.

Bullying has been documented as a significant determinant of predicting intent to leave an organization. In a study by Simons (2008) even though this study did not control for all the factors known to predict turnover behavior, the intent to leave the organization increased as bullying behavior increased. S. Johnson and Rea (2009) found that nurses who were bullied were almost twice as likely to leave their current position within the next 2 years ($p<.001$) and three times more likely to leave nursing within the next 2 years ($p<.001$). Research has also established the relationship between bullying by leadership and the outcomes of intent to leave the organization (Blake, 2012; S. Johnson & Rea, 2009).

Studies that have reported data on nurses' intent to leave have limitations. The majority of studies reviewed were quantitative which measured the hypothetical or perceived

intent to leave their current job (Blake, 2012; S. Johnson & Rea, 2009; Maxfield et al., 2005). This methodology is problematic because of the lack of data on nurses that actually left and the lack of circumstances or reasons for communicating the intent and/or actual departure.

Flinkman, Leino-Kilpi, and Salantera (2010) reported through an integrative review of research that studied the nurses intent to leave, 30 out of 31 studies were quantitative. There was a wide variation of measures used to gauge leaving intention (24 different instruments). Out of these 31 studies only one measured the number of nurses that not only indicated the intent to leave but that actually left their employer. Two studies which were longitudinal were reviewed that measured the frequency in which nurses actually left their immediate work environment, employer, or the profession of nursing and the reasons for leaving (Rongen et al., 2014). These studies differed in intent and processes and did not identify the specific characteristics of the work environment that impacted intent to leave.

The most referenced longitudinal study was the European Nurses Early Exit (NEXT) study (Kutney-Lee, Wu, Sloane, & Aiken, 2013; Rongen et al., 2014). This was a survey that was administered to nurses and nurses' aides in ten European countries. A follow-up study was conducted one year after premature departure finding that 9.3% of 1,924 nurses who intended to leave actually left. Even though work environment was one of the variables in this study, the discriminating factor was related to work characteristics such as high work demands and low job control and work ability which included perceived ability to physically and mentally cope with job demands. Premature departure was evident in nurses with low work ability and significantly increased when associated with poor work-related characteristics. They found that nurses with low work ability were more likely to change employer or leave the profession. Those with high work ability were more likely to stay with

the employer and nursing despite unfavorable work-related characteristics. A key finding of the study was that there existed a gap of 6 months between intent and actually leaving which implies the importance of the nurse manager role in intervening with those that express an intent to leave the organization (Rongen et al., 2014).

A second study which was a retrospective longitudinal study was conducted by Kutney-Lee and associates (2013) . The intent of this study was to determine how changes in the work environment at a hospital level were associated with burnout, intent to leave, and job dissatisfaction. Using the same hospitals at two data points (1999 and 2006) they found that an improvement of work environment was a strong negative association with a change in rates of burnout ($p < 0.01$), intention to leave ($p<0.01$), and job satisfaction. The study was not able to determine if those that indicated their intent to leave in the 1999 study, actually left.

Instead of studying the factors that contribute to a nurse's intent to leave, Tourengeau, Cummings, Cranley, Ferrone, and Harvey (2010) conducted focus groups to determine the factors that influence nurses to remain employed in Canada. Eight categories that were determined through thematic analysis aggregated to job satisfaction although "job satisfaction" as a single category did not emerge as the reason for remaining employed. A conclusion was the importance of focusing on the work environment to retain nurses not the nurses' behaviors. The aspects of work that influence retention may differ in countries with different values and norms.

**Collaboration**

Collaboration has been identified as crucial to the outcome of patient safety (AACN, 2005; Kohn et al., 2000). Professional organizations have addressed collaboration of all

healthcare professionals providing patient care through development of standards, policy statements, and ongoing research (Baggs & Schmitt, 1988; Dechairo-Marino, Jordan-Marsh, Traiger, & Saulo, 2001; Schmalenberg & Kramer, 2009).

Because of concerns about adversarial relationships within the healthcare setting, the National Joint Practice Commission (1981) developed a model of collaborative practice between nurses and physicians (*Guidelines for Establishing Joint or Collaborative Practice in Hospitals)* . This model which was supported by the American Nurses Association and the American Medical Association, proposed five essential factors of collaborative practice: communication, competence, accountability, trust, and administrative support (Devereux, 1981). Despite any theoretical justification for the identification of these five factors, subsequent research in a demonstration project showed that increased collaboration resulted in increased quality of care, patient satisfaction, nursing job satisfaction, coordination and decreased need for physician supervision of nursing.

There has been much work since 1981 in defining collaboration. Studies by Baggs and Schmitt have focused on collaboration within the critical care setting since the early 1990s (Baggs & Schmitt, 1988, 1997).

In 1997, Baggs and Schmitt conducted a study to determine the perceptions of the process of collaboration between nurses and resident physicians. Nurses and resident physicians were interviewed to gain an understanding of collaboration by identifying antecedents and outcomes to collaboration through analysis of the interviews.

The antecedents identified were “being available” and “being receptive.” Availability was defined as more than physical proximity. Having the time to interact with each other and be available intellectually were crucial for collaboration to occur. In order to be available

intellectually, staff must be knowledgeable about the work being done and have mutual understanding of each other's role in the provision of patient care. How receptive the care providers were to each other was found to be an important component of the process. Receptiveness meant the importance of having the right attitude, which was expressed as active listening, openness and questioning, respect and trust in each other. Outcomes identified from the perspective of these nurses and resident physicians included improved patient care, control of costs, and feeling better at the job which related to the creation of a positive work environment.

AACN (2005) identified true collaboration as part of their work on healthy work environments. In true collaboration "the unique knowledge and abilities of each professional are respected to achieve safe, quality care for patients. Skilled communication, trust, knowledge, shared responsibility, mutual respect; optimism and coordination are integral to successful collaboration" (p. 190). AACN reported that for 90% of its members and constituents, collaboration with physicians and administrators was among the most important elements in creating a healthy work environment. Mutual concern between members of the health care team that quality patient care will be provided are key organizational elements of work environments that attract and retain nurses (AHA, 2002; AONE, 2005; Maxfield et al., 2005).

Schmalenberg and Kramer (2009) studied collaboration and its impact on the practice environment within the context of magnet hospitals. The magnet designation is earned by hospitals that have demonstrated characteristics of work environments that attract and retain well qualified nurses who promote quality patient care (ANCC, 2014).

This study was an attempt to develop a common understanding of what constitutes good, high-quality relationships between physicians and nurses. A synthesis of six studies that they had conducted on nurse-physician relationships in magnet hospitals was completed. Five types of nurse-physician relationships were identified: (a) collegial where there is an equality of trust, different but equal power, and knowledge and respect; (b) collaborative where there is a mutuality of trust, power, respect, and cooperation; (c) student-teacher roles; (d) friendly stranger which is an absence of feelings with formal exchange of information and knowledge; and (e) hostile/adversarial which is marked by anger, verbal abuse, real and implied threats, frustration, hostility, and unequal power.

Collegiality in the nurse-physician relationship has been addressed. Baggs and Schmitt (1988) concluded that collegiality is not the case between nurses and physicians because of the existence of a hierarchical relationship that is inherent in patient care. Within healthcare, there will always be a hierarchical relationship because of physicians' power of "writing orders" and responsibility for most health care decisions. One of the types of relationships identified by Schmalenberg and Kramer (2009) was collegiality where there is an equality of trust, power, and respect. The equality of power in this characteristic is contrary to that of Baggs and Schmitt.

Collaboration involves the coordination of patient care, cooperation between those involved with provision of care, and sharing of goals and planning to ensure optimal outcome for the patient (Baggs & Schmitt, 1988). Regardless of how collaboration is defined by those using the term, open communication is key to ensuring efficient, effective care. Hostile and adversarial relationships (Schmalenberg & Kramer, 2009) and behaviors such as poor

communication, abusive behavior, and disrespect (Heath et al., 2004) are devastating to collaboration and the existence of a healthy work environment.

**Patient Care Outcomes**

The Joint Commission and the IOM in their publications have established the need for changing the communication and collaboration of healthcare team members because of the effects of disruptive behaviors on patient safety (Kohn et al., 2000; Page, 2004; TJC, 2001, 2008). Research has been conducted that addresses the relationship of the practice environment on patient outcomes ("Disruptive behavior in healthcare facilities causes harm to patients.," 2010; Flynn, Liang, Dickson, Xie, & Suh, 2012; Manojlovich & DeCicco, 2007; TJC, 2004) and specifically the effect of disruptive behaviors on patient outcomes ("Disruptive behavior in healthcare facilities causes harm to patients.," 2010; Maxfield et al., 2005; Rosenstein & O'Daniel, 2005; Smetzer & Cohen, 2005).

Analysis of safety event reports and sentinel events has been a strategy by organizations to determine the presence of disruptive behaviors and their effects on the clinical outcomes of patients ("Disruptive behavior in healthcare facilities causes harm to patients.," 2010; TJC, 2004). The Joint Commission released a synopsis of sentinel events that were related to medication errors from 1995-2003 (TJC, 2004). This synopsis suggested that communication is a top contributor to the occurrence of these events. The Pennsylvania Patient Safety authority conducted a review of self-reports of safety events to determine root causes ("Disruptive behavior in healthcare facilities causes harm to patients.," 2010). The data showed that out of 177 safety events, 41% were a result of conflicts between healthcare clinicians. The behaviors cited were refusal to adhere to procedures (17%), and absences or delayed responses that resulted in patient care delays (10%).

Few studies have been reported that established a relationship between clinical outcomes to the practice environment. Flynn, Liang, Dickson, Xie, and Suh (2012) conducted a non-experimental study and examined medication errors, staffing levels, and nurses' perceptions of their practice environment. The Practice Environment Survey (PES-NWI) was administered to nurses to determine a rating aggregated at the unit level.

The PES-NWI is utilized in the industry to evaluate the practice environment from the nurse's perspective. It consists of five subscales: (a) Nurse Participation in Hospital Affairs; (b) Nursing Foundations for Quality of Care; (c) Nurse Manager Ability, Leadership and Support of Nurses; (d) Staffing and Resource Adequacy; and (e) Collegial Nurse-Physician Relations (Lake, 2002, p. 181). According to Lake (2002), two subscales (Nurse Participation in Hospital Affairs and Nursing Foundations for Quality of Care) are used to address facility-level phenomena, while three subscales (Nurse Manager Ability, Leadership and Support; Staffing and Resource Adequacy; and Collegial Nurse-Physician Relations) address unit-level phenomena. Reporting research that utilized this score in the determination of effects on patient outcomes is important to this research because of the inclusion of collegial nurse-physician relations.

The frequency in which medication errors were intercepted by nurses was established through the review of incident reports which rely on accurate self-reports. Data on staffing levels during the data collection timeframe were also analyzed. The conclusions of the study were supported by the results of the study. Staff levels were not associated with medication errors, medication interception practices, or practice environment. These results did demonstrate a significant positive association ($p>.001$) between the nurses' perceptions of their practice environment and nurses' error interception practices. The strongest association

with nurses' interception practices was that of collegial nurse/physician relationships and foundations for quality of care.

While Flynn found a significant relationship between practice environment and clinical practice, Manojlovich and DeCicco's (2007) findings differed. Data on adverse patient outcomes were obtained from the review of pressure ulcer, ventilator acquired infections and central line infections prevalence. Correlation and multiple regressions were conducted at each nursing unit level in an attempt to determine a relationship between the two variables. No significant relationship existed between the practice environment and adverse patient outcomes.

The studies that are commonly referenced to substantiate the impact of disruptive behaviors on patient care outcomes queried healthcare professionals on the perception of or potential to impact patient care (Maxfield et al., 2005; Rosenstein & O'Daniel, 2005; Smetzer & Cohen, 2005).

The ISMP survey on workplace intimidation measured perceptions of staff related to presence of the disruptive behavior of intimidation and the effect on patient outcomes (Smetzer & Cohen, 2005). Seventeen percent of respondents felt pressured to accept a medication order despite concerns about its safety on at least three occasions in the previous year, 13% had refrained from contacting a specific prescriber to clarify the safety of an order on at least 10 occasions, and 7% said that in the previous year they had been involved in a medication error where intimidation played a role. Maxfield et al. (2005) reported countless examples of caregivers who delayed action, withheld feedback, or went along with erroneous diagnoses rather than face potential abuse from a colleague from the Vital Smarts study, Silence Kills.

Rosenstein and O'Daniel (2005) conducted a study of physicians, nurses, and administrators on their perception of the effects of disruptive behaviors on clinical outcomes. The data were presented as descriptive statistics which reflected the agreement or disagreement with the stated questions. Respondents felt that there was a strong correlation between disruptive behaviors and the occurrence of adverse events (67%), the occurrence of medical errors (71%), compromises in patient safety (51%), and compromises in quality (71%). When asked, "Are you aware of any specific adverse event that did occur as result of disruptive behaviors?" 80% answered "no"; "Are you aware of any potential adverse events that could have occurred from disruptive behaviors?" 60% answered "yes"; and "Could disruptive behaviors potentially have a negative effect on patient outcomes?" 94% answered "yes."

Patient satisfaction is often cited as another parameter that is affected by disruptive behaviors or the environment where they receive care. How patients perceive their environment while being cared for in hospitals is measured through patient satisfaction surveys. The survey results reflect the satisfaction with the care delivery from the nursing unit in which the patient was discharged. It is measured most commonly by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey which is a national standardized, publicly reported survey of patients' perspectives of their hospital experience ("HCAHPS fact sheet [CAHPS Hospital survey]," 2012) ("HCAHPS fact sheet [CAHPS Hospital survey]," 2012) . This survey tool measures communication with nurses and doctors, responsiveness of hospital staff, management of pain, communication about medicines, discharge information, cleanliness and quietness of the hospital environment,

overall rating of the hospital, and willingness to recommend the hospital to friends and family.

Two studies were reviewed that examined the relationship between patient satisfaction and nurses' perception of their work environment (Boev, 2012; Kutney-Lee et al., 2009). Whereas Kutney-Lee and associates utilized the HCAHPS survey, the tool utilized in the study by Boev (2012) was unique to the adult critical care units where the study was conducted. This particular tool had not been tested for psychometric characteristics and had only been used in this one setting.

The nurses' perception of their practice environment was measured by means of the PES-NWI in both studies. The study by Boev focused on the scales related to staffing and resources, leadership, participation and foundations of quality care. Although one scale (nurse's perception of the nurse manager) was significantly related to patient satisfaction ($p=0.18$) there was no relationship between the composite score and patient satisfaction.

This was contrary to that of Kutney-Lee and associates who were able to show that the nurses perception of their work environment measured by the PES-NWI composite score was significantly ($P<.001$) related to all ten measures of the HCAHPS patient satisfaction survey. The subscale of quality of work environment also showed a significant (<.001) positive association with patient satisfaction for nine of the ten measures. The results of this study suggested that improving the nurse's work environment in the hospital could result in improving patient outcomes including better patient experiences.

**Culture of Safety**

The concept of a culture of safety considers group values, attitudes, perceptions, competencies and behaviors influencing performance of organizations with respect to safety

(Nieva & Sorra, 2003). Organizations with a positive safety culture are characterized by mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventive measures (Nieva & Sorra, 2003). The literature continues to support the notion that an organization's culture and related climate play a large and important role in the manifestation of disruptive behaviors at work (Hoel & Sheehan, 2011).

The Joint Commission (TJC, 2005) determined the importance of a culture of safety in the quest for safe, quality patient care with a resultant decrease in medical errors. The presence or absence of a relationship between culture and organizational performance (e.g., medical error occurrence) has been reported in the patient safety literature (Clarke, 2006). Rosenstein (2008) found that disruptive behaviors have been shown to have a negative impact on work relationships, team collaboration, communication efficiency, and process flow, all of which can adversely affect patient safety and quality of care.

Organizations have proposed strategies to improve communication between healthcare professionals at the point of direct patient care (Martin & Hemphill, 2012; Rosenstein & O'Daniel, 2008; TJC, 2008) Strategies to prevent these behaviors from occurring involve leadership commitment and development, education of all team members on communication, collaboration and relationship building, development of policies and procedures to guide staff in their decision making and most importantly, development of a code of conduct that establishes the foundation for behaviors in the organization. Martin and Hemphill (2012) and Reiter et al. (2012) focusing on the problem of disruptive behaviors from a physician viewpoint, proposed strategies for dealing effectively with physician colleagues whose behaviors were not consistent with professional standards, policies or practices.

Conclusions made by Rosenstein (2008) included a need for organizations to recognize the full impact of disruptive behaviors, hold individuals accountable for their behavior, and provide training and support not only to reduce the incidence and consequences of disruptive events but also to improve efficiency of communication and team collaboration in an effort to improve outcomes of care.

**Summary**

The goal of this research is to answer the question, "How do nurses working in the inpatient hospital setting describe experiences with behaviors that compromise a healthy work environment?" Approaching the research question qualitatively contributes to the gap in current literature by providing the opportunity for individual nurses to share their experiences in their own words. The methodology as presented in the next chapter facilitates the understanding of the structure of the organization and the processes employed in the provision of patient care. The methodology will further determine from an organizational perspective the presence of disruptive behaviors in the work setting and establish how these conditions and behaviors could potentially contribute to nursing retention and turnover.

# CHAPTER THREE – METHODOLOGY

This chapter will describe the methodology that was used to carry out this research. It will include a description of the context of the research, determination of the case which is the focus of the study, the sample selection, data collection and analysis, limitations of the methodology used, and a summary of the process.

I chose the case study for the design of my research. The case study is a research strategy which focuses on understanding the dynamics present within single settings (Eisenhardt, 1989) and how some factors can interact differently and have different consequences in different cases (Sandelowski, 1996). The case study enables the researcher to gather data from a variety of sources and converge the data to contribute to an enhanced understanding of the case (Baxter & Jack, 2008; Stake, 2005; Yin, 2003). It can be conducted using either quantitative or qualitative data.

The choice to conduct this study using qualitative data facilitated the examination of the phenomenon of disruptive behaviors within the context of the hospital setting. It is important to understand the personal significance of these behaviors to the nurses that work in that environment, how their understanding influences their behavior when confronted with these situations, and how the events or meanings are shaped by the context in which they occurred (Maxwell, 2013; Sandelowski, 2011).

## Selection and Description of Case

This research was conducted in a 256-bed hospital located in the Rocky Mountain region of the United States. Important to this research is the fact that this hospital is a nationally recognized leader in establishing and maintaining a culture of patient safety ("Quality awards and recognition - A reflection of our commitment to excellence," 2015).

The nursing department which employs approximately 500 nurses has been designated a magnet organization which recognizes healthcare organizations that promote nursing excellence and quality patient outcomes, while providing care in a safe, positive work environments (ANCC, 2014).

This hospital provides tertiary level of care to 107,000 local residents and is a referral center for outlying rural healthcare facilities. The total service area of the hospital consists of 40 counties in two adjoining states, encompassing 121,000 square miles with a population of approximately 545,000. This service area is very rural (approximately 4.5 people per square mile) compared to the nation as a whole (approximately 79.6 people per square mile; Anonymous, 2010).

**Description of Sample**

Critical to the case study approach is determination of the unit of analysis (Baxter & Jack, 2008; Miles & Huberman, 1994; Sandelowski, 2011; Yin, 2003). The unit of analysis of this study, determined through the development of the research questions is nurses who were employed at the facility at the time of the study.

Purposive sampling was the method used to satisfy predetermined boundaries of the data collection. The goal of purposive sampling was to achieve representativeness of the individuals selected, yet capture the heterogeneity in the population (Maxwell, 2013). To meet those goals, the nurses invited to participate in the interview process satisfied the following criteria:

1. Staff nurses who worked in a nonsupervisory position providing direct patient care or,
2. Nursing leaders who either directly or indirectly supervised the staff nurses and,

3. Work in the inpatient setting at the organization on one of the seven identified units: medical/surgical (3), critical care (2), and maternal/child (2) without regard as to years of experience, number of hours a week worked, or shift worked.

The goal was to interview at least two staff nurses, one clinical coordinator, one nurse manager, and the responsible director for each inpatient nursing unit. This sampling would include a minimum 14 staff nurses, seven clinical coordinators, seven nursing managers, and three directors in addition to the nurse executive of the organization (Table 1).

Table 1

*Purposive Sampling Grid*

| Nursing Unit | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Chief Nursing Officer | | | | X | | | |
| Director | | X | | X | | X | |
| Nurse Manager | X | X | X | X | X | X | X |
| Clinical Coordinator | X | X | X | X | X | X | X |
| Staff Nurse Days | X | X | X | X | X | X | X |
| Staff Nurse Nights | X | X | X | X | X | X | X |

**Data Collection**

Planning for data collection involved identifying a contact person at the organization. The nurse scientist of the organization provided guidance which facilitated the acceptance of the project. As chairman of the Nursing Research Committee in the organization, the nurse scientist coordinated the presentation of the research proposal to the hospital Nursing Research Committee on two separate occasions for input on the design, sample, and collection of data. Revisions were made to the proposal based on feedback prior to submission of the proposal to the dissertation committee. These revisions focused on clarification of the research question and revisions to the research design.

Subsequent to feedback and approval of the research proposal from the dissertation committee, the study was submitted to and approved by the Institutional Review Board (IRB) of both Fielding Graduate University (Appendix A) and the IRB that supports the organization (Appendix B).

Once final revisions were made based on feedback from the IRB, the research study data collection commenced. The data collected were twofold: semi-structured interviews and review of organizational documents.

The goal of the interviews was to explore how nurses and nurse leaders working in a hospital setting described their experiences with behaviors that had a negative effect on their work environment. The development of the interview schedule (Appendix C) was aimed at establishing a baseline as to what behaviors would compromise that work environment and whether any of those conditions as verbalized by the interviewees existed in their work environment. Interviewing staff nurses provided an understanding of the phenomenon from the individual perspective. The managerial and/or leadership perspective was realized through interviews of the nurse leaders.

The second part of the data collection involved review of documents which provided insight into the organization structure and expectations that supported the provision of patient care (Appendix D). The intent of this review was to determine how the organization defined and communicated expectations related to behaviors of the employees and medical staff, how they defined disruptive behaviors, and how the organization managed occurrences of these behaviors. The review of the aggregated reports described in Appendix D provided outcome data related to patient and nursing outcomes. This data provided the researcher with an additional source to determine the existence of disruptive behaviors in the organization.

A letter of invitation to participate was developed and submitted to the organization for review (Appendix E). Due to union negotiations that were ongoing at the time, the letter was revised at the request of nursing leadership, eliminating the call for participation of only those who had or were experiencing these behaviors. The revised invitation was distributed through email to each unit manager and placed on each unit bulletin board by the organization's nursing research office (Appendix F). Potential participants were instructed to contact the researcher directly through email or telephone.

Upon receipt of email or telephone responses from the staff nurses and nursing leaders, a copy of the consent to participate (Appendix G) was provided. This consent included information about the potential risks, benefits, and actions by the researcher to ensure confidentiality of the information gained through the interview process. The consent also included contact information of the researcher as well as the IRB should they have further questions. If the interview was conducted face-to-face, the consent form was explained and signed prior to the start of the interview. For interviews that were conducted telephonically, a copy of the consent was sent electronically with instructions to return via email a statement attesting to the understanding of the contents and conditions of the study prior to the scheduled interview.

Interviews were scheduled at a mutually determined place, date, and time. The interviews were conducted from 15 December 2014 through 15 May 2015. Each interview lasted from 30-75 minutes. Three interviews were conducted on site and the remaining 16 were conducted telephonically. Telephonic interviews have been debated in the literature as to quality of data collection (Novick, 2008). Novick (2008) found few research reports on the pros and cons of telephonic interviews. The preponderance of telephonic interviews reflected

the preferences of those participating because of personal time and work schedule and the flexibility of location for both the researcher and the participant. Demographic information was collected at the beginning of each interview. At the conclusion of each interview, participants were given a $10 gift coffee card in appreciation for the time spent on the interview. Follow-up contact through email was initiated as needed to clarify content of the interview.

**Pilot Study**

The first four interviews were conducted as a pilot study to test the interview process. This included an evaluation of the interview questions, the order in which the questions were asked, and the logistics of conducting the interviews. Two nurse managers and two staff nurses were interviewed for the pilot study, three of which were conducted over the telephone. Digital recording equipment and processes proved unreliable which was the most valuable lesson learned from the completion of the pilot study.

It was also determined that the order in which the questions were asked was important to the flow of the interviews. Asking open-ended questions that gave the nurses the opportunity to talk about their work environment instead of the ideal work environment set the tone for the interview. This order also facilitated the sharing of information as to how the behaviors make the individual "feel," a key component of why I chose to do this study.

The initial intent of this study was to examine the communication between nurses. It was evident from the interviews completed during the pilot study that nurse to physician communication was as important to the nurses interviewed as the communication with their nurse colleagues. Therefore, the relationships between nurses and physicians were added to the interview schedule and the research question was revised to reflect this change.

The pilot study also tested the use of the same questions for staff nurses and nurse leaders. Even though it was decided to minimize the differences between the staff nurse and nurse leader questions, there were differences in the slant or way to ask the same question in order to determine the leadership perspective.

**Data Analysis**

Thematic analysis was used to identify, analyze, and report patterns in the qualitative data obtained during this research (Braun & Clarke, 2006). This method was appropriate because it considered the data from a very broad perspective (interview transcripts, organization documents, and memos created throughout the process) to discover patterns and develop themes (Maxwell, 2013; Miles & Huberman, 1994). This allowed the reporting of experiences, meaning, and realities of the participants as shared during the interview process and the convergence of data from other data sources.

The first phase of thematic analysis, which started with the first interview, was to become familiar with the data (Miles & Huberman, 1994). To document my reactions, impressions, and resurfacing of my own experiences that were triggered during the interview process, a memo was created for each interview. The digital recording was then reviewed and a verbatim transcript was produced. In order to ensure confidentiality, the names of the participants and their respective nursing units remain confidential. Transcribing the interviews facilitated connection with the data and initiation of data analysis. Repeated active reading of the transcripts and memos throughout the data collection facilitated the search for patterns and meanings. This was important to the process due to the reflection that took place as the data were continually reviewed.

The coding process commenced with transcription of the interviews. Breaking down the interview data to the most basic information was necessary to identify repeated patterns of meaning contained in the transcription (Braun & Clarke, 2006).

Once codes were generated, they were grouped and displayed which is a key activity of the analysis of qualitative data. This process supported the research by presenting organized, compressed information that permitted conclusion drawing and action (Miles & Huberman, 1994). Themes were identified and then reviewed to ensure there was clear, identifiable distinction between the themes.

The interviews generated data from two perspectives: the staff nurse and the nurse leader. Reviewing the codes from each perspective was important to determine the presence of absence of congruence. For instance, initially the codes were sorted by position of the nurse in the organization: staff nurse or nurse leader. This was important to determine differences in responses to identical questions. It was determined that there was overlap in the grouping of codes when sorted in this manner. The codes were then regrouped regardless of source of the information and reviewed again for clarity and identifiable distinction between them. It was important to determine how well they fit together and the overall story told (Braun & Clarke, 2006).

The themes were then defined and named. The process of review, refinement, and defining the themes ensured that the essence of the data had been captured (Braun & Clarke, 2006; Maxwell, 2013). Once the themes were determined, data extracts from the text that supported each theme were connected with the appropriate theme. These verbatim extracts reflected the nurses' experiences consistent with the research question. This brought the data into context and reestablished the relationship among the elements of the text (Maxwell,

2013). It is at this point that analysis of the themes and interpretation of the significance commenced

The analysis of data utilizing thematic inquiry is not linear. Data collection and analysis are occurring simultaneously and involve moving back and forth between the data, codes generated from review of the data and analysis, coded extracts of the data that are being analyzed, and analysis of data that are being produced (Braun & Clarke, 2006; Miles & Huberman, 1994). This contributes to the rigor of the analysis process.

Throughout the process of this research, strategies were implemented to strengthen the validity and enhance the overall trustworthiness of the data and final report. These included triangulation, reliability between interviews, and management of the potential of researcher bias.

Triangulation is using multiple perceptions to clarify meaning, verifying repeatability of an observation or interpretation (Stake, 2005). This research included interviews and organizational documents as the data sources. The interviews were designed to document multiple perceptions. Job positions held by nurses (CNO, Directors, Managers, Clinical Coordinators, and Staff Nurses) enhanced the representativeness of the data. The convergence of the analysis of interview data and conclusions from the review of documents provided by the organization contributed to the understanding of the phenomenon of behaviors that have a negative effect on their work environment.

The consistency in the interview process was pivotal to the outcome of the research. Digital recording and verbatim transcription of the interviews, creation of a memo at the conclusion of each interview, and adhering to the interview schedule contributed to the reliability of the interview process. Even though probing questions were used to gain an

understanding of what the specific responses meant to the participant, the interview schedule guided the interview process. Because it is very common for nurses to change settings for personal and professional reasons, they might bring in comparisons from other settings. This being a potential limitation, care was taken by me to clarify that the experiences that were described were in the organization where currently employed.

Researcher bias was a general threat to the validity of the study results. It was important to understand how my values and expectations may have affected the processes or outcome of the research (Miles & Huberman, 1994). As a nurse with over 40 years of experience, I have been a staff nurse, nurse leader, CNO, and most recently, a surveyor with a national hospital accreditation organization. In order to minimize the influence of my experience on the interview process, I was identified only as a nurse who is working toward a PhD. Because of the personal significance of this topic, documenting my impressions, biases, conclusions, and understanding how I am influencing what the participant said was an ongoing priority (Maxwell, 2013). This self-reflection during the course of this topic of research facilitated the integration of my personal, professional, and philosophical awareness (Bentz & Shapiro, 1998) and contributed to the process of data analysis.

The generalization of this research is not meant to be transferable across organizations or the healthcare industry. It is appropriate only for the audience to view the findings as fitting or applicable to their own experience (Sandelowski, 2011).

**Summary**

This chapter presented the methodology for this study that included the design of the study, sample and setting, data collection procedure, and a description of data analysis process. An assumption of this research is that studies continue to support the notion that

organizational culture plays a large role in the management of disruptive behaviors. The purpose of this study is not to analyze the culture of the organization but to explore the experiences of nurses with behaviors that compromised a healthy work environment.

# CHAPTER FOUR – FINDINGS

This chapter will present the findings of this study. The research was conducted to determine how nurses working in a hospital setting described their experiences with disruptive behaviors that compromise a healthy work environment. The data collection was twofold: (a) semi-structured interviews of staff nurses and nurse leaders and (b) review of documents that established the context of the organization in which the interviews were conducted and the framework for identifying, managing and preventing the behaviors.

## Demographics

Nineteen interviews were conducted which included 11 staff nurses and 8 nursing leaders. The sample of nurses interviewed was consistent with the roles of nurses according to the purposive sampling grid. Table 2 compares the proposed sampling grid and the actual sample of participation.

Table 2

*Interview Participant Sample Grid*

| Nursing Unit | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Chief Nursing Officer | /----------I----------/ | | | | | | |
| Director | /-------X-------/ | | /----------I----------/ | | | /-------I-------/ | |
| Nurse Manager | I | X | X | I | I | I | X |
| Clinical Coordinator | X | X | X | X | I | X | X |
| Staff Nurse Days | I(R) | I(R) | I | I | I | I(R) | X |
| Staff Nurse Nights | I(R) | I | X | I(D) | I | I | X |

Legend: (I) indicates nurse participated in interview. (X) indicates positions that did not participate in interviews. Staff nurse cells with (R) indicates nurses that rotated between days and nights.

Variation occurred with the participation of nursing units and number of participants from each nursing unit according to the sampling grid. The number of nurses that responded to the invitation letter and subsequently participated in the interview process was a concern. Although 50% of the eligible nursing leaders participated, the 11 staff nurses interviewed

represented less than 4% of the staff nurses assigned to these six units of which there were no males who participated. There were also nurses that responded but never followed through on the process to participate. One of the inpatient units was not represented in the study except for the director over that particular unit despite multiple attempts to recruit nurses from that area.

Demographically all but one of the nurses was female ranging in age from 22 – 59 (mean age = 40.12). The years of experience as a nurse ranged from 6 months – 38 years (mean experience = 16.4). The length of time employed at the organization ranged from 4 months – 25 years with the length of time in their current position ranging from 3 months – 25 years. Of the staff nurses, four worked permanent day shift (0700-1900 hours), three worked permanent night shift (1900 – 0700 hours) and four rotated between days and nights).

Table 3

*Demographics of Research Participants*

| Demographic | Nurse Manager | Staff Nurse | Demographic | Nurse Manager | Staff Nurse |
|---|---|---|---|---|---|
| Sex | *N*=8 | *N*=11 | Nursing Experience (Yrs) | *N*=8 | *N*=11 |
| Male | 1 | 0 | 1-5 | 1 | 4 |
| Female | 7 | 11 | 6-10 | 1 | 2 |
| | | | 11-15 | 1 | 1 |
| Age | | | 16-20 | 2 | 1 |
| 21-30 | | 5 | 21-25 | 1 | 3 |
| 31-40 | 3 | 0 | >25 | 2 | 0 |
| 41-50 | 3 | 5 | | | |
| 51-60 | 2 | 1 | | | |
| Basic Nursing Degree | | | Length at Org (Yrs) | | |
| ADN/ASN | 4 | 4 | <1 | 1 | 1 |
| BA/BSN | 4 | 7 | 1-5 | 1 | 7 |
| | | | 6-10 | 1 | 1 |
| | | | 11-15 | 2 | 1 |
| | | | 16-20 | 1 | 0 |
| | | | 21-25 | 1 | 1 |
| Current Nursing Degree | | | Time in Position (Yrs) | | |
| ADN/ASN | 0 | 2 | <1 | 1 | 3 |
| BA/BSN | 4 | 7 | 1-5 | 2 | 5 |
| Med/MSN | 4 | 2 | 6-10 | 2 | 1 |
| | | | 11-15 | 0 | 1 |
| | | | 16-20 | 0 | 0 |
| | | | 21-25 | 1 | 1 |

**Document Review**

Documents were selected to establish a foundation as to the context of the organization prior to the interviews. Due to the difficulty in acquiring the documents, the review of and conclusions made as a result of the review were completed as the documents became available.

The documents reviewed that determined the structure of the organization included the mission, vision, and values of the organization; the strategic plan of both the organization and the nursing department; the overall organization chart as well as that of the nursing department and policies that established the behavioral expectations and guided the organization in the identification and management of behaviors that were not in compliance with the code of conduct.

The second group of documents reviewed was outcome reports that resulted from the relationship of processes and structure of the organization. These included a nurse satisfaction survey; cultural assessment survey; report of nursing metrics such as turnover, vacancies, and staffing levels; and patient satisfaction survey. It is important to note that it was not the intent of the study to determine relationships or correlations between the documents or results of the surveys. The data presented are for the purpose of describing results that were collected and analyzed during the time frame of the data collection for this study.

The data on patient satisfaction were reviewed. The feedback from patients remained consistent during the time frame of the data collection. The organization met their goals in both the area of an overall stay rating and whether those that responded to the survey would recommend the hospital to family and friends.

**Determination of Themes**

The coding and analysis of groups of codes from the data resulted in the identification of three themes. These themes reflect the nurses' expectations of a healthy work environment as well as descriptions of behaviors experienced by the nurses in their actual practice environment. The subthemes which emerged from the analysis of data reflect the nurses' description of the inconsistencies in practices that they encountered on a daily basis that influenced the presence of disruptive behaviors. The three themes with the respective sub-themes are

1. Communication that supports collaborative relationships between health care professionals.
    a. Inconsistency in relationships between nurse colleagues
    b. Inconsistency in relationships between nurses and physicians
2. Leadership that is visible and accessible and supports the work of the direct care providers.
    a. Inconsistency in individuals being held accountable for their behaviors
    b. Inconsistency in communication and evaluation of the organizational expectations.
3. Available resources are utilized to support safe, quality patient care.
    **a.** Inconsistency in nursing role delineation, preparation, and performance

**Theme #1: Communication that supports collaborative relationships between health care professionals**

Discussions of the expectations of a healthy work environment with the participants focused on relationships which were dependent on communication, collaboration, and support of each other. These communication preferences were important regardless of the

role or position of colleagues in the organization. In general, the characteristics of relationships that were important to nurses and nurse leaders were described as collaborative, being able to speak up without fear, able to resolve conflict between those involved respectfully, mutual trust, approachable physicians, supportive, team-oriented, feeling connectedness and open, honest, and respectful communication. These characteristics were reflective of the organization's mission, vision and values, and service expectations.

A staff nurse summarized the environment and relationships on the nursing unit where she worked when queried about a healthy work environment.

> I like our floor; we have good rapport amongst each other; we get to know each other; we are helpful; if a nurse needs something, another nurse is there to help them out; we are adaptable; if assignments need to change because of admissions or discharges, we adapt to it.

Teamwork and collaboration were values that were openly discussed. Teamwork was described as having coworkers that offer to help when not busy, that help others who are struggling, that speak up on colleagues' behalf, and that bring out the best in each other. Collaboration was described as "dedicated people trying to do the right thing," "meaningful, thorough, and accurate handoff between nurses. One staff nurse in discussing a healthy work environment summed up the importance of collaboration:

> One in which effective communication between doctors and nurses, therapists, pharmacists, dieticians, receptionist and aides.… All staff, everyone knows what is expected, knows the plan and works together to coordinate that and get it done.

Two surveys were reviewed that included measures of organizational teamwork and communication: the Nurse Job Satisfaction Survey and the Culture Assessment Survey. The results of the Nurse Job Satisfaction Survey which was conducted in 2013 (Appendix D), were congruent with the feedback received from those interviewed. Both nurse-to-nurse

interactions and teamwork between coworkers scored greater than 60% which was considered high satisfaction by the organization.

While the results of the nursing satisfaction survey were reported in 2013, the Cultural Assessment Survey was administered and resulted within 3 months of the interviews. The survey instrument used to assess the organization for a culture of patient safety was the Safety Attitudes Questionnaire (SAQ; Appendix D). The results were reported as teamwork climate score and safety climate score.

According to the executive summary of the organization's survey results, teamwork climate was the perceived quality of teamwork between personnel within a given unit. A low teamwork climate stemmed from persistent interpersonal problems among the members of a given unit. When teamwork climate was low, employees felt that their coworkers were not cooperative, that their voices were not heard by management, and that their efforts were not supported.

In 2014, 12 hospital departments were in the danger zone (<60%) for teamwork climate compared to 6 in 2012. Of those six, three were identified as in danger in both surveys. One half (six) of the departments did not improve over the past 6 years. This result was contrary to feedback from the nurses; anecdotally, the teamwork was strength of the individual nursing units. Of the six units that participated in this research, three were included in the departments in the danger zone for teamwork

The safety climate represented frontline workers' perception regarding the level of commitment to and focus on patient safety within a given unit. Results reflected the degree of consensus of frontline assessments of patient safety norms and behaviors within a patient care area. The results of the safety climate were much the same as the teamwork climate; in

2014, eleven hospital departments were in the danger zone compared with five in 2012. Of the eleven that were in the danger zone, only two were in the danger zone in 2012. Three of the six nursing units that were represented in this research were in the danger zone for teamwork climate (<60%). Four of the six nursing units were in the danger zone for safety climate (< 60%). Of concern was that three of the six units were in the danger zone for both teamwork and safety climate.

The organization climate at the time of the survey was quite different in 2014 than when the nursing satisfaction survey was conducted in 2013. According to feedback from staff nurses, nurse leaders, and the CNO, new facilities had been opened, staffing was unstable due to changes in occupied beds, and the nurses' union contract was going through negotiation.

When considering the results of the surveys in relation to the interview data, the safety culture and teamwork experiences were affected by stressors present in the organization. The conditions that were present in 2014 at the time of the administration of the Culture Assessment Survey were improved by the time frame of the interviews for this research.

**Subtheme #1a: Inconsistency in relationships between nurse colleagues**

The desire for consistency in how nurses relate to each other was evident from the interviews. These inconsistent behaviors characterized those as described in the literature as disruptive behaviors. The nurses were able to articulate, from both a hypothetical perspective and the reflection of actual experiences of disruptive behaviors, how inconsistent behaviors affect their practice. The disruptive behaviors that were voiced included gossip, intimidation, blaming, yelling, complaining without offering solutions, leaving coworker feeling

disrespected, brushing off concerns when asking for clarification, receiving inaccurate report on handoff, being talked down to when given information, or being discouraged from asking questions. Nurses that experienced these behaviors felt inadequate, unprofessional, disrespected, and incompetent.

> Coworker nurse that I know is tough to work with … she prides herself in being difficult because she has gotten a benefit from it in the past. But it is not pleasant … When I am on a project with her… I think great. She has been here a long time. She has a lot of pull.

The stress of working with colleagues who were not consistent in their behavior was voiced by many of the nurses. Significant is the actions taken by nurses when treated disrespectfully. Some just "blew it off because it happens a lot." This coping mechanism was common to those interviewed that had been put in this situation.

> Have to put it aside no matter what it is, even if it is something that you didn't do right … You have to continue to be professional regardless of how that prior shift went.

> Personally, I just kind of soak it in and go on with my day; I am a very internal person and try …. I am there to get my job done and do the best I can do and therefore have to make the best of the team players that I have for the day. And to respond in a manner that would be confrontational would only make my day worse for the rest of the shift.

Relationships with nurses in other departments were also described. The goal was for thorough, respectful communication between nursing units. Examples were voiced that did not reflect this respectful communication.

> Between nursing in other units, there are specific nurses to look out for. Getting transfers, no communication; ask for clarification – nurses are crabby, rude, short and make you feel stupid.

One example described a situation that a member of another department did not feel respected by the charge nurse of one of the nursing units included in the research.

> I was just talking to an EMT the other day that had dropped off a patient; the first thing that he told me was "I dropped off a patient the other day and that charge nurse was so rude." I think that sometimes those night nurses are gruff and can be short with other people; I think that they… they get the job done but I don't think it is warm and fuzzy with another unit. I know who he is talking about and she does come across that way quite often; I believe it went beyond warm and fuzzy but was not respectful.

The experiences that exemplified inconsistency in relationships and communication and seemed to affect the interviewee the most were those related to bullying. The intent of this research was not to contribute to the lack of consensus in the definition and labeling of constructs such as incivility, bullying, aggression, and horizontal violence but to learn about the concepts in the nurses' own words.

The description of the experiences which nurses considered bullying did exist in this organization. The term "bullying" was voiced in 6 of the 19 interviews. The sources of the bullying varied but all represented a "power over" relationship. The bully was in the role of charge nurse, nurse manager, staff nurse, specifically, experienced staff nurses in relationships with new nurses. A particular staff nurse described her experiences with being bullied by a charge nurse.

> Had a charge nurse that was bullying me; it was awful, an awful 10 years. She was really mean. She yelled at me, she talked behind my back. She nitpicked me a lot; I almost quit. The manager didn't take care of it; didn't do anything about it. I couldn't talk with her [the bully] because she was nasty. You can't communicate with someone that is mean when you are talking to them. The manager did nothing to coach her to keep her from doing this.

A second nurse shared her experience with bullying by a charge nurse in which she eventually left the nursing unit where this occurred:

> I had a charge nurse that … started to yell at me across the nurses' station about going to lunch. She yelled this across four or five people. Everyone just looked; it was awkward for everybody. [I felt] embarrassed, belittled, disrespected at a human level let alone at the professional level. She was a real bully and like she decided that it came to me that she did not like how I did my job …. She henpecked me until it was

> uncomfortable enough that I just moved on. She didn't talk to everyone that way; she definitely had a gruff manner about her but it just seemed to escalate; incidents like that. I decided that I had enough and left the unit. I went to the manager and he encouraged me to confront this individual. I didn't.

The long-term effects of low self-esteem and fear of going to work were apparent in the descriptions by the nurses that had been bullied. One nurse voiced how she continues to struggle with her confidence even though it has been 6 years since the resolution of the experience.

> It was over 6 months that I experienced little things; I felt put down, paranoid of things that she would fuss at me about; I remember avoiding her. It was embarrassing; it has lingered over a year and a half. She undermined my confidence in decision making in patient care on that unit; felt second guessed and not supported; scared to go to her to cover my patient for lunch; went to other nurses for relief. I am now more on the lookout for it [bullying]. I haven't spoken up; I still am not comfortable speaking up on someone else's behalf. …I don't want to jeopardize my position. It is not the culture of our unit to stand up for people as a group and say that it is not OK.

Bullying was also observed by others. The following example is that of a staff nurse who described the approach of the nurse manager and how staff members were bullied by this individual.

> Authoritative, dictatorship, by the book, lack of feeling, demeaning, regimented. One of his first interactions with one of the staff members… he started screaming to _____ in his office with the door open. Screaming, "You don't talk that way to me" …. And all the staff heard it

A second example is one in which the behavior was reported to and eventually observed by a nurse leader at the time.

> She had been here probably three years with three years of experience; thought she knew it all. Basically when she would work with the staff, in particular the oncoming or off going, she would be demeaning to them; she would yell at them; make them cry; in fact in one of her last interactions she did make one of the nurses cry during change of shift report; you didn't do this, you didn't do that. She wasn't a good fit and everyone recognized it. People were afraid to approach her, including management. Historically in talking with the staff, she was a bully, she basically bullied all the staff ---- demeaning, overpowering and intimidating to the staff.

The term bullying was used in an interview with a nurse manager pertaining to some staffing situations. When discussing behaviors of nurses on this unit, the nurse manager relayed this example of "bullying" of new graduate nurses that had occurred.

> The veteran staff did not appreciate when a new grad came to them. So you are a new grad, you come to me and ask me what you should do. I am going to give you my opinion what you should do. Some nurses are offended that the new grad would ask you then go ask someone else ---- They called it nurse shopping. The veteran nurses were short, snappy to the point where I had one new grad in tears telling me that she said she would never go ask for help from that nurse again.

The relationship with coworkers was pivotal to the provision of patient-centered care. The continued presence of non-teamwork-promoting behaviors was troublesome but coped with on an individual basis. The presence of bullying behaviors articulated by nurses exemplified the power relationships present with the practice environment.

**Subtheme #1b: Inconsistency in relationships between nurses and physicians**

The focus of this research was to describe behaviors experienced by nurses. Participants, when questioned about relationships with colleagues in the work environment, consistently responded with examples between nurses and physicians. The inconsistencies felt by nurses in their relationship with physicians depended on the department or specialty of the physician.

Positive words or phrases that were used to describe relationships with physicians included collegial, approachable, respectful, open and receptive to what we have to say, very thankful, and able to clarify concerns without conflict, and don't make you feel talked down to when giving suggestions. There were questions relating to the relationship between nurses and physicians on the Nurse Job Satisfaction Survey. The relationship between nurses and

physicians scored high in five out of six of the units: Nurse to physician interactions (58-67%) and "physicians appreciate what I do" (59-67%).

> I actually think it [nurse/physician relationship] is pretty good: They are approachable for questions one on one. Have good customer service. When we call on the phone with updates, never come across as if we had asked a stupid question or that we are wasting their time by asking the question. They are respectful of our expertise as nurses and value our opinion.
>
> When we work with hospitalists for instance, --- they are a breath of fresh air – very thankful, very respectful, and ask your opinion and listen to what you have to say.

The negative responses were isolated examples that focused on one or two service lines. The one unit that scored low (35% on interactions and 45% on physician appreciation) was the same unit that expressed the most dissatisfaction with relationships with physicians in the interview process. These responses described physicians that were non-collaborative, tunnel-visioned, and non-collegial. Specific behaviors described included don't say thank you, don't value our opinions, and are rude and abrupt. When asked for clarification of a staff nurse who used the term 'disruptive behaviors' in association with physicians, the nurse replied with "putting someone down" or "criticizing the nurse in a patient's room." The following describe the behaviors that were problematic for the nurses in their relationships with physicians.

> Physician was upset because his size of gloves was not available …. He was rude, abrupt, uncalled for. Felt unappreciated and it affected me the rest of the day.
>
> I approached him when he was on the unit. I asked him if there was any way he could enter his orders on the [required] form. He exploded on me. "Do you realize how complicated you are making us physicians' lives? And you are compromising my patient's care. I want them to have this [medication] and I can't give it because of this form" … and he walked away.

The expectation to be able to communicate telephonically with the physician without fear of getting yelled at was voiced by staff nurses and nurse leaders alike.

> I've had physicians get upset because they expect something to be done or changed and their communication was not clear; and so when I called to clarify, they got upset and snapped at me and came down on me and said, I said this and why didn't you do that. [They] were not open to why; after explaining, they were able to listen to me and say OK, I expect this to be done; now go do it.
>
> A physician was paged by the nurse; nurse was standing by the phone waiting for him to return the call. As she was standing waiting, saw a patient that was going to fall. She went to help the patient and missed the call from the physician; was yelled at by the doctor to the extent that it put the nurse in tears.

Nurses validated the importance of collaborative relationships with physicians. Working in an environment where colleagues displayed mutual respect and trust was critical to the provision of quality and safe patient care. Despite the fact that the incidence of non-collaborative relationships with physician was either infrequent or nonexistent in some departments, it created a practice environment that was stressful for the nurses.

**Theme #2: Leadership that is visible and accessible and supports the work of the direct care providers**

Staff nurses described their expectations that nursing leaders be fair, honest, respectful, and supportive and have strong interpersonal skills. It was important to those interviewed that leadership through contact with the nurses made them feel trusted and valued, understood what their work involved, and asked for feedback on issues that affected their work. Creating and maintaining a non-punitive environment was also an expectation of both nursing leaders and staff nurses.

Respect for work/life balance was important to both the staff nurses and nurse leaders. For the nurse leader this issue was a two-fold expectation: ensure work/life balance for their staff and be assured work/life balance for them in their roles as nursing leaders.

Visibility and accessibility of leadership whether it was their immediate supervisor, director, or the leadership of the organization were very important to those working at the bedside. According to most interviewed, the nurse leaders that were most accessible and visible were the clinical coordinator and nurse manager. To many this also included the work of the charge nurse who by job description was a staff nurse and not classified as a nursing leader.

The further away in the chain of command of the bedside staff that the leader served, the less visible were the leaders. In one department, the staff nurses did not know who their director was and infrequently saw the senior leadership. In yet another department, the staff knew who their director was but did not feel the support or the visibility of that position. One director who was new to her position was known by those she supervised, was visible, accessible, and supportive to those under her. Generally staff nurses and middle management (nurse manager, clinical coordinator) did not feel a connection with the senior leadership of the organization.

The concern over the lack of visibility of the CNO was inconsistent. If the staff members were on committees as part of shared governance or participated on hospital-wide committees, their exposure and relationship with the CNO was positive. Nurses that worked nights or rotated between days and nights were less apt to see the CNO.

> CNO ---um --- you know, I haven't seen much of her and I think I know what she looks like from hospital meetings ---- do not feel her presence.

> I physically saw CNO during contract negotiations for updates; that is the only time I have seen her.

The nursing director's perspective on the visibility of the CNO was much more understanding. The rationale for lack of visibility of the CNO was the span of control of the

position in the organization. The position of the Chief Nursing Officer is also the VP for Hospital Operations (Anonymous B, 2015).

> With her two roles, it is very difficult for her to make contact with the nurses. I think the staff do not know it because they do not see her. She has a job – it is too much. They don't see her and can't connect with her. She has a huge span of control. I do see the CNO more now that I am in a leadership position.

The results of the Nurse Job Satisfaction Survey reflected a high degree of satisfaction (>60%) with nursing management (clinical coordinator, nurse manager and nurse director). This was in contrast with the nurses' satisfaction with nursing administration (CNO) which was <60%. The items that measured the staff's satisfaction with nursing administration validated the feedback received around visibility of the CNO.

**Subtheme #2a: Inconsistency in individuals being held accountable for their behaviors.**

The most common expectation of a healthy work environment and a contributor to the perpetuation of experiences with disruptive behaviors was the importance of holding others accountable for their behaviors**.** Accountability was felt to be important not only from the leaders but also as employees in holding each other accountable. One of the service expectations of the organization addressed the behavioral expectation of personal accountability: "Accept the responsibilities of your job; adhere to policies and procedures; live the values of this organization and hold each other accountable to follow the service expectations." It is important to the nurses that the nurse leaders are relentless in holding their staff accountable for their behaviors fairly and non-punitively. Accountability to the staff nurse meant to communicate to the staff when problems were resolved. The staff nurses wanted to see results of the intervention either through a change in behavior, one-on-one feedback, or a change in policy

The perception that physicians were not held accountable for their actions was a frequent comment from staff nurses and nurse leaders alike.

> Some in [physician] groups think rules don't apply to them. Unfortunately not a strong enough leadership to say to them …. Seem oblivious to a team effort … want to do it their own way and this attitude is tolerated. Even other physicians know who can get away without following rules.

> There is not as much accountability for the physician staff …. Physicians are allowed to do things unacceptable and inappropriate like that and nobody … There wasn't any course of action to address it. I asked questions, "why did this happen? How did this happen? Why was he allowed to do this?" The answer was that "because he didn't want to and nobody makes him."

When disruptive behaviors of the medical staff were discussed, the interviewees were asked if any policy or code of conduct existed that guided them in the identification of the behaviors or the actions to take when they experienced these behaviors. There was no consensus from staff nurses or nurse leaders as to the existence of the policy, the contents of the policy, or education on the policy.

> Until recently with appointment of CMO [Chief Medical Officer], physicians did not receive guidance as to expectations of communication. If there is a physician discipline policy, it is not well known.

> I believe there is a code of conduct but having it enforced is another thing. Our unit has developed our own – everyone is expected to act in a professional way. The service expectations are the code of conduct for every employee.

Nurses who experienced disruptive behaviors by physicians did not have any knowledge of the organization's recommendations for course of action. One nurse shared that if the behavior involved a clinical issue, they would go to the charge nurse for help in resolving it. This nurse went on to say that she felt it didn't make a difference by going to the charge nurse or manager.

**Subtheme #2b: Inconsistency in communication and implementation of leadership expectations**.

In an effort to determine behavioral expectations of leadership there was considerable discussion about the service expectations. Staff nurses and nurse leaders expressed how the service expectations were perceived more as a customer service expectation. According to some staff interviewed, the education around the service expectations was focused more on customer relations and not much time was spent on how employees should behave or the consequences of noncompliance.

> During orientation and on an ongoing basis, service expectations which focus on patients [are discussed]. Have lost sight of staff and behavioral expectations. Nothing out formally to staff as to behavioral expectations and what happens if they are not followed. What kind of behaviors constitutes disruptive behaviors for instance?

During the review of the service expectations, it was determined that how the staff members were expected to treat patients, visitors, and fellow employees was explicitly addressed. This was contrary to the feedback received during interviews. The service expectations of the organization are based on the service promise: "We promise to obsessively and compassionately focus on exceeding the expectations of every patient/guest and fellow team member using the organizational services expectations as the road map" (Organizational Service Expectations Pamphlet, 2015, Appendix D).

The first expectation, internal service, expects employees to serve and care for coworkers as they would for patients and guests. It is here the behavioral expectations are laid out: "Treat our colleagues as professional through courtesy, honesty and respect. Encourage other peoples' work; praise whenever possible and make new staff members feel welcome." The second expectation articulated the behavioral expectations of personal accountability: "Accept the responsibilities of your job; adhere to policies and procedures; live the values of this organization. Hold each other accountable to follow the service expectations." The remaining seven expectations were more focused on the patient/guest.

The term “disconnect” was frequently used when participants were queried as to how the expectations of the organizational leadership were communicated to the direct care providers. This disconnect referred to the flow of information: Communication by the nurse managers of expectations to staff, communication flow from administration to bedside staff, and behavioral expectation communication evaluation to ensure everyone “walks the talk.” This disconnect was validated through comments by staff nurses, nurse clinicians, and nursing leaders.

> From the staff nurse perspective: I think it is highly disconnected. They do not understand the big picture when implementing new processes or policy changes. The bombardment of information and changes, and the attitude that we told you once and now we expect you to do it.

The disconnect felt by the staff nurse was confirmed by the nurse manager who is responsible for ensuring that information received by them in organization-level meetings were passed on to their staff in a meaningful way.

> We directors and managers go to meetings expected to carry the message to the unit-level staff. Need to improve how we close the loop in communicating information from the meetings.
>
> At times when there is a big initiative that the organization is getting ready to push out, there seems to be somewhat of a disconnect. There is so much information to trickle down to staff --- it’s hard to disseminate what’s really important. (Nurse Leader)

Depending on the nursing unit, there were examples of how leadership met the expectations of communication. One staff nurse responded how expectations were communicated in a timely manner.

> The information comes to us from our manager. We have standards of practice, councils, and different people in research teams, magnet, house wide council, and unit-level council. It filters from the top down.

Consistency was expressed as critical in the compliance with policy changes and standards of practice. Examples were given that implied a negative effect on the provision of patient care.

> There are some nurses that if you question them about what they are doing or what they have done, they get defensive … [She has] been a nurse for a long time and thinks she is always right; makes you feel stupid ---- I've been doing this longer than you. We have a lot of policy and procedures that are changed; some nurses are doing it as they have always been doing it and they are not going to change when there is evidence based to change it. Nurses that are doing it their way because that's the way they have always done it.

> One physician, it is a little rocky….we question, like. She doesn't follow policy or protocol for how early to induce or she will finagle it to make it look like it is medically necessary when it is not.

A requirement of an organization that is accredited by TJC is the development of a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety (TJC, 2015). This standard also requires that organizations create and implement a process for managing behaviors that undermine a culture of safety. The organizational documents required by this standard were very difficult to obtain primarily because of a lack of awareness of the existence of the policy and lack of knowledge of the content. Three documents were received: organization service expectations, policy on discipline/discharge, and a policy on reviewing and managing conduct.

The review of the content of these documents was important to determine the organization's behavioral expectations of their staff members and the plan for managing noncompliance with the policy. The service expectations were applicable to all employees. The policy on discipline/discharge outlined the management of employees. Exempt from this policy were medical staff, leadership, and union employees.

The policy on reviewing and managing conduct outlined the course of action when physicians displayed behaviors that were in violation of the policy. The behaviors that were identified were very general, specified as poor interactions with colleagues or staff, failure to follow a policy, and medical record issues. Even though the policy on conduct received was a medical staff policy, the CNO communicated that she had used the process identified in the policy to manage discipline and management of issues within the nursing department. This policy had not been consistently communicated to staff nurses and nursing leaders.

**Theme #3. Available resources are utilized to support safe, quality patient care**

Resources include the physical environment, supplies and equipment availability, staffing to support the needs of the patient, and staff education and training to ensure competent staff. One staff nurse summarized the expectations of a healthy work environment from the perspective of adequate resources:

> One which is clean, setup appropriately, equipment functioning; helps make the day go smoother; help adequate – extra hands if needed. If you need to be in another patient's room, then you have coworkers that can cover for you.

The importance of the physical plant, supplies, and equipment was noted but the priority subject of resources was that of people. Feedback on staffing considerations was multidimensional. Nurses' concerns included availability of adequate staff according to the acuity of the patient, clinically competent coworkers and clearly defined roles. Clinical competency of colleagues was not an issue with the nurses interviewed.

From a staffing perspective, the unavailability of help and inappropriate patient loads were the main concerns of an unhealthy work environment. Having to work with short staffing was described from the perspective of having coworkers that were unwilling to help,

coworkers that were lazy or not willing to "carry their own weight," and coworkers that did not want to be bothered, wanting to do their own thing.

> There was a nurse that was quite a bit older and had been a nurse obviously for a very long time. She liked to take care of her patients alone. She didn't care for having anyone else assist her. It wasn't so much a team effort on her part; her patients she was very possessive over, she was very busy and therefore wasn't available to assist other nurses.

Leadership's planning and oversight of staffing was important. Concerns voiced included management that keeps patient loads manageable; staffing that provides a balance of experience on each shift, and the preparation and identification of competent preceptors. The educational availability was a concern primarily from the night staff who felt it was difficult to attend offerings. It felt like there were not any efforts to accommodate or meet the needs of all staff. The content and quality of orientation for new staff nurses and the ongoing education was positively regarded.

A nursing outcome that has been reported to affect disruptive behaviors in the practice environment is nursing turnover. Nurses were asked if they were aware of coworkers that left their nursing unit or transferred between units because of these experiences with disruptive behaviors. While the literature supports the effects of disruptive behaviors on nursing turnover, the small sample size did not confirm this. The primary reasons for nurses leaving their units were family needs, spouse job change, and professional advancement. The nurses that had experienced bullying transferred within the organization or the "bully" left the practice environment. Two of the nursing units experienced a change of nurse managers within the year and a half prior to the interviews. There were isolated examples of nurses leaving due to their not agreeing with the changes in philosophy and expectations and being made accountable for their behavior. One nurse spoke about her intent to leave.

> I debate leaving every once in a while due to no follow through, people are not held accountable and the presence of lazy nurses and scary nurses.

During the course of the data collection, one of the nursing units was experiencing critical relationship issues between the nurse manager and the nursing staff. This situation did result in nurses transferring out of the unit because of nurse manager behavior and performance.

The data related to turnover and vacancy rate validated the perceptions of staff and nurse leaders during the time frame of data collection for the Culture Assessment Survey which reflected teamwork and patient safety. The effects of opening new facilities, shifts in staffing, and an increase in staffing needs because of an increase in bed capacity were evident in the nursing outcomes of vacancy rates and turnover rates. At the time of the Culture Assessment Survey the vacancy rate was 11.03% which is a twofold increase from June of 2014 and the turnover rate was 13.85% which was 3.5 % higher than that in June. Over the next 5 months the turnover rate decreased to 10.25% and the vacancy rate decreased to 8.28%. The nurses on staff were stable during this time frame.

**Subtheme #3a: Inconsistency in nursing role delineation, preparation, and performance**

Critical to leadership that is supportive to the bedside nurse is how nurses are prepared for their roles and how they perform those roles according to job expectations.

The variation in the role performance of the charge nurse was noted by staff nurses and nurse leaders. A nurse manager confirmed the inconsistency between charge nurses and the need for coaching to help them think critically. According to the staff nurses interviewed, there was variation in how charge nurses supported them in their work. There was an expectation of the charge nurse role; to physically check in with the nurses at intervals throughout the shift and inquire if there was anything they could do for them. According to

the staff nurses interviewed, there was variation in how charge nurses performed their job and supported them in their work.

> So when they don't seek us out and ask what they can do for us, I don't feel as supported by them. It's just a simple drive by and hi how are you doing. Some of them will really jump in and help; it is their job to keep everything working smoothly on the floor. Not just assign patients for the next shift.

> It depends on the charge nurse. The night shift have worked together for years and are friends outside work and when someone is not a part of the group working, they sort of get dumped on with patients.

A second role that was discussed was that of the nurse clinician who is responsible for the staff education on the individual nursing unit. From the perspective of the nurse clinician, there appeared to be incongruence between the job description, position expectations, and responsibilities of the nurse clinician. This position is considered a staff nurse by job description without supervisory responsibilities, yet perceived to be part of the leadership team. The resulting frustration is the complexity of the job which affects the work-life balance, as expressed by one of the nurse clinicians.

In one department, there was confusion as to the delineation of roles of the clinical coordinator and the nurse clinician. The clinical coordinator is responsible for the day-to-day management of the nursing unit. Staff nurses interviewed expressed that the roles were very scattered. "I think that whole role … there is not really consistent anything." The staff nurse expressed further that there was not a good definition and communication of the expectations of the people that they put in these roles. Confusion existed as to the decision-making authority of the roles and how they were different than the nurse manager. Leadership confirmed that there were issues with the two roles and the nurses filling them which contribute to the confusion felt by the staff nurses.

The preparation of nurses to fulfill the roles of nurse manager, clinical coordinator, and nurse clinician was a concern. A nurse in one of these positions commented, "We spend 12 weeks orienting a staff nurse with everything carved out for them. What about these people that come into higher level positions about their support of being oriented to the organization?" One clinical coordinator who had been in the position for months had received no orientation to the role. The nurse manager had failed to discuss the job expectations with her. When selected for the clinical coordinator position, her knowledge of the job was based on her personal experience as a staff nurse and the expectations of the job from that perspective.

**Conceptual Framework**

The relationship of the themes and subthemes as determined through thematic analysis fit into the conceptual framework of the structure-process-outcome (SPO) model as described by Donabedian (1988). Donabedian (1988) originally developed this model as an evaluation framework that supports a systematic inquiry into health systems. The model has traditionally proved valuable in examining the clinical processes and outcomes of care, explicitly linking the structure and processes of care to subsequent patient outcomes (Carayon et al., 2006).

The model is developed around three elements: structure, process, and outcome. The structure element includes the organizational structure, the material resources, and the human resources. It is seen as the responsibility of leadership to ensure the implementation of the structural elements designed to enable caregiving work processes and relationships that produce desired patient outcome. According to Donabedian the two other means of assessing quality include evaluating the processes of care and evaluating the outcomes of care. The

process element is the domain of those who use the work processes, relationships, and interventions to achieve quality patient care whereas the outcome element reflects the efforts of everyone from organizational leadership, unit leadership, and clinical staff. These outcomes are the results of structure and process that affect patient satisfaction, staff satisfaction, and most importantly, clinical outcomes.

The model is linear and unidirectional: Each component of the model is influenced by the previous component; outcomes are influenced by process, and process is influenced by structure (Donabedian, 1980). The model is limited in its recognition of the interactions and interdependencies among system components (Carayon et al., 2006). For instance, in order to interpret the patient and nursing outcomes, efforts must be made to understand the structure and processes in place that contributed to those outcomes. Once the outcomes have been realized, what changes to structure or processes are necessary to achieve the desired goals and outcomes?

The overall goal of every hospital or healthcare organization is to systematically develop and reinforce organization strategies, structures, and processes that seek to achieve quality patient care and employee job satisfaction (Kramer & Schmalenberg, 2008). This conceptual framework is appropriate to this study of disruptive behaviors in the hospital practice environment as it depicts the potential effects of disruptive behaviors on the practice environment, patient care outcomes and nursing outcomes.

A depiction of the integration of the themes and subthemes into the SPO model has been developed (Figure 1). The three themes are process elements and are reflective of the nurses' expectations of a healthy work environment. The structure element for this study is represented by the foundations of the organization: strategic plan, physical resources, human

resources, and policies that describe the performance expectations from leadership. The evaluation within this element involved discovering the contextual factors that were in place to minimize or eliminate disruptive behaviors.

The process component of the model is that which is most pertinent to the research questions which focus on experiences with disruptive behaviors. The subthemes represent the conditions in the practice environment that contribute to the existence of disruptive behaviors. Collaborative relationships were compromised by inconsistent communication between nurses and nurses and physicians. The perpetuation of the behaviors was attributed to the inconsistency of holding people accountable. The utilization of available resources was critical to nurses in accomplishing their goal of safe, patient-centered care but the inconsistency in the process of preparation and utilization of resources was an obstacle to this goal. The positive and negative outcomes depicted in the model are theoretical based on the available literature and not determined through the data collections and data analysis.

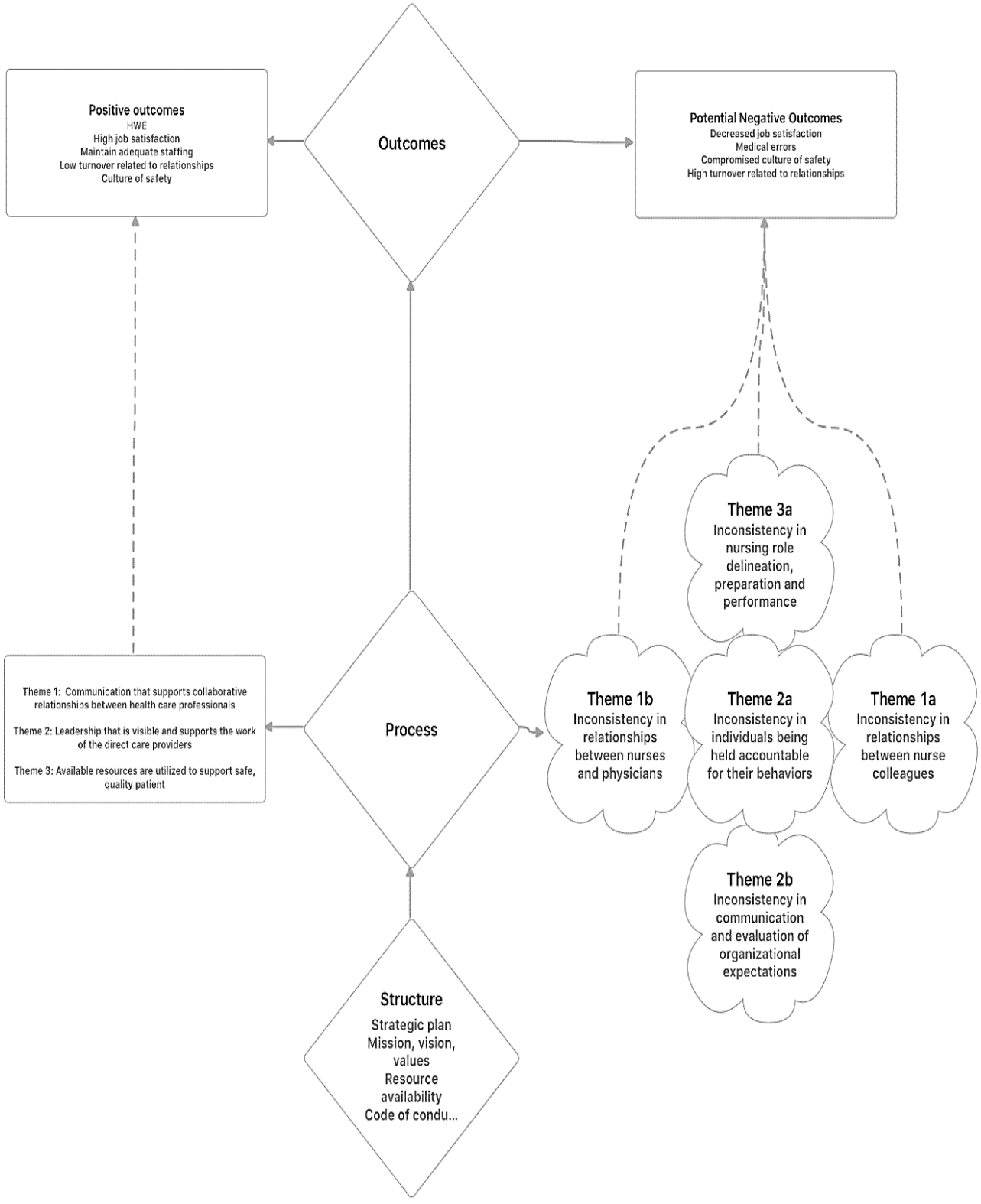


*Figure 1*. Depiction of structure, process and outcome incorporating themes.

**Summary**

The goal of this study was to examine the experiences of nurses in the hospital setting with disruptive behaviors. It was not the intent of this research to establish a relationship between structure and process or process and outcome. The findings of this research as depicted in the structure-process-outcome model, assume these relationships and offer possibilities for future studies. The focus of this study was on the processes in place that contribute to the existence of disruptive behaviors.

The results of the data analysis of this research suggest that disruptive behaviors exist in this organization as a result of non-collaborative communication, failure to hold staff accountable, and a breakdown in the communication of expectations from leadership. The commitment to provide patient-centered care by the nurses contributed to the manner in which they coped with the behaviors of their colleagues.

# CHAPTER FIVE – DISCUSSION, LIMITATIONS, and RECOMMENDATIONS

## Discussion

This study was undertaken as a case study to determine nurses' experiences with behaviors that compromise a healthy work environment within the hospital setting. Considerable attention was spent on exploring and understanding the presence of disruptive behaviors, how the nurses coped with the behaviors, and how their practice environment was affected by the behaviors. The literature has shown how these behaviors compromise a healthy work environment with eventual impact on nursing and patient outcomes (Rosenstein & O'Daniel, 2005; TJC, 2008). Comparing the actual experiences of the nurses' interviews with the concepts of a healthy work environment highlighted the positive and negative aspects of the work environment of these nurses.

Important to the organization's goal of clinical quality and a culture of safety was to maintain commitment to nursing excellence through maintaining designation as a magnet hospital. With this designation come expectations that are characteristic of a healthy work environment (AACN, 2005; ANCC, 2014; Kramer & Schmalenberg, 2008) . The nurses' expectations of a healthy work environment included four: skilled communication, true collaboration, appropriate staffing, and supportive nurse-manager relationships. These expectations were reflected in the themes, and the inconsistencies that were perceived by the nurses were reflected in the subthemes as described.

Disruptive behaviors did exist in this organization. Non-collaborative communication between nurses and physicians and communication challenges between nurses were described. Even though the nurses did not use the term disruptive behaviors to describe their experiences, the research and literature on disruptive behaviors is applicable to those

experiences as voiced by the nurses (Dellasega, 2011; Felblinger, 2009; Martin & Hemphill, 2012). The behaviors voiced could be termed incivility, relational aggression, horizontal violence, or verbal abuse.

There has been much research focusing on the lack of consensus in the use of labels when describing these behaviors (Bartlett & Bartlett, 2011; Embree & White, 2010; Hutchinson, Jackson, Haigh, & Hayter, 2013; Lamontagne, 2010).These efforts have diverted attention away from the effects of the behaviors on those that experience it in their work setting. When working to eliminate these behaviors from the work environment, the focus needs to change to how to prevent any behaviors that compromise a healthy work environment regardless of the label or categorization. In reality, how important are the subtle differences in incivility, intimidation, verbal abuse, and relational aggression? A shift needs to be made to focus on why they occur and what effects they had on the nurses and their colleagues. These behaviors are all non-team-promoting behaviors (Reiter et al., 2012). The power of this phrase summarizes the concern from nurses when colleagues, nurses, and physicians alike, did not communicate collaboratively.

Throughout the conduct of this study, it was obvious how the work of the nurses was affected by their relationship with colleagues and leadership that served to support them and their work. The disruptive behaviors that nurses experienced were less problematic than the inconsistency in how the behaviors were managed. It was important to the nurses that individuals who displayed behaviors that compromised the teamwork and patient care be held accountable for those behaviors. Holding all team members accountable for modeling desirable behaviors, and enforcing behavioral expectations consistently and equitably among

all staff members is key to eliminating disruptive behaviors in the practice setting (Hickson, 2007; TJC, 2008).

Despite the fact that the goal was not to validate or concentrate on bullying behaviors specifically, there were examples shared by the nurses. These experiences were consistent with the defining characteristics of bullying; the behaviors were repeated and persistent and directed towards one or more individuals (Leymann, 1996). There were long-term effects on the nurses and their professional practice. A most troubling fact that was shared was the nurses not feeling the support of leadership in holding the bully accountable for the behaviors. These individuals described how behaviors had been allowed to continue, how lack of follow through existed, and the unresponsiveness of leadership when these behaviors were identified.

New nurse managers also felt the consequences of nurses who had not been held accountable. They were confronted with nurses that "have always done it this way," were resistant to change, and didn't live up to the behavioral expectations of the organization. These situations put the nurse managers in an untenable situation by their predecessors. Failing to monitor for and address inconsistency in communication and clinical practice impacts the organizational goal of patient-centered, safe and quality patient care (Reiter et al., 2012).

There were examples where disruptive behaviors by physicians were dealt with once they were appropriately reported. This varied between nursing units depending on the culture established by the leaders of those units. The lack of knowledge of staff as to what disruptive behaviors look like contributes to the lack of appropriate reporting and their just "letting it go."

The themes that were identified reflected the nurses' expectations of their work environment to ensure safe, patient-centered care. Pivotal to meeting this goal was existence of a collaborative relationship with the entire team of healthcare providers. The coordination that occurs through high quality communication supported by shared goals, shared knowledge, and mutual respect enables an organization to achieve the desired outcomes (Gittell, 2009). This relationship has been studied as relational coordination which provides a research-based framework for managers to use to improve provider relationship, communication, and quality of care. Research has shown that relational coordination between nurses and other providers is significantly related to overall quality; increased relational coordination reported by nurses showed a decrease in adverse events (Havens, Vasey, Gittell, & Lin, 2010).

The collaboration was not only an expectation between nurses and nurses and physicians but also between the bedside care providers and their leaders. There has been extensive research in the role of leadership in creating and sustaining a healthy work environment (AACN, 2005; ANCC, 2014; AONE, 2005; Kramer & Schmalenberg, 2008, 2002).The leadership expectations that emerged from these interviews impacted the existence of disruptive behaviors. Through the interview process, nurses expressed how important it was to have leadership that is visible, accessible, and demonstrated through their presence an appreciation for their work. This is consistent with the literature which identifies visible leaders as a foundation of healthy work environment and a strategy for the elimination of disruptive behaviors from the workplace (AACN, 2005).

Power and a power differential have been known to contribute to the presence of disruptive behaviors. Literature has shown that coworkers are the most frequent source of

hostile workplace behaviors. (Bartlett & Bartlett, 2011; Einarsen et al., 2011; Felblinger, 2009; Hutchinson et al., 2006; S. Johnson & Rea, 2009). In workplace aggression literature, power has been operationalized as the position in the organization and occasionally as gender and race/ethnicity (Einarsen et al., 2011; Elias, 2008) .

Examples of disruptive behaviors and the specific experiences of bullying in this organization described by the nurses did have a balance of power component: charge nurse to staff nurse and experienced staff nurses to new nurses. These have been explained in the literature as examples of social power.

French and Raven identified at least five bases of social power: legitimate, reward, coercion, referent, and expert (Elias, 2008). Legitimate, reward, and coercion coincide with hierarchical sources of power. It is the base of referent and expert power that is applicable to coworkers as the source of workplace bullying. Expert power refers to influence that arises from someone having specialized knowledge or experience in a particular area, which is something coworkers and subordinates certainly can manifest. Referent power is influence grounded in one's likeability and connections to and positions within various social networks in the organization. Lower status individuals may enjoy positions of influence by virtue of their personality and their connections (Elias, 2008).

The nurses' expectations for consistency in leadership performance, visibility and communication of behavioral expectations, and accountability are supported by the theory of high reliability. High reliability is defined as persistent performance at high levels of safety over a long period of time (Chassin & Loeb, 2013). The assumption is that by focusing on a culture of safety, robust process improvement, and engaged leadership, medical errors will be minimized and eventually eliminated.

The characteristics key to establishing and maintaining high reliability are centered on people and their relationships; people who are helpful to and supportive of each other, who trust one another, and who have friendly and open relationships which emphasize credibility, attentiveness and personal trust (Ruchlin, Dubbs, Callahan, & Fosina, 2004). These characteristics must be modeled by leaders in the organization which include nurse and physicians in an effort to eliminate disruptive behaviors in the organization. The evolution of an organization becoming a high reliable organization requires assessing for trust and disruptive behaviors, developing a code of conduct, and implementing it throughout the organization to all staff (Chassin & Loeb, 2013).

The strategic operating plan which integrated the mission, vision, and values and the strategic initiatives structurally defined this organization. It reflected a goal of a culture of safety, collaboration, and teamwork. The literature continues to support the notion that an organization's culture and related climate play a large and important role in the manifestation of disruptive behaviors at work (Hoel & Sheehan, 2011). Disruptive behaviors might be better understood as an organizational process and within the context of organizational culture rather than purely as characteristic of individuals (S. E. Lewis & Oxford, 2005; Liefoogle & Davey, 2003) .

The ultimate goal in creating a healthy work environment and eliminating disruptive behaviors from the work environment is that of patient safety. A requirement of this organization's accreditation is that a culture of safety and quality must be created and maintained (TJC, 2015). Supportive to that requirement is that organizations develop a code of conduct that defines acceptable behaviors and behaviors that undermine a culture of safety and create and implement a process for managing behaviors that undermine a culture of

safety (TJC, 2015). Leadership is expected to enforce a code of conduct consistently and equitably among all staff. Policies that are specific to medical staff must complement and support the policy that is present for non-physician staff articulating how and when to begin disciplinary action (TJC, 2008).

Understanding these leadership expectations is important to this research because of the feedback that was received through staff interviews. The document review and interviews conducted provided a gap analysis of the particular organization's implementation of recommended strategies. As discussed earlier, it was very difficult to determine from the documents reviewed the inclusiveness and effectiveness of the code of conduct. It was very difficult to determine how and if disruptive behaviors were addressed because of the fragmented approach evidenced by the policies reviewed. This was confirmed by both staff nurses and nursing leaders that reflected a lack of knowledge of a policy that guides the physician behaviors and communicates the recommended course of action to the bedside staff.

Incongruence was identified between leadership expectations and reality as experienced by nurses. The nursing staff reported behaviors exhibited by staff and physicians that were not in alignment with the goals, mission, vision, and values of the organization. The leadership regularly monitored the effectiveness of the structures and processes in place by means of surveys that measured patient satisfaction, nurse job satisfaction, employee engagement, and safety cultural assessment. The effectiveness of the communication of mission, vision, and values and goals of the organization was reported to be measured through annual performance evaluations of their employees.

This organization was chosen for this case study because of its reputation as a leader in patient safety. The document that contributed most to the findings of this research was the Culture Assessment Survey (Appendix D) which measured the teamwork climate and the safety climate. Review of the executive summary provided by the organization revealed the pervasive decline organization-wide in the teamwork and safety culture scores over time. It was unclear the strategies employed in response to the information in these survey results in the past. A plan of action was outlined in the executive summary for 2015 which had not yet been implemented. One would question the sustainment of a culture of safety in this organization evidenced by the cultural assessment results as presented in these findings. This was unexpected due to the culture of safety that the organization purports to demonstrate and the industry-wide recognition as a leader in patient safety that the organization has received ("Quality awards and recognition - A reflection of our commitment to excellence," 2015).

**Limitations**

At the time that the planning for this research was being undertaken, the organization was in the process of renegotiating the nurses' union contract. The negotiation was lengthy and very difficult from the input from staff nurses, nurse leaders, and the chief nursing executive. Because of this situation, nursing leadership requested that the original letter of invitation (Appendix E) be amended. The amended letter (Appendix F) was much more general, focused on healthy work environments and "behaviors that compromise a healthy work environment." Eliminating the actual situations that were sought for this research potentially decreased the likelihood of recruiting nurses who had or were currently experiencing disruptive behaviors.

The descriptions of the experiences of the nurses were personal and vulnerable to the dynamic nature of their practice environment. In addition to the contract renegotiations, there were major changes that occurred within 6 months of the interviews that affected the nurses directly. The expansion and relocating into new facilities created staffing challenges for leadership. This was due to increases in census and changes in bed capacity in some areas with resultant high nurse turnover, vacancy rate, and resultant hiring of new staff. Two of the units experienced a change in nursing leaders within the last 2 years which created changes in philosophy and uneasiness for some of the staff interviewed. Relationships between the nurse manager and nursing staff in one of these two units resulted in staff leaving and the eventual replacement of the nurse manager prior to the completion of the data collection.

The original design of this study was to determine experiences between nurses. It was during the pilot study interviews that relationships between nurses and physicians were verbalized. Due to time and distance constraints, physicians or physician leaders were not interviewed. Their input would have contributed to the subject of disruptive behaviors from their perspective. Clarification of the organization's communication of behavioral expectations was lacking.

The conduct of the interviews telephonically was a potential limitation of the study. The participants were given the choice between a face-to-face or telephonic interview. Because of the distance to the participating organization, the majority of the participants chose to be interviewed over the telephone. This option increased the flexibility of time from the perspective of the nurse but eliminated capturing the nonverbal communication that could contribute to the topic of discussion. For some participants, the ability to be more open with a phone interview was possible. Although telephonic interviews have been debated in the

literature as to quality of data collection, few research reports have been published that have established pros and cons of this method (Novick, 2008).

**Recommendations**

This study was conducted to hear from nurses in their own words and stories related to behaviors that compromise a healthy work environment. The findings were consistent with the literature in that relationships that formed between team members is the foundation of trusting and supportive work of nurses at the bedside. There are opportunities for future research based on the results and conclusions of this research

This research was not designed to establish a causal relationship between behaviors and outcomes. Theory related to patient and nursing outcomes was presented to show potential consequences of the presence of disruptive behaviors. The outcome data that were reviewed as part of this research provided context to the interview data. A future study would be to focus on the relationship between structure and process, and process and outcomes as they relate to the presence of these behaviors in the organization is indicated.

Quantitative studies have concluded that disruptive behaviors are not just exhibited by nurses and physicians (Rosenstein, 2002). The problem is more pervasive. A future study would be to expand the interview process to include other healthcare workers that interface at the direct patient care level, such as housekeeping, patient care technicians, laboratory personnel, physicians, and other ancillary services.

There is also a need to determine the effectiveness of strategies that have been proposed to prevent, eliminate, or manage disruptive behaviors from the practice setting (Kohn et al., 2000; TJC, 2008). A void in the literature is determining the effectiveness of staff education on the prevention of disruptive behaviors in their work setting. Experts in the

field have called for more than education; it involves assessing the culture of the organization and not focusing solely on changing knowledge or behaviors of individuals (AACN, 2005).

Throughout the interview data, the role of power and power differential was evident. There lack research reports on the role of power in the existence of disruptive behaviors within the nurses' practice environment. Further research on power and how nurses perceive power as a factor in disruptive behaviors is warranted.

This case study looked at the concept of behaviors from two perspectives – staff interviews and review of documents. Adding another dimension to the data would have enhanced the data that were analyzed through the interviews and document review. The value of spending time in the organization and establishing a relationship with the nursing staff and leadership would serve to understand the culture of the organization and any dynamics that effect the provision of patient care.

This study did not identify a preponderance of nurses that expressed an intent to leave their employment at this organization due to the environment created by behaviors. Despite this fact, it was obvious from the review of literature presented for this study, the need for longitudinal studies of reasons for leaving and the actuality of leaving the employment.

**Summary**

This study was conducted to explore the existence of disruptive behaviors in the hospital environment by nurses. Hearing the nurses' first-hand experiences solidified the importance of this study to the delivery of safe and quality patient care. The themes that were generated were applicable to the structure-process-outcome model. The document review was pivotal to understanding the structure element. The themes reflected the process element of the model. Three themes were identified: (a) communication between care providers, (b)

visible leadership and (c) appropriate utilization of resources. Reflective of the processes in the organization, the themes served to describe how well the leadership and staff were in compliance with the expectations as set forth by the organizational leadership. The outcome element reflected the results of the structure and process that had potential effects on patient satisfaction, staff satisfaction, and clinical outcomes.

The primary research question was, "How do nurses working in the inpatient hospital setting describe experiences with behaviors that compromise a healthy work environment?" Nurses were not only able to describe their experiences but also articulated what they felt were characteristic of a healthy work environment. Their feedback included how their work environment compared. Disruptive behaviors were isolated events between nurses and between nurses and physicians. The nurses' desire for visibility of leadership, consistency in communication, and consistency in holding others accountable were the most important findings of this research. The focus on the performance of leadership that emerged in this research was unexpected but consistent with the literature. Focusing efforts on the prevention, identification, and elimination of these behaviors by leadership needs to be the priority.

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# Appendix A

## IRB Approval Fielding Graduate University

FGU Institutional Review Board | (805) 898-4034 | IRB@Fielding.edu

FIELDING
*Graduate University*

December 5, 2014

Connie Schultz
Cc: Stephen Murphy-Shigematsu, Connie Corley

**RE: IRB No. 14-1103 (Pilot/Dissertation) "Nurses experiences with behaviors that compromise a healthy work environment in the hospital setting" by Connie Schultz.**

Dear Connie,

Congratulations! On behalf of the Fielding Institutional Review Board, it is my pleasure to confirm that the IRB documents received for the **Nov 2014** IRB review cycle have been **APPROVED.**

| | |
|---|---|
| STUDY ID: | 14-1103 SCHULTZ Connie (HOD Nov 2014) |
| CATEGORY: | Full IRB Review (Non-Expedited) |
| DETERMINATION: | Approved (12/5/2014) |
| EXPIRATION: | 12/4/2015 |

**This study is subject to continuing review by 12/4/2015 unless closed before this date.**

This approval does not replace any other permissions or approvals required of students, faculty, or other researchers. If committee or other approvals are required to conduct your study, all approvals must be received by the researcher before recruitment, enrollment, or data collection begins. Each school has very specific requirements for approvals to be obtained and the IRB requests that you ensure that all requirements have been met. If institutional/organizational approvals are required, retain a copy of the approval(s) with your study documents.

The following information is provided to help you comply with human subjects protection requirements:

1. You must adhere to the Belmont Commission's ethical principles of respect, beneficence, and justice.
2. You must use the final IRB approved study documents to conduct your study.
3. All recruitment materials must receive IRB approval prior to utilization.
4. You must submit reports on unexpected or serious adverse events experienced by participants.
5. Federal guidelines require that projects undergo continuing review at least once a year. You will receive a communication approximately 4 weeks prior to the expiration date noted above. Complete and return the required documents prior to the expiration date to avoid a lapse of approval.
6. After you complete your study, go to http://web.fielding.edu/private/research/IRB_Forms.asp and download the Status Report form. Email the completed form to irb@fielding.edu.
7. Documentation of informed consent and a written research summary for your project must be maintained for at least three years following the date of completion. Documentation may be in hard copy, electronic, or other media formats. The IRB may review your records relating to this project.

Any proposed changes or modifications to your approved study must be submitted to the IRB for review and approval. Some changes may be approved by expedited review; others may require full board review. **Revision**

Appendix A (cont'd)



**Request Instructions** can be downloaded from the IRB website.

1M

Once your study has completed, you must submit an IRB **Status Report** form to the IRB office. Submitting this form will initiate the formal closure of your study OR allow you to request an extension of your approval expiration. This form may be submitted at any time during your approval period but must be received to later than 2 weeks prior to your study expiration date. The Status Report form can be downloaded from the IRB website.

Please contact irb@fielding.edu if you have any questions or require further information.

Best wishes,

Annabelle Nelson, PhD
Institutional Review Board Chair
Fielding Graduate University

# Appendix B

## IRB Approval Billings

**INSTITUTIONAL REVIEW BOARD OF BILLINGS**

**SERVING**
Billings Clinic Montana Cancer Consortium St. Vincent Healthcare Other Independent Investigators & Institutions

December 12 , 2014

Connie K Schultz RN MN MA PhD-c
Principal Investigator
P.O. Box 127
Fort Peck MT 59223

Dear Ms. Schultz,

**REVISED MINIMAL RISK PROTOCOL – NURSING RESEARCH**
Minor revisions to the following protocol to include a new consent form were approved using expedited review procedures on December 12, 2014, by the Institutional Review Board of Billings:

FIELDING GRADUATE UNIVERSITY
Connie K Schultz RN MN MA PhD-c, Principal Investigator
BILLINGS CLINIC NURSING RESEARCH
"Point of Contact": Jeannine Brant PhD APRN AOCN, Nurse Scientist

| | |
|---|---|
| *Conduct Site:* | Billings Clinic |
| *Principal Investigator Affiliation:* | Fielding Graduate University, Santa Barbara CA |
| *Dissertation Committee Chairman:* | Stephen Murphy-Shigematsu PhD<br>Fielding Graduate University, Santa Barbara CA |

**14.05** Nurses' Experiences with Behaviors that Compromise a Healthy Work Environment in the Hospital Setting

*Materials reviewed include but are not limited to:*
Revised Protocol *Appendix A:* Invitation Poster *(to Nurses),* revised to include a small incentive to participate ($10 gift card), and a Consent Form

Also received was the December 5, 2014, letter of IRB approval from Fielding Graduate University for the above-named protocol. Enclosed is a stamped, approved consent form for the above-numbered protocol. Please notify the IRB office if additional information is required.

Sincerely,

James A. Patten, Attorney-at-Law, Chairman

Enclosure: Approved consent form for Protocol **14.05**

Copy: Miranda Meunier GNP-BC, Billings Clinic Nursing Research Council
Billings Clinic Geriatrics

Jeannine Brant PhD APRN AOCN, Billings Clinic Nursing Research Council
Oncology Clinical Nurse Specialist and Research Scientist
Billings Clinic Inpatient Cancer Center

The Institutional Review Board of Billings is in compliance with the regulations of the Food and Drug Administration, effective July 27, 1981, and all amendments thereto, contained in Title 21 of the Code of Federal Regulations, Parts 50 and 56.
The Institutional Review Board of Billings is registered as DHHS OHRP/FDA Nos. IRB00003499 and IORG0002899.

Tel (406) 238-5657 ~ Fax (406) 238-5669
1020 North 27th Street, Suite 120 Billings MT 59101-0760

# APPENDIX C

## Interview Schedule

Interview Schedule/Questions

1. How would you describe your work setting?
2. How would you describe relationships with colleagues?
3. Have you ever experienced behaviors of your colleagues that made you feel disrespected or devalued? Tell me about it. If so, how did that make you feel? What was your course of action?
4. Have you ever observed behaviors or experiences between colleagues that was disrespectful? Between the nurse and the supervisor? Between the nurse and the physician? Between the nurse and other nursing unit or departments?
5. Are you aware of any colleagues that left your unit or transferred between units because of these experiences?
6. How would you describe a healthy work environment?
    a. What behaviors would compromise the healthy work environment?
7. How would you describe your leaders? (NM, Clinical coordinator, Nursing Director, CNO)
    a. How effective are your nurse leaders at dealing with these behaviors when they occur?
8. How are the behavioral expectations of the organization communicated to staff?
    a. How does leadership evaluate the effectiveness of this communication?

Questions to be answered through document review:

1. What are the mission, vision and values of the organization and how are they communicated to the staff of the organization?
2. What are the expectations of the organization concerning professional conduct, collaboration and communication?
3. How does the organization determine the effectiveness of these expectations?

# APPENDIX D

List of and description of organizational documents reviewed

1. Organizational Overview 1: A description of the organization in terms of the following:
    a. Mission, Vision, Values
    b. History
    c. Geographical location
    d. Services provided
    e. Number of licensed beds
    f. Total RN full-time equivalents
    g. Population served

2. Service Expectations: Pamphlet that summarizes the service expectations of the employees and communicates the mission, vision, values and "who we are" to all who come in contact with the organization.

3. Organization Chart – with attachment of Nursing Division Organization Chart (2015)

4. Strategic Plan for Nursing Practice (2013). Comprehensive plan developed in 2013 for the calendar years of 2014-2017.

5. Strategic Operating Plan (July 2010) Organization strategic plan and evidence of integration of nursing division strategic plan into overall.

6. Organization-level Policy: Reviewing that could lead to corrective or disciplinary action, up to and including termination (2015). Scope is focused on physician conduct.

7. Organization-level Policy: Discipline/Discharge (2013) "Conduct and/or performance that interferes with operations, brings discredit to the organization and/or is offensive to patients, fellow employees, or visitors will not be tolerated". Lack of direction in P& - who to hold MD accountable; no definition of behaviors. Guideline for administering disciplinary action of all staff except for leadership (Manager and above), physician, union employees.

8. Cultural Assessment Survey (December 2014): Executive Summary and Recommendations. The Safety Attitude Questionnaire which has been found to be predictive of clinical and operational outcomes such as patient and nurse satisfaction, burnout, clinical outcomes. The questionnaire measured 8 dimensions: teamwork climate, safety climate, job stress, stress recognition, working conditions, and perception of senior management, perception of local management and workload and pace. The findings from the 2014 cultural assessment were analyzed to identify high performing departments as well as

identify departments in need of assistance and to develop recommendations for focused intervention and improvement.

9. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey – national standardized, publicly reported survey of patients' perceptions of their hospital experience ("HCAHPS fact sheet [CAHPS Hospital survey]," 2012) . Twenty-seven item survey reported as a set of ten measures: communication with nurses and doctors, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness and quietness of the hospital environment, overall rating of the hospital, and willingness to recommend the hospital to friends and family.

10. Nursing Job Satisfaction Survey (2013). This survey is administered by the National Database for Nursing Quality Indicator (NDNQI). It is a web based survey to collect data on work satisfaction and work index from nurses employed in an NDNQI participating hospital. The survey results included data from the Job Enjoyment Scale, Adapted Index of Work Satisfaction and the Adapted Nurses Work Index. The Adapted Index of Work Satisfaction collected data on nurse's decision making, task, nurse to nurse interactions, nurse to physician interactions, autonomy, professional status and pay. The Adapted Nurses Work Index collected data on professional development, supportive nursing management and nursing administration (ANA, 2009).

11. Data on nurse turnover, nursing vacancy rate and staffing levels from report obtained from CNO.

# Appendix E

## Letter of Invitation – Original

Dear Nursing Colleague,

Have you or someone you know experienced behaviors by coworkers that are intimidating, disrespectful or demeaning? Have you or someone you know experienced behaviors that compromise a healthy work environment?

My name is Connie Schultz and currently a doctoral student at Fielding Graduate University. I am conducting research about these behaviors as they are experienced by nurses in the workplace.

If you are a nurse or nursing leader and interested in this topic or can answer yes to any of the previous questions, I would like to interview you for my research.

It is critical to my research study that I have the opportunity to share a conversation with you. For information addressing participation in the research, you may contact IRB of Billings re: Protocol 14.05

I can be contacted through email: conniemk51@gmail.com; or cell phone: 406-698-1152.

Sincerely,

Connie K Schultz, RN, MN, MA

# APPENDIX F

## Letter of Invitation - Revised

Dear Nursing Colleague,

My name is Connie Schultz and currently a doctoral student at Fielding Graduate University. I am conducting research on behaviors that compromise a healthy work environment as experienced by nurses in the hospital setting.

If you are a nurse or nursing leader and interested in this topic, I would like to interview you for my research.

If you volunteer to participate in the study, you will be interviewed by me. Completing the interview will take approximately 30-45 minutes. The interview will be scheduled at a time and place mutually agreed upon by you and I. The interview can also be conducted telephonically or using Skype. The interview will be recorded and transcribed into a document that will be utilized for the research. In appreciation for your time and efforts in participating in my research, a $10 gift card will be given at the conclusion of the interview.

Any information that is obtained in connection with this study and that can identify you will remain confidential. This study has been reviewed and approved by the IRB of Billings and Fielding Graduate University IRB.

It is critical to my research study that I have the opportunity to share a conversation with you.

I can be contacted through email: conniemk51@gmail.com; or cell phone: 406-698-1152.

Connie K Schultz, RN, MA, MN

# APPENDIX G

## Consent to Participate

APPROVED
DEC 12 2014
IRB OF BILLINGS

IRB of Billings Protocol: **14.05**
IRB Initial Approval: 10/14/2014
IRB of Billings Last Approved Revision: 12/12/2014
Page 1 of 1

INFORMED CONSENT FOR RESEARCH PARTICIPATION

*Nurses' experiences with behaviors that compromise a healthy work environment in the hospital setting*

You are invited to participate in a research study that will explore nurses' experiences with behaviors that compromise a healthy work environment in the hospital setting. You are eligible to participate in this study because you are a registered nurse employed at Billings Clinic.

I, Connie K Schultz, RN, MN, a doctoral candidate at Fielding Graduate University, Santa Barbara, CA, am conducting this study in partial fulfillment of the requirements for the degree of Doctor of Philosophy. My academic advisor is Stephen Murphy-Shigematsu, PhD. As sole researcher, this study is supported by my personal funding.

Participation in this study is voluntary. I ask that you read this form and ask any questions you may have before participating in the study. You will be interviewed by me at a mutually agreed time and place. A telephonic interview or an interview over Skype is also possible. The interview, which will take approximately 45-60 minutes, will be recorded and transcribed into a document that will be utilized for the research. The recordings and the transcribed documents will be kept private and stored securely by me.

The risk of participating in this study is minimal. Completing the interview may raise uncomfortable feelings or distresses for some participants.

Any information that is obtained in connection with this study and that can identify you will remain confidential. Any demographic information obtained will be reported in aggregate in order to maintain anonymity. Results will not be shared with anyone within the organization prior to dissemination of a final report to the organization that presents aggregate findings with no identifiable information.

For questions about your rights as a research participant, contact the Institutional Review Board (IRB) of Billings, which is a volunteer group that acts as a research subject advocate. The IRB has reviewed this consent form for clarity of information. If you have any questions, comments, or concerns about this study or about your rights as a research subject, you may call the IRB at (406 )238-5657.

INFORMED CONSENT
This study has been explained to me, and I have read this consent form in its entirety. All of my questions have been answered to my satisfaction at this time. I consent to participate in this study, and I understand that by signing this form, I have not given up any of my legal rights. I will be given a copy of this consent form.

_____ _____

Signature of Research Subject Date