

June 2021

LOST IN TRANSLATION: A HOLISTIC PERSPECTIVE ON NURSE PEER RELATIONSHIPS

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LOST IN TRANSLATION: A HOLISTIC PERSPECTIVE ON NURSE PEER RELATIONSHIPS

A Dissertation Presented

by

MAUD LOW

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2021

NURSING

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by

MAUD LOW

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DEDICATION

To my sister, Deirdre, who supported me and saw both the big and small pictures. And to her alter-ego, Wilhemina Murray, for the humor necessary to stay engaged in such a project.

ACKNOWLEDGMENTS

Heartfelt thanks to Associate Dean Jacelon for her expert and ever-present support and guidance. I want to thank my sister, Deirdre, for her consistent belief in me and never-ending reserve of creative ideas and resources. Thanks to Dan Gerber for telling me to “quit whining” when I desperately needed it! Thanks to Ginny Chandler for her unique perspective and belief in me. Thanks to Liz Theroux and Ruth Critcher for their endless hours of editing expertise and support. And thanks to Jen Dolan who walked dozens of miles with me as I complained and whined and struggled.

ABSTRACT

LOST IN TRANSLATION: A HOLISTIC PERSPECTIVE ON NURSE PEER RELATIONSHIPS

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Nurse peer relationships are the phenomenon of interest for this study. What is currently known about these complex relationships is fragmented rather than holistic. Behavioral expectations regarding teamwork and social support are among the explicit components of nurse peer relationships. But most of the publications on this topic are focused on an implicit phenomenon, nurse peer aggression. This is likely because of the long-standing, widespread negative impact of the ironic problem of nurses (society's professional caregivers) bullying each other, particularly on nurses and their patients. Despite decades of research, little progress has been shown in reducing the confusing and destructive phenomenon of nurse peer aggression. Interestingly, studies have identified several positive aspects of nurse peer relationships that contrast with the negativity of nurse peer aggression and portray the confounding complexity of the nurse peer relationship. The holistic meaning of the nurse peer relationship to nurses is explored through this study.

Methods: A grounded theory method was used with 14 hospital-based registered nurse participants who were interviewed about the meaning nurse peer relationships have had on their work, their lives, and their sense of self. This inductive approach gathered both positive and negative experiences and reflected the perspectives that the nurse participants brought to understanding nurse peer relationships. These findings provide new insights into nurse peer relationships, including aggression situated within the context of the complex relationship among nurse peers.

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CHAPTER 1

RESEARCH OBJECTIVES

Topic of Interest

Research on nurse peer relationships (NPRs) has largely focused on nurse peer aggression (NPA). NPA has been widely studied, finding among other things, that nurses are exposed to peer aggression in the workplace more than twice as often as workers in other professions (Roberts, 2015). The world-wide (see Table 1) persistent phenomenon of NPA is made all the more intriguing when one considers the irony of society's caregivers intentionally hurting their own kind (Johnson, 2009). Yet, despite decades of research, NPA continues to be a major factor in nurses leaving practice (MacKusick & Minick, 2009; Moore, Leahy, Sublett, & Lanig, 2013), the global shortage of nurses (Vessey, Demarco, & DiFazio, 2010), and reduced quality of patient care (Wright & Khatri, 2015).

Table 1: Country of NPA Study by Number of Publications (2007-2017)

Country	Number of Publications
US	17
Australia	11
Canada	13
Norway	8
Korea, Iran	5
Italy, Taiwan, Spain, UK	4
Pakistan, Sweden	2
Poland, Slovenia, Singapore, New Zealand, Malaysia, Ireland Japan, Greece, Turkey, Brazil, Israel, South Africa, Portugal	1

By focusing narrowly on the problem of NPA, researchers may have omitted essential aspects of NPRs within which NPA is situated. The complexity of NPRs requires exploration beyond the negative acts that have been so well documented. The researcher sought to fill this research gap through the conduct of this study: a holistic, situated, exploration of the meaning attributed by nurses to their workplace peer relationships (see Figure 1).

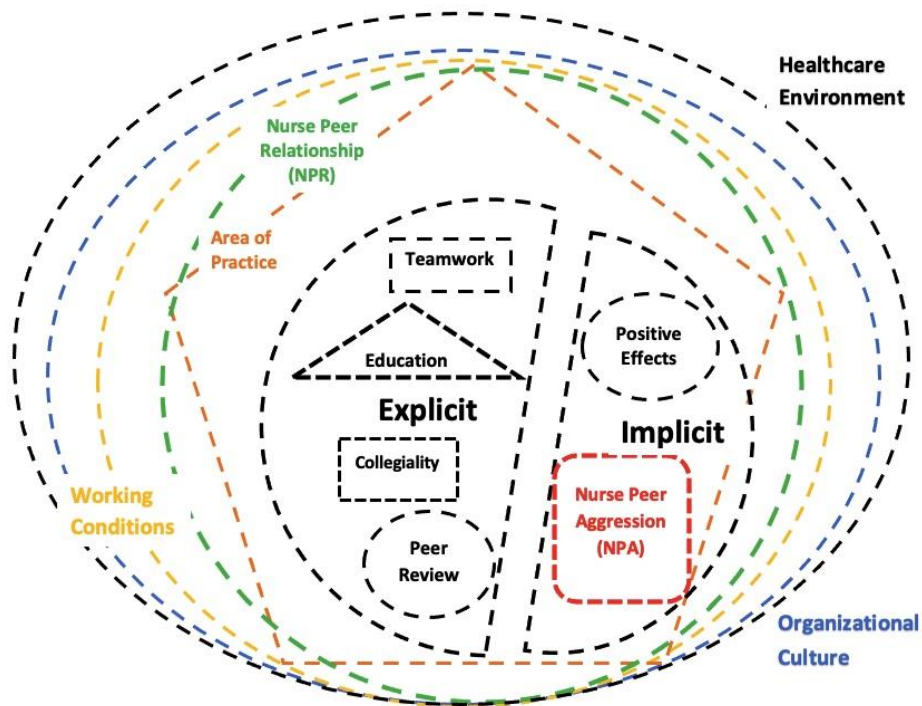


Figure 1: NPR and NPA Situated within Related Concepts

The study description is structured as follows. In Chapter 1, an overview of NPRs is presented, including the significance of the problem, scope of the problem, purpose of the study, research questions, definition of terms, and assumptions and limitations of the study. A review of literature is presented in Chapter 2, including: literature search strategy, explicit and implicit aspects of the NPRs, and a discussion of symbolic interactionism as the theoretical framework for the study. Chapter 3 details the use of

grounded theory methodology to research the meaning that nurses ascribe to NPRs. The grounded theory method, data sources, management, and analysis as well as research integrity, researcher qualifications, triangulation, and the research timeline are presented. In Chapter 4, the coded findings from the interviews are presented under the headings of relational factors, nurse characteristics, and environmental factors. In Chapter 5, the resultant model of the NPR is discussed. It consists of sub-parts, which are each presented and discussed. Chapter 6 follows, in which the model and its applications are described, including its relationship to existing literature and communication models, and interventions for each NPR Model intervention point. Finally, Chapter 7 concludes the study, covering study strengths and limitations, and implications for future research. The discussion begins with the significance of the problem.

Significance of the Problem

NPA is a far-reaching and persistent problem with dangerous consequences for all concerned. It has been reported that up to 70% of U.S. nurses have been treated aggressively by their peers (Vessey, DeMarco, Gaffney, & Budin, 2009). A study from the U.K. found that 85% of nurses had witnessed or been victims of workplace aggression (Hoban, 2004). NPA has been identified as a primary contributor to nurses leaving clinical practice (Laschinger, Leiter, Day, & Gilin, 2009; MacKusick & Minick, 2009; Moore, Leahy, Sublett, & Lanig, 2013). New nurse turnover costs organizations in the United States an estimated \$1.4 billion to \$2.9 billion per year (Meyer, Shatto, Delicath, & von der Lancken, 2017)

On an individual level, nurses have experienced depression and anxiety as a result of NPA (Lin, Corina, & Magley, 2008; Bardakçı & Günüşen, 2014; Berry, Gillespie, Fisher, Gormley, & Haynes, 2016). In addition, other serious mental health problems have resulted from NPA (Hurley, 2006; Laschinger & Nosko, 2013; Murray, 2009). NPA “leads to lowered work motivation, decreased ability to concentrate, poor productivity, lack of commitment to work, and poor relationships with patients, managers and colleagues” (Yildirim, 2009, p. 509). Nurses also suffer physical problems including eating disorders and cardiac problems related to NPA (Hurley, 2006; Laschinger & Nosko, 2013; Maddalena, Kearney, & Adams, 2012; Murray, 2009).

More importantly, NPA has negative consequences for patients. Poor patient satisfaction (Governance Institute, 2009), medical errors (Wright & Khatri, 2015), and dangerous safety issues (Houck & Colbert, 2017) have been attributed to NPA. Nurses dealing with the stress of NPA have less time and energy to contend with the unfortunate but expected stressors of the high tech, life and death, healthcare workplace (Gountas & Gountas, 2015). As a result, the Joint Commission on Accreditation of Healthcare Organizations put forth nurse leadership standards (LD.03.01.01) that recognize and support holding employees accountable for peer intimidation, disruptive behaviors, and interpersonal aggression because they can lead to medical errors, preventable adverse patient outcomes, poor patient satisfaction, increased cost of care, increased malpractice risk, and turnover (JCAHO, 2012). Thus, NPA is recognized a threat to nurses, the nursing profession, and patients alike.

Although the problem of NPA has spurred extensive research activity, there has not been meaningful improvement in the incidence or severity of the problem. Research on NPA began as early as the 1980s (Meissner, 1986), yet, as of January 2018, the American Nurses Association is recruiting a panel of experts for a 4-6-month project called #EndNurseAbuse (ANA, 2018). Its goals are to:

- Identify the barriers to effective reporting of violent and abusive incidents.
- Investigate workplace 'zero tolerance' policies for strengths and weaknesses and seek to understand the effectiveness of such policies.
- Develop policy recommendations to address barriers to reporting.
- Identify strategies to strengthen 'zero tolerance' policies. (ANA, 2018)

The study presented is designed to bring a change in perspective to the study of NPA by pulling back the researcher's lens and considering NPA as only one component of a complex phenomenon, the NPR. This change in research approach has revealed information about both NPR and NPA that previous methods did not.

Scope of the Problem

Several concepts contribute to the specific focus of the study, NPRs. As previously described, the study encompasses all aspects of NPRs (see Figure 1). Another facet of the research scope is the limitation to nurse peer relationships, as opposed to general workplace peer relationships, physician-nurse or nurse-supervisor relationships, or nurse-nurse's aide relationships. Thirdly, this study captures a holistic perspective that mimics the intersectionality of multiple relationship dynamics as experienced by nurses. Justification for these research foci is presented below.

By focusing exclusively on NPA, many researchers may have narrowed their view to the exclusion of the context of the NPRs through which NPA must be understood. The

relationship between nurses in the workplace is complex and multi-faceted (Blackwood, 2016). Although NPA occurs with disturbing frequency, studies have also found that once a nurse has been treated aggressively by a peer, the most common and effective source of support in dealing with this problem is another nurse peer (Purpora & Blegen, 2015; Purpora, Blegen, & Stotts, 2015; Vessey et al., 2009). NPRs in their totality, warrant investigation based on sensitive and thorough investigation of the nurses' lived experience. This research gap is the focus of this study.

Studies in fields such as organizational psychology, sociology, and psychology have explored a range of complications within workplace peer relationships (Lewis & Megicks, 2017; Sias, Gallagher, Kopaneva, & Pederson, 2012; Trépanier, Fernet, & Austin, 2013). Even if the focus is limited to the hospital setting, any number of relationships could be identified for analysis of workplace aggression. However, NPA is of particular interest because of nursing's foundational value of compassion and caring being the antithesis of aggression directed at nurse peers. In addition, as peers, nurses involved in NPA do not have a line relationship within the hierarchical structure; thus, official power inequities are not a part of their relationship dynamics. Also, co-workers or peers have been found to be the most frequent source of maltreatment among nurses (Dumont, Meissner, Whitacre, & Corbin, 2012; Laschinger, Wong, & Regan, 2013). Finally, nurses are by far the largest group of healthcare professionals (Bureau of Labor Statistics, 2017). Farrell and Shafiei (2012) suggest that nurses are most affected by workplace aggression with their nurse peers compared with other work relationships.

For these reasons, NPA has had wide-spread research activity for the past three decades.

NPRs are multifaceted, ever evolving, and unique to individuals and settings. These complex relationships have been studied in terms of individual components or attributes of the relationships rather than as they naturally occur, holistically situated within the context of the healthcare workplace. Beyond NPA, a range of components of the NPR exist, including: explicit roles such as collegiality (Bae, 2011; Menard, 2014), teamwork (Schmutz & Manser 2013; Welp & Manser, 2016), education (Fleming, 2017; Carlson, Pilhammar, & Wann-Hansson, 2009; Regan et al., 2017; Topa, Guglielmi, & Depolo, 2014; Winokur, 2016), and peer review (American Nurses Credentialing Center, 2009; ANA, 1988; Davis, Capozzoli, & Parks, 2009; Haag-Heitman & George, 2011), as well as implicit roles including support in dealing with traumatic workplace events (Kellogg, Barker, & McCune, 2014; Trossman, 2016), managing emotional labor (Edward, Herceliniskyj, & Giandinoto, 2017; Elliot, 2017; Kaur & Malodia, 2017), managing uncertainty (Cranley, Doran, Tourangeau, & Kushniruk, 2012), and managing stress (Brown, Broderick, & Sully, 2013; Vahedian-Azimi et al., 2017; Rice, Bennett, & Billingsley, 2014). NPRs also account for positive effects on nurses, such as developing social capital (Hofmeyer & Marck, 2008; Shin & Lee, 2016) and professional dignity (Sabatino, Kangasniemi, Rocco, Alvaro, & Stievano, 2016).

As a whole, the research findings on NPA and NPRs portray a disjointed image of loosely related characteristics, attributes, and behaviors that may or may not influence positive and negative NPRs (Robnick, 2012). The findings from this study shed light on

the components and characteristics of this relationship, as well as how these components influence behavior. Within the broader context of NPRs, NPA is better understood and solutions to it made more achievable.

Purpose of Study

The purpose of this inquiry was to develop substantive theory that describes the social processes that influence NPRs.

Research Questions

- What are the perceived social processes that influence NPRs?
- What behaviors influence NPRs?
- What interactions influence NPRs?
- What meaning do nurses ascribe to NPRs?

Definition of Terms

Terms defined in this section include NPR, NPA, nurse, work setting, and social process.

- **Nurse Peer Relationship (NPR)** is defined as the interpersonal connection between nurse peers.
- **Nurse Peer Aggression (NPA)** is defined as persistent, focused, and purposeful negative interactions between nurse peers.
- **Nurse** is defined as a registered nurse actively employed in hospital-based clinical practice.

- **Work Setting** is defined as the unit or “floor” on which nurses are employed working under a single manager or director within the healthcare facility.
- **Social Process** is defined as activities, actions, and operations that involve the interactions among people.

Method

Constructivist grounded theory is the method used for this study. This method suited the study in that the researcher co-constructed the resultant theory with the participants, focusing on the complex world of the nurse in clinical practice. Of the range of philosophies and approaches within grounded theory research, the constructivist approach was chosen for the study because of its acknowledgement of the researcher being an active participant in the world of interest to the study. Charmaz (2006) is the author currently most closely associated with this type of grounded theory method. Her publications offer specific suggestions for the methodology and informed the design of the study. This is outlined with greater specificity in Chapter 3.

Assumptions and Limitations

The assumptions and limitations of the study are defined next.

Assumptions

The study investigated NPA as a phenomenon situated within the context of NPRs. The study was designed to take a broad perspective by studying all aspects of the NPR, which include not only aggression, but also collegiality, education, teamwork, peer review, support during adverse events, and other relationship characteristics.

Assumptions Regarding NPA

- Nurses who perpetrate aggression do so consciously or unconsciously seeking power.
- Nurses learn aggression by having experienced aggression.
- The culture in many nursing workplaces supports NPA.

Limitations

This study was limited by several factors that commonly complicate grounded theory research (Hussein, Hirst, Salyers, & Osuji, 2014). Bias may have affected the research via sampling processes, construction of guided interview questions, the interview process, coding data, theme development, and drawing conclusions from the findings (Charmaz, 2006; Hussein et al., 2014). Therefore, guards against these problems were built into the study design, such as the oversight of the coding process by the researcher's committee for validation of themes and checking for bias.

Similarly, the interviewer's tone, body language and responses, both verbal and non-verbal, can have subtle effects on findings. So, a pilot interview was performed and evaluated by the researcher's committee chair for any influencing findings. This feedback provided the novice researcher valuable information on conducting guided interviews with neutrality and openness.

Additional research limitations include the participants' ability to recall past events, their ability to describe their own experiences, the tendency to want to please the researcher, and potentially other factors influencing the truthfulness of their responses. Again, every aspect of the study was scrutinized by senior researchers.

The study was limited by the homogeneity of the participants. The findings of the study cannot be applied to populations other than those studied. The study used a word-of-mouth, snowballing technique for recruitment of participants. As such, the findings of the study do not reflect all nurses, rather it only reflects those nurses who participated in the study. All the participants, by definition, they were motivated to join a research study and interested in research. It could also mean that participants had reason to wish to discuss NPRs. Participants were from western or central Massachusetts, where nurse salaries are among the highest compared to the other U.S. states (U.S. Department of Labor, 2017). However, the cost of living is also high in Massachusetts compared to other states, especially in the areas of healthcare, housing, electricity (Buell, 2017). Finally, because of the researcher's hospital community connections, some participants were connected to psychiatric or obstetrical nursing. With these specific characteristics, the study findings cannot be generalized to the general nursing population.

Theoretical Framework

The theoretical framework for the present study is constructivist symbolic interactionism. This approach suits it well as it focuses on complex worlds where the researcher participates with the research subjects in constructing new theory. Charmaz (2006) is the current authority on this aspect of grounded theory methodology. Her work informed the design, which is described in greater detail in Chapter 3.

This chapter has outlined general aspects of the research study including the significance of the problem, the focus of the problem, the purpose of the study, the

research questions, definition of terms, assumptions and limitations, and theoretical framework. Next, a review of literature is presented. The findings support the need for a qualitative study of the meaning that nurses make of their peer relationships.

CHAPTER 2

LITERATURE REVIEW

Introduction

This chapter presents the nursing and allied health literature that relates to the focus of this study. Literature on NPRs was searched using CINAHL and PubMed databases for publications from the past ten years (2007-2017), English language, and full-text availability (see Figure 2). Choosing search terms was challenging as there are so many terms in use to describe workplace peer aggression (see Table 2). The findings were sorted for duplication and relevance, yielding 136 pertinent publications. To this group, an additional 35 studies were added as they were discovered through review of the research identified via the search process. The total 171 studies are presented below, according to how the findings inform the understanding of NPRs.

Explicit characteristics of NPRs are presented first, followed by implicit characteristics. NPA is presented as one implicit NPR phenomenon and is organized as: statements on NPA from professional organizations, concept analyses, individual antecedents, situational antecedents of NPA, NPA outcomes, and NPA interventions. Next, the positive effects of NPRs (healing traumatic workplace events, developing positive characteristics of individuals, and managing workplace stress) are discussed. Finally, literature on symbolic interactionism is presented as it is the theoretical framework upon which the product of the study, the NPR Model is based.

Nurse Peer Relationships (NPRs)

Publications which met the inclusion criteria are presented here, organized first according to explicit or implicit factors. This schema presents the official (explicit) versus the informal (implicit) characteristics of NPRs, informing the design of the study in which NPRs are analyzed based on data from documents describing and defining NPRs by nursing organizations (explicit) and data from interviews on nurses' lived experiences of NPRs (implicit).

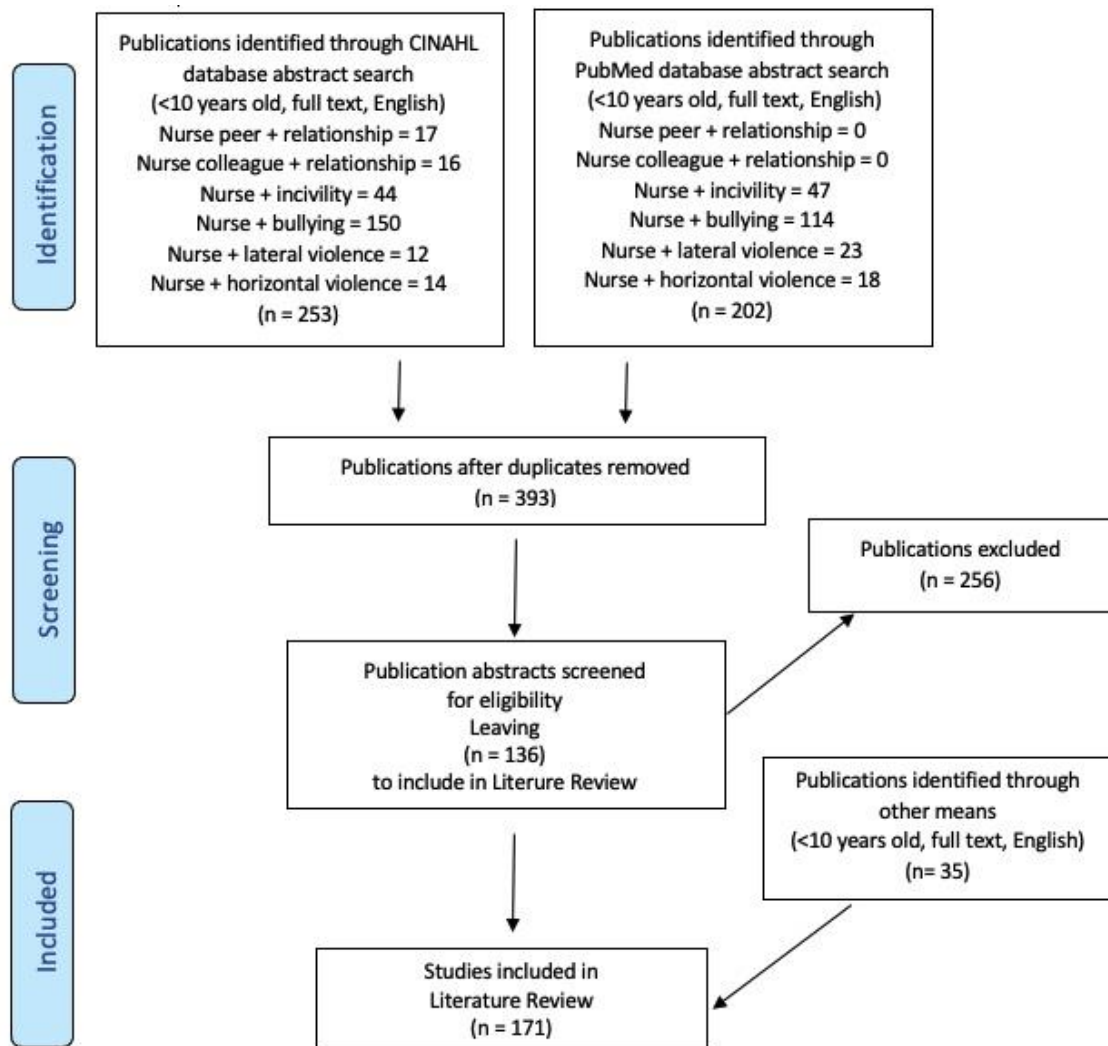


Figure 2: Prisma Diagram of Literature Search on NPRs

Table 2: Terminology of Workplace Peer Aggression

List of Terms	
bullying	organizational violence
emotional abuse	psychological harassment
horizontal aggression	psychological terror
horizontal hostility	psychological violence
horizontal violence	relational aggression
Incivility	sabotage behavior
interpersonal hostility	social aggression
lateral aggression	verbal abuse
lateral hostility	verbal violence
lateral violence	workplace aggression
mobbing	workplace bullying
moral distress	workplace harassment
moral harassment	workplace incivility
organizational aggression	workplace sabotage

Explicit Factors

Workplace policies, organizational codes and professional directives define explicit aspects of NPRs. Key components of these as described in the literature search findings are discussed below. They are collegiality, teamwork, education, and peer review.

Collegiality

NPRs work within an environment with the expectation of collegiality. However, Bae (2011) found that among foreign-educated nurses, the lack of collegiality or organizational socialization was an important predictor of the intent to leave practice. Bae's study was based upon a secondary analysis of a hospital database, consisting of 752 RNs. These results do not reflect a randomized trial and is therefore not applicable to all nurses, but the volume of participants brings creditability to the study's findings. Menard, 2014, explored the collegiality of the NPR and found that there was an inverse

relationship between collegiality and missed or omitted nursing care. Thus, the collegiality of NPRs appears to influence nurses remaining in their jobs as well as the quality of patient care.

Teamwork

In the nursing workplace, teamwork is identified as an important aspect of the nurse's role; because most health care is delivered by a team of clinicians with separate roles, the team members must work in harmony. Beyond the competence of the individuals making up the team, the team's relational efficacy also contributes to patient safety outcomes (Schmutz & Manser, 2013). Welp and Manser (2016) found independent associations between teamwork, clinician well-being, and patient safety. This metanalysis (Welp & Manser, 2016) considered 98 research studies published between 2000 and 2015, therefore it is both thorough and recent. These findings underscore the importance of research on relationships in the healthcare setting.

Like collegiality, teamwork has been found to have independent associations with both nurse well-being and patient safety (Welp & Manser, 2016). Nurses' health and well-being has been shown to be affected by the degree and quality of workplace teamwork (Halpin, Terry, & Curzio, 2017; Klopper, Coetzee, Pretorius, & Bester, 2012). Conversely, dysfunctional teams have been shown to be a source of stress for nurses as well as other clinicians (Gabriel, Diefendorff, & Erickson, 2011; Van Bogaert, Clarke, Roelant, Meulemans, & Van de Heyning, 2010). In summary, the quality of teamwork of NPRs affects patient safety, nurses' health, and workplace stress. Distinction between

how nurses work with non-nurse colleagues versus fellow nurses could be researched specifically, in order to assess NPRs as a unique phenomenon.

Education

Nurses are often amazed to find themselves teaching other nurses early in their careers. Orientation and mentorship of fellow nurses is a common expectation of the nursing role. The success of the new nurse's transition into practice and his/her intent to stay are influenced by the education provided by more experienced nurses (Regan et al., 2017). The tone of these educational encounters has been shown to be particularly important to positive outcomes (Fleming, 2017; Regan et al., 2017).

Unfortunately, being expected to teach while continuing to perform their usual duties was found to create significant stress for nurses (Carlson et al., 2009) making the maintenance of a supportive tone difficult for the overtaxed senior nurse. These results were based on a study with only 13 staff nurses being observed and 16 nurses participating in a focus group, warranting further research. In addition, nurses who encounter negativity during their orientation to new jobs may experience pervasive, long-term negative effects (Topa et al., 2014). However, these results were found using self-report measures, which should be a study limitation. Conversely, another way that nurses affect peers in terms of education is by being the greatest influence on the decision to seek advanced degrees (Winokur, 2016).

In sum, education is a function of the nurse's role, which can be enriching and supportive but also may increase stress in the workplace. This "double-edged sword" aspect of NPRs is a theme to be seen frequently throughout the literature review.

Peer Review

Over the past two decades, an additional expectation that employers have of nurses is peer review. This type of performance appraisal is an expectation for facilities seeking “magnet” status (American Nurses Credentialing Center, 2009) and is advocated by the American Nurses Association in the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015b). The ANA supports the use of peer review as means of self-regulation as well as accountability and professionalism in practice (Haag-Heitman & George, 2011; ANA, 1988). Davis et al. (2009) show that peer review can draw in a range of generations, support satisfaction and engagement among nurse peers, and “create positive relationships, foster a better work environment, and allow peers to increase individual and group accountability” (p. 251). However, this publication was written from the nurse manager perspective and did not include feedback from staff nurses, who are the people doing peer review. Anecdotally, the author of this present study has seen peer review have a negative effect on group dynamics and become a means of NPA.

Explicit aspects of the NPR—collegiality, teamwork, education, and peer review—were discussed above. Several of these concepts have both positive and negative implications for nurses’ work lives. The explicit components of the NPR have commonalities and differences from the implicit components, which are described in the following section. Comparing the two reveals incongruous findings and underscores the importance of research which encompasses NPRs as a situated whole.

Implicit Factors in NPRs

Implicit factors in NPRs are broad, ranging from the well-researched topic of nurse peer aggression (NPA) to positive effects of NPRs. The following section summarizes research findings on these unofficial (implicit) characteristics of the NPR and is presented as follows: aggression in NPRs (statements on NPA from nursing organizations, concept analyses, individual antecedents of NPA, situational antecedents of NPA, NPA outcomes, and NPA interventions) and positive effects of NPRs (healing from traumatic workplace events, developing positive characteristics of individuals, managing workplace stressors).

Aggression (NPA)

NPA has been a topic of scholarly publication for over 30 years (Meissner, 1986; Dellasega, Volpe, Edmonson, & Hopkins, 2014; Fida, Laschinger, & Leiter, 2018). Examples of NPA range from such behaviors as “scolding in a wrong way, pressing to resign, leaving out in the cold, and {psychological} burning,” to threats of and actual physical harm (Lee, Kang, Seonyoung, Lee, & Kim, 2013). The most widely used instrument for measuring NPA in quantitative research is the Negative Acts Questionnaire – revised (Purpora, Cooper, & Sharifi, 2015). This quantitative instrument is limited in that it only collects information on nurses’ recollection of witnessing or receiving mistreatment and it fails to assess perpetration of NPA. Thus, we have little understanding of the motivation for perpetration of NPA from the research. This is a major shortcoming, because without access to the perpetrator of NPA, causation is impossible to investigate.

Nurse researchers all over the world (see Table 1) have contributed to the continuously evolving body of science on NPA. Nevertheless, the phenomenon continues unabated. Confounding issues are many and include: a variety of search terms (see Table 2) and multiple academic fields investigating NPA without coordination with other fields. The fields researching NPA include but are not limited to: nursing (Wolfe & McCaffrey, 2007), medicine (Jafree, Zakar, Fischer, & Zakar, 2015; Vahedian-Azimi et al., 2017), business (Boddy, 2010; Lewis & Megicks, 2017; Pilch & Turska, 2015), organizational psychology (Armmer & Ball, 2015; Glambek, Skogstad, & Einarsen, 2016), communication (Sias et al., 2012), social psychiatry (Sansone, Leung, & Wiederman, 2012) and applied psychology (Gabriel et al., 2011).

Other concerns are the lack of a widely accepted definition of NPA (Granstra, 2015), and the variety of instruments used to measure NPA (Hamburger, Basile, & Vivolo, 2011). These issues confound the ability to compare studies and build on previous research findings. The following discussion of NPA is presented under these headings: statements on NPA from governing agencies, concept analyses, individual antecedents, situational antecedents, outcomes, interventions, and research issues.

Statements on NPA from Professional Organizations

The extent and severity of the problem of NPA has prompted professional organizations to release statements regarding the problem. In 2015, the American Nurses Association (ANA) released a position statement on “Incivility, Bullying, and Workplace Violence.” In this document, the ANA describes the roles and responsibilities of nurses and employers to maintain a culture of respect, free of bullying, incivility, and

workplace violence (2015). The document describes nursing employers and academics as having a moral, ethical, and legal responsibility to make the work environment healthy and safe (ANA, 2015a). Similarly, the American Association of Colleges of Nursing (AACN, 2008) and the American Psychiatric Nurses Association (APNA, 2008) have published documents that condemn incivility and harassment in the nursing workplace. These agencies set the expectations for nurses and are held in high regard by those both within and outside of the nursing profession. Their weighing in on NPA indicates the seriousness of the problem. Nevertheless, statements on NPA have not been shown to translate to a change in the lived experience of the nurse's work life.

Concept Analyses

Three publications defining and clarifying NPA concepts were found in the search of the literature. There are differences and similarities among the three publications, highlighting the issue of the range of search terms for NPA (see Table 2). Embree and White (2010) used the term "nurse-to-nurse lateral violence" to analyze NPA, which was said to derive from "role issues, oppression, strict hierarchy, disenfranchising work practices, low self-esteem, powerlessness, perception, anger, and circuits of power" (p. 166). Embree and White called upon organizations to teach nurses skills for managing NPA. Next, Vagharseyyedin (2015) used the term "workplace incivility" to describe NPA; the concept was analyzed to promote clarity in nursing research and practice and to guide the design of interventions to reduce the problem.

More recently, Abdollahzadeh, Asghari, Doshmangir, Hasankhani, and Vahidi (2017) used the term "workplace incivility" for a concept analysis exclusively from

the perspective of the nurse. The publication focused on prevention of workplace incivility. The identified themes included “a missing ring in [the] system, working in the shadow of fear, and being scapegoats,” (Abdollahzadeh et al., 2017, p. 1). Unlike Embree and White (2010) who looked to employers to address NPA, both Vagharseyyedin (2015) and Abdollahzadeh et al. (2017) placed the responsibility for correcting NPA on nurses themselves. They urged the development of skills to manage workplace incivility. Each of these concept analyses contributed to clarification of NPA-related concepts in different ways. Unfortunately, the problem of having too many terms in use for NPA is seen in the range of concept analyses and continues to thwart the integration of research findings and, therefore, the advancement of this research topic. In addition, teaching nurses skills to manage NPA does not address the existence of the NPA phenomenon in the first place.

Individual Antecedents of NPA

Identification of the antecedents of NPA is essential to understanding and eliminating it. Authors have described many antecedents to NPA including the most obvious, “the presence of two or more people, with one or more as the source of the incivility” (Vagharseyyedin, 2015). As antecedents are identified, nurse researchers can develop a deeper understanding of NPA, which may form the foundation for new strategies to eliminate it.

The characteristics of individuals drawn into the drama of NPA have been researched with a variety of findings (Hamblin et al., 2015). The studies are presented

here, organized as: characteristics of the self, negativity, experience/generation, and rationalization.

Among the research findings culled from the literature were studies that implicate aspects of the self as antecedents to NPA. High self-efficacy was found to positively affect such outcomes as coping with workplace incivility, burnout, turnover intention and mental health issues (Fida et al., 2018). Similarly, high rates of NPA were found to be related to low self-esteem in some studies (Losa, Iglesias, & Becerro de Bengoa, 2012; Ling, Marshall, Xu, & Lin, 2014) but not in another (Berry, 2015). One study, Ling et al. (2014), found that sabotage behavior, defined as purposeful destruction of good service, was related to low self-esteem among a group of nurses. However, it is unclear whether low self-esteem was the cause or the result of the destructive behavior. Self-efficacy and self-esteem appear to be important considerations in understanding NPA (Roberts, 2000; Egues & Leinung, 2013). Another study found that self-understanding was important to a nurse's professional identity (Ramvi, 2015). However, that study was based upon a single case and would need to be replicated with a larger number of participants to be generalizable. What has not been explored is the potential that nurses as a group may be more likely to exhibit personality characteristics affecting either the relationship with the self or relationships with others. It stands to reason that a group of people (the vast majority of whom are female) who have chosen to be professional caregivers might have similar personality characteristics that affect interpersonal relationships.

It has been suggested that the nurse's daily exposure to human pain and trauma can prompt negativity (Kidd & Finlayson, 2010). Negative affect is an individual characteristic which is significantly associated with most types of workplace bullying (Oh, Uhm, & Yoon, 2016; Chang, Teng, Chu, Chang, & Hsu, 2011). Nicholson, Leiter, and Laschinger (2013) found that workgroup civility had an inverse relationship with workplace cynicism. However, it should be noted that the researchers found only a small effect size in the study population (Nicholson, Leiter, & Laschinger, 2013). Nevertheless, negative affect has been found to be an important precursor of NPA. One model explains this phenomenon as follows: "low attitude → negative perceptions → negative acts" (Ma, Wang, & Chien, 2017).

Berry et al. (2016) explain further the circular nature of negativity in the nurse workplace; this explanation identifies NPA as both the cause and effect of nurse negativity. These authors posit that nurses internalize emotions after having experienced NPA, because a part of the dynamic is for their concerns to be minimized or ignored by colleagues. Indeed, several studies found that nurse participants were encouraged by peers to use verbal abuse to stop the nurse aggressor (Hutchinson, Wilkes, Jackson, & Vickers, 2010; Brotheridge, Lee, & Power, 2012). Further, the development of negative informal alliances and misuse of organizational processes are antecedents to bullying (Hutchinson et al., 2010). This cycle, it is believed, develops into a self-perpetuating culture of negativity and aggression. The research makes it clear that NPA and negativity are closely associated and detrimental to nurses and patients. It is less clear from the research how to address these problems.

In the current workplace, nurses from a variety of backgrounds, including multiple generations and a variety of educational backgrounds, work side by side. As such, differences in generation, education, values, and experience can lead to friction and aggression. One study found that “Generation X nurses reported more negative experiences than did Baby Boomer nurses on all measures,” (Leiter, Price, & Laschinger, 2010; Smith, Andrusyszyn, & Laschinger, 2010) and younger nurses showed more willingness to leave employment due to perceived NPA than older nurses (Armmer & Ball, 2015). Similarly, new graduate nurses (who may or may not be of a single generation) were found to be at higher risk for NPA, which is attributed to a lack of confidence and social connection (Budin, Brewer, Chao, & Kovner, 2013; Weaver, 2013). New nursing graduates were found to require a range of supports: a manageable workload, meaningful orientation, inter-professional teamwork, a welcoming environment, constructive feedback, emotional support and debriefing, and engagement within transformational and authentic leadership to establish a professional identity and remain in the profession (Chachula, Myrick, & Yonge, 2015). Nurses with even a single year of work experience were significantly less likely to experience NPA than new graduate nurses (Li, 2016). Interestingly, other studies revealed that even older nurses who were either new to a setting or new to the profession were vulnerable to NPA (Longo, 2013; Weaver, 2013). Thus, two separate characteristics, generation, and length of practice, have been conflated at times in the research, making a clear understanding of the influence of each factor difficult.

The character traits and values espoused by the nursing profession—caring, compassion, and support for others—are in direct contrast to the phenomenon of NPA. The tension of opposing values presents the likelihood that perpetrators of NPA may be in denial of or purposefully rationalizing their negative actions. Several studies support this notion. Leong and Crossman (2016) found that nurses explained their aggression toward their peers as “tough love.” Likewise, another study suggested that when engaged in NPA, some nurses believe themselves to be providing education (Jiyeon & Seonyoung, 2016). However, the Jiyeon and Seonyoung (2016) study was done using a participant group of only 20 and should be replicated with larger groups. As with generation and experience, rationalization and denial may have been conflated in research, but might have separate effects on outcomes. Interestingly, nurses’ rationalization and denial of NPA highlight the irony of NPA.

The individual antecedents of NPA found in the research and summarized here were the self-related characteristics of negativity, experience/generation, and rationalization. Except for experience/generation, these characteristics are psychologically based and could be changeable or treatable. Alternatively, they could be characteristics which may track with the characteristics of the care-taking personality. No studies have explored these connections.

Meanwhile, the setting in which NPA occurs may be equally or more predisposing to NPA than individual characteristics. It might be that even with several of the individual characteristics described above, without the precipitating context, a nurse might not perpetrate NPA. The reality is that individual antecedents always occur along

with situational antecedents. Studies that seek information on this natural state of the experience of NPA are not well represented in the literature.

Situational Antecedents of NPA

At its most basic level, the essential antecedent of NPA is the presence of two or more nurses, with one or more as the source of the aggression and another as its target in the nursing workplace (Vagharseyyedin, 2015). Contributory characteristics of individuals to NPA were presented above. In addition, a host of situational factors have been identified as precursors of NPA. These studies are discussed below, organized as: power dynamics, organizational culture, working conditions, and area of practice.

Oppressed group behavior has been said to be the primary etiologic factor in NPA (Andrews, Burr, & Busby, 2011; Ebrahimi, Hassankhani, Negarandeh, Jeffrey, & Azizi, 2017; Roberts, 2015). “Powerlessness and fear are the basis for a cycle in which aggression and anger toward the more powerful is turned inward toward one’s own group. The behaviors keep the group from organizing and developing the sense of unity and cohesiveness necessary to support each other and gain power in the culture” (Roberts, 2015, p. 3; paraphrasing Freire, 1971). Oppressed group behavior as the origin of NPA is a theory that posits that NPA results from the hostile, hierarchical, healthcare work environment, where nurses hold little power (Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013; Croft & Cash, 2012; Hossein, Hadi, Reza, Carol, & Azim, 2017; Wilson 2016). Powerlessness was found to be an insidious antecedent to NPA (Embree & White, 2010; Longo & Smith, 2011), which can be counteracted through

access to opportunity, support, and formal power through human resource supports (Smith et al., 2010).

As a predominantly female profession within a patriarchal culture, Dubrowski (2013) analyzed the ways that nurses are oppressed in the workplace. “Understanding the structure of nursing’s oppression allows nursing to begin to formulate a thoughtful response to oppression and helps nursing find its voice in the larger world of the healthcare system” (Dubrowski, 2013, p. 205).

One study found that leaders empowering staff had the strongest impact on decreasing NPA (Kaiser, 2017). Further, an empowering, mentorship relationship between leaders and staff can have a direct influence on nurses’ longevity in the workplace (Fredrick, 2014). Inversely, managers contribute to NPA by using punitive leadership tactics that disempower nursing staff members (Wilson, 2016).

The culture of a work environment sets the stage for the relationships that form and are enacted therein (Embree & White, 2010; Giorgi et al., 2016; Khadjehturian, 2009). Hutchinson et al. (2010) found that organizational culture and characteristics were confirmed to be critical antecedents of NPA, influencing both the occurrence and consequences of NPA. Similarly, the work environment was found to have an impact on NPA and its prevention (Ganz et al., 2015; Catling, Reid, & Hunter, 2017). As mentioned previously, workplaces that use authoritarian leadership tactics tend to have higher rates of on-the-job violence (Blackstock, Harlos, Macleod, & Hardy, 2015; Yasin, Muhammad, & Amran, 2016). Another study, Myers et al. (2016), found that nurses’ depictions of NPA were consistent regardless of having different organizational

structures in their workplaces. The authors suggested that culture rather than structure sets the stage for NPA (Myers et al., 2016). Blackstock et al. (2015) found that negative informal alliances that isolate particular nursing staff predict NPA. These findings were obtained through an on-line survey study with 103 nurse participants, so replication with larger groups and a randomized design could validate these findings.

Looking at the culture of the nurse workplace from a positive perspective, Schoonbeek and Henderson (2011) endorsed and described “building a learning culture” (p. 43). Purpora et al. (2012) proposed that a “change in the oppressive social structure of hospitals may be needed to truly address horizontal violence in the best interest of the quality and safety of patient care” (p. 31). Similarly, Laschinger, Finnegan, and Wilk (2009) demonstrated the value of working in collegial work settings in which nurses respected one another and refrained from NPA. D’Ambra and Andrews (2014) studied transition programs for nurses and found that while they are associated with improved satisfaction and nurse retention, these programs address NPA by acculturating new nurses to the experience of NPA. They found no evidence that the organizational culture that tolerates NPA was addressed or affected by these programs.

Studies found that working conditions appear to be important antecedents to NPA. Specific aspects of working conditions include workload, which was consistently found to be the highest reported stressor, with inadequate staffing and managing multiple role demands given as explanations; and role issues, which also appear to contribute to NPA (Bardakçı & Günüşen, 2014; Bostrom, Hörnstena, Lundmana, Stenlundb, & Isakssona, 2013). An example of role-related issues was the finding

that nurses with advanced degrees suffered more NPA than those with baccalaureate or lower educational attainment (Bostrom et al., 2013). Presumably, holding advanced degrees blurred role boundaries and contributed to role ambiguity among nursing staff.

Multiple studies implicated over-all work environment as an important factor in the prevalence of NPA (Olsen, Bjaalid, & Mikkelsen, 2017; Oyeleye, Hanson, O'Connor, & Dunn, 2013; Smith, Morin & Lake, 2017). Olsen et al. (2017) found that NPA functions as a mediator between many work climate dimensions and outcomes such as job satisfaction and work ability. In addition, outcomes such as job performance, job stress, and burnout were shown to be affected by working conditions (Oyeleye et al., 2013; Smith et al., 2017).

Budin et al. (2013) point out the “chicken or egg” nature of the issue of work environment and NPA behaviors: “Although more verbal abuse is seen in environments with unfavorable working conditions, and RNs working in such environments tend to have less favorable work attitudes, one cannot assume causality. It is unclear if poor working conditions create an environment where verbal abuse is tolerated or if verbal abuse creates an unfavorable work environment” (p. 302).

Clinical area of practice has been investigated with a variety of findings implicating particular types of nursing specialties that appear to set the stage for NPA. One study found psychiatric nurses to be especially prone to NPA (Madzhadzi, Akinsola, & Mabunda, 2017). As a psychiatric nurse, the author finds this especially ironic, as these professionals might be expected to bring a greater awareness of interpersonal dynamics to the NPR. Other studies identified labor and delivery

(Reynolds, Kelly, & Singh-Carlson, 2014), emergency department (Alves & Gustavo, 2015; Li, 2016; Teymourzadeh, Rashidian, Arab, Akbari-Sari, & Hakimzadeh, 2014), and the perioperative setting (Bigony et al., 2009) as especially prone to NPA. It appears that areas of high stress or patient acuity may be implicated in prompting NPA.

In the preceding section, research findings on situational antecedents of NPA were presented. They were organized as power dynamics, organizational culture, working conditions, and area of practice.

NPA Outcomes

NPA results in many untoward outcomes that cause problems for nurses, the nursing profession, and patients. In this section, patient safety, nurse morbidity, job satisfaction, and intent to leave are discussed as NPA outcomes.

Of the outcomes that ensue from NPA, patient safety concerns are the most worrisome (McNamara, 2012). Several research teams have reported that even subtle forms of NPA can have negative effects on patient safety outcomes (Hutchison & Jackson, 2010; Laschinger, 2014; Reynolds et al., 2014; Wolfe & McCaffrey, 2007). Laschinger (2014) proposed that NPA interferes with effective communication about patient care needs and processes, which interferes with effective patient care. The impact of NPA “cannot be overestimated, both in terms of errors, substandard care, and the negative effects of high turnover of experienced RNs who leave, compounded by the inexperience of newly hired RNs” (Wolf, Perhats, Clark, Moon, & Zavotsky, 2017).

Another compelling outcome of NPA is the effect that it has on nurses themselves. Studies examining NPA reflect 27% to 80% of nurse participants reporting

experiencing NPA (Sauer & McCoy, 2017). One study found that NPA impacts nurses' health depending upon the support resources that the nurse may have in her life, including friends and family, and whether the nurse is parenting children (Karatza, Zyga, Tziaferi, & Prezerakos, 2016). With so many nurses being affected by the phenomenon of NPA, a thorough understanding of the specific mental and physical effects NPA has on nurses is essential.

The mental health of nurses is directly affected by NPA (Bardakçı & Günüşen, 2014; Berry et al., 2016; Lin et al., 2008; Reknes et al., 2013; Trépanier et al., 2016; Wing, Regan, Laschinger, & Heather, 2015). NPA was found to lead to low self-esteem, anxiety, sleep disturbance, recurrent nightmares, and depression (Garth, Todd, Byers, & Kuiper, 2018). Another research finding brought greater specificity to these outcomes, stating that NPA “was linked to stress, anxiety, and posttraumatic stress symptoms unrelated to gender, race, educational attainment, prior history of being bullied, or work history on the unit prior to RN licensure” (Berry et al., 2016). Nurses with baseline anxiety and depression were found to fare worse than those without these baseline characteristics; as a reciprocal relationship was found between exposure to NPA and symptoms of anxiety and fatigue (Reknes et al., 2013).

Physical health effects such as eating disorders, weight loss, frequent headaches, even hypertension and angina have resulted from NPA (Hurley, 2006; Laschinger & Nosko, 2013; Maddalena et al., 2012; Murray, 2009). In particular, new graduate nurses suffer from these negative health consequences of NPA (Maddalena et al., 2012; Sauer & McCoy, 2017).

A Korean study found that nurses were coming to work while sick because they wanted to avoid the wrath of their peers if they were to call out sick (Kim et al., 2016). However, this study was based upon findings of only 20 nurses and should be replicated with larger participant groups and in varied settings.

A major concern among healthcare leaders is the effect that NPA has on job satisfaction, which is linked to nurses' burning out and leaving the profession. This phenomenon fuels nurse shortages, thereby negatively impacting healthcare. Recent studies have explored how these concepts inter-relate and are discussed below.

NPA was found to be a predictor of low job satisfaction in nurses (D'Ambra & Andrews, 2014; Laschinger, Leiter, Day, & Glin, 2009). Shatto & Lutz, 2017). The dynamic of NPA leading to nurses leaving their work was explored by Purpora & Blegen (2015). They found an association between NPA and job satisfaction with positive peer relationships attenuating the negative relationship between NPA and job satisfaction (Purpora & Blegen, 2015). Furthermore, a correlation was found between NPA and intent to leave nursing practice (Armmer & Ball, 2015; Viotti, Converso, Hamblin, Guidetti, & Arnetz, 2018). Results also showed that the longer nurses were employed, the more likely they were to see themselves as victims of NPA (Viotti et al., 2018). And younger nurses showed more willingness to leave employment due to perceived NPA than older nurses (Armmer & Ball, 2015). Another study found that a lack of peer support was related to lower job satisfaction (Han, Trinkoff, & Gurses, 2015). In these studies, there is some confusion and conflation of nurses' intent to leave their

current employment with their intent to leave the profession either temporarily or permanently. These concerns add to the lack of clarity regarding outcomes of NPA.

The negative outcomes associated with NPA include patient safety, nurse morbidity, job satisfaction, and intent to leave nursing. The research supports that the problem of NPA is dangerous and warrants effective intervention. In the following section, publications on NPA interventions are described.

NPA Interventions

Nurse researchers have proposed and tested a variety of means to rid the profession of NPA. Perreira, Berta, Ginsburg, Barnsley, and Herbert (2017) found an association among the concepts of work attitudes, work-related behaviors, and perceived organizational support. This underscores the potential for change that leaders in nurse work-settings wield. Education, leadership, zero-tolerance, and resilience are the categories of anti-NPA interventions to be described in the following section.

Educational interventions geared toward eliminating NPA have been frequently reported in the literature over the past decade. The following section describes these studies and their findings. The organization is as follows: recognition of NPA, assertiveness training, cognitive rehearsal, comportsment, and team building.

Nurses often fail to recognize NPA when they witness or experience it in the workplace (Armstrong, 2017; Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Schwartz & Leibold, 2017; Taylor & Taylor, 2017). This is yet another problem for the conduct of research on NPA. It has been found that educational programs that teach nurses to identify and name NPA have been developed and shown to be helpful in

dealing with NPA (Dahlby & Herrick, 2008; Nikstaitis & Simko, 2014; Schwartz & Leibold, 2017).

Assertive communication is another teachable skill that has been shown to assist nurses who encounter NPA (AHC Media, 2016; Ceravolo et al., 2012). Similarly, developing emotional intelligence can improve outcomes for NPA (Bennet & Sawatzky, 2013). A third related skill nurses can develop to manage NPA is giving and receiving feedback. In one study, nurses valued giving and receiving feedback in private (unless patient safety was at risk), delaying confrontation, using a calm tone, and acknowledging the co-worker's point of view (Lux, Hutcheson, & Peden, 2012). Padgett (2015) supported nurses in raising challenging conversations with peers to respond to NPA. Another study used a NPA case study to prompt a dialogue among nurse participants (Clark & Kenski, 2017). The study found that participants who subsequently spoke up to resolve issues, reported "better patient outcomes, greater satisfaction in the workplace, and heightened organizational commitment" (Clark & Kenski, 2017, p. 60).

Cognitive rehearsal is the educational process of role-playing a situation to develop skills in handling challenging real-life scenarios. A review study found that cognitive rehearsal was the best method to help nurses manage NPA (Stagg & Sheridan, 2010; Stagg, Sheridan, Jones, & Speroni, 2013). The high efficacy of cognitive rehearsal, sometimes called "role playing" or "simulation," to decrease NPA was found in other studies (Armstrong, 2017; Stagg et al., 2013; Ulrich, Gillespie, Boesch, Bateman, & Grubb, 2017). However, a third study assessed nurses, six months after an NPA-

orientated cognitive rehearsal program, finding that 70% of the participants believed they could handle NPA, yet only 16% reported they responded to NPA when it occurred (Griffin & Clark, 2014; Stagg et al., 2013). A high-tech version of cognitive rehearsal was developed and tested by Mallette, Duff, McPhee, Pollex, and Wood (2011) in which nurses, using avatars, acted out strategies to address NPA in a virtual hospital setting. It was also found to be successful helping participants to manage NPA (Mallette et al., 2011).

Cognitive rehearsal programs have been successfully used in transition programs for new nurses moving from school to the hospital (Regan et al., 2017; Rush, Adamack, Gordon, & Janke, 2014). This approach, like all cognitive rehearsal programs, was effective, as it helped the victim of NPA (the new nurse) develop protective skills in a supportive environment.

Another type of educational program to address NPA is that of comportment education. Professional comportment can be defined as a dignified conduct or manner and is considered critical for effective relating, communicating, and collaborating with colleagues (Clickner & Shirey, 2013). Two studies found that perceptions of professional comportment were associated with decreased NPA (Kenneth, 2017; Oja, 2017). Developing professional comportment promotes mutual respect, harmony, commitment, and collaboration among nurse colleagues, which was shown to be enhanced through educational interventions (Kenneth, 2017).

A final type of education intervention for NPA studied in the collected research is team building. Barrett, Piatek, Korber and Padula (2009) found that group cohesion and

nurse peer interaction scores improved after a team building intervention. “Group sessions focused on building trust, identifying and clarifying roles, engaging staff in decision making, role-modeling positive interactions, and holding each other accountable” (Barrett et al., 2009).

The preceding section has summarized research on educational interventions aimed at nurse victims managing NPA. Educational programs aimed at communication skill development and cognitive rehearsal have shown the greatest efficacy of all anti-NPA interventions (Stagg & Sheridan, 2010; Stagg et al., 2013). However, they do not actually eliminate NPA, rather they provide a way for nurses to manage NPA situations. In addition, the degree to which nurses used these techniques in their work lives was much lower than the level of skill development they attained in training (Griffin & Clark, 2014; Stagg et al., 2013).

Aggression (NPA) Summary

Various aspects of leadership were found to have significant influence on NPA. Olender-Russo (2009) suggests that nurse leaders should advance a culture of regard as an antidote to NPA. Authentic leadership has been said to diminish NPA, emotional exhaustion, and burnout among nursing staff, while enhancing job satisfaction (Laschinger, Wong, & Grau, 2012; Smith et al., 2017; Yokoyama et al., 2016). A quantitative study (Kaiser, 2017) found a correlation between leadership style and levels of incivility. However, this research was conducted using a convenience sample of 247 nurses; therefore, it is not generalizable to all nurses (Kaiser, 2017). Parker, Harrington, Smith, Sellers, and Millenbach (2016) found that nurse leader participants with support

from human resource specialists were able to successfully develop policies, performance reviews, and unit-based educational programs to address NPA. In addition, Smith et al. (2017) found that “nurse manager qualities were the principal factor of the nurse work environment associated with incivility” (p. 1). Studies also found that as nurses perceived caring from nurse leaders, episodes of NPA reduced (Longo, 2009; Poulsen, Khan, Poulsen, Khan, & Poulsen, 2016). Similarly, Othman and Nasurdin (2013) found that supervisor support was positively related to work engagement.

Another leadership concern found to effect NPA is that of workload (Yokoyama et al., 2016). As managers of nursing units, nurse superiors have the power to exert some degree of control over the flow of patients and staffing ratios. Therefore, the problem of workload in nurses’ work lives appears, from the staff nurse perspective, to be manageable by administration. It is unlikely that nurse managers have the same perspective, as they are caught between the demands of administration and the needs of the staff. This points out an essential factor to the understanding of NPA—perspective.

As leaders, nurse managers have the responsibility of managing NPA episodes. One management strategy for such situations is the 360-degree interview (Lanza, Zeiss, & Rierdan, 2009). The authors found that this approach has merit but is limited by the need for an administrative support for the technique to implement it on a nursing unit.

A program of “zero-tolerance” has been proposed as a solution to the problem of NPA (ANA, 2015a; Wilson, 2015). The American Nurses Association (2015) released a statement on NPA, which presented their stand of “‘Zero tolerance’ for incivility,

physical violence, and bullying across nursing specialty, practice, and academic setting” (p. 1). Wilson (2015) echoed the call for zero-tolerance programs across the nursing profession to curb NPA.

One study found that zero tolerance programs have not been successful (Castronovo, Pullizzi, & Evans, 2016). These authors boldly suggest that employers should be provided financial incentives to make sure that anti-NPA policies are enacted (Castronovo et al., 2016). This suggestion does not appear to be realistic in the current economic state of healthcare world-wide. Moreover, “zero-tolerance” is a slogan which is meaningless if nurses do not recognize NPA or feel a lack of power to call out the behavior.

Resilience has been defined as “the ability to return to a state of normalcy or to ‘bounce back’ from adversity” (Turner, 2014). Delgado, Upton, Ranse, Furness, and Foster (2017) found that “resilience is a significant intervention that can build nurses’ resources and address the effects of emotional dissonance in nursing work” (p. 71).

One study found that peer support enhanced emergency department nurse participants’ resilience when they were confronted with NPA (Hsieh, Hung, Wang, Ma, & Chang, 2016). Another study showed that peer support was positively associated with resilience score (Hsieh, Chang, & Wang, 2017). Thus, there appears to be a reciprocal relationship between resilience and peer support in the context of NPA; that is, NPA can be managed if the victim has peer support, and peer support appears to protect from NPA. McDonald, Jackson, Wilkes, Vickers (2011, 2013) found that programs aimed at increasing nurse resilience were effective in reducing NPA. Although, it seems

that success in this case was the NPA victim's ability to survive and bounce back from NPA, rather than actually decreasing NPA.

McDonald et al. (2011) found that "collegial support provided the most significant benefit when facing challenges or negative outcomes at work, even more effective than that of support from partners or close friends" (p. 126). In summary, resilience and programs to strengthen resilience among nurses appear to shield nurses from the dangers of NPA, rather than eliminating NPA. There seems to be such a strong connection between resilience and support that one should ask whether "support" rather than "resilience" was the operative factor in nurses withstanding NPA. Again, the ability to withstand NPA is not the same as eliminating NPA.

The preceding section presented the key research findings regarding interventions to address NPA. Educational programs, leadership, zero-tolerance programs, and resilience were discussed with all showing some degree of positive effect on nurses who experience NPA. Several issues were identified with this research, suggesting that formulating interventions for a phenomenon that is not well understood may be premature.

NPA research findings in the past decade were presented and discussed in this section of the literature review. Although NPA is only one component of NPR, it is one that has been an active focus of nursing research. Despite the proliferation of studies conducted on NPA—presented as individual antecedents, situational antecedents, outcomes, and interventions—the problem of NPA continues. It has been suggested that the "overall quality of bullying, harassment, and horizontal violence research is

limited; there particularly are few data-based intervention studies that provide foundational information useful for adoption by clinical settings” (Vesse et al., 2010). Important concerns that were identified in this review were: the variety of terms to describe NPA blur the interpretation of findings; antecedents of NPA are numerous and comprise both individual and situational characteristics, the relationships among these factors is still largely unclear; NPA is a severe, persistent, and dangerous world-wide problem; perspective is essential when assessing an episode of NPA; “zero-tolerance” is a slogan that is meaningless if nurses do not recognize NPA or feel empowered to call out the behavior; interventions to increase the ability of the nurse to withstand NPA do not eliminate NPA; and interventions may be premature without better understanding of the lived experience of nurse and the meaning that NPR have to her. In the following section, the positive effects of NPR are presented and explored through a summary of current research findings.

NPR Positive Effects

NPRs include NPA as well as positive aspects of NPRs. The next section explores positive aspects of NPRs, organized as follows: healing from workplace violence; developing positive characteristics in individuals; and managing workplace stressors. Longo (2011) studied nurses caring for nurses using Nursing as Caring Theory by Boykin and Schoenhofer (1993). “Tending to a caring environment” was found to be the central motivation of the nurse participants (Longo, 2011).

Healing Traumatic Workplace Events

Positive nurse peer relationships have been shown, in multiple studies, to support and heal the emotional trauma of NPA (Bloom, 2014; Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012; Jiyeon & Seonyoung, 2015; Moore, Leahy, Sublett, & Lanig, 2013; Purpora et al., 2015; Tamburri, 2017; Topa et al., 2013). In fact, nurses who have suffered trauma from workplace peer aggression seek help from other peers more often and with more success than from any other source (Rodwell, Demir, & Gulyas, 2012). This presents a confounding finding to the understanding of NPA—nurses psychologically injure each other but also heal each another.

Developing Positive Characteristics of Individuals

Research has shown that NPRs have positive effects on nurses' development of positive characteristics including social capital and dignity.

Social capital is defined as “the sum of the actual and potential resources derived from the network of relationships possessed by a social unit” (Nahapiet & Ghoshal, 1998). This concept represents the informal power that an individual has in the social setting and derives from positive relationships with peers. Shin and Lee (2016) found that nurses' social capital was positively related to job satisfaction and quality of care (self-reported). This study (Shin & Lee, 2016) was conducted at two university-affiliated teaching hospitals, so would not necessarily represent nurses working in other healthcare settings. Another study found that high levels of social capital among nurses are related to happiness at work, job satisfaction, and quality of work life (Hofmeyer & Marck, 2008).

Sabatino et al. (2016) found that nurses' relationships with nurse peers were linked to the social aspect of the concept of dignity. Similarly, Blackwood (2016) found that nurses who role-modeled a culture change toward dignity in practice found that "positive things happened on wards not just because she or her senior managers were around or had initiated them" (p. 4). Both social capital and dignity support nurses' sense of self in their profession and have positive implications for their engagement in their work. These studies exemplify the power of NPR to influence positive change.

Managing Workplace Stressors

Workplace stress can be the cause of nurses' emotional strain and burnout, and lead to them abandoning their profession (Elliot, 2017; Kaur & Malodia, 2017; Kellogg et al., 2014). However, the studies reviewed for this study showed that NPRs counteract the effects of workplace stress on nurses (Vahedian-Azimi et al., 2017). Several types of stress—emotional labor, adverse event stressors, and professional uncertainty—were studied. The results are discussed below.

Emotional labor is the act of displaying outward emotion to adhere to workplace or social norms. This results in suppression of authentic emotion, resulting in emotional stress (Elliot, 2017; Kaur & Malodia, 2017). Researchers found this phenomenon to be an important implicit component of nursing work (Elliot, 2017; Kaur & Malodia, 2017). Edward et al. (2017) highlighted the connection between emotional labor, peer support, and the growth of emotional intelligence among nurses. Supportive work environments, shared decision-making among peers, and facilitating the development of emotional intelligence and resilience were among their recommendations (Edward et al., 2017). A

study with renal nurses showed that they engage in significant emotional labor (Brown et al., 2013) These nurses identified “co-workers as the most important source of support due to their availability and a sense of shared experience” (Brown et al., 2013, p. 246). Again, the importance of NPRs in support of nurses’ work lives is evident.

The work of the acute-care nurse encompasses witnessing the most critical aspects of human experience, including pain, loss, illness, and death. When significant emotional incidents occur, both anticipated and unanticipated, nurses will respond with natural human emotion (Kellogg et al., 2014). Managing these experiences repeatedly as a part of ones’ work life occurs largely with the support of NPRs. Trossman (2016) studied the nurses’ emotional management of adverse events in the acute care workplace and emphasized the importance of peer support. A study focusing on oncology and palliative care nurses (Wittenberg-Lyles, Goldsmith, & Reno, 2013) found that the value of nurse peer communication and support is unique because of the high frequency of emotionally challenging events, including grief, loss, and patient death. Another study found that peer storytelling sessions helped grieving nurses to feel supported while making sense of their experiences (Rice et al., 2014). These authors found that through storytelling sessions “a dynamic relationship between mental, spiritual, and emotional-behavioral responses to grief” emerged (Rice et al., p. 551); creating cognitive readiness to learn about death and the development of emotional resilience.

Nurses who are new to practice, new to a setting, or encountering a new situation deal with professional uncertainty. One study found that nurses often rely on

the expertise of colleagues as a main source of information in such situations (Cranley et al., 2012). Unfortunately, these authors found that participants were often reluctant to admit their lack of knowledge and therefore did not express the need for support from peers. It would follow that by strengthening their trust in their peers, nurses could become more capable of asking for help.

The positive effects of NPRs were summarized in this section. These included: healing traumatic workplace events, social capital, and managing emotional labor. This concludes the presentation of literature findings on NPRs. In the next section, the theoretical framework for the study, symbolic interactionism, is presented.

Theoretical Framework: Symbolic Interactionism

Symbolic interactionism (SI) is an approach to the study of “human group life and human conduct” (Blumer, 1969, p. 1). SI forms the theoretical framework for the grounded theory research process. Studying meaning within NPRs, is an especially good fit for the SI approach to qualitative, grounded theory research. The following characteristics of SI support its application to NPRs: the basic premises, methodological approach, and the disempowered role nurses have in the healthcare workplace.

Blumer (1969) wrote that three premises underpin SI: 1) humans act toward things based on the meaning those things have for them; 2) the meaning derived from those things comes from the social interactions associated with them; and 3) these meanings are perceived and interpreted through a process the individual uses in relating with the world. Applying these premises to NPRs translates as: 1) nurses act toward peers based on the meaning that nurse peers have for them; 2) the meaning nurses

derive from peer relationships come from the social interactions associated with NPRs; and 3) the meanings nurses make of NPRs are perceived and interpreted through a process that individual nurses use in relating with the world. These statements outline the theoretical framework of the study and focus on human interaction as they relate to the study.

Methodological concerns can hamper research design, especially when something as subjective as relationships are the focus of study. SI and grounded theory have the advantage of having the “capacity to orient questions, inform design options, and refine analytic directions” (Handberg et al., 2015, p. 1023). Thus, SI drove the research methodology.

Lastly, the topic of NPRs lends itself well to the use of SI as the theoretical framework because the intent of this study is to reveal the meaning that NPRs have to nurses within the context of healthcare where nurses are at the lower end of the hierarchical structure. Denzin (1992) posits that SI is an interactionist framework which speaks to those who “occupy powerless positions in contemporary society” (p. 20). Nurses hold little power in the healthcare workplace. Therefore, the study benefits from an SI theoretical framework as appropriate to the individuals and the contextual elements of the NPR.

SI frames the study presented here by outlining the essential elements of this research interest, that of human interaction and its meaning, and driving the research design, particularly as the design relates to examining those of little power within large organizations.

This chapter has presented published literature on NPRs over the past ten years as well as a brief discussion of the study's theoretical framework, SI. The studies that met the criteria for inclusion were presented based on explicit factors (collegiality, teamwork, education, and peer review) and implicit factors (NPA and positive effects of NPRs). The complexity of the NPA phenomenon is seen as situated within many other aspects of NPRs. Explicit factors of the NPR have a place in the understanding of this relationship, and include socialization, teamwork, education, and peer review. However, the implicit characteristics of the NPR comprise a far greater volume and range of research studies than those regarding the explicit characteristics.

NPA is the most notorious, but not the only, implicit factor of NPRs. Antecedents of NPA include individual and situational factors, each of which appear to play a role in setting the stage for NPA. Research on the outcomes of NPA show the extent of the damage it can do to nurses, patients, and the nursing profession. Studies on a variety of interventions to reduce NPA have been shown to have a degree of efficacy, but this success is not in the elimination of NPA, rather it is in helping nurses withstand NPA. Chief among the many positive aspects of NPRs is the finding that nurses rely on nurse peers to heal from NPA, as well as other workplace hazards.

In summary, NPRs are multifaceted, complex, and sometimes contradictory. The infamous aspect of NPRs, NPA, has not been successfully addressed through a campaign such as "zero tolerance," which is often the recommended approach. The analysis and discussion of these research findings has been parsed into a framework of antecedents, characteristics, outcomes, and other aspects for presentation purposes. However, the

lived experience of finding meaning in NPRs occurs situated within all these factors simultaneously. The complexity of the literature review demonstrates the need for a new, more holistic approach to the understanding of NPRs; one drawn directly from nurses who are active in clinical practice. Thus, this grounded theory study of the meaning that nurses make of their workplace peer relationships clarifies the confounding characteristics of NPRs, illuminating the path to correcting this long-standing problem. The next chapter presents the methodological design of the study.

CHAPTER 3

METHODOLOGY

Introduction

Grounded theory (GT) methodology was used for this study to yield findings on the meaning that NPRs hold for nurses in clinical practice. The findings inform newer theory regarding how nurses inter-relate and the meaning of this relationship to nurses. In this chapter, the topics covered are grounded theory method, data sources (triangulation, interviews, and continuous reflexive journaling); data management, data analysis (constant comparative method, coding, memorizing, theorizing, theoretical sampling, and theoretical saturation); protection of human subjects, trustworthiness (credibility, triangulation, peer debriefing, and member checks); dependability and confirmability (audit trail and reflexive journaling); researcher qualifications; and a research timeline. The study methodology, grounded theory (GT) based on symbolic interactionism (SI), is presented first.

Method: Grounded Theory

Charmaz (2006) describes the GT approach as systematic, flexible “guidelines for collecting and analyzing qualitative data to construct theories that are grounded in the data” (p. 2). This research technique involves the researcher figuratively entering the lives of the participants by listening to their accounts of experiences, relationships, and, most importantly, the meaning these things have to them. From the early stages of data collection, the GT researcher notices and records both participants’ statements and his/her own reflexive responses to witnessing participants’ experiences and discussions

(Charmaz, 2006). Next, qualitative coding is conducted as the data is sorted and synthesized. As the coded data builds and is combined with reflexive findings from the researcher, memos accumulate and eventually themes will emerge(see Figure 3). These themes are fed back into the structure of the guided interviews to flesh out and investigate developing theoretical components and researcher hunches. Charmaz (2006) describes the culmination of these processes as “an abstract theoretical understanding of the studied experience,” or “grounded theory” (p. 4).

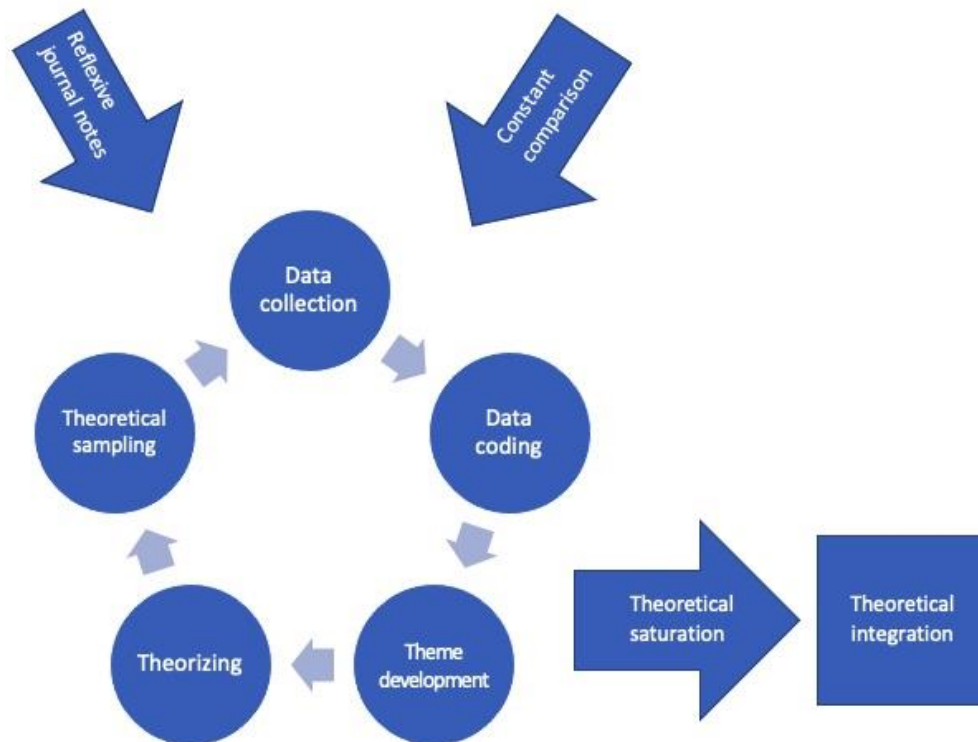


Figure 3: Grounded Theory Process

Within GT exist several subcategories of philosophies and approaches. Charmaz (2006) asserts that researchers who use GT are a part of the same world they are studying and that the theoretical picture produced from the research process is one of interpretation of this world, rather than being an exact rendering of it. This contrasts

with Glazer and Strauss' (1967) views on GT, in which theories emerge from data separately from the scientific observer or researcher. Charmaz's, or the "constructivist" approach, fits well with this study as it acknowledges the researchers' lengthy career in nursing and nursing education, which cannot be completely separated from the data-based theory this study will produce. On the contrary, the researcher's thoughts and feelings regarding the research will be collected and analyzed as reflexive journaling and considered one view among many" (Charmaz, 2006, p. 54).

Data Sources

The primary sources of data for this study were the participant interviews. Additionally, triangulation data included NPR-related job description information from an online government site and continuous reflective journaling or field notes.

Nurse Job Descriptions

The researcher accessed statements about the expectations of NPRs to healthcare administrators from open access government documents. The review of these documents was intended to be helpful in identifying explicit aspects of the NPR as described by the organizations and to serve as triangulation. Triangulation in qualitative research is defined as "the use of multiple methods or data sources to develop a comprehensive understanding of the phenomenon" (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). It is also used to test validity by seeking information on a phenomenon from different sources. Document review provided disparate data sources

on NPRs to compare with interview data. These findings were intended to enrich the understanding of explicit characteristics of NPRs.

Documents can be valuable information sources for GT research, as they are accessible, represent discrete moments in time, legally unassailable, and not subject to emotions (Lincoln & Guba, 1985, p. 277). Charmaz (2006) writes that texts or documents are often used as supplementary data in GT studies, providing a backdrop for the analysis of interview-derived data. These documents represent the nursing profession's explicit statements on NPRs and are important to bring to the analysis. As such, the study includes a review of NPRs from the perspective of nurse administrators as a means of comparing explicit aspects of NPR with implicit NPR findings from the nurse interviews.

Interviews

Information regarding the study's approach to interviewing participants is contained in the following section. It is organized as follows: setting, recruitment, access, participants, demographic data, and interview process.

Setting

In qualitative research, the research setting goes beyond the physical environment where the data is gathered (Holliday, 2016). The research setting includes such aspects as the timing of the data collection and cultural influences on both the researcher and the participant. The interviews for this study occurred in the summer

and fall of 2018 into and including all of 2019. They were conducted in coffee shops, restaurants, or hospital cafeterias throughout Southern New England.

This research occurred at a time in western and possibly global society where people were experiencing increasing interpersonal divisiveness, mounting to what has been called “a crisis of democracy” (Laruffa, 2017, p. 56). But it is important to note that the period of data collection preceded the COVID-19 pandemic, which had great impact on healthcare, nurses and presumably NPRs. Nevertheless, the unrest of the study period affected every level of society and was especially intense within institutions where power inequities are built into the hierarchical scaffold, such as hospitals (Brown, 2013). This background cultural crisis forms the outermost contextual realm for the NPR within the healthcare environment at the time of the study (see Figure 1). Similarly, economic, and political factors influenced healthcare and forced changes to nurses’ work environment. Nurses and patients were experiencing the fallout of such changes while wielding little power in their formulation. All these issues combined to influence NPRs. Other cultural factors, such as nurse unionization and related actions, economic changes that can affect individual nurses’ levels of stress, and the increasing numbers of mother-headed single parent households in the U.S. over the latter half of the 20th century, (Statistics Portal, 2017) also affected the setting in which NPRs have existed and evolved.

Recruitment

Nurse participants were recruited via word-of-mouth, snowballing means. An advertisement was posted at the College of Nursing at the University of Massachusetts

Amherst and at three local hospitals (see Appendix A). Therefore, participants were limited to the state of Massachusetts.

Access

The researcher recruited nurse participants through posting advertisements for participants around the University of Massachusetts Amherst College of Nursing campuses, both in Amherst and in Springfield, and at three local hospitals.

The inclusion criteria for individual interview participants were as follows:

- Registered nurses with an active license in the United States.
- Registered nurses who are fluent in the English language.
- Registered nurses who are willing to discuss their perceptions, attitudes, and behaviors about NPRs in a semi-structured face-to-face interview with the researcher for approximately 60 minutes in duration.
- Registered nurses who are willing to have the semi-structured face-to-face interview audiotaped and transcribed.
- Registered nurses who have access to email to contact the researcher about their willingness to participate in the research study.

The exclusion criteria for individual interview participants were as follows:

- Registered nurses who do not have an active license in the United States.
- Registered nurses who are not fluent in the English language.
- Registered nurses who are not willing to discuss their perceptions, attitudes, and behaviors about NPRs in a semi-structured face-to-face interview with the researcher for approximately 60 minutes in duration.

- Registered nurses who are not willing to have the semi-structured face-to-face interview audiotaped and transcribed.
- Registered nurses who have no access to email.

Participants

The cohort of nurses represented in this study includes hospital-based nurses with a range of professional experience, areas of specialization, and educational levels. All the participants were Caucasian, native English speakers, female, and from a single geographical location, western Massachusetts. Two of the participants identified as belonging to the LGBTQ community. The participants' varied in terms of their number of years of practice and clinical specializations, as well as in their levels of experience and insight regarding NPRs, although they also described many commonalities.

Demographic Data

Demographic information on the participants of this study is described here. The recruitment techniques contributed to the demographic characteristics of the cohort. The study participants were recruited using a snowball technique, relying on word-of-mouth communication, and posting recruitment signs at local hospitals and through the College of Nursing and the community hospital where the researcher teaches. Another recruitment source was the biannual nurse preceptor workshop that the researcher coordinates. This workshop attracts nurses from all over New England for a day of professional development around the skills involved in working with new staff and/or nursing students. Although this source for study participants could have recruited

nurses from geographically diverse locales, nurses from further away who were interested in participating in the study ended up declining, unfortunately, because of the logistics of the in-person interview. In the end, 14 nurses were interviewed (see Table 3 below).

The participant group represented a range of years of professional experience, from 1-5 years to over 30 years, and were fairly evenly distributed throughout the sub-categories. Five areas of clinical specialization were represented. Two of them, obstetrical and psychiatric nursing, were likely represented because they were the researcher's own areas of specialization. In addition, nurses who specialized in cardiac disease and bone marrow transplant participated. Interestingly, enrollment numbers from emergency nursing were high, even though the researcher has no links to this specialty. It may be that NPRs are of interest to nurses in high-stress settings such as the emergency department. The participant cohort included nurses with three levels of educational backgrounds, three with associate degrees, six bachelors prepared, and five with master's degrees. This represents a high educational profile than might be expected among hospital-based staff nurses. This could also relate to the researcher's own background and professional connections. Two of the fourteen participants self-identified as belonging to the LGBTQ community.

Table 3: Study Participants Education and Work Demographics

Years in Nursing Practice				
1-5	6-10	11-20	21-30	Over 30
2	4	3	2	3
Clinical Specialty				
Cardiac	OB	Psych	ED	BMT
1	2	6	4	1
Highest Level of Education				
AD		BS		MS
3		6		5
Length of Time in Current Position				
0-3	4-9	10-15	16-20	Over 21
5	3	3	0	3

Interview Process

Informed consent was obtained at the beginning of each interview (see Appendix B). A demographic data sheet (see Appendix C) was used to collect the following information: pseudonym, number of years as a Registered Nurse, area of specialty, current nursing position or last position held, gender, highest level of nursing education, and length of time working in current or last position (in years).

An outline of the guided interview is presented in Appendix D. Charmaz (2006) describes guided interviews and GT methodology as “open-ended, yet directed, shaped yet emergent, and paced yet unrestricted” (p. 28). One-to-one interviews were chosen as the primary source of data for the study because to use a focus group could have complicated the interpretation of individual nurses’ ideas about the meaning of NPRs. The researcher met in person with participants and audio recorded the interviews using a hand-held recording device. Of note, the relationship between the interviewer and participant is important to their interaction and affects the data to be obtained. Thus,

the researcher's identity as an experienced nurse was expected to be supportive to authentic communication with the participants.

The semi-structured interview questions and prompts were developed with the intent of obtaining information on the meaning of NPRs to the participants. The questions stem from the review of literature, and they are organized to address the negative aspects of NPRs last to support participants in presenting their own thoughts and feelings about NPRs without the potential influence that could be caused by the researcher bringing up the negativity of NPA first. The semi-structured interview format allowed the participants to self-determine the aspects of NPRs that hold the most meaning in their work lives. As a result of the iterative process of reflexive journaling, additional questions on effect(s) of unionization on NPRs and whether participants thought they had ever been perceived as a bully were added after interviews revealed these new areas of interest.

Continuous Reflexive Journaling

The researcher collected and considered field notes to promote reflexivity and support the iterative process throughout the conduct of this study. This continuous collection of informal notes by the researcher reflected information on tone, body language, volume, and emotional responses of the participants, which are not reflected in transcribed data. In addition, the interviewers' thoughts, impressions, and emotional responses to the participant during and following the interview were collected in the reflexive journal. These data points added richness to the interview transcripts and informed the expansion of the interview questions.

The researcher maintained an ongoing log of reflections throughout the study development, data gathering, and analysis stages of research. The review of this iterative process revealed a varied collection of additional data and nuanced observations regarding the study. Of note, three of the 14 participants presented such that the researcher came away with the impression that they had bullied nurse peers. The non-verbal cues the participants displayed, their emphasis on being extremely “direct” or confrontational with nurse peers who were at fault or had fallen short in practice in some way implied an aggressive stance within these relationships. In each of these three cases, the participant discussed their actions with a tone of pride. As though they saw themselves as strong, assertive, or as leaders in holding nurse peers accountable for their actions when others might not have spoken up in a similar scenario. These findings prompted an addition to the semi-structured interview question guide: a question regarding whether participants thought that nurse peers had ever perceived them displaying NPA. This in turn led to the addition of a question about whether they had ever apologized following a situation where, in retrospect, they felt regretful. Several of the subsequent interviews revealed positive findings regarding both new questions.

The reflective study log also captured several occasions that occurred during the study where the researcher was the recipient of nurse peer communication that felt aggressive and involved the use of power. These situations occurred during the study period and were therefore included as relevant data. As a participant/observer, the researcher in grounded theory research is highly involved in observing the self as well as

other participants. Therefore, the researcher's experiences and reactions were explored in the reflective log, adding to the data the real-time experience of being on the receiving end of NPA. The following is an excerpt from the reflexive study log:

Was bullied by RN in a clinical setting. In the role of the nurse educator arrived at the clinical unit and was 'greeted' by ... the charge nurse who knew my name although I had not met her previously.... 'Can you do me a favor? Can you make sure the students stand during change-of-shift report? My staff are not going to report because the room is too crowded. And BTW, you cannot wear perfume to this unit. We have a person who needs to be hospitalized when exposed to perfume!' I replied that I was not wearing perfume. [She then said,] 'It is definitely you.' She came back to me twice shortly thereafter saying, 'I'm sorry that I was abrupt with you but ...' These [seemingly apologetic] comments did not in any way feel apologetic – instead they seemed to be an opportunity gauge how upset she had made me.

[Two days later] Received a text from an employee/friend who works on the same unit. Out of the blue said, 'I just had to tell you no one has anything but nice things to say about you. The boss wants to know if you want a job here.' [I was then] thinking that a conversation had occurred about me that prompted the charge nurse to feel threatened and wish to exert power over me.

Experiencing the emotions resulting from NPA in real time added to the richness of the reflective log data. Those findings contributed to the researcher's understanding of the use of power to create a hierarchy where none officially exists. Another revelation from these experiences was the resultant interpersonal shutting down of the target of NPA (in this case, the researcher) in the face of unexpected aggression.

Data Management

The data was coded and managed using NVivo, a qualitative data analysis computer software program. As a student at the University of Massachusetts Amherst, College of Nursing, NVivo was available to the researcher for such purposes. Its features include: "Ability to import data from multiple media, multiple coding options using a

range of techniques, including a Quick Coding box, and powerful search, query, and data visualization tools” (University of Massachusetts, 2018). The master key, transcripts of the interviews and audio recordings of participants who have given permission for the use thereof were kept in a separate locked cabinet in the researcher’s locked office on campus after the conclusion of the study and will be maintained securely indefinitely. Participants were offered the option to indicate that they did not wish the researcher to use their audio recordings, but none made that choice. All participants provided written permission for the researcher to use their audio recordings and were informed that the recordings will be maintained securely indefinitely.

Data Analysis

The data was analyzed according to constructivist grounded theory methods. Constant comparative method, coding, memos, theorizing, theoretical sampling, and theoretical saturation are presented and discussed below. Data analysis involved both aggregate written documents and quotations from interviews.

Constant Comparative Method

All through the GT research process, the researcher constantly compares new data with previously collected data, looking for similarities, differences, trends, and eventually, themes (Charmaz, 2006). This process is important when comparing statements from the same participant, as well as comparing the statements among different participants. Likewise, findings obtained from document review, continuous

reflexive journaling, and interviews were compared, looking for contradictions and validations. These revelations were compared in the analysis stage of the study.

Coding

Audio recordings of in-person interviews were first transcribed using a professional transcription service. Next, using a constructivist grounded theory approach (Charmaz, 2006), the transcribed data was coded line by line by the researcher using NVivo software. As new codes emerged, previously analyzed transcripts were re-explored for these codes (Thorne, 2000). In open coding, the researcher read through entire transcripts while writing interpretive memos in response to the data. To ensure rigor of the analysis and interpretation, this process continued until a final list of themes had emerged and saturation was affirmed by review of the committee chair (Sandelowski & Barroso, 2007). Meticulous coding from the start of data collection supported the research process by accurately representing the participants' lived experiences and allowing the researcher to create categories and relationships among theoretical concepts (Charmaz, 2006).

Memos

Memo-writing is considered an essential step along with data coding and data analysis (Charmaz, 2006). Memo-writing is not to be reserved until all data has been gathered. Rather, it should be continuous and emerge from the researcher's field notes and musings as the research process proceeds. Questions, ideas, and connections can

arise through memo-writing. These important observations were fed back into the data-collection tools by adding to or changing the guided interview questions.

The next step in the grounded theory process is progression from memo-writing to the development of relationships among the identified theoretical concepts. As such, the coded concepts were developed into theory through the pictorial arrangement of them in relationship. This was arrived at and described visually through schematic representation.

Theoretical Saturation

Charmaz (2006) defines theoretical saturation as the time “when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of your core theoretical categories” (p. 113). During the analysis process, each major category that emerged from coding was monitored for both the need for theoretical sampling and potential saturation. Charmaz (2006) recommends that when the researcher is at an impasse in analysis, she recode data to look for new leads rather than assuming saturation prematurely. These ideas were utilized in the conduct of this study. No theoretical sampling was indicated.

Research Integrity

Research integrity was maintained through the following techniques: protection of human subjects, trustworthiness, dependability and confirmability, and researcher qualifications.

Protection of Human Subjects

The researcher completed the Collaborative Institutional Training Initiative (CITI; Appendix E). Institutional Review Board approval was obtained before beginning the data collection process. Informed consent was received from all the participants (Appendix B). The informed consent indicated that in agreeing to participate in the study, they were to be interviewed for approximately one hour. In addition, participants had the opportunity to decline or agree to the use of their recorded voice and whether they wished to make themselves available to the researcher for member checking, which occurred within 12 months from the time of the interview. All participants were provided a mental health resource referral list (Appendix F). None of them appeared to be distressed in any way following the interview.

To protect the privacy of the participants, the master key, transcripts of the interviews and audio recordings of participants who have given permission for the use thereof were kept in a separate locked cabinet in the researcher's locked office on campus indefinitely.

It was made clear that the participant could choose to withdraw from the research study at any point and/or decline to answer any question(s) without any penalty. This would be accomplished by the participant indicating their intent to withdraw and providing their identifying pseudonym to the researchers via email. No participants made this choice.

Participation in the study should not have had any direct benefits for participants. However, it may have been beneficial to the participants in that it allowed

them to express and analyze interpersonal experiences which may have been unresolved. This could have been cathartic for participants. None of the participants became overwhelmed with the discussion of sensitive topics. In case participants experienced troubling emotional responses to participation in the study, they were able to seek therapeutic support available through area resources using a mental health resource form (Appendix F) provided to them by the researcher. Despite her mental health background, the researcher did not act as a mental health professional for participants. Role clarity is essential to the conduct of the study.

Trustworthiness

In keeping with qualitative methodology, trustworthiness, in lieu of generalizability, was the aim in this study (Polit & Beck 2006). To assure quality and rigor in the qualitative research process, demonstrating trustworthiness through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985) was planned for the study. The following approaches were used to demonstrate trustworthiness of the study: triangulation through document review, member checks, audit trail, and field notes.

Credibility

Charmaz (2006) suggests that proof of credibility of GT research is established through the researcher achieving intimate familiarity with the topic, showing data sufficient to support merit claims, making systematic comparisons between observations and categories, having strong logical links between data and

analysis, and forming findings that readers would arrive to had they assessed the same data on their own.

Member Checking

The process of “member checking” is used in grounded theory research for the purpose of sharing with participants the emerging concepts for respondent validation (Sikolia, Biros, Mason, & Weiser, 2013). Birt, Scott, Cavers, Campbell, & Walter (2016) said:

The trustworthiness of results is the bedrock of high-quality qualitative research. Member checking, also known as participant or respondent validation, is a technique for exploring the credibility of results. Data or results are returned to participants to check for accuracy and resonance with their experiences. (p. 2)

Three participants were contacted to perform member checks. The three participants had agreed to be contacted for member checking at the time of consenting to the study. The researcher arranged recorded zoom meetings where she reviewed the study processes and findings including the NPR Model. The feedback from the participants was overwhelmingly positive, supporting the validity of the findings taken from the data analysis. Specific points that were agreed with included: the need to seek to better understand and support positive NPRs; the importance of changing the charge nurse role to be permanent and less a flashpoint for NPA; the unfortunate truth that change-of-shift report is often a theatrical stage for NPA drama; weekend groups are extremely important to the work life of the nurse; and the importance of developing strategies to be used in entry to practice education to better prepare nurses for navigating NPRs. The participants expressed excitement and support for the identified

intervention points and thought that they could be implemented and make positive changes in NPRs.

Dependability and Confirmability

To claim trustworthiness, a research study must prove to be both dependable and confirmable. In the next section, these topics are described for the study within the following categories: audit trail and reflexive journaling.

Audit Trail

An audit trail was developed to provide a map of the researcher's logic, methods, data collection processes, analyses, and theoretical thinking. The researcher's raw records must be accessible to an auditor to assure trustworthiness (Lincoln & Guba, 1985, p. 109). The following categories of materials (adapted from Lincoln & Guba, 1985, p. 320) were maintained from this study as a part of the audit trail: 1) raw data (recordings of interviews, field notes, documents to be analyzed); 2) data reductions and analysis products (write-ups of field notes, written notes from the coding of data); 3) data reduction and synthesis products (notes on construction of categories and themes and from meetings with committee chair in discussing these topics); 4) process notes (notes regarding design and trustworthiness); 5) materials relating to intentions and dispositions (reflexive journals).

Reflexive Journaling

As described above, the researcher maintained reflexive journaling throughout the study, from the beginning of recruitment through the completion of the writing

process. This process provides rich data regarding observations of the researcher that are not reflected in the transcribed interview data. The researcher's own thoughts and responses to the interviews were collected as well and considered valuable data by constructivist GT philosophy.

Researcher Qualifications

The researcher has been a registered nurse for 35 years, working in clinical practice, advanced practice, and nursing education in the clinical areas of women's health and psychiatric mental health. As a part of the Ph.D. education process, the researcher has completed courses on conducting qualitative research both in the College of Nursing and the School of Education. In addition, she has collaborated with a peer on coding and data analysis of a qualitative research project. This background and experience supported the conduct and analysis of the research.

Triangulation

Triangulation is an aspect of the research process whereby data is collected from a different source on the same topic and compared to the original data for the purpose of assuring validity (Researchgate.net, 2020). Triangulation helps to establish credibility of the research findings (Sikolia et al., 2013). It was originally planned to be achieved by searching for online sources of nurse job descriptions that include the employer's expectations of NPRs. However, that plan became infeasible as few nurse employers' job descriptions were found online. Instead, a comprehensive index of common job descriptions and components thereof, O*NET.org., was used. This site came at the

recommendation of a Director of Human Resources colleague from a large institution of higher learning. It was the Employment and Training Administration, U.S. Department of Labor's (ETA/USDOL) site of job descriptions. This site is self-described as:

The O*NET system is maintained by a regularly updated database of occupational characteristics and worker requirements information across the U.S. economy. It describes occupations in terms of the knowledge, skills, and abilities required as well as how the work is performed in terms of tasks, work activities, and other descriptors.

The O*Net summary report for the role of "registered nurses" and "acute care nurses" were found to be the most applicable terms for expanding the study's scope and perspective in understanding the expectations of NPRs in the workplace. These two job descriptions were quite similar in content. Both organized job expectations under varied headings, which included tasks, knowledge, skills, abilities, work activities and work contexts. The content was reviewed with an eye toward identifying the employer expectations of nurses that relate specifically to NPRs.

The O*Net findings were then compared with the major findings from the interview data as presented in the previous chapter. The O*Net findings are presented in Table 4 below along with the related thematic findings from the interview data. Each skill described as an important component of the job description for the roles of the registered nurse and/or acute care nurse was found to be directly related to each of the major findings from the interview data. This alliance of data supports the trustworthiness of the study.

Table 4: O*Net Job Description Components that Relate to NPRs for RNs and Acute Care Nurses Compared to Interview Thematic Findings

Skills	Registered Nurse (RN) and Acute Care Nurses Role Expectations	Related Thematic Findings from Interview Data
Tasks	<p>Consult and coordinate with healthcare team members.</p> <p>Observe nurses and visit patients to ensure proper nursing care.</p> <p>Collaborate with members of multidisciplinary health care teams.</p> <p>Provide formal and informal education to other staff members.</p> <p>Read current literature, talk with colleagues, and participate in professional organizations or conferences to keep abreast of developments in acute care.</p> <p>Participate in patients' care meetings and conferences.</p> <p>Participate in the development of practice protocols.</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>
Knowledge	<p>Psychology: Knowledge of human behavior and performance; individual differences in ability, personality, and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioral and affective disorders.</p> <p>Education and Training: Knowledge of principles and methods for curriculum and training design, teaching and instruction for individuals and groups, and the measurement of training effects.</p> <p>Therapy and Counseling: Knowledge of principles, methods, and procedures for diagnosis, treatment, and rehabilitation of physical and mental dysfunctions, and for career counseling and guidance.</p> <p>Sociology and Anthropology: Knowledge of group behavior and dynamics, societal trends and influences, human migrations, ethnicity, cultures and their history and origins.</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>
Skills	<p>Active Listening</p> <p>Social Perceptiveness</p> <p>Service Orientation</p> <p>Speaking</p> <p>Coordination</p> <p>Monitoring</p> <p>Instructing</p> <p>Learning Strategies</p> <p>Persuasion</p> <p>Social Perceptiveness</p> <p>Time Management</p> <p>Systems Analysis</p> <p>Systems Evaluation</p> <p>Management of Personnel Resources</p> <p>Negotiation</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Characteristics</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>

Abilities	<p>Oral Comprehension</p> <p>Oral Expression</p> <p>Problem Sensitivity</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>
Work Activities	<p>Assisting and caring for others</p> <p>Establishing and maintaining interpersonal relationships</p> <p>Interpreting the meaning of information for others</p> <p>Translating or explaining what information means</p> <p>Training and teaching others judging the qualities of things, services or people</p> <p>Developing and building teams</p> <p>Coordinating the work and activities of others</p> <p>Communicating with supervisors, peers, or subordinates</p> <p>Coaching and developing others</p> <p>Guiding, directing, and motivating subordinates</p> <p>Resolving conflicts and negotiating with others</p> <p>Handling complaints, settling disputes, and resolving grievances and conflicts, or otherwise negotiating with others</p> <p>Judging the qualities of things, services, or people</p> <p>Provide consultation and advice to others</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>
Work Contexts	<p>Work with work group or team — 81% responded “extremely important.”</p> <p>Impact of decisions on co-workers or company results — 69% responded “very important.”</p> <p>Coordinate or lead others — 44% responded “very important.”</p> <p>Deal with unpleasant or angry people — 56% responded “once a week or more but not every day.”</p> <p>Frequency of conflict situations — 54% responded “once a week or more but not every day.”</p> <p>Level of competition — 33% responded “moderately competitive.”</p> <p>Deal with physically aggressive people — 56% responded “once a month or more but not every week.”</p>	<p>Self-Awareness</p> <p>Situational Awareness</p> <p>Interpersonal Skills</p> <p>Nurse Trait</p> <p>Nurse State</p> <p>Explicit Environmental Factors</p> <p>Implicit Environmental Factors</p>

Work Styles	Adaptability/Flexibility Cooperation Concern for Others Dependability Independence Leadership Stress Tolerance Self-Control Social Orientation	Self-Awareness Situational Awareness Interpersonal Skills Nurse Trait Nurse State Explicit Environmental Factors Implicit Environmental Factors
Work Values	Relationships — Occupations that satisfy this work value allow employees to provide service to others and work with co-workers in a friendly non-competitive environment. Corresponding needs are co-workers, moral values and social service. Support — Occupations that satisfy this work value offer supportive management that stands behind employees. Corresponding needs are company policies, supervision: human relations, and supervision: technical.	Self-Awareness Situational Awareness Interpersonal Skills Nurse Trait Nurse State Explicit Environmental Factors Implicit Environmental Factors

Another important aspect of the triangulation information is the comparison between what the job descriptions reflect, which presumably describe the expectations of nurse managers and administrators of nurse employees, and the nurse interviewees' perspectives on the importance of NPRs to nurse administrators. Reading through the job expectation information, nurse employers have specific and copious expectations of the NPR. This finding contrasts with the findings from the interview participants who downplayed the importance of NPRs in their employer expectations. Rather, participants overwhelmingly felt that employers only expressed expectations about their roles, including expectations related to NPRs, at their annual reviews. They felt that it was their own self-imposed expectations for NPRs that played out in their day-to-day peer interactions. As described in the previous chapter under the headings Explicit Environmental Factors, Manager Related Factors, and Lack of Interest in NPRs, study

nurses did not see their nurse managers or administrators as being invested in attending to NPRs. Rather, they saw the explicit expectations for NPRs found in written policies or job descriptions as merely perfunctory.

The acute care nurse job description NPR role components differed from that of the registered nurse around the notions of systems relations, professionalism, and dealing with conflict or aggression. These differences highlight the challenges faced in acute care settings, which may not be as expected in sub-acute care settings. This finding was supported in the data from the interview participants who worked in acute care settings, which reflected encounters with conflict, aggression, and systems issues. Issues of professionalism were not emphasized by the participants as important to their experiences of NPRs.

In summary, triangulation achieved validation of the study's interview findings. But, simultaneously, it showed a disconnect between the job description contents describing the NPR and the perception of the interviewees about their manager's investment in the NPR. Rather, it showed the enormity and complexity of nurse employer's expectations regarding NPRs. This was contrary to interview findings in which nurses universally dismissed as perfunctory or unimportant any expectations of NPRs by their employers. This suggests that the NPR is far more important to employers than nurses recognize. This disconnect warrants further analysis through the research process.

Research Timeline

The research process (see Table 5) was longer than initially planned due to a myriad of factors including the onset of the pandemic and its effect on the researcher's teaching obligations. Also, recruitment was more prolonged than initially anticipated.

Table 5: Research Timeline

Time Frame	Applications/ Requests	Interviews	Coding/Analysis	Comments
May 2018- Sept. 2018	Seek IRB approval			
Sept. 2018- Sept. 2019	Approval granted	Interviews with nurse participants		Publicize request for nurse participants
Oct. 2019- Dec. 2019			Begin review and coding of documents	
Jan. 2020- March 2020			Continued coding/analysis	
March 2020- June 2020				Pandemic, increased requirements for teaching
June 2020- Sept. 2020			Begin analysis and model development	
Sept. 2020- Nov. 2020		Conduct member checks	Collect triangulation data	
Nov. 2020- Jan. 2021			Complete analysis and write-up	

Chapter 3 presented data collection, data analysis, protection of human subjects, trustworthiness, researcher's qualifications, and the research timeline planned for this study. This grounded theory study was done by collecting, coding, and analyzing data from interviews and reviewing documents to uncover new insights into NPRs and NPA situated therein. Measures are described to safeguard the wellbeing of the participants. The results of the research have the potential to refocus the efforts of the nursing profession to eliminate NPA through an improved understanding of the NPR.

CHAPTER 4

INTERVIEW FINDINGS

This chapter presents the interview finding themes or factors which affect NPRs. They were identified through the coding process from the 14 interview transcripts. The iterative process of sorting and coding using NVivo software revealed multiple themes and subthemes. Major themes developed through this process were relational factors, nurse characteristics, and environmental factors (see Figure 4). Within each theme, several sub-themes and, for some, a further level of delineation was identified and is presented below. Because all the nurses interviewed for this study identified as “she, her,” those pronouns will be used in the discussion. Although it is acknowledged that nurses may also be non-binary or male in gender.

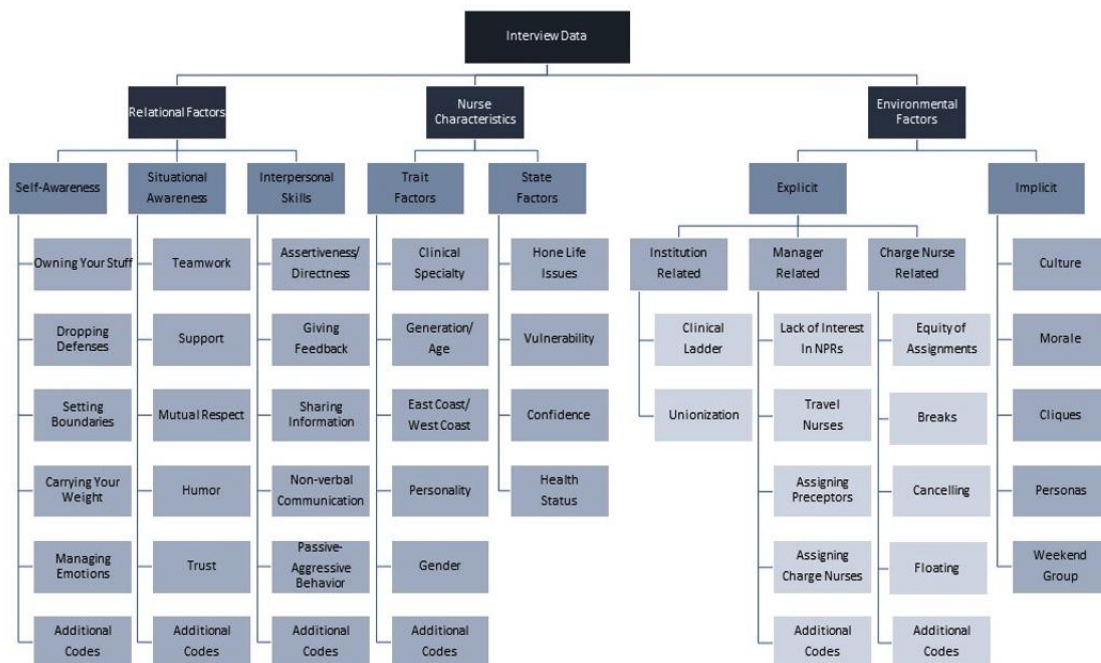


Figure 4: Code Tree of NPR Interview Findings

Relational Factors

Relational factors are those that describe interpersonal influences on NPRs. They include self-awareness, situational awareness, and interpersonal skills. Each of the interviewees described in detail the importance of relational factors in making meaning from NPRs. They are described below.

Self-Awareness

Self-awareness has been defined as the capacity for being the object of one's own attention, actively identifying, processing, and storing information about the self (Morin, 2011). For this study, self-awareness factors include owning your stuff, dropping defenses, setting boundaries, carrying your weight, managing emotions, recognizing aggression in yourself, and denial. Most of these themes or factors speak to a nurse's insight into her own function within the NPR. Denial, presented lastly, is the lack of such insight.

Owning Your Stuff

The notion of "owning your stuff" exemplifies self-awareness in a profound way. It implies admitting to shortcomings or vulnerabilities. One participant, described the phenomenon of "owning your stuff" in a situation with a male peer who had previously been highly critical of others:

And he said, 'Oh, I did that wrong.' And that was like, 'Whoa, he said that!' So, I think there is a comfort or an ease that comes from more familiarity. And I think I've definitely owned my stuff with him, my errors or whatever. And I'd like to think that that has helped there be ease, at least between the two of us. I think it's made him feel safer. Because he does feel like an insecure person.

This quote shows the benefit of both Iris and her peer using self-awareness in admitting their own shortcomings or “owning their stuff.” In this case, the dynamic was perceived as allowing a highly critical peer to also see the acceptability of being imperfect. This situation is more likely to come about in relationships with a high degree of trust as well as individual self-confidence. Another example is presented in the following quote where the nurse talks about taking responsibility for herself:

I do my own work. I have support groups. I do therapy. I have a lot of conversations with a manager now that I can trust. I talk to other coworkers. I say, ‘Please give me feedback and ...Anything you want to tell me.’ And people feel like they can. ... it takes a lot of work. And this just didn't happen. We're talking about years of being in health and human services. Years of being a social worker before being a nurse.

Dropping Defenses

“Dropping defenses” is strongly related to “owning your stuff” but involves recognition of the skills of a critical peer as well as accepting one’s own shortcomings. Iris continued to describe the same situation, saying how over time, she let her defenses down with the critical peer and was able to find genuine respect for his expertise:

I've become more comfortable with that nurse. In part, I've had to let go of my feeling of needing to protect myself in letting on because he does know a lot...he's just one of these people who just makes it a point of paying a huge amount of attention to policies... I have become more comfortable with saying, ‘Hey, how do you look up a policy?’

Another nurse described using an appreciation of different skills, talents, and limitations among nurses as a guide to patient assignments rather than a competitive element. She talked about working with an ICU nurse who came to her emergency department to help, saying that:

...in a trauma room, that's where [the ICU nurses are] going to feel comfortable. And honestly, the way I saw it too as an emergency nurse, yes, I'm competent, but they're more competent [with those skills]. And so why would I not have somebody who's better at it do that, and then I'm freed up to use my skillset as an emergency nurse.

Setting Boundaries

Another important factor revealed in the interviews was that of nurses setting boundaries for themselves. In the following quote a nurse describes having a clear boundary between homelife and work life: "I just feel so much like I try to park my personal stuff at the door, to the extent that I can. And I have a breathing technique that I do on my way into the unit."

Similarly, another interviewee described a grounding technique she used to prepare herself for the workplace, setting a boundary between her needs and those of her patients, saying "I'm exhaling, just really consciously trying to leave my stuff with my kids or ... whatever, ... out there. I'm rested, I'm fed, I'm here for my patients."

The next quote shows the extent to which one nurse considered boundaries as important to her work:

I think that's the most beneficial thing, ... not taking your work home, but [also] not bringing home to work. I see some nurses that they're very involved in what's going on at home, which I completely understand. I have a daughter who has severe allergies, she has asthma, chronic asthma, and so sometimes I'm very pulled away from work. But if I can get somebody to help take care of that at home so I can be present in work, it really helps with just how my workflow goes, how my energy goes at work. There's less negativity, there's less emotions that are unnecessary to be in the workplace ...

The following example shows how friendships outside of the workplace can complicate clear NPR boundaries:

I've also seen it go poorly with nurses who just are ... They got too close and then something happened at work and they weren't able to cope with it in the right state of mind because they had an argument the night before, or they're really good friends. A big thing that I really see a lot is people who are really good friends. When one nurse is going through something and might say a side comment to one of them. Very unmaliciously, but just said something, because they were in the moment, they were rushing around and stuff, and they needed help, and someone wasn't helping. And the other nurses will kind of gang up on that one nurse. So, there's a lot of bullying, I guess is what happens, [people think] 'she's my friend, why would she be rude to me!?' ... if you can just realize that this nurse was in the moment, was doing a million things, nobody was helping her, and she said something that might have been a little rude, and not take it to heart, you know?

The following is a quote from one of the study nurses in which she describes how boundaries can become blurred with familiarity:

... those areas become very blurred. At least that's my experience. I think that what happens in any relationship when you start to get to know people well enough, there's a certain entitlement. I think not necessarily a legitimate one, but there's an entitlement that sort of almost says, okay, I know you well enough, now I can push these limits because we're more like family and you're not going to just run my butt down to human resources if I get into a little bit of an argument with you and our voices get raised.

Carrying Your Weight

An especially important factor that relates to boundaries and self-awareness is that of each nurse carrying her own weight. As with most of the coded factors of NPRs, this concept exists on a continuum from carrying your weight to not carrying your weight. One participant said, "I know that they're going to carry their own weight or taking responsibility for the work of their own assignment."

Another interviewee described the importance of weight carrying (an aspect of self-awareness) but acknowledged the simultaneous importance of situational

awareness (to be discussed in another section), saying, “I’m not going to have to take care of their patients. And they’re going to be aware of me and my patients.”

Managing Emotions

Nurse participants also talked about the importance of managing emotions in the clinical setting, which requires a high degree of self-awareness, saying, “You have to be smarter than your anger.” Another participant said, “I can't afford to get angry and lose my perspective. I can't change the situation, only thing I can control is how I react.”

Recognizing Aggression in Self

At an even deeper level of self-awareness one participant talked about the revelatory experience of retrospectively recognizing her own aggression in a NPR, which she felt did not fit with her self-image:

Yeah. I like to think, especially because of my experience, and maybe because of who I am, that I don't wanna belittle anybody, and I want to be patient and be supportive of people who I work with. There was a time when I found myself being short with a new hire, and caught myself, like, ‘Whoa, what am I doing?’

Another interviewee shared a similar retrospective insight when asked about time when others might have seen her as a bully.

I know she knew what I thought about her.... I don't think I would change how I said things because I was disappointed that she should have realized that she wasn't cutting it, and that she really needed to be somewhere else.... I could see from her perspective I might have been bullying, because to me she wasn't safe ... at all, for patient care, in our setting.

This insight shows the benefit of self-reflection in understanding the difference between what one intends to convey and what may be perceived by the person receiving that communication.

Denial

The absence of self-reflection can be understood as denial. This phenomenon is seen in the following quote from one study participant, wherein the speaker seems to both admit and deny bullying:

Maybe some of the young need a bite now and again.... I don't bully, I really don't. I don't feel like I do. But yes, I interrupt. Because if they're not getting the subtlety then you just have to make it stop. They have to take care of the patients and do it right. And if they're not doing it after repeated subtleties you've just got to say, this is what we expect.

This quote also speaks to the close association of directness with NPA.

Directness, in its more positive iteration is discussed further in the upcoming section on interpersonal skills. The tension of one interpersonal concept existing along a continuum, having both positive and negative poles is a recurring phenomenon of the NPR research findings.

The preceding section outlined the themes regarding self-awareness within the theme of relational factors of NPRs. They included owning your stuff, dropping defenses, setting boundaries, carrying your weight, managing emotions, recognizing aggression in self, and denial. The next section depicts a second theme within relational factors, that of situational awareness.

Situational Awareness

Nurses with situational awareness have been described as able to “anticipate patients’ needs by knowing what’s going on, why it's happening, and what’s likely to happen next. By seeing the big picture, nurses can recognize events around them. They act correctly when things go as planned and react appropriately when they don’t”

(Cohen, 2013, p. 64). Like self-awareness, situational awareness exists on a continuum from a high level to a low level. From the study findings, the categories of coded themes that depict situational awareness include teamwork, support, humor, trust, apologizing and thanking, checking in, checking with a third party, and reframing. At the other end of the spectrum of situational awareness are the categories of competition, disregarding the feelings of others, blinders on, abandoning peers, wild west or every man for himself, and habit. One interviewee described situational awareness as being essential to NPRs:

First of all, you have to have awareness ... that's really, really important. Not all nurses have ... awareness. Or they might superficially be aware, but they're not really aware.... They'll say they're aware ... but the[ir] actions and the behaviors don't match that statement. So, you first have to be aware. Second, you have to really want it. You have to really say, 'These relationships are important.'

Teamwork

The concept of teamwork is extremely important to the work of the hospital-based nurse. The following quote shows the close alignment nurses have with their teammates or peers: "When someone is eating their meal, if their patient calls, we will cover it, unless it's something we have to ask them.... We work very well together." Interestingly, further in this chapter we will see the same scenario where a nurse is answering a call for another nurse but that action is seen as NPA. The interpretability of actions in the NPR is represented in the model in Chapter 5 as the intention-perception tension (see Figure 7).

In the following quote the interviewee describes teamwork among nurse peers in greater detail:

It comes down to teamwork, it comes down to communication. It comes down to making sure that you know when to ask for help. To give an example, when they say an ambulance is on the way in, ... the expectation is that everybody gathers in that room. We all delineate what we'll be doing with the patient, that we cooperate and that we know our role, and that we support each other. One nurse would never have to manage that, so the patient becomes everybody's patient. We support each other.

Support

Closely associated with teamwork is the NPR phenomenon of support. The following quote shows one participant's experience of NPR support both on the unit and off.

She's my go-to person ... [e]ven if she's not working, I'll just text her and say, 'Oh, this really hard thing happened,' and she's just that constant support of reassurance and that feeling of when nobody else seems to really get it, it's usually, it is, it's your peers that truly understand what you're going through. But she's that one that will see me feeling a little frantic and say, 'All right, okay, ... what do you need me to do?'

The next quote shows another support description wherein only one nurse peer offered the particular type of support this nurse interviewee needed at that moment in taking in the reality of a patient death: "This older nurse was the only one who could get through to me that I was ... doing the right thing.... She was just the only one who could really tell me that it was okay."

The third example of a participant statement relating to teamwork places the importance of peer support in the context of the nurse's work world.

I think that the quality of the nurse peer relationship has a huge effect on my feeling of satisfaction with my job. And I think good, respectful relations between nurses definitely makes for a better, safer environment for the patients. If I'm stressed out about something that somebody said to me that felt not respectful or whatever, where's my attention?

Humor

Several interviewees discussed the importance of humor in the experience of NPRs. One interviewee described one of her most valued NPRs saying,

She was amazing.... We used to laugh every shift 'til we cried. We just had something about, no matter what was going on that day was not going to end with both of us not laughing about something. We could just look at each other, like if one of the doctors came by and was acting ridiculous, she would just kind of give me the side eye, and we'd be gone, right there in front of them. Humor is an important part of everything I do.

Trust

Another important aspect of situational awareness to the study participants was trust. One participant said, "They're going to trust me and ... I can trust them to be aware of what's going on in our section and the whole ... department, [and] trust that they're going to work to take care of our patients." Another interviewee remarked:

The trust that you gain in working with people, you know who are your clinical experts ... who are good critical thinkers ... And if you're having a problem differentiating between situation A versus situation B and you say to your co-worker, 'What do you think I should do?' When you trust that co-worker then you trust their opinion, and they help guide you to be a better nurse.

Apologizing/Thanking

A certain level of situational awareness is required for a nurse to realize when to apologize or to thank a peer. These seemingly simple actions can be foundational, especially when working in highly charged situations where emotions can flare. One participant remarked, after thinking about the staff accepting her (in the charge nurse role) pushing them during a very stressful shift, "I think it's because I said, I'm sorry, I

had to do this, and thank you for sucking it up. Thank you so much. Totally appreciate it. You understand why I had to do it? They [said] yes.”

Another study participant talked about receiving and accepting an apology from a nurse peer, explaining, “We had a conversation about it [and] she apologized. I definitely felt like I expressed my reaction and my reasons about it. And we kind of got over it.” In this next quote, the nurse uses self-reflection to identify when to apologize: “and then you come back around, and you can recognize that those moments were a little bit, maybe embarrassing or not the way I wanted to present myself and I apologize.” The social niceties of apologizing and thanking were deemed to be important to NPRs and spoke to the situational awareness of nurses involved.

Checking In

“Checking in” was defined by the interviewees as a casual connection between nurses where one nurse asks the other how her shift is going. One study nurse explained in detail, saying:

I’ve had nurses where I’ve ...ask[ed] them a question and they’re [so] stressed out [that] they just go off. I also know myself that I have not been supportive or positive in the way that I want to be if I don’t have my stress in check. Everybody’s capable of being inappropriate. It’s constantly checking in. I’m hypersensitive to [aggressive] behavior of not just my peers, but myself. Like I don’t like it if I’m being snarky or inappropriate or short or impatient. And I think we’re ripe for it. Which is why we have to constantly be aware of it and check in with each other.

Checking with a Third Party

A different form of checking that participants talked about was used when a concerning peer interaction has occurred in the workplace and a nurse involved seeks

out an uninvolved peer to gain perspective on the situation. One nurse felt that having an impartial third party was so important to nursing that coaching should be made available, saying:

I kind of want to be a life coach. Not a life coach in general, I think there's a need to be a life coach for nurses in their career. Most nurses in institutions have nowhere to go to have that private, safe conversation related to personal growth and how to negotiate a situation, without losing who they are.

Another example of checking with a third party is shown in the following quote where the nurse had not recognized bullying but saw through the eyes of the third party:

[She said] 'Well, one of them's bullying, one of them is a follower of the bully!' I didn't really recognize it. I really searched my imagination, like, what am I doing wrong? I tried all these different ways to communicate, and then somebody said, 'You know, they're just classic bullies. I was like, you're right.'

A similar comment came from a participant who had first been a social worker, prior to becoming a nurse. Supervision is the process where a junior counselor or therapist has regular meetings with a more seasoned therapist to discuss their cases. It is a strategy to strengthen skills and minimize conflicts. The interviewee said, "In social work they have supervision built into the job structure, it's expected of them! We [nurses] really need that too!"

Reframing

Related to "checking it out with a third party" is the concept of reframing, wherein a nurse considers an interaction and can see it in a different light. This can occur through a discussion with another person or through an internal self-reflective process over time. One participant described a NPA situation where she was feeling

incompetent based on the feedback from her peers but was able to see another perspective of her work by talking it through with her nurse manager, saying:

Through the eyes of the peers who are so negative toward me, ... I [said to myself] 'apparently, I can't do this ... I'm not the right kind of personality for this role, and I'm miserable all the time.' It was only [by listening to my manager's perspective] that in his reflection that I was doing fine.

Competition

One nurse spoke about the ease that she felt when working with a peer in the absence of competition: "So doesn't have the need to prove anything to me as far as knowing more than me." This quote exemplifies the phenomenon where nurses use knowledge as power within the NPR.

Disregarding Feelings of Others

At the opposite end of the spectrum of situational awareness is the destructive behavior of disregarding the feelings of nurse peers. As a nurse, it would be out of keeping with the profession's inherent value of caring to intentionally disregard the feelings of another person. However, nurses in the study described several such situations. The following quote exemplifies this dynamic; in it the nurse describes a heated situation and reports her own behavior with a peer where she saw herself as being direct or clear. In listening to and rereading the situation, NPA seems self-evident in the wording and tone, especially the disregard of the feelings of her peer:

...she said, 'my feelings were hurt when you talked to me like that last week.' And I looked at her and I [said], 'I don't give a fuck about your feelings, quite frankly. I [said] '...what I give a fuck about is patient care and you were not participating!' [Then she repeated] 'but you hurt my feelings!' And I said, again, 'I

don't care about your feelings.... we're here to take care of patients. Your feelings were hurt because you dumped on me and I called you on it!

Blinders On

Participants used the term “blinders on” to describe nurses who either through lack of experience, inability, or choice do not have situational awareness beyond their own assignment. Although having “blinders on” was felt to be acceptable and even expected from novice nurses, it was thought of as problematic and selfish when seen in experienced colleagues. One especially kind participant said:

I never think someone's choosing not to help. I think sometimes people just [haven't developed] situational awareness. And if they don't have a keen sense of what else is going on, outside of their eye view, then they just have to ... be directed that way.

Another interviewee explained novice nurses' lack situational awareness this way: “As an experienced nurse you can have a little empathy for that. Because ... it's not that they're egocentric or self-focused or selfish, it's developmental.”

A third nurse participant described working with a colleague who went so far in lacking situational awareness as to listen to music with headphones while working and precepting her:

...my preceptor wore headphones while she was working, with music playing. So, she'd be sitting at the computer with her headphones on, and I'd have to ask her things. And she would always act really startled when I came to her, and specifically said, 'Don't come up behind me.' So, I needed to do a dance just to interact with her, ... It felt extreme. She didn't welcome me to ask things.

A similar statement was: “I sort of see it as a developmental thing, that the new nurse has the blinders on and that's okay for her, but after x amount of time, you ought to see them being able to absorb the [whole situation].”

Abandoning Peers

An extreme example of the lack of situational awareness is abandoning peers. It is possible that a nurse could be intentional in this act of aggression, but for a person who chooses nursing as a career to consciously place a colleague in danger seems extreme. An example was described by a nurse participant: "I worked in a really intense adolescent girls' unit [that was] really violent. The [nursing] teams, if they were mad at one another, they wouldn't back each other up in a code. [It was] really dangerous." Because of the danger involved with this situation, it goes beyond the lack of situational awareness into the realm of NPA masquerading as lack of situational awareness.

Wild West/Every Man for Himself

"Every man for himself" or "wild west" is a phenomenon described by several study participants. This is a situation where the whole nursing unit has "blinders on," and where it is not expected for one to look beyond their own patient assignment at the status of nurse peers. One interviewee explained, "I have floated to units ... where call bell's going off, [and] nobody answers it. Nobody. Sitting right next to it. Because it's not their patient. Even if it's something simple ... this was normal on that unit."

Habit

Finally, the absence of self-awareness is depicted, as one of the participants explained that her understanding of NPA is that the system nurses work in places them in a position of disempowerment, which results in unconscious and habitual NPA: "In an un-empowered situation, turning to the person next to you and treating them unkindly happens. I think somehow even though we are much more empowered than we were, I

have a feeling that that behavior is somehow ingrained in the system.” Another nurse described it as follows:

I have worked on the unit, there have been times where it’s been really brutal. Like not the right mix of people or the chemistry is not good or whatever is going on. And then we stop talking to each other. And then we start back biting, you know, talking behind each other’s backs, getting really short. All of that. You don’t think it’s a big deal at the time and then you realize it begins to feed upon itself and a really negative energy starts to take over.

The preceding section describes situational awareness themes within the category of relational factors of the NPR. The subcategories included teamwork, support, mutual respect, humor, trust, apologizing/thanking, checking in, checking with a third party, reframing, competition, disregarding feelings of others, blinders on, abandoning peers, wild west/every man for himself, and habit. In the following section, the third and final relational factor theme, interpersonal skills, will be described.

Interpersonal Skills

Interpersonal skills have been described as “the communication that occurs between two people in the context of their relationship and that, as it evolves, helps to negotiate and define the relationship” (Chichirez & Purcărea, 2018). The codes that relate to interpersonal skills from the study findings include assertiveness/directness, giving feedback, and sharing information. At the other end of the spectrum are the negative aspects of interpersonal skills included negative non-verbal communication, passive-aggressive behavior, reporting errors, and verbal attack. Each of these is presented below.

Assertiveness/Directness

The theme of assertiveness or directness was frequently discussed by the study participants. It was most often considered a positive interpersonal skill, something that participants were proud of, as in the following example: “Not for me personally because like I said, I’m somewhat assertive, and if something’s bothering me or I’m not getting along with you, I will definitely let you know. We have to have a conversation.”

For other participants, directness was described within the context of a narrative from a clinical situation, as in this example and the one that follows: “I did say, I know I told you several times to get a blood sugar on that patient. And you did not do it!” The next quote also shows the purposeful use of directness-come-aggression with a nurse peer:

Maybe some of the young need a bite now and again, that’s the problem. I don’t bully, I really don’t. I don’t feel like I do. But yes, I interrupt. Because if they’re not getting the subtlety then you just have to make it stop. They have to take care of the patients and do it right. And if they’re not doing it after repeated subtleties you’ve just got to say, this is what we expect.

One participant talked about directness being a necessity of the specialty of emergency nursing, contrasting it with nurses who work on other units:

...if somebody’s sitting in your chair and you need it ... on the inpatient floors, somebody’s there going, ‘I can’t believe she’s sitting in my chair. I can’t believe it.’ They would talk about how she’s sitting in your chair again. In the emergency department, they just say, ‘Are you going to be long? I need my chair.’ Then you get up and nobody’s feelings are hurt. Everybody’s over it, because we’ve moved on to the real problem at hand.

Another participant shared a narrative that depicted two nurse peers both using directness in a heated clinical situation:

I said [something] about needing some help. She said to me, 'You know, eventually you're just going to have to face things around here.' I just looked at her and I said, 'So, are you going to help me?' I felt her hostility.

Another narrative unfolded in the study data about an experienced nurse explaining to a novice nurse that she gave a poor report:

Let's be honest, you don't give a good report.... I was trying to ask you questions to help you—I'm not trying to be a bitch—learn how to give a good [report] ... Because your report is nowhere near what the standard is for this unit.

Another form of directness one participant described was restating a perceived unreasonable request to show the requesting nurse peer how unreasonable she is being. But in the example below, the "direct" nurse involved the rest of the staff in the dispute and alienated her colleague:

'I'm just going to say out loud what you just said to me. Then you tell me it's okay.' Everybody in the room stops talking, and I said, 'I just want to say it out loud so we all understand the situation I have ...' Then she left the room and I [asked the other people present], 'Now I just said it to you, does it make any more sense to you than it just did to me?'

Assertiveness is also used to set boundaries, which are essential to NPRs as previously discussed. Here is one example from the study data:

[Sometimes] you have to flat out say, 'this is not okay. You cannot speak to me this way. You can't name call. You can't roll your eyes. Like we need to be able to work together.'... I've had probably three [situations] in my career, that I've stepped up to and kind of had a conversation. And my expectation is that we recognize each other's insecurities.

Giving Feedback

Related to directness is the interpersonal skill of giving feedback as in the following example: "You have to nip this in the bud before it becomes a huge deal.... if you let it fester you're just going to get resentful!"

In the following quote, a study participant described how a problematic nurse peer behavior improved with the benefit of feedback: "...that behavior has abated quite a lot. And he's been given some negative feedback for just the sheer number of these [reporting of nurse peer errors]."

Sharing Information

Nurses depend upon the sharing of information to provide safe patient care. They also learn from each other through information sharing as described in the following quotation: "Sharing information, ... whether it's about a particular patient or about what's worked [is important], especially when working with a challenging patient; to have a coworker with whom you even have some shorthand, based on previous experiences of helping each other [improves care]."

Non-Verbal Communication

The topic of non-verbal communication came up repeatedly in the study data and always in a negative context. An example was: "We were very busy. She was ... sitting at her desk, on her phone, and ... didn't even look up to ask if there was anything she could do."

Another example of negative non-verbal communication was: "We walk[ed] into the break room ... and then, without saying anything, [she] leaves. It's generally a friendly unit, everybody says hi.... And it just felt like blatant lack of communication [and] ignore[ing] me."

One participant talked about examples of negative non-verbal communication:

“If she asked a question there was the eye-rolling and the sighs.... Her abrasiveness in the way she asked for help didn’t make them feel like she really wanted the help.”

Other behaviors showed tension nonverbally, such as in this participant’s quote:

“People start getting irritated with each other, frustrated with each other, being short with each other, snippy with each other, and eye-rolling.”

Passive-Aggressive Behavior

A concept of interpersonal relationships related to negative non-verbal communication is that of passive-aggressive communication. “Passive-aggressive behavior is when you express negative feelings indirectly instead of openly talking about them” (Web MD, 2020). The following quote depicts the negativity conveyed in a passive-aggressive way among nurse peers:

[After I got the] report, I said, ‘Thanks for that, thanks for giving me that heavy patient.’ And she just kind of looked at me and she walked away. That day there were four of us on the floor, including her, there were three of us who were running around like crazy people, and [we] just kept noticing she is way down at the end of the hallway ... texting on the phone.

Another example of passive-aggressive behavior occurred in this response, when a nurse described being in rounds and asking a resident to look up an important value if she didn’t know it, saying, “So she’s in back [of me], she [replied], ‘Yes, it’s like giving you report in the morning.’ I [said], ‘Okay, whoa! [We need to talk about this!])”

A final example of passive-aggressive behavior recalled in the study data was one where an emergency nurse was assigning more patients to a nurse already dealing with an acute situation:

[The charge nurse said,] 'I know you're here with this vented patient, but you have the open room, so we're just putting some easy patients in there.' I said, 'Oh, you can put whoever you want in there. Until this blood pressure gets above 70, I won't get any work done. You can put the patients in there, do not put my name on them, this is my one-to-one patient right now.'

Reporting Errors

Like passive-aggressive behavior, submitting incident or error reports to the administration about the actions of a nurse peer without discussing the situation directly with the nurse involved was reported as a mode of NPA. One participant described a colleague who was in the habit of filing incident reports in this way. She explained: "[He] actually really took pride in the number of these [incident reports] that he put in ... rather than saying to a peer, 'Oh, I see you gave that Gabapentin three hours late. Why did that happen?'"

A related example linked the possibility of perceived NPA and error reporting behavior: "I don't think in a catty way, but I guess maybe from their perspective they might have seen it as bullying. Talking to leadership, that what they did was unsafe."

Verbal Attack

An overt interpersonal behavior that could be seen either as a lack of skill or a strategic skill within a toxic environment is that of a verbal attack, as one nurse stated, "This particular person said to her, 'You know nobody likes you.' ... And it made this person ... cry and [think] she would just quit nursing because no one like[d] [her]."

Another example was a nurse participant recounting her own verbal aggression with a peer: "I said to her, 'You're 40 years old.... by 40 you should really have it

together.... I'm not going to coddle you. You're not 22!" The speaker shared this narrative with a tone of pride in the directness she used. She did not focus on or appear to be cognizant of this situation being perceived as NPA. This could be understood as an example of the difference between intention and perception, which will be explored in greater detail in Chapter 5, which discusses the NPR Model.

The third and final theme of relational factors, interpersonal skills, was presented above, this included assertiveness/directness, feedback, sharing information, nonverbal communication, passive-aggressive behavior, reporting errors, and verbal attack. This rounds out the section containing three subcategories within the theme relational factors of NPRs: self-awareness, situational awareness, and interpersonal skills. These factors held meaning to the nurse participants of the study. The second major category, that of nurse characteristics, is presented next.

Nurse Characteristics

Participants referred to characteristics of themselves and nurse peers as important factors in navigating and making meaning of NPRs. Through the coding process, two major subcategories of nurse characteristics were identified: state, those characteristics that described a nurse at that point in time or on that day; and trait, those characteristics that were long-lasting or permanent. The Oxford Review (2020) describes these two types of characteristics of the person, trait and state, as important factors within workplace psychology literature. The nurse characteristic subcategories are presented below.

State

A state is a temporary condition that an individual experiences for a temporary period. After the state has passed, they will experience another condition. For example, someone who says, “I am feeling quite anxious about this interview,” or “I feel confident about doing this IV start” are describing states (Oxford review, 2020). How each nurse presents in the moment to the lived experience of the nurse peer interaction stood out as especially important to the meaning made of these interactions. Home life issues, vulnerability/confidence, and health status all contributed to the meaning that nurses made of the dynamics of NPRs and are presented below.

Home Life Issues

Many things can affect one’s state while working, and chief among them are home life issues. Study participants cited personal issues outside of work impacting NPRs in many ways. One nurse put it this way: “There could be something spiritually, culturally, personally... There could be an end-of-life case. And that person might have someone at home who’s really chronically ill right now and they can’t cope with that end-of-life patient.” Another interviewee described assuming an understanding that nurse peers having home life issues that affect their work: “Well, you know what, maybe she’s got something private going on, and it’s really a hard day for her. We’re lucky she’s here. So, let’s take care of her. Let’s give her a little TLC from our side.”

Vulnerability

Related to home life issues is the broader concept of vulnerability. A nurse might be in a vulnerable state for many reasons, including home life issues. One interviewee

explained the process of working through difficult conversations with a nurse peer as including exposing one's vulnerability:

[For example], she would know my vulnerability and what I was thinking ... and worried about. And I would ... understand her rationale and we could come to a middle ground.... My intent when I have conversations with people ... is that I'm going to give you my side, you're going to give me your side, and we're going to come to a middle ground so that we can work together.

Another example of vulnerability affecting NPRs was offered by a participant who felt that not knowing something as a new nurse made her vulnerable with peers:

... to be afraid of other nurses and ... afraid to ask questions, to feel like, oh, I better look online before I ask this question.... or is there any way I can get an answer to this question without asking somebody who might then find me out for not knowing this information when I was a first-time hospital nurse?

Yet another example was expressed by one study nurse who said, "I think when people ... feel vulnerable, they're not as constructive in their behavior toward one another."

Confidence

Confidence could be viewed as the opposite of vulnerability. It too was discussed repeatedly by the study participants as important to NPRs. One quote summed up how one nurse built up her self-confidence over time, working with many different people, as an antidote to the experience of NPA:

I guess it goes back to ... confidence. I get positive interactions, positive feedback from fellow nurses, I get positive feedback from patients, positive feedback from physicians and other team members that if you want to start to bully me, I'm strong, I feel strong myself, and I'm also surrounded by confidence that other people who matter to me have instilled in me.

Health Status

The nurse participants spoke frequently about health status as a determining factor in the way NPRs play out. Among the most frequently discussed health status issues were those of fatigue, working many shifts in a row, or doing off-shift work that affected their state and thereby their NPRs. Another concern within the realm of health status participants identified as affecting their NPRs was pregnancy. Three participants described how a pregnant nurse peer affects patient care assignments and, in so doing, NPRs, for example:

One of our other nurses, she was very pregnant, and [her supervisor] put her ... [with] a mental health patient that came in, and he came in for homicidal ideation. And he had an outburst.... Thankfully, she wasn't injured, but everybody was just like, 'Why?'

Similarly, one labor and delivery nurse said, "There could be somebody [a nurse] who's just had a miscarriage, and so they don't want to take care of that labor patient because [it was so] raw."

Other health issues were identified as well such as in this quote:

We have a nurse who's a diabetic.... When I go downstairs to get lunch, I'll grab him ... juice or something like that, because he tends to run low. So, there's a lot of support on my unit, which I'm really thankful for.

Finally, in one interview the participant talked about working with colleagues struggling with addiction issues and how that dramatically affects their interactions.

Home life issues, vulnerability/confidence, and health status were the subcategories of the state nurse characteristics identified from the study data. The following section presents the highly important findings related to trait nurse characteristics.

Trait

Trait characteristics are described as “something that is part of an individual’s personality, a long-term characteristic that shows through their behavior, actions, and feelings. It is seen as being a characteristic, feature, or quality of an individual. For example, someone who says, ‘I am an outgoing person’ or ‘I am a shy person’ is stating that these attributes are a permanent part of who they are” (Oxford Review, 2020). Trait characteristics identified from the study data included clinical specialty, generation or age, east coast-west coast, personality, gender, and attractiveness.

Clinical Specialty

Interviewees cited clinical specialty frequently in describing permanent traits of particular types of nurses. One nurse talked about emergency nurses being direct as opposed to “inpatient nurses” who may tend to skirt around a topic. On the other hand, a psychiatric nurse interviewed for the study emphasized the tendency to attend to process issues for nurses in that specialty:

... especially on a psychiatric unit, because the inclination of all of us is to process, that’s why we’re in this job. So, when we get into weird dynamics of how we treat each other I think we would probably ... I’d like to think that we would [apply] that [process to our own dynamics].

Generation/Age

Nurses’ age and generation were often identified as trait characteristics important to the NPR. A young nurse described a positive NPR with a colleague: “We’re very close in age. And I think that we have very similar ways of nursing, and because of that, I think we’re very attuned to each other’s routines, and need for help, or need to

debrief with one another.” Another interviewee described the differences among various generations of nurses and workplace ethics: “The new grads, it’s kind of funny.... I think it’s generational, what expectations are for work ethics. So, I have had to say, ‘Hey, nurse’s aid’s busy,’ ‘Alarm’s going off,’ or ‘Bell’s going off,’ ‘We all need to take turns taking care of it,’ kind of thing.” Similarly, three other interviewees talked about situational awareness being linked to age or generation and increasing or improving over time.

East Coast/West Coast

A singular finding was the distinction one nurse made between nurses working on the east versus west coast of the United States. It is possible that she was the only nurse with this unique work experience or that others had had that experience but did not notice the same differences. She described it as follows:

There was a big difference between starting nursing in the west coast, versus coming back to the east coast. On the west coast, everyone is very friendly up front.... You were very friendly initially, and then it was hard to make deeper connections. You had lots of friends, but you didn't have any true people who you felt really connected with. Coming to the east coast, everyone is very abrasive up front. You have to prove yourself; you have to prove that you’re a good team member, that you're smart, that you know what you’re doing, and then once you’re accepted, you form incredibly strong relationships.

Personality

Personality was identified as a very important trait characteristic affecting NPRs. One nurse talked about personality determining the capability of the individual nurse rather than seeing that person as lazy or disinterested:

If someone's not pulling their weight, and I've had examples of people who just can't do more than what they are doing, sometimes you have to read that situation. And sometimes you know that that person can't do anymore. They do not have the capacity. You know their personality; you know how they are. You know if you ask them to do one more thing, that's going to break them.

The "strong," "assertive" or "direct" personality, as a "typical" characteristic for the emergency nurse, as previously mentioned, came up from several interviewees.

Personality was also identified as determining how one communicates. One interviewee said she was a "communicator" and would never use the "silent treatment." Another interviewee said that leadership was a part of her personality and contributed to her having the skills to do the charge nurse role.

Finally, one participant talked about working with a nurse peer who used indirect communication and described that as how her family relates to one another, considering it to be a permanent part of her personality.

Gender

A nurse's gender came up as important to the NPR in several ways. One example is a situation where the nurse was male, and the female charge nurse was making assignments being mindful of his physical size and the potential for violence from the patient. In this situation, the male nurse was questioning the assignment and seemed to lack insight into the violence potential. The charge nurse said, "He said, 'That's not fair.' And I said, 'Oh, it most certainly is fair that we react like that.' I [said], 'We're women. You're not.'"

Another gender-related statement described males as being more influential than females in the clinical arena. "I think that people listen to men in general more

than they listen to women. If you have a guy on our unit who's got some strong opinion about a patient care, people are going to listen to them more than they're going to listen to one of us women. I do feel it. Even the people I work with now would tend to be like ... it's that culture."

Attractiveness

A gender-related issue that came up in the interviews was that of physical attractiveness. One interviewee said:

If they're attractive, everybody wants them.... It's like we don't matter anymore. They follow all the pretty young girls in there. Some of our male nurses are orienting females. If you get a female that's attractive, they're loving it. I've seen the attitude of the guy who's orienting a woman who's not that attractive, or who's older. They're not having any of it. They don't want to deal with it.

The nurse characteristics with the subcategory of trait were discussed in this section. The subheadings included specialty, generation/age, east coast/west coast, personality, gender, and attractiveness. This section was preceded by a discussion of the nurse characteristics subcategory of state. The category of environmental factors is presented next.

Environmental Factors

An important and frequently discussed type of factor affecting NPRs is that of environmental factors within the nurse workplace. Explicit and implicit environmental factors were both important in the meaning that nurses made of their NPRs and are described below.

Explicit Environmental Factors

Explicit environmental factors important to NPRs are structures or phenomena that are officially recognized by the nurse workplace administration. They are presented here organized as follows: institution-related factors, manager-related factors, and charge nurse-related factors.

Institution-Related Factors

Institution-related factors within NPRs are the explicit environmental factors of the workplace that are determined by the whole hospital or institution. These include clinical ladder and unionization.

Clinical Ladder

A clinical ladder is an institutionally sponsored system that provides career advancement levels within the role of staff nurse. As such, it inherently creates hierarchy among nurse peers, which can affect NPRs. One participant said:

I think that there is this expectation of ... professional growth.... I'm just finishing my application for my clinical nurse three, ... in order to get to that point, you have to be [charge nurse] for some time. [Also], precepting [experience is required].

That interviewee went on to describe the competition among experienced nurses to see who would be chosen to precept, to do the charge role, in part because those roles are valuable to advancement up the clinical ladder, and because the nurses took pride in being identified by administration as leaders.

Unionization

As the interviews proceeded, the importance of unionization to the NPR became more noticeable and was eventually added to the guided questionnaire. One interviewee described how a union disallowed peer review because of how it could affect the NPR: “They wanted us to do peer-to-peer evaluation, but the union ... said no, we’re not doing that.... Evaluation is a management role. We don’t want the staff nurses involved in that. They didn’t want bad feelings, and I get that.”

Another way that unionization affects the NPR was described by an interviewee as supporting the nurse group and helping nurses feel less vulnerable, which is important to NPRs as described above. She said:

I think it helps us feel collegial. We are in a union together.... And I think also just for my own safety as a nurse. I definitely feel the union is behind me, and so I feel less vulnerable in the sense of if I make a mistake, I have more protection.

The effect of unionization in reducing nurse vulnerability was articulated by two other nurse interviewees, one of whom said: “I think it does. I think the biggest thing is because in a union environment, nurses tend to support nurses.”

In the preceding section, the explicit aspects of the environmental factors, clinical ladder and unionization, affecting NPRs were outlined. The next section presents a second category of explicit environmental factors, those related to the role of the nurse manager.

Manager-Related Factors

Among the explicit environmental factors that affect NPRs are those that are related to the nurse manager. These include lack of interest in NPRs, the hiring and use

of travel nurses, the determination of which nurses will precept new hires and/or work with nursing students, how change-of-shift report is managed, favoritism, reporting of issues, and unit retreats and teambuilding efforts. These factors are described below.

Lack of Interest in NPRs

The nurse respondents felt that their nurse managers did not take interest in nor responsibility for NPRs. One said:

I believe that the hospital where I work has teamwork as one of its goals, but it's not really spoken about other than when the goals get trotted out [in the review process]. [But] I don't recall anything in my training, in my orientation, that spoke about that. It's not really spoken about.

Another nurse participant spoke about policy versus the lived situation, saying that her institution "has a zero-tolerance policy for any kind of harassment, which includes lateral violence. And then there's the realities of being a nurse and how that translates into day-to-day relationships and responsibilities."

Travel Nurses

Travel nurses are mobile employees who travel to various institutions and locations to fill temporary staffing needs. These employees often have different expectations from those of the permanent nurses, which can affect the NPR; for example they don't usually do the charge or preceptor roles, nor are they cancelled during low census times. They are hired by the Nurse Manager. One participant said:

It was all of us working as a team, supporting this nurse, who was a traveler, ... was not familiar with all the intricacies of our system. I mean ... she doesn't know all the things about [our hospital]. But you could tell that she was really, really worried. And we just all rallied around her and the patient.

Assigning Preceptors

Precepting is the one-to-one educational process undertaken by an experienced nurse with a new nurse or nursing student, acclimating them to their new role. It can take days to months depending on the individual and the setting. When a nurse is called upon to precept is seen as a recognition of that person's expertise but can also be seen as extra work without any associated financial reward. One interviewee described a complicated scenario where she was assigned to take the place of another preceptor because of the input of staff nurses. This change affected the NPR and even became known to the new hire who became uncomfortable with her new peers. She said:

It feels like a power move on the first preceptor's end, to kind of dictate the relationship that we have. It almost feels like she's the one controlling our kind of relationship.... That just felt unnecessarily uncomfortable, while I'm trying to teach and [the student's] feeling hurt thinking that [the first preceptor] didn't want her to teach anymore.... I don't mind if she's rude to me, but I hate feeling like this new, young student is already feeling like she's been [mistreated].

Several participants talked about poor experiences being precepted. One said: "That person's role was really to put me in my place, make sure I knew that I was not really supported.... I felt very much on my own." The competition to precept was described by one study nurse, who said staff would wonder "who's being picked [to precept], and it's very hush hush.... My colleagues [said], 'Oh, she's teaching, but I was never asked to teach.'"

Assigning Charge Nurses

Being assigned to the charge nurse role is like being assigned to be a preceptor in that both are assigned by the nurse manager, they are reserved for senior, expert,

nursing staff, and they are (for the study participants) temporary roles. Both roles can be requirements of advancement on a clinical ladder. In addition, both roles can be either seen by nurses as evidence of their value or an extra burden not worth the effort. One interview described her reaction to assignment change: “And so one day [the manager] didn’t feel like I should be charge [nurse] two days in a row ... and I felt like it was somewhat of an attack, personal attack, professionally.”

Another nurse participant explained the importance of being in charge: “The manager that said this person must be in charge because ... somebody who is an expert has to be there and kind of lead the department.”

Although the charge nurse role requires high-level specific skills, study participants reported limited training for the it (some said the same thing about the preceptor role). One study participant said:

I was never instructed on how to do ... [the roles of charge and preceptor].... I walked in one night shift, and I saw my name was the [charge] nurse. I never had any training.... I've learned by watching, but you're kind of put into this situation of ... sink or swim.... It was terrifying the first night, because you feel very responsible for all of your other staff.

The nurse, who was quoted earlier, talked about a highly competitive peer who saw frequently being assigned to be the charge nurse as proof of his superiority to peers:

At one point he'd noticed that he'd been in the charge role quite frequently, and [said], 'Whoa, I guess they see that I really oughta be in charge.' ... And [I thought], 'Not always.' ... I don't love that role, but it feels important to do it sometimes. I want to be an equal with my peers and I want to be somebody who's perceived as being able to do all the roles of an experienced nurse.

Report Format

Change-of-shift reporting occurs each time a shift of nurses changes, which is usually several times each day. The shift change is the official time when important patient information is given from one group of nurses to the next. The nurse manager will often determine how report occurs. For example, it can happen between just two nurses, but more often occurs with one nurse from the off-going shift reporting to the entire on-coming shift of nurses. Another report format is for the charge nurse to give report on all of the patients.

According to the study participants, giving report can create a “stage” where NPR and NPA can be acted out in a public way. One nurse described the difficulty of giving report as the charge nurse to the next shift because of one nurse:

It felt that [I was being bullied]. Because in thinking about it, it made me wanna make myself small. I wanted to shrink back. [The nurse from the next shift was able to] create an environment in which other people felt uncomfortable. I hated being in the charge role in that job, because it meant that I had to give report to this night nurse who would do a lot of cross-examining around medical stuff.

From the opposite perspective, another nurse described receiving report and being afraid to ask too many questions and yet not having all of the information she needed to take care of her patients: “I remember report was my time to ask all these questions before they leave.... I would feel very out of control if I didn’t feel like ... if I was starting off my shift ... [and] I didn’t know any of the patients very well.”

Another interviewee described how intimidated she felt asking questions in report, saying that the nurse giving report “was so dismissive of me ... [She would say], ‘Oh, come on, that’s not important. Don’t worry.’”

When a charge nurse from the off-going shift was required to give report on the whole patient population, even though she usually had cared for a subset of those patients, it created another concern, according to one interviewee who had to do so:

And the fact that I was giving report on the whole unit; I was giving report on people who weren't even my patients. It was a 20-patient unit. So, there were people who I knew the basic information about, and not about why they had this particular blood draw yesterday, or something ... [This one nurse would] be at a computer [looking up all of the answers to the questions I was being asked]. So [she let her frustration out about my lack of knowledge by] sighing, and eye rolling.... [And] when you called her on it, then you would get [a passive-aggressive answer] if she answered ... sometimes she might not have even answered ... feigning that she was so exasperated she couldn't.

Favoritism

The nurse manager makes the decisions about awarding time off to the staff nurses. These decisions were especially important to the nurses in the study. One interviewee shared a narrative about a junior nurse who had the expectation that she would have a school vacation off; however, that was a highly sought-after week, and she was low in seniority, which plays an important role in determining the awarding of time off. In the end, the junior nurse did get that week off, but the interviewee described that it was because she cried to the manager about it:

Imagine this, she's a new nurse. She couldn't believe that she didn't get the February school vacation off, even though she had tickets to go to Florida with her family. But the manager gave her the week off. Because she's crying!

Another description of favoritism in nurse managers was described as follows:

It's going to play out in a different way with different leaders. One leader ... had favorites, and it was obvious.... What that does, like in any situation, it sets up a negative attitude towards your peers.... If they're a good leader ... they bring you together ... [and] they respect everybody's differences and respect everybody's opinions. [Favoritism] is not a way to build any kind of comradery. It sets

everybody up against each other. Leaders with good boundaries make really good leaders.

Nepotism is a form of favoritism. One nurse described a scenario where she knew that the nurse supervisor was married to the medical director and felt that the supervisor's staffing decisions were related to that relationship and her spouse's choices for the unit.

Reporting Peers

Different from change-of-shift report is the concept of reporting peers to the administration for making an error without discussing the situation with the peer. Here is a description of how one interviewee felt it impacted the staff:

[The reporting system] is a useful system in the sense that it can make things change that need to change, but it can be [a way to] abuse power ... when it's done to peers without speaking with them. [A nurse who often filed error reports in this way had us] all on edge when we worked with [her], about what we might do that could possibly generate one of these reports.... That made for just a very uncomfortable shift.

Retreat

Nurse managers will sometimes plan "retreats" where nurses are scheduled to meet off the unit for team-building activities. This type of activity came up with two of the interviewees, who both saw these experiences as helpful, and commented that the retreats "kind of helped us be able to work through some of those issues," and that they would help to "pull us out of the rut and get us to a better place."

In the previous section, a second aspect of the theme of explicit environmental factors, those related to the nurse manager role, was presented. Next, similar explicit environmental factors, which relate to the role of the charge nurse, are described.

Charge Nurse-Related Factors

The set of factors that relate to the charge nurse or clinical nurse leader roles are presented next and include equity of patient assignments, breaks, cancelling, floating, and on-call status.

Equity of Assignments

Among the most important factors that affect NPRs, perceived inequity in patient assignments was the most frequently mentioned by the study participants. They described this issue in two ways, from the point of view of the charge nurse making the assignments and from the point of view of the staff nurse receiving the charge nurse's assignments.

When making patient assignments as a charge nurse, two participants described having a process that ensured equity through a "rotation schedule" for assignments that "matched peoples' strengths and weaknesses." Another interviewee described a float nurse complaining to her, as the charge nurse, about the equity of her assignment. She described how she used directness to explain to the floating nurse that she simply did not have the skills needed to take the other assignments available on that shift.

Another nurse shared her recollection of coming back to the emergency department after taking time away to teach. She was very concerned about how

challenging an assignment she would be given might be, especially because she did not trust the particular nurse who would be the charge nurse on that shift and, therefore, making the assignments. She texted the charge nurse: "Please don't put me in a critical care assignment. I haven't touched a patient in 11 weeks," then said that she "never heard from her." She ended up calling out ill so that she would not be put into an anxiety-producing position.

Breaks

Whether a nurse is doing 8- or 12-hour shifts, being given a chance to take breaks is very important. For a nurse to go on break she must have another nurse cover for her patient(s) while she is gone. One participant emphasized that the communication between the nurse going on break and the one covering was of great importance so that the patient would have a seamless experience.

Another interviewee said that there were units she had been floated to where "You won't even get a break! No one checks on you!" Another nurse talked about a situation where she offered to cover for a colleague so she could go on a break but received a rude response. So, she confronted her about it, saying, "I just want you to know that the [charge nurse] had sent me to give you a break, and you were so rude to me, when all you needed to say was, 'I don't need a break right now, maybe in a little bit.'"

Cancelling

When the patient census is low, most nursing units will cancel one or more nurses who had been scheduled for that shift. Usually, the nurse can use vacation time or elect not to be paid if she wishes to be cancelled. One participant shared:

I was signed up to be in the charge role. So we had a moment, and luckily there's a collegiality between us, where we all looked at each other and said, 'Does anybody want [time off]?' Because sometimes somebody wants to be canceled and that's great. At other times [if no one wants to], having to be cancelled creates difficulty among the nursing staff.

Floating

Similarly, a nurse may come onto her home unit and find that she has been floated to another unit for a shift. This happens when one unit is overstaffed, and another is understaffed. The experience of floating can be negative because the floating nurse is providing unfamiliar care in an unfamiliar place with new colleagues. That situation can be much riskier and more uncomfortable than working on your home unit. The charge nurse will often determine who is to float. This is usually rotated among the staff for equity and transparency. But study participants mentioned how floating could cause friction among nurse peers and having a float nurse on their unit can also cause problems with NPRs. One participant described a scenario where she was in charge and had to defend her choice of patient assignments because the float nurse lacked the necessary skills to care for most of the unit patients.

On-Call

Nurses on some units will be required to "take call," which is to have assigned shifts during which they must stay at home but be available to the unit in case they are

needed and will be called in to work. One participant explained how one nurse felt mistreated using the on-call process:

This is an additional shift that is an expectation as part of the unit that everyone works one on-call shift every six weeks. But she said that she'd been on call twice this summer before this shift; every time she's been on-call, she's been called in. And she [said], 'I don't want to come to work for a fourth day.' She was literally crying. And then when she got in she [was] angry because she looked at the assignments, and the acuity had changed ... [and she was no longer needed].

In the immediately preceding section was detailed the last of the three types of explicit environmental factors which affect NPRs, those related to the charge nurse role. They included determining who does the charge nurse role, equity of assignments, breaks, cancelling, floating, and on-call factors. At this point the discussion shifts from explicit to implicit environmental factors.

Implicit Environmental Factors

Implicit environmental factors affecting NPRs are those that are hidden from the official organization of the nurse workplace but are often just as important as the explicit factors described previously. The implicit environmental factors, described next, include culture, morale, competition, financial issues, cliques, personas, and weekend group.

Culture

Organizational culture has been described as "the underlying beliefs, assumptions, values and ways of interacting that contribute to the unique social and psychological environment of an organization" (Gotham Culture, 2020). Several of the interviewees spoke about having a name for the culture of their nursing units. One was

referred to as “Ohana,” a Hawaiian word meaning “family”: “My last job I was in Hawaii, and so Ohana was a word we used to describe ourselves as family.... And we wanted to make sure that we’re going to depend on each other.” One nurse participant talked about a unit that went by the motto “Nobody Sits Until We All Sit”; she had floated to that unit and admired their culture.

Another nurse talked about the culture of a unit, which was influenced by the unit’s managers, that was called “Gracious Space”:

The whole thing is peer relationships.... as opposed to going over their head. If you can’t do that, or if you feel uncomfortable doing that, then part of gracious space is that our managers will meet and be the mediator with two of us speaking, and sort of initiate it. It’s really difficult to have those conversations with other people. It’s difficult to initiate them and easy to ignore.

Another cultural description that came up several times in the interviews was regarding answering call bells for nurse peers. In the following description, the interviewee felt offended that her patient’s calls had been answered by her peer:

It’s just [not] our culture on our floor... answering the call bell for my patient, [while] I’m sitting right next to her.... She wasn’t listening to me ... she went and took care of my patient and I already had a plan.... [She] didn’t realize she was doing that to me. Thus, it is culturally derived how a nurse should respond to a call bell of patient to whom she is not assigned.

One nurse participant described a unit culture referred to as “Play Nice in the Sandbox,” which had the expectation that nurses get along with one another on that nursing unit.

[We use the] term we all need to ‘Play Nice in the Sandbox.’ [That means] you can’t make backhanded comments. You can’t roll your eyes. You need to say ‘ouch’ if someone offends you to let them know that they hurt your feelings right in the moment.

Morale

Nurse participants were deeply concerned with morale in the workplace, which is an implicit factor. One nurse said, “Negativity spreads way easier than positivity. It just does. It’s something terrible in our culture that everyone would love to talk about what’s bad going on instead of something that’s good.”

Cliques

A classic social phenomenon seen in groups is that of the clique. These social subgroups are notorious for being exclusive, which can lead to disharmony among nurse peers. One interviewee described this phenomenon: “There’s this group of nurses who are very connected with [the resident] doctors.... They are cliques that ... feel so high school, or so silly that we still do that, but we often have those cliques.”

Personas

The terms “Pollyanna,” “Queen Bee,” and “Savior” were used by the interviewees to describe nurses who played predictable, socially important roles within the dynamics of the NPR. A “Pollyanna” was described as one who sees only the positive in others. This was mostly considered a positive characteristic, but also unrealistic and specifically unhelpful when a nurse was looking for a sounding board to discuss a difficult relationship situation with a third party. The “Queen Bee” was described as the person in the nurse workplace who holds the most social power; this individual could determine whether someone was “in” or “out” of the highest-level social group. The “Savior” was defined as the nurse who managed the most challenging clinical situation or took the unwanted overtime or open shift in a time of crisis. It was implied that this

role afforded the individual positive regard from fellow nurses and administration, as well as a sense of pride.

Weekend Group

A “weekend group” was described by numerous participants as the sub-group of nurses on a shift who frequently work together. Participants emphasized how important the mix of personalities and talents within their weekend group was to their enjoyment of their work experience. If the mix of personalities of a weekend group was not good, participants would seek to switch weekends, or even shifts or jobs. Trying to work through personality clashes within a weekend group was often not felt to be achievable or worth the trouble to attempt.

One nurse described a positive weekend group experience as follows: “I was working with some people that I always worked with on the weekends, and we did a lot of sharing.... There was a lot more teamwork as opposed to [other groups].” Another interviewee said: “I happened to be working with people that I knew really well, because I worked with them every third weekend for 10 years. So that professionalism and closeness was beneficial, we shared tasks ... we ended our shift on a high note, regardless of what came in the door.” And a third participant also highlighted the importance of the weekend group:

I've always had a group of our weekend peers. Part of the culture was you don't call out sick on the weekend and leave your friends hanging. You really supported your team and I feel like we have the best leadership on the weekend, where we have to really rely on each other. I feel like I have a really great team that I work with, and I love the people that I work with. That's one of the reasons why I'm still working.

Findings Review

The implicit environmental factors relating to NPRs detailed above included culture, morale, competition, cliques, personas, and weekend group. Both explicit and implicit environmental factors were shown to be important to the understanding of the meaning that NPRs had to the study participants. Together with the previously described relational factors and nurse characteristics, these themes made up the totality of coded findings from the study and serve to form the basis for the NPR Model to be described in Chapter 6.

The findings from the interviews provided a rich and nuanced portrait of the NPR. Relational factors, consisting of self-awareness, situational awareness, and interpersonal skills are foundational to the NPR with each sub-component existing on a continuum from highly developed to underdeveloped. Importantly, each of these factors is not inborn but can be developed in each nurse, thereby potentially improving NPRs.

Next, the interviewees shared that nurse characteristics are similarly important to NPRs. Trait and state were the sub-categories revealed from the data within nurse characteristics. Any individual's trait characteristics are generally permanent. Of interest, though, is the benefit to nurses of simply being aware of the trait-derived differences between oneself and the other in considering factors affecting the NPR. That alone could be instrumental in altering one's perception and thereby the meaning taken from NPR issues. State characteristics, on the other hand are varied and highly

changeable. Therefore, each nurse has the potential to optimize the state they bring to the workplace. This holds great promise for effective interventions.

Drawing the research lens back from the individual nurse, environmental factors were described and categorized next. They were organized into subcategories of explicit and implicit environmental factors. Interviewees provided many and varied examples of the impact of these factors simultaneously as the setting in which NPRs occur. As important as the relational and nurse characteristics are, they exist within the complicated and highly influential environmental factors, all contributing to NPR dynamics. With these findings in mind, the study was further developed using data from other sources, which are described in the following chapter. The study findings that support the grounded theory technique are fully explored through Chapters 4. That sets the stage for presentation of the theoretical model in Chapter 5.

CHAPTER 5

NURSE PEER RELATIONSHIP MODEL

This chapter presents the symbolic model of NPRs that emerged from the thematic interview findings and was supported by the reflexive study log and to some degree by the triangulation data. The NPR Model is presented under the major headings model overview, structural components, and dynamics. The overview depicts the complexity of the nurse's multidimensional work world. The role components derive from the coded data and include, from the smallest to the largest, the individual nurse, the nurse dyad, the weekend group, the shift, the nursing unit, the hospital, and the society. The NPR Model dynamics are then described under the headings of intention, message, perception, reaction, response, and intervention points. A discussion of the model follows.

Model Overview

Individual hospital-based nurses are assigned responsibility for the wellbeing of a particular group of patients for a given shift. Simultaneously and implicitly, they are expected to manage the shared responsibility of the needs of the whole nursing unit through relationships with peers, while one of them has the often-temporary responsibility of being "in charge" and thus hierarchically superior to the other nurses for that shift (the temporary nature of the charge nurse role is not always the case but was for all study participants).

While they care for their assigned patients, nurses relate to a complex web of other patients, nurses, and colleagues from other disciplines, as well as patients,

families, and visitors. These constituents have diverse agendas and priorities. This situation occurs within the politically, fiscally, and organizationally fluid world of the hospital, which is moored within the ever-fluctuating larger society. As events unfold at various levels within this multi-tiered, ecological social model, effects ripple toward and away from the individual nurse and from nurses' relationships with their peers, thus influencing individual behavior and perceptions within NPRs (see Figure 5). One nurse participant described the contextual forces depicted in Figure 5 impacting NPRs, as follows:

You have macro processes, and you have micro processes. And they all were playing out, it [is] like an overlay ... the concentric circles, everything overlaying, and it's all interconnected, and none of it is less important than the other. It's all happening at the same time.

The NPR Model is complicated and is presented as subcomponents first, then all the components are presented at once in the final depiction of the model. The subcomponents include structural components and dynamics and are described below.

Structural Components

The NPR Model depicts multiple structural layers affecting the hospital-based nurse's work experience (see Figure 5: Model of Structural Environmental Factors Affecting NPRs). These include, from the smallest to the largest, the individual nurse, the nurse dyad, the weekend group, the shift, the nursing unit, the hospital, and the society. Each level of social dynamics affects how nurses relate to their peers as well as to others.

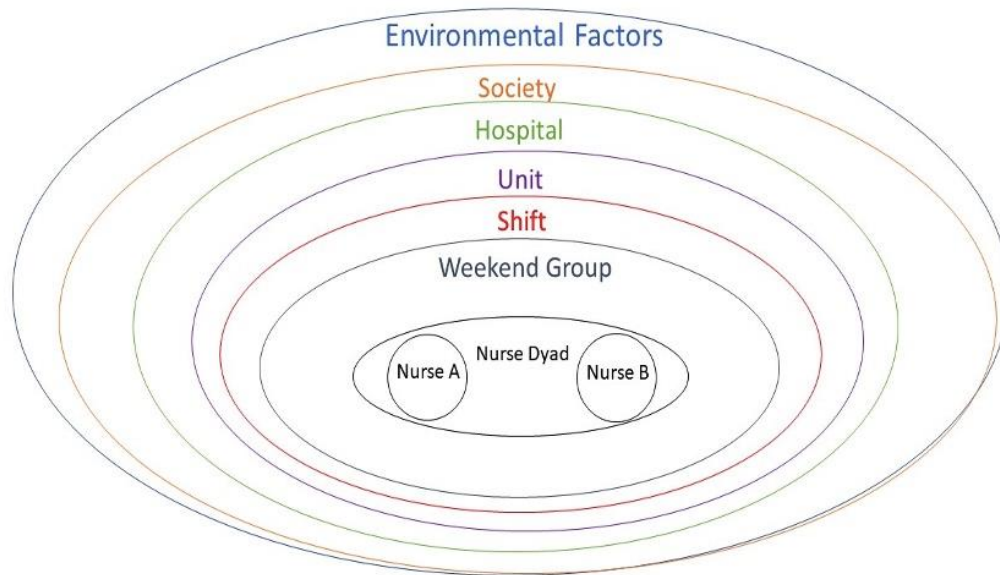


Figure 5: Model of Structural Environmental Factors Affecting NPRs

Individual Nurse Factors

The categories of the internal dynamics each nurse brings to the NPR are depicted on the left in the Model of Individual Nurse Factors Affecting NPRs (see Figure 6) and relate to Nurse A and B seen in Figure 5. The individual nurse functions within NPRs under the influence of both state and trait factors and with specific relational factors (the sub-components of each factor type are listed on the right in Figure 6).

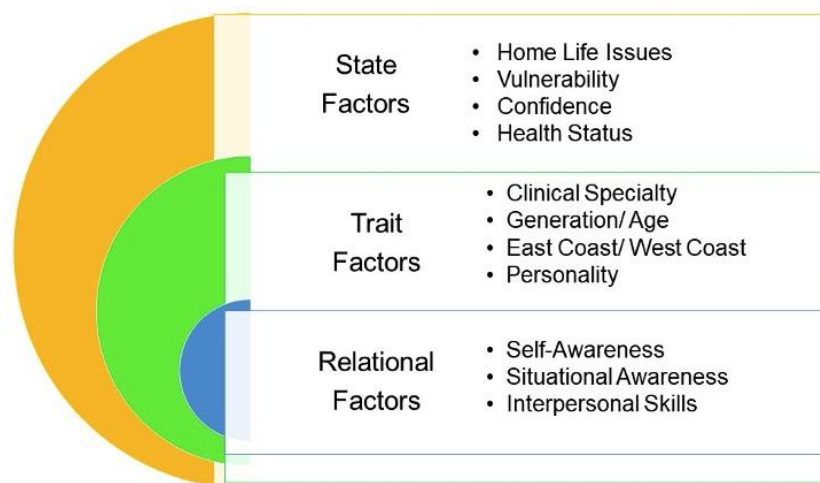


Figure 6: Model of Individual Nurse Factors Affecting NPRs

State Factors

As described in Chapter 4, state factors are temporary conditions that change throughout the course of a shift, day, or week. One interviewee stated, “No one's perfect ... there are good days and bad days.... Because we work on a small, intense, intimate unit, and what we do and how we treat each other, it has a ripple effect.” Another participant posited, “Everything is impacting [the NPR], including what you bring in from home or wherever else, whatever is going on with you.”

Trait Factors

NPR trait factors are those that do not fluctuate throughout an individual's life and affect how nurses relate to their peers. One nurse described her personality as a trait that manifested in NPRs, saying, “I tend to be conflict avoidant to a fault, like maybe I didn't address things in the moment, but it also kind of takes me time to process things sometimes.” It could be argued that being conflict avoidant is something that could be altered through skill development, but it was presented as a permanent or trait characteristic by the study participant.

Each nurse arrives at work with her own configuration of state, trait, and relational factors, which influence how their relationships will unfold that day. These factors exist within the setting of environmental factors, all setting a stage for NPRs.

Relational Factors

The study findings showed the immense importance of several types of relational factors within the individual nurse as being highly influential to the NPR.

These were organized as being related to self-awareness, situational awareness, and interpersonal skills, and the findings are described below.

Self-Awareness Related

The interview data revealed a range of findings that detail the self-awareness of the individual nurse and emphasized self-awareness related factors are highly indicative of how NPRs proceed in that nurse's career. As presented in Chapter 4, they include, from most spoken about to least, being self-aware, owning your stuff, dropping defenses, setting boundaries, carrying your weight, managing emotions, recognizing aggression in self and denial. As nurses developed maturity and gained experience, they reported that their self-awareness grew and thus they experienced better NPRs.

Situational Awareness Related

Most nurses in the hospital setting have a primary professional responsibility for the well-being of an assigned group of vulnerable patients or a single patient, depending on acuity. Learning how to give direct and indirect care to patients is the focus of nurses' entry to practice education. This includes communication with patients, physical assessment, interpreting lab values, carrying out medical orders, knowledge and implementation of complementary interventions, evaluation of interventions, as well as juggling competing patient needs within each nurse's assignment. As patient volume and acuity change, the nurse must triage (designate degree of urgency to) her activities to provide optimal care to her group of patients. The weight of this responsibility alone is daunting, especially for those new to practice. How a nurse is managing this

complicated scenario directly affects how she will interact with others, of specific interest, other nurses. But the study findings revealed the simultaneous, often ignored, and crucial-to-NPRs need for each nurse to attend to situational changes on the unit that occur beyond their own patients, i.e., maintain situational awareness.

The data on situational awareness was organized into the following sub-categories, on a spectrum from most aware to least aware: teamwork, support, mutual respect, humor, trust, apologizing/thanking, checking in, checking with a third party, reframing, competition, disregarding feelings of others, blinders on, abandoning peers, “wild west” or “every man for himself,” and habit. These examples of situational awareness among nurses were identified as very important to how NPRs played out in the nurse’s work world.

Interpersonal Skill Related

The final component of the individual nurse structural components is that of interpersonal skill-related factors. Interpersonal skills were also deemed by the interviewees as important to the NPR. They were presented as being more a result of skill development than either a situation (state) or personality (trait). They included such skills as assertiveness, giving feedback, and non-verbal communication. And at the negative pole of the same factor, passive-aggressive behavior, and denial.

In summary, self-awareness, situational awareness, and relational factors represent the internal dynamics brought to the NPR by each individual nurse. The study participants identified these as highly important to the workings of the NPR.

Nurse Dyad

The relationship between two nurse peers is the next simplest building block of the NPR Model after the intra-nurse factors. Its understanding is essential to the ultimately complex experience of NPRs in the workplace. As peers, nurses need to uphold a relationship that can support the development of positive mutual support and respect. Long-lasting friendships with nurse peers were often described as extremely important and meaningful by study participants.

Conversely, study participants also described nurse peer interactions leading to alienation, social inequity, an unofficial hierarchical relationship, and profound psychological suffering. According to participants, rivalry and friction can become the dominant factors within some NPRs, becoming NPA. This caused psychological distress and led to nurses leaving their positions. As previously described, situational awareness beyond one's own assignment, or not having "blinders on," is very important to the nurse dyad within the NPR. This awareness is manifested by offering support when a peer is becoming overwhelmed. Nurses who do not display such awareness, especially if they are not novices, can be perceived as selfish or challenging to positive NPRs.

Weekend Group

Within each shift the staff is divided into subgroups that rotate to cover, most often, every other weekend. This creates a shift subgroup that the participants referred to as their "weekend group." The weekend group ends up working together most often of all groups of nurse colleagues. Participants frequently referred to the importance of having "the right mix of skills and personalities on their weekend group." An example of

this importance came from one participant who said that her peers have switched weekends or even shifts to not work with particular groups or individuals.

Shift

Hospital-based nurses almost always work in shifts, filling specific and sometimes rotating schedules to allow 24-hour coverage for patient care. Relationships are formed among the shift workgroup, which are much more intense and important to the nurse's work experience than those with nurses on alternate shifts. One interviewee talked about how specific nurse shifts are often pitted against each other when peers or administrators make generalizing statements about whole shifts. For example, one interviewee described a nurse manager saying in a meeting that the "evening's [shift] never finishes their admissions." She expressed how damaging these kinds of statements can be; creating or deepening divisions between shifts.

Nursing Unit

At the next level of complexity within the NPR landscape are the mechanics of the individual hospital unit or floor. Simultaneous to caring for their assigned patients, nurses must collectively manage the needs of the whole nursing unit. Unlike patient care, this aspect of the nurse's role is not generally emphasized in entry-to-practice education. Many factors influence the milieu of the nursing unit at any given time. Participants identified emergencies, changes in patient acuity, the status of nurse peers, and admissions as influencing factors. They emphasized the importance of the characteristics of the nurse peer group with whom they worked as being extremely

important to how they viewed their work. Factors such as the presence of nursing students, per diem nurses, travel nurses and novice nurses impacted the nurse group working together that shift.

At the same time, on the unit level nurses must relate to a complex web of colleagues, patients, and visitors with varying agendas and priorities. Relating to doctors is often thought of as the most problematic source of anxiety and bullying in the hospital setting. This can be true; however, a myriad of other professional people come and go on hospital unit, including consultant physicians, social workers, physical and occupational therapists, administrators, cleaning staff, dietary personnel, etc. all bring unique perspectives and agendas to the nurse, who has the role of being both the patient advocate and ultimate liaison with all care providers.

Also, at this level, nurses have a formal relationship with their nurse manager (NM) who may or may not be visible and involved in the shift-to-shift workings of the hospital nursing unit. Unlike the charge nurse role, the nurse manager holds a permanent position with the responsibility to hire, fire, promote, sanction, empower, and represent the nursing staff. Approval of staffing and schedules were reported by participants as important aspects of their relationship with the NM. Another function of the nurse's relationship with the NM is that the importance or value of the NPR to administration is manifested through the NM. Participants discussed how nurse managers could be "an ally or executioner" when working through NPR issues with the involved nurses.

Hospital

At the hospital level, participants described major influences on NPRs to include, the role of human resources (HR) on individual disputes with either peers or management, unionization, and inter-unit dynamics. Events discussed by the participants that impact this level are leadership changes, union activity including strikes, how various departments respond to unit emergencies, distribution of limited resources, pressure to accept admissions, pressures to float staff to other units, leadership changes in hospital administration, politics within the hospital, lay-offs, and other inter-unit factors. Within each hospital, particular sub-codes repeatedly were mentioned as important to the meaning that study nurses made of NPRs. These include human resources, unionization, and inter-unit relationships. Each of these is detailed below.

Human Resources

Several participants saw great importance in involving the human resources department in navigating NPR issues. However, the notion of bringing a nurse peer dispute to human resources was described most often in terms of “reporting” on another nurse or amplifying the dispute’s importance or seriousness to administration. Other than a few participants suggesting it was necessary, most did not view working with human resources as a helpful step in resolving peer disputes; instead, it was depicted as a way to escalate issues or raise the stakes between disputing nurse peers, especially when those involved did not try to communicate with each other to resolve the issues first.

Unionization

Some of the participants pointed out an important aspect at the hospital level of dynamics is that of unionization. Many of the study participants were employed at a unionized hospital, others were not. For those who were, they spoke of the value the union held for them. It had the effect of coalescing individual nurses into a whole with agency and voice. A few nurses talked about having been in unionized environments in the past but that it had not held much meaning to them.

Inter-Unit

Inter-unit dynamics were also described as being a source of friction or harmony that affect NPRs. As nurses admit, discharge, or transfer patients from one unit to another, the disparity between units becomes an important factor in NPRs. Patients may need to be transferred out of the emergency department to other hospital units that may not be prepared or staffed for those admissions. As such, the contrasting agendas can set the stage for disharmony or even NPA. How nurses handle these scenarios is influenced by state, trait, and relational factors, as well as the environmental influences from the shift, unit, hospital, and larger society.

Society

The nurse, nurse peer relationship, and hospital unit are all situated within the politically, fiscally, and organizationally fluid world of the whole hospital and/or hospital-system, which is moored within the ever-fluctuating larger society. Broad scale factors including racism, sexism, paternalism, economic shifts, national and local politics all exert influences on all societal relationships including the NPR. The experience of the

global pandemic has brought this issue to light, (which occurred after data collection for this study) as nurses have struggled with the lack of supplies such as personal protective equipment and with other powerful issues including fear of contracting or transmitting the virus, overwork, uncontrollable patient acuity and volume, and the frequency of and lack of family presence for patient death.

As events unfold at various levels within this multi-tiered structural model, effects ripple toward and away from nurses and their peer connections thus influencing individual behavior within nurse peer relationships. At the same time, communication occurs between nurse peers, where the subtle and not-so-subtle influences of the contextual factors play out in terms of NPR dynamics.

NPR Dynamics

NPR dynamics held the largest volume of participant comments and, from review of the researcher's reflexive study log, held strongest emotional response from participants. Narrative descriptions of nurse peer dynamics (as presented in Chapter 4) were of great significance to the participants as evidenced by the emotional import they gave to them, especially but not exclusively the negative interactions they have had with nurse peers. Some of these narratives harkened back to decades earlier, yet still prompted tearful recounting by the nurse interviewees. The model depicting nurse dyad communication dynamics in the NPR (see Figure 7) shows the interpersonal forces that make up the NPR. Dynamic forces within the model include intention, message, perception, reaction, and response. They are nested within the multilayered NPR setting described in the previous section.

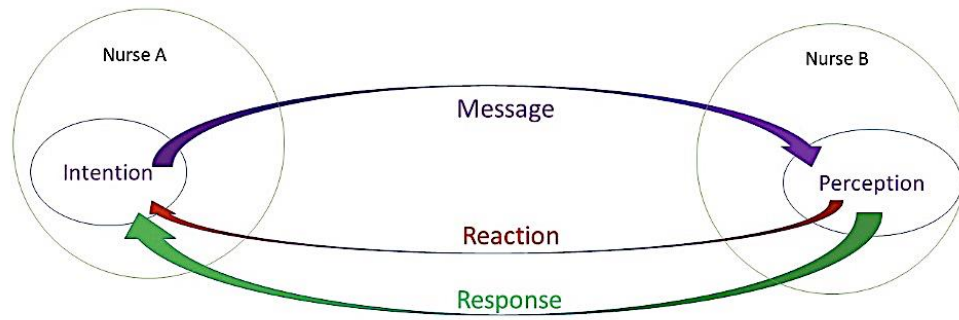


Figure 7: Model of Nurse Dyad Communication Dynamics within NPRs

Study participants described many meaningful NPRs that were supportive and highly important to doing their best nursing work and deriving meaning from their professional experiences. They also described meaningful situations where the relationship and communication between nurses became strained and problematic. The NPR Model (see Figure 8) depicts the factors affecting communication, which is the foundation of NPRs.

Intention

All communication begins with the intention to relate information to another individual. Positive NPRs can be developed and supported by communication that is clear, positive, and mindful in its intention. Conversely, in negative NPR situations, the intention of a communication was described by participants as sometimes colored or overwhelmed by emotion, urgency, setting, competing stressors, past experiences, or other factors related to one or both individuals involved in the communication. Thus, the intention of a communication can be altered by unintended trait, state, interpersonal skill, and/or environmental issues, changing the intended message put forth by Nurse A to something quite different than the one perceived by Nurse B.

Message

Within NPR communication, the message is the statement that is made from one nurse to another, it can be explicit or implicit, verbal and/or non-verbal. It may or may not match Nurse A's intent, as previously described. The message includes not only the words used but the meaning behind the words, tone of voice, eye contact, and other body language used by the speaker. The timing and setting for nurse peer communication came up repeatedly as important and meaningful to participants. One example of the importance of setting is the phenomenon of nurse peer communication during change-of-shift report. Interviewees frequently spoke about the heightened drama of messages sent and received during report as one of several flashpoints or predictors of NPA.

Perception

Perception is the understanding that the recipient has of the message sent by the other communicator. It is depicted in the model as distinct from intention because both the sender and receiver of the communication is influenced by environmental as well as internal state, trait, and relational factors, which alter perception. As the researcher noticed signs of possible NPA perpetration among participants, without any self-identification of such behavior, the interview question guide was revised to incorporate the whether the interviewee nurse suspected that she had been perceived as a NPA perpetrator. This yielded some interesting responses, including several descriptions of nurses using self-reflection and identifying times they could have been perceived as bullies. Here is one example:

She didn't say it personally to me, but she reported me to the managers. That's the only time I've ever been accused of lateral violence. But you know what? I don't blame her for feeling that way. Because at that moment I was so angry. And this had been going on for a while.... And then what I realized was I was being passive/aggressive. Instead of having talked to her prior to getting to that point of frustration, I held on to my anger, and I held on to it, and I held on to it. And then she did one more thing, and I lost it.

Reaction

A reaction within the NPR Model is a quick response to a communication that may be highly emotional and unconscious. When an individual is triggered in an interpersonal situation, the response will be automatic and frequently less than ideal. Several participants described retrospectively recognizing having been hypercritical or reflexive with a comment that could have been perceived as NPA by others. Importantly, a reaction differs from a response in the model. They are two different ways for Nurse B to communicate back to Nurse A after the reception of a message from that person. One nurse described a reactive response after being asked about an assignment:

I just said I didn't want that assignment. It wasn't that I had thought it out, it just came out automatically from my fear of that situation. Afterwards, I can see how badly I can across in that moment. I was embarrassed by it.

Response

The response route is an alternative to a reaction in the model. Participants described times when after an emotion-evoking interchange with a peer, they sometimes allowed time to pass during which their emotions calmed, and they were able to be more deliberate about the interaction. This was described as an alternative to

reacting in the moment when emotions often ruled the response. Several participants described seeking out a third party to discuss the situation with to gain perspective before addressing the situation with the party involved. Participants spoke about responding being more positive than reacting. A response is a carefully considered, conscious answer to the original nurse peer communication message. From the reflexive study log came the following passage, depicting how the researcher answered the question of “What is the best response to NPA in the moment?” which was posed to her by a peer:

She asked a great question: ‘What is the “right way” to handle the (NPA) in real time?’ My answer was ‘Ouch!’ [It shows the hurt received right in the moment without justifying or explaining it] And to slow down to get grounded [not be dissociated]. [Also] to ask clarifying questions such as ‘Let me be clear what you are asking of me, for example, “You want me to have all the students to stand up all every report because staff in not joining report. Is that right?”’

For a nurse to be able to have the healthiest possible response, factors such as location and timing were deemed to be very important. One interviewee said:

There’s been other times where you have people walking in different directions communicating to one another in kind of somewhat of a tense way. And you need space and time.

Intervention Points

An intervention point is marked on the NPR Model (see Figure 8) and indicates specific points where interventions, education, skills development, or guidance could be developed or used to achieve more positive NPR outcomes, either to support positive NPRs or diminish NPA. Of note, nurse traits are not among the intervention points, as

one's generation or race cannot be altered; although, being aware of trait differences with peers can be helpful.

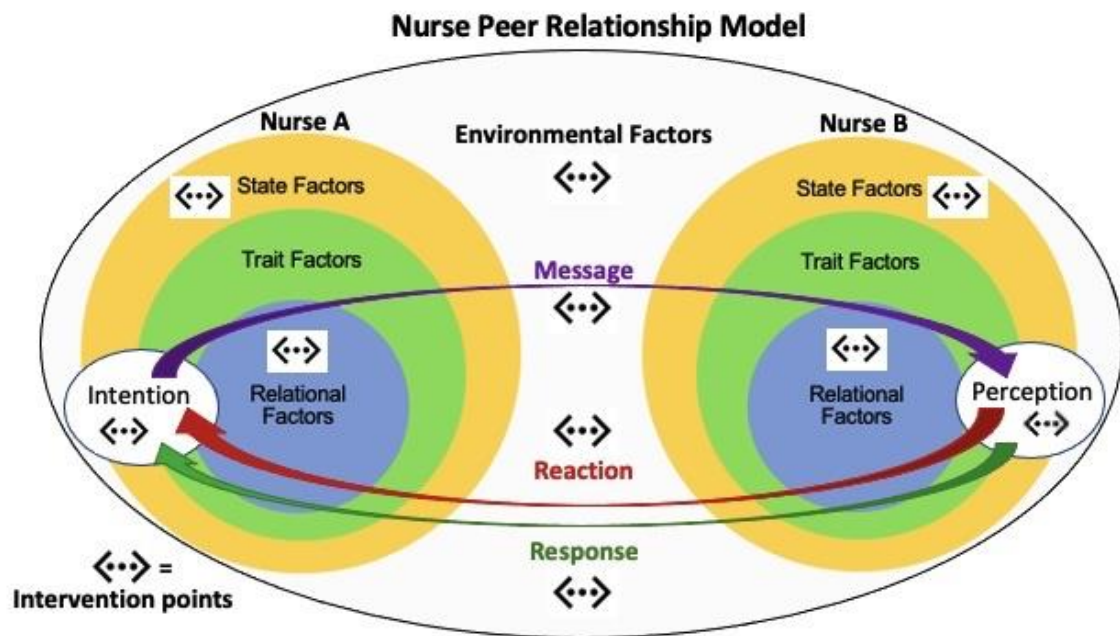


Figure 8: NPR Model

Intervention points include state, interpersonal skills, intention, perception, environment, message, reacting, and responding. The interventions germane to each point are explored in the next chapter.

NPR Model Summary

In summary, the NPR Model depicts the vast complexity of the context and dynamics affecting the hospital-based nurse work world. One participant said, "I kept thinking that it [the NPA at work] was my fault. But it turns out that there are so many factors influencing the situation that it can't only be me." From the multifactorial, concentrically nested context to the internal and external influences altering intention verses perception, the NPR is a set-up for misunderstandings among highly stressed

peers. The benefit of having the model is that it shows intervention points wherein nurses, nurse educators, and nurse administrators can make inroads toward improving the situation and reframing our understanding of NPRs. Next in Chapter 6, those ideas will be explored.

In this chapter the NPR Model was presented and described structurally and functionally. These concepts included structural components and dynamics. The next chapter discusses the study and resultant model compared with existing literature and theory and as they reflect and relate to nurses, nursing education and related research.

CHAPTER 6

DISCUSSION

This study explores the meaning that nurses make of NPRs through the interview findings and the iterative process of grounded theory research. The findings presented in the previous chapters represent a wealth of rich and nuanced information on this complex and important relationship as depicted by the NPR Model. In this chapter, the thematic findings are placed in the context of existing research and theory. The topics covered include: the NPR Model in the context of existing literature, the NPR Model in the context of existing communication models, interventions for intervention points, limitations of the study, and implications for research, nursing practice, nursing education, and administrators. The NPR Model is presented in the context of preceding literature, pointing the way forward for research, practice, and education in nursing.

NPR Model in the Context of Existing Literature

An interpretive definition of theory uses theoretical models as imaginative depictions of relationships among abstract concepts as understood from empirical observation (Charmaz, 2006). As a constructivist grounded theory, the model presented in the preceding chapter exemplifies this notion. It does not show causal relationships among concepts, as a positivist approach might; instead, it conceptualizes the phenomenon of NPRs in abstract terms colored by multiple social realities as an interpretive theory. The theory presented in this paper came about inductively from the interview data rather than from previous research. At this point, the grounded theory process requires the study findings be compared to the research and theoretical

findings that preceded it (Glaser & Strauss, 1967). In this section, the study's findings on NPRs are compared with existing and preceding knowledge and new insights are gleaned. The literature review presented in Chapter 2 was structured using NPRs as the larger umbrella with NPA as only one component thereof. The 171 studies were organized by explicit and implicit characteristics of NPRs with subcategorizations within each section. The literature summary findings are compared with the study findings below under the same headings, explicit and implicit NPR factors. NPA is discussed as one of the implicit factors.

Explicit NPR Factors

The official or explicit aspects of the NPR are those that healthcare organizations describe in their written materials on the role of the nurse, such as in job descriptions or performance review materials. In the review of literature, the triangulation materials, and the findings from this study, the same explicit aspects of NPRs were reported: collegiality, teamwork, education, and peer review. An interesting contribution this study brought to the discussion was the belief held by the study participants that nurse managers and administrators were not interested in NPRs, despite the organizational statements to the contrary. Interviewees felt that managers only became involved with NPRs when formal complaints were filed, or the working of the unit was affected. As was discussed in the section on triangulation, the study participants believed that, although the terms "teamwork" and "collegiality" appeared in their performance evaluations, their nurse managers did not truly care about NPRs and their effects on individual nurses. Several participants described ongoing NPA that had been brought to

the attention of management, but nothing was done about the situation. This left the nurse feeling adrift with these troubling behaviors and resulted in the consideration of distancing strategies, such as changing shifts or even resigning, in addition to the negative psychological impact the situation was having on her.

Explicit nurse roles, charge, and preceptor, came up repeatedly in the study as nurse interviewees talked about their positive and negative experiences enacting and working with others in those roles. It seems counterintuitive that those roles were often described as having been assigned without any training or preparation for the nurses. This finding points out two accessible avenues for NPR positivity to be strengthened, unit culture to be changed, and NPA to be diminished: require specific training and ongoing support for the charge and preceptor roles. This type of structural support would improve the nurses' ability to enact these roles as well as show nurses that management does appreciate how important these roles are to NPRs.

Another important implication of the charge and preceptor roles is the way they are assigned and rewarded by administration. As a rotating assignment among senior nurses on the unit, "being in charge" was a temporary role for all the study nurses. This reportedly created an element of competition among nurse peers as detailed in Chapter 4. Also, as nurses rotate in and out of the charge role, they have temporary power over their peers in terms of assignments, floating, overtime, and other decisions that impact the nurse's workplace experience. This can lead to perceived favoritism, vindictiveness, or scorekeeping among nurse peers. Having permanent charge nurse positions could be

preferable to the existing situation, creating a more stable and predictable hierarchical work environment.

Implicit NPR Factors

Implicit factors are those that are not expressed openly, instead they are communicated among the members of a society through subtle means yet are no less important to group members than the explicit factors. NPA is the most prominent of the factors identified in the literature review of implicit NPR factors and will be discussed first. Next, positive implicit factors of NPRs are discussed, comparing the previous literature findings with those from the study and NPR Model.

NPA

As a subcategory of implicit factors affecting NPRs, NPA was found to be by far, the focus of the largest number of publications (Meissner, 1986; Dellasega et al., 2014; Fida et al., 2018). This section compares that research with the findings of the present study organized under the headings: individual antecedents, situational antecedents, outcomes, and interventions.

The individual nurse characteristics which have been suggested as associated with NPA in existing literature include negativity (Oh et al., 2016; Chang et al., 2011), clinical experience (Leiter et al., 2010; Smith et al., 2010) or generation (Longo, 2013; Weaver, 2013), and rationalization (Jiyeon & Seonyoung, 2016). These findings harmonize with the findings of this study in that the model depicts the complex characteristics that each nurse brings to the NPR. State, trait, and relational factors are

at once more expansive and specific than the limited characteristics defined in previous research and applied to relationship dynamics. This appears to be an important area for further research investigation.

Previous studies on NPA have identified situational antecedents including power dynamics (Wilson, 2016), organizational culture (Embree, 2010; Giorgi et al., 2016; Khadjehturian, 2009), working conditions (Bardakçı & Günüşen, 2014; Neslihan & Partlak, 2016; Bostrom et al., 2013), and area of practice (Madzhadzi et al., 2017; Reynolds et al., 2014).

Findings from the study presented support the importance of the situation and environment as influential to the occurrence of NPA. In addition, this study found situational antecedents were associated with positive NPRs, about which there is little previous research. The model depicts nurses A and B simultaneously seated within the context of their weekend group, shift, unit, hospital, community, and society, all of which continuously shift and change exerting myriad individual and collective effects on NPRs.

One example of a situational antecedent of NPA identified in the study was unit culture. The concept of “wild west” or “every man for himself” was described as a culture on a nursing unit where each nurse only took responsibility for their own patients. This would normally not be acceptable on most nursing units, but within particular settings, it did occur. And that culture was seen as dysfunctional by the nurse participants and an antecedent to NPA. This finding was in keeping with previous research findings (Embree & White, 2010; Giorgi et al., 2016; Khadjehturian, 2009) yet

expanded upon those studies by depicting how an individual nurse characteristic can become the cultural norm for a whole unit and an antecedent for NPA.

Among the most widely studied phenomena of NPA are its impacts on individual nurses (Sauer & McCoy, 2017), the profession (Armmer & Ball, 2015; Viotti et al., 2018), and patient care (Hutchison & Jackson, 2010; Laschinger, 2014; Reynolds et al., 2014; Wolfe & McCaffrey, 2007). This NPR study supported these findings, depicting situations where nurses left their positions after attempting to work through NPA without success. Here is an exemplary quote:

I did everything I could possibly do, and it still didn't get better. It became a daily ordeal. I just didn't want to go in every day that I knew she [the nurse aggressor] was working with me. I couldn't sleep, it was affecting my other relationships too. So I left, even without another job to go to. I had to.

This quote is only one example of the profound affect that NPA had on an individual nurse. The present study did not look at the profession as a whole or at patient outcomes, so findings on those issues are not available to compare to the preceding literature.

The literature review identified research studies on interventions to prevent or combat NPA (Perreira, Berta, Ginsburg, Barnsley, & Herbert, 2017). Their findings included cognitive rehearsal (Stagg & Sheridan, 2010; Stagg, Sheridan, Jones, & Speroni, 2013), comportment training (Kenneth, 2017; Oja, 2017), and communication skill development (Dahlby & Herrick, 2008; Nikstaitis & Simko, 2014; Schwartz & Leibold, 2017) as all successful anti-NPA strategies. The nurses interviewed for the present study did not mention educational experiences that prepared them for or strengthened their skills in navigating NPA. Instead, they described self-reflection and discussions with

third-party peers to gain perspective regarding NPA. A succinct example was offered by one participant who described what happened when she spoke to an uninvolved third party who was aware of the situation with the offending nurse, “[She said to me,] ‘She was just in a mood! No big deal let it go!’ and that totally changed my point of view.” This shows how informal conversations among supportive colleagues can diminish perceptions of offense within nurse dyads. One can speculate that more formal and organized efforts, such as those cited in the literature, might have positive effects. An interesting finding was that none of the 14 participants mentioned that having had such training.

Leadership strategies were another intervention toward management of NPA identified in the review of literature (Laschinger et al., 2012; Smith et al., 2017; Yokoyama et al., 2016). Nurse participants in the present study did not see that this played out in their work lives. One interviewee said:

After a couple of years, we found out that all the complaints [about bullying among nurse peers] that were brought to her [the nurse manger] ... needed to be in writing. We said, ‘So we were supposed to be writing all this stuff down and sending it to you or giving it to you?’ [She answered] ‘Yes.’ Did she tell us even once while we were complaining that it needed to be in writing? No.

Another participant said:

I think what’s important is ... [change has] to start from the top down. It can’t just be the nurses and their relationships. It has to start with managers and people managing the managers. If they are not on board with having good relationships and being positive rather than being negative [it won’t translate to the nursing staff].

Educational interventions aimed at nurse victims managing NPA have also been researched prior to this study. Educational programs aimed at communication skill

development (Stagg & Sheridan, 2010; Stagg et al., 2013) and cognitive rehearsal (Regan et al., 2017; Rush et al., 2014) have shown the greatest efficacy of all anti-NPA interventions (Stagg & Sheridan, 2010; Stagg et al., 2013). However, these strategies do not actually eliminate NPA, rather they provide a way for nurses to manage NPA situations. In addition, the degree to which nurses used these techniques in their work lives was much lower than the level of skill development they attained in training (Griffin & Clark, 2014; Stagg et al., 2013). The key previous research findings regarding interventions to address NPA including educational programs (Armstrong, 2017; Stagg et al., 2013; Ulrich et al., 2017), leadership zero-tolerance programs (ANA, 2015a; Wilson, 2015), and resilience (Turner, 2014; Delgado et al., 2017) were discussed in Chapter 2, with all showing some degree of positive effect on nurses who experience NPA. However, several questionable issues were identified within this research, suggesting that formulating interventions for a phenomenon that is not well understood may be premature. The present study identified limited impact of organizationally sanctioned programs on the incidence or experience of NPA except for several unit-based cultures that supported positive NPRs. This suggests that the prevention and management of NPA be reassessed and redeveloped based on real nurse experiences. Specific interventions to diminish NPA and improve NPRs are contained in the interventions for the intervention points, to be outlined further in this chapter.

Positive NPRs

The review of literature presented several publications on the positive aspects of NPRs consisting of healing traumatic workplace events (McDonald et al., 2016),

developing positive characteristics of individuals (Hsieh et al., 2017) and managing workplace stressors (Hsieh et al., 2016). The present study findings largely support each of these effects of positive NPRs. As described in Chapter 4, participants experienced frequent and numerous rewards from positive NPR experiences. They described personal growth, skills development, teamwork, and mutual support resulting from their best NPRs. Positive NPRs were so valuable to the nurses interviewed for the study that their benefits went beyond those expressed in the previous literature findings, which were limited to helping nurses with workplace problems and personal development. In fact, positive NPRs held great meaning to the study nurses. They made their work experiences worthwhile and, when threatened, became a reason to leave employment. One example emphasized the importance of being a part of the right weekend group, which is how nurses refer to a group of nurses who work together on the same weekend shifts, and often during the week as well. When the personnel in one's weekend group was less than optimal, nurses left those shifts and sometimes their jobs. A "weekend group" is not necessarily an explicit factor of the nurse's workplace, rather it may be considered happenstance by administration; but it was of paramount importance to the study nurses.

Among the most important pieces of new knowledge that came from this study involved participants' perspectives on the significance of positive NPRs, along with their associated characteristics. The existing literature holds sparse information on this most meaningful of relationships in the workplace. Yet the study nurses sought and valued positive NPRs as the ideal working situation. And they shared hard-earned insights as to

how they worked with peers toward developing and maintaining those highly valued positive relationships, including increasing both self-awareness and situational awareness and developing interpersonal skills. Nurse participants emphasized using patience, self-reflection, and emotion management, while expanding self-awareness and situational awareness in working in problematic relationships on the path to more positive NPRs. These insights are depicted in the NPR Model as the many intervention points, which identify areas for new strategies to improve NPRs.

The preceding section summarized the NPR Model in the context of existing literature, which covered explicit and implicit factors including NPA as well as positive NPRs. The present study confirmed many of the previous literature findings while expanding the contextual understanding of the lived experience of NPRs. The model highlights the complexity of the work environment of hospital-based nurses and the intersectionality of their personal and work worlds and how they hold meaning for nurses. The NPR Model offers a new understanding of the NPR and points to specific areas for strategies to move these important relationships in positive directions.

NPR Model in the Context of Existing Communication Models

Another level of theoretical understanding of NPRs can be gleaned from models of communication. The dynamic aspects of the NPR Model, presented in the Model of Nurse Dyad Communication Dynamics within NPRs (Figure 7), derive from communication models previously developed by social researchers. Adler and Towne (1978) state that everything that has been and will be accomplished by people involves communication with others. Consequently, many, if not most, social and organizational

problems derive from communication issues that have led to relationship problems. Success both on and off the job stems from one's ability to transfer and express ideas to their peers (Adler & Towne, 1978). Maslow (1970) posits that the ability to manage personal needs arise mainly from the ability to communicate.

Adler and Towne (1978) state that communication starts with mental images within an individual, which lead to a desire to convey those images to another person. They define mental images as ideas, thoughts, pictures, and/or emotions. In the NPR, this equates to the "intention" coming from Nurse A, as depicted in Figure 7. The communicator or "sender" must translate the images into symbols that the receiver can understand, this is called "encoding." Adler and Towne (1978) state that the symbols often are words but also can be pictures, sounds, body language or sense information (e.g., touch or smell). In the NPR Model, this equates to the "message" sent from Nurse A to Nurse B. The encoding process is depicted in the model where the "intention" is changed by the trait, state, and interpersonal skill characteristics of Nurse A, becoming a "message" potentially quite different from the original "intention," not necessarily within Nurse A's awareness.

When the "message" is received by another person, it is "decoded." Just as a sender must encode messages, receivers must interpret the symbols and decode the information back into images, emotions, and thoughts that make sense within their thought processes. Adler and Towne (1978) say that when messages are decoded exactly as the sender intends and the images of the sender and receiver match, then effective communication has occurred. Where communication breaks down, according

to Adler and Towne (1978), is the differences in their personal experiences, perceptions, and emotional responses, leading to differences in how communications are encoded, transmitted, received, and decoded. These differences influence the meanings attached to words, sounds, and gestures used in communication, all too often complicating communication. These concerns are depicted in the NPR Model as the “message” and its interpretation by Nurse B through that person’s state, trait, and relational factors, again affecting the “perception” of the “message.”

Communication models offer a pictorial representation of the communication process. Such models are used in the business world to consider their message impact and optimize outcomes with the consumer. The communication model that best fits the NPR is the Transactional Model of Communication (Businesstopia, 2018). In this model, senders and receivers are both equally important in communication. It relates communication with social reality, cultural upbringing, and relational context [relationships]. Non-verbal feedback like gestures, body language, is also considered as feedback in this model. Barnlund’s (1970) Transactional Model of Communication (see Figure 9 below) is particularly applicable to the NPR in that it is a multilayered feedback system wherein the answer from one party is the message for the other.

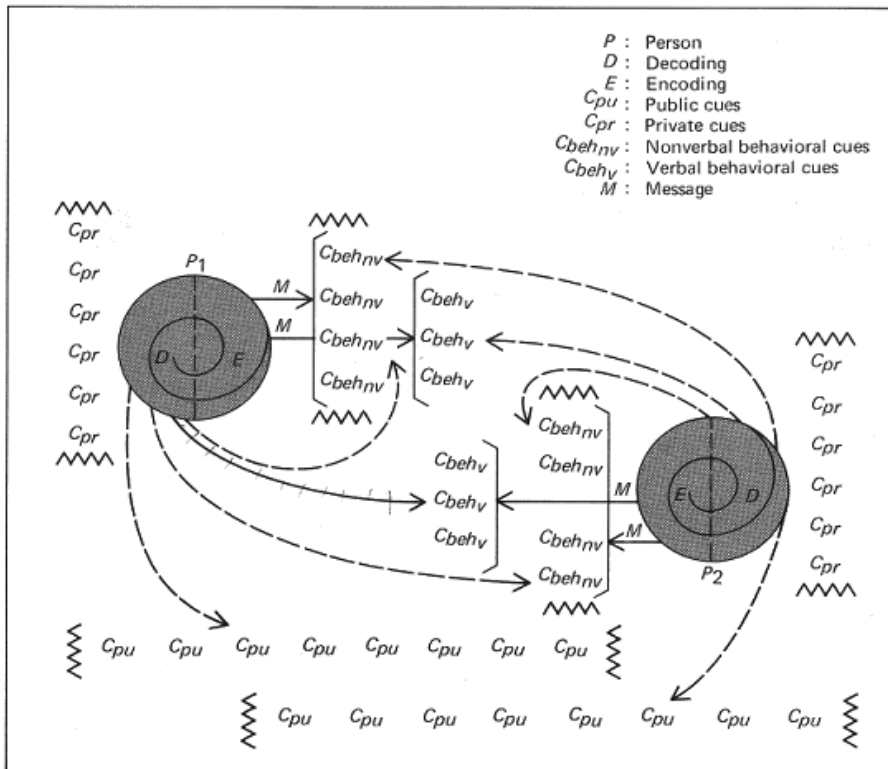


Figure 9: Barnlund's (1970) Transactional Model of Communication

Barnlund's model has been said to hold several advantages when compared to other models of communication. These include: the depiction of the communication sender and receiver both sharing the field of experience at the time of the communication; that it presents the structures of simultaneous message sending, noise and feedback; and that it is said to be the most systematic model of communication. Disadvantages of this model are that it is highly complex and that both sender and receiver must understand each other's codes. Barnlund's model is like the communication dynamic aspects of the NPR Model.

Thus, communication models have contributed to the development of the dynamic aspects of the NPR Model (see Figure 7: Model of Nurse Dyad Communication Dynamics within NPRs). Importantly, the underpinning communication theory supports

the emphasis on individual characteristics in changing both the delivery and interpretation of an intended message potentially leading to communication errors and thereby relational problems.

Interventions for Intervention Points

The findings of the study have led to the NPR Model (see Figure 8), which is highly influenced by both personal and environmental factors on multiple levels simultaneously, as well as the specific intervention points. The intervention points are areas that offer opportunities for intervention; where strategies can be invoked to modify and improve the outcome of the NPR. This realizes the sought-after research outcome, one that had not been posited from preceding research studies, that of multiple targeted means to improve NPRs. Each intervention point is detailed in the following section, with accompanying potential intervention strategies to address issues in that area. The intervention points include state, relational factors, intention, message, perception, reaction, response, and environment.

State

Each person arrives at work in a particular mood based on a myriad of physical and emotional factors that influence us each day. Managing the self that one brings to work is the responsibility of each person but is rarely discussed in that way. Nurses, and other high stress workers for that matter, can be taught, as mentioned by several of the study participants, to make a conscious effort to leave non-work issues at the door, set healthy boundaries, and present their best self at the workplace. Participants talked

about using breathing exercises to bring about a calm, grounded self before starting work. Such exercises are simple, free, and can be easily learned. They can be directed toward enhancing both self-awareness and situational awareness.

Relational Factors

In the NPR Model, relational factors are self-awareness, situational awareness, and interpersonal skills. Each nurse moves along a continuum from high to low development in each of these three areas, owing to life experience, baseline personality, and skill acquisition. Likewise, nurses can be prepared in nursing school and/or seek supportive training in these areas. Nursing administration, both in practice and education, must be more intentional about personal development in nurses. At the same time, nurses and nursing students must take on the responsibility of managing their own personal development.

Intention

The intention of Nurse A in the NPR Model is the initial thought or idea she wishes to communicate to Nurse B. The intention precedes and is different from the message, or the perception, in that it is not yet colored by the unconscious processes of state, trait, or relational factors. The more self-awareness that Nurse A has, the more discernment she can bring to the intention that underpins a communication. Therefore, improving self-awareness is key to clarifying and improving intention. Nurses can use self-reflection, individual and/or group counseling, and checking with a third party as means to improve the intention of their communication.

Message

The message sent from Nurse A to Nurse B (see Figure 7: Model of Nurse Dyad Communication Dynamics within NPRs) builds upon intention and is affected by unconscious processes that influence tone, eye contact, body language, and wording to the point of potentially overshadowing intention completely. Therefore, developing an accurate assessment of one's verbal and nonverbal communication is key to improving the message. This is essentially self-awareness. A technique that can help assess that the desired message has been sent is to check the communication with the receiver as in asking, "What did you hear me say?" This requires a grounded presence in the moment of the communication. The skills of emotion management, grounding techniques, and self and situational awareness can be learned and improved upon. There are a variety of techniques one can use to improve self-awareness and emotion regulation. For an individual to be comfortable enough to realistically assess the self requires a degree of confidence and maturity. Programs such as resilience training, mindfulness, and dialectical behavioral therapy are all techniques that could be offered to assist with this type of growth. Study participants suggested "supervision" and life coaching specifically for nurses, because this type of growth is so essential to their clinical work and success in the profession.

Perception

Perception is in the eyes of the receiver. Nurse B receives the message from Nurse A and interprets it through her state, trait, and relational influencing factors (see Figure 7: Model of Nurse Dyad Communication Dynamics within NPRs), which can

greatly influence the meaning of the communication. For example, if a nurse has experienced harsh sarcasm in her past, she may be more sensitive to any sarcastic overtones in receiving messages from others. Even if no sarcasm was intended from Nurse A, there could be a tendency to perceive it and misunderstand the message. Therefore, each nurse needs to consider her own biases in the perception of communications. Just as Nurse A can check with Nurse B about what was perceived in a communication; Nurse B can slow down the communication and check with Nurse A as to what was intended in a communication. For example, such statements as, “Help me understand you, you are asking me to ... Is that right?” This technique is akin to that used by several nurses in the interviews, when they restated the request from another nurse with the intention to allow Nurse A to see how unrealistic the request was. This technique has the potential to come across as passive aggressive, so the tone and non-verbal communication used with it is important. The overriding and helpful aspect of this process is the slowing down of the communication so that both parties can consider and restate intention, message, and perception to make the communication coherent and accurate.

Reaction

A reaction to a communication within the NPR Model occurs when Nurse B has a reflexive answer to Nurse A’s message (see Figure 7: Model of Nurse Dyad Communication Dynamics within NPRs). This may occur when the perception of the message sent was triggering, which may or may not match the intent of the message. This is more likely to happen during emotionally charged situations. The rapid, reflexive

answer can fuel further devolution of the interaction. Having the ability to sit with one's initial reaction to a negative perception of a message from a nurse peer requires a degree of emotional regulation. As previously mentioned, a program developed for use in mental health called Dialectical Behavioral Therapy uses techniques to assist in emotion regulation, which could be adapted for use with nurses desiring to improve those skills.

Response

The response Nurse B provides to the message received from Nurse A is an alternative to a reaction. The difference is that the response occurs following time for reflection and allowing time for the initial emotions to dissipate. In so doing, the nurse can consider the situation thoughtfully, seeking areas that one can agree with or take accountability for as well as those that require addressing or exploration with the other person. Prior to responding, the receiver of the message can check out thoughts and feelings with a third party or alone using self-reflection. In a response, as opposed to a reaction, the nurse can plan the setting, words, timing of the return communication; non-verbal influences can be carefully considered and managed to improve the interaction.

Environment

The environment in which NPRs play out is multilayered and complex, consisting of concentrically nested social spheres from the largest to smallest including society, hospital, unit, shift, weekend group, and nurse dyad (see Figure 5: Model of Structural

Environmental Factors Affecting NPRs). Each layer brings its own influences, which ripple in and out affecting each associated layer and the individuals involved.

Interventions to optimize these telescoping worlds toward improving NPRs could be as simple as providing spaces where two nurses could go and have a private conversation, something not often available to nurses. Another possible change to improve the work world of the NPR would be to change how change-of-shift report is conducted so that it is less a stage for NPR drama to be enacted. Report could be conducted between just the off-going and on-coming nurse rather than the whole shift of nurses to lessen the drama factor. Making the charge nurse role a permanent position, as previously mentioned, could also improve the NPR environment. As well, just acknowledging the current issues affecting one's world can bring a grounding effect to a potentially fraught interaction. For example, if Nurse A shares feedback with Nurse B and at the same time says, "I may be a little sensitive right now because I have a loved one in who is sick at home, so I could be overanalyzing things." Or "We are all on edge right now because of the layoffs, so I just want to acknowledge that as a background reality affecting us as we try to solve this problem together." Such caveats could be used to reframe otherwise inflammatory communication and bring nurses together in difficult moments.

In this section, each of the intervention points from the NPR model was presented along with an exploration of possible data-supported interventions. These included state, relational factors, intention, message, perception, reaction, response, and environment.

Chapter 7

CONCLUSION

In this final chapter, the study is summarized, implications are outlined, and conclusions are described. The chapter is organized as follows: strengths of the study, limitations of the study, implications for research, implications for nursing practice, implications for nursing education, and implications for administration.

The grounded theory approach has offered a lens to view NPRs in a new way. Rich, subtle insights into the lived experience of hospital-based nurses and the NPR have been illuminated through this study. Applying this new knowledge to nursing practice, education, and administration brings hope for improving NPRs and diminishing NPA.

Strengths of the Study

This qualitative research study offers a model that posits connections and relationships among underlying factors that affect NPRs. The NPR Model with specific intervention points brings new opportunities for immediate interventions to improve the important and frustrating issues around NPRs. Preceding research has not offered these connections nor data-driven next steps. In addition, the flashpoints depicted in the NPR Model identify areas of concern in the nurse workplace, where NPRs are threatened. One of the strengths of this study is that identifying and understanding the flashpoints that occur in NPRs, as depicted in the NPR Model, signified potential targeted interventions worthy of further study.

An overall take-away from this study is the knowledge that as nurses experience inevitable challenges in NPRs, they can reframe those interactions as resulting not only from the interactions between themselves and their peer(s) but also from the multilayered ecological environments around them. Nurses need to look beyond the immediate interaction to the far-reaching environmental factors. This broader lens will help nurses to avoid self-accusation in NPRs gone wrong and instead take a wholistic approach, which offers more promise for the future.

Finally, the study offers hope for nurses in practice that as they work through NPRs, their ability to develop self-awareness, situational awareness, and relational factors, will contribute to more positive NPRs for themselves and those with whom they work. At the same time, this study identifies the environmental factors that contribute to NPR concerns. New approaches to the structure and function of the hospital-based nurses' workplace are identified through this study. Therefore, next steps in improving NPRs have at once more specific and more broad implications.

Limitations of the Study

As a constructivist grounded theory qualitative study, this research project was designed to develop a theoretical model depicting the meaning nurses make of the NPR. These findings are not applicable to groups other than those represented by the demographical characteristics of the study participants. An obvious limitation of this study is the homogeneity of the participants, being all white, all female, all cis-gender, and all Massachusetts residents. There is a need to repeat the study with minority populations, including nurses of color, males, gender fluid individuals, nurses from other

regions of the United States and in other countries. Another limitation is that only limited areas of clinical practice are represented in this study. Future studies should seek out nurses in a greater variety of clinical settings and levels of practice beyond hospital-based nurses.

Implications for Research

Future research must proceed from the limitations of this study to explore its accuracy and applicability. Quantitative approaches could be developed to test the theoretical relationships represented in the NPR Model. As previously mentioned, replication studies with varied populations including a variety of races, ethnicities, sexual preferences, gender identifications, and geographical locations would be appropriate next steps.

There is a need to explore positive NPRs through the research process to establish factors that support and promote these important relationships. This study pointed out the lack of understanding of what makes a positive NPR, what the antecedents are, and how they can be promoted and supported in the clinical and educational realms.

Some additional ideas for future research projects related to NPRs include further exploration of antecedents of and ways to develop and sustain self-awareness, situational awareness, emotion regulation, and boundary setting in nurses. Another approach would be to explore nurse characteristics and how they influence NPRs, these could include clinical specialty, age, geographical area, educational background, and other demographic factors. Although these would be considered trait characteristics

that cannot be changed, an understanding of issues that predict NPR issues allow nurses to consider clashing characteristics carefully and guard for predictable issues.

Implications for Nursing Practice

The NPR study revealed important implications for nurses in practice. These are organized below according to flashpoints and skill development.

Flashpoints

As the data was reviewed, repeating patterns emerged, these included predictable “flashpoints” or triggers, which appeared to be situations that are set-ups for disharmony among nurse peers. These scenarios were repeatedly described by interviewees as antecedents of interpersonal drama among nurses (see Table 6: NPR Flashpoints below). As depicted in Table 6, many of the flashpoints are related to time and schedules (see left column); these include granting/denying time off, extended breaks, not breaking others, unnecessary overtime use, calling out sick, coming in late and leaving early. The right-hand column shows additional flashpoints, which include charge nurse and preceptor roles, floating and working with floating nurses, unequal patient assignments, hiding from assignments or availability to peers and patients, lack of situational awareness, and change-of-shift report. Knowing particular scenarios that predict difficulty in NPRs can be important to nurses in practice, understanding when they are in a situation where there is potential to encounter challenges related to the NPR can allow them to prepare for and/or avoid them. Similarly, it is equally important

for nurse managers and other administrators to develop strategies that can help avoid predictable NPR disharmony.

Table 6: NPR Flashpoints

Time-Related	Other
Granting / Denying Time Off	Charge Nurse and Preceptor Roles
Extended Breaks / Not Breaking Others	Floating / Working with Floating Nurses
Overtime Use, Unnecessary	Unequal Patient Assignments
Calling Out Sick	Hiding from Assignments, or Lack of Availability to Peers and Patients
Coming in Late	Lack of Situational Awareness ("Blinders On")
Leaving Early	Change-of-Shift Report

Reflection and Skill Development

The study found the repeated importance of nurse awareness in NPRs. Therefore, educational and skill development programs toward self and situational awareness and emotion regulation could become offerings for nurses in practice. Ongoing support for nurses in practice should include access to counselors who can assist with developing awareness and interpersonal skills as well as group training and workshops to help with development and support of these crucial skills.

Implications for Nursing Education

Educational programs for both pre-licensure nurses and nurses in practice should focus on interpersonal skills and communication, and self and situational awareness plus emotion regulation as helpful approaches to improve NPRs. Teaching nursing students communication techniques including mentally slowing down during stressful interactions, grounding techniques, repeating back what was communicated and asking

what was understood, delaying reactions in favor of responses, checking it out with a third party, using the “ouch” technique to communicate hurt simply and in the moment could each be incorporated into both didactic and simulation learning programs. In addition, exploring the necessity of apologizing and accepting apologies, giving fair feedback, asking for feedback, mindfulness, limit setting, and healthy boundaries would also be positive changes in nursing education based on this study. More broadly, nursing education needs to teach nurses to take responsibility for one’s own health, including mental health, and emphasize the establishment of boundaries before each shift, possibly using mindfulness and resilience techniques.

Difficult conversations can be practiced in the sim lab where students can explore responses to aggression that do not aggravate the situation but preserve the nurse’s dignity. Another approach faculty can use is to share with students’ narratives of situations they have experienced where they learned about themselves and navigating interpersonal issues in the workplace. As well, nursing students need to be taught about their responsibility not only for their patient assignments but for the whole unit including the well-being of their nurse peers. Throughout nursing education and even after graduation, nursing faculty can and should be available to new nurses as an impartial third party with whom to discuss challenging NPR situations. On a more global level, nursing faculty need to teach all through the program that perfection in nursing practice is an illusion because as human beings, we all make mistakes. Therefore, the same forgiveness we each must have for our own shortcomings must be reflected in accepting and forgiving errors in nurse peers.

Implications for Administrators

Several changes for the hospital administration level have been suggested based on the findings of this study. This first, as previously mentioned, is that of the charge nurse role. Administration should consider the potential benefits of making this a permanent role rather than one that rotates and becomes a flashpoint in the workplace. Secondly, the change-of-shift report as an open meeting, which unfortunately can become a theatrical setting for NPR drama to play out, should be reconsidered. Administrators should explore alternative ways to manage the patient hand off that do not have this effect. Of equal importance is the establishment of backup staffing for all hospital units. People get sick, instead of nurse callouts becoming another flashpoint prompting NPA, hospitals must always set up contingency plans for nursing staff illness. Another important change to bring to the workplace is the fortification of positive NPRs. These crucial connections hold great meaning to nurses and must be supported by administration. Nurse administrators will themselves encounter difficult interpersonal situations and need to ongoingly be working on their own skills with the understanding that they will be role-modeling these encounters for the nurses around them. Another important administrative change suggested by this study is for nurses to better perceive the concern administration has for NPRs. Administration needs to demonstrate through action, not only written materials, that they are concerned about NPRs, or better communicate their concern so that nurses are aware of it.

Similarly, demonstrating support for positive NPRs would be a supportive next step. Finally, in terms of a structural perspective, hospital settings need to have small

meeting spaces available where colleagues can meet privately to speak about difficult topics without risk of being interrupted.

In this chapter study strengths and limitations were described. Then, implications for practice, research education, administration, and research were detailed. Despite the homogeneity of the participants, this study has expanded knowledge about NPRs and contributed to new directions for research, practice, education, and administration.

Appendix A. Advertisement for Participant Recruitment

Be part of an important nursing research study!

- *Are you a clinically active Registered Nurse?*
- *Do you want to contribute to the understanding of nurse peer relationships?*

If you answered YES to these questions, you may be eligible to participate in a nursing research study.

The purpose of this research study is to gain a deeper understanding of the nurse peer relationship. An interview will last approximately one hour. Participants will receive an incentive Dunkin Donuts Gift card worth \$15. No medications will be given.

Registered Nurses, who speak fluent English, with access to email are eligible to participate.

This study is being conducted at the University of Massachusetts Amherst College of Nursing. The interview

Please call Maud Low at [REDACTED] for more information.

Appendix B. Informed Consent Form

Introduction:

You are being invited to participate in a research study on the meaning of nurse peer relationships (NPRs). This study is being done by Maud Low from the College of Nursing, University of Massachusetts Amherst. You were selected to participate in this study because you meet the inclusion criteria (a registered nurse, fluent in the English language, with access to email for possible follow-up communication about this study).

This paper explains the details of the study. We are requesting your cooperation for a voluntary participation in this study. Therefore, please read this paper or we will read it for you so that you are fully aware of the procedures. There may be some words in this paper that you are not familiar with. If so, please feel free to ask about those words or any other aspect of the study or consent form.

What is the objective of the study?

The objective of this study is to gather data on the meaning that nurses give to NPRs.

What will I be asked to do?

If you decide to participate in this study, it will take about 45 to 60 minutes of your time. If you consent to be available for follow-up communication, that may occur within 6 months of the interview. You will be asked a series of questions on the following topics:

1. Tell me about any official requirements of the “nurse peer relationship” where you work or have worked.
Follow-up probes:
Examples: orientation, education, peer review, teamwork.
What did/ does this mean to you?
2. Tell me about the nurse peer relationship(s) you encountered on your last day of work.
Follow-up probes:
What do they mean to you?
3. Tell me about a good relationship at work with a nurse peer.
Follow-up probes:
Can you give an example of what made it so positive?
What contributed to the success of the relationship?
What contributed to your reactions and responses within the relationship?
What contributed to the other nurse’s reactions and responses within the relationship?
How did this relationship affect your subsequent interactions with workplace nurse peers?
How did the work environment and/or leadership affect this relationship?
What did/ does this relationship mean to you?
4. I’m trying to get the whole range of nurse peer relationships. So, tell me about a problematic workplace nurse peer relationship you have had.
Follow-up probes:
Can you give an example of what made it so problematic?
Does this fit your definition of “bullying”?
What do you think motivated the “bully” in this instance?
What contributed to the occurrence of those events?
What contributed to your reactions and responses during those events?

How did this relationship affect your subsequent interactions with workplace nurse peers?

How did the work environment and/or leadership affect this relationship?

What did/ does this relationship mean to you?

5. Looking back over your career, what general thoughts or feelings do you have about workplace nurse peer relationships?

Follow-up probes:

How have your thoughts and feelings on NPRs changed over time?

How do you see your future in dealing with NPRs?

6. Do you have any other thoughts, feelings, or comments about NPRs?

Possible risks

Some of the questions that you will be asked could cause you emotional upset or you may hesitate to answer them. You are free to skip such questions or to withdraw from the whole study at any time. If you feel upset after completing the study or find that some questions or aspects of the study triggered distress, you will be provided a mental health resource list.

What are my benefits of being in this study?

You may not directly benefit from participation in this study, however the information obtained from you will help the understanding of the research topic. If you have had challenges with nurse peer relationships, it may be a relief speak about them with a concerned listener.

Do I receive compensation?

You will receive a \$20 gift card from Dunkin Donuts as an incentive after the interview.

How will my personal information be protected?

All of the information collected during the study will remain confidential. The information from the interview will be assessed looking for themes which are common to multiple participants. In addition, direct quotes from participants will be used as study data. The data will be stored securely and will be made available only to the persons directly involved with this or a subsequent related study by this researcher. Tapes will be destroyed once they are transcribed unless you indicate giving permission to use your voice as a part of the data discussion and presentation. Your real name will not be recorded in the notes or the transcribed data. Thus, your name will not appear in the report which arises from the study.

Can I stop being in this study?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not wish to participate. To withdraw from the study, please send the researcher an email stating your desire to withdraw and the pseudonym you chose to use. Please retain these pieces of information so that you have the necessary information to withdraw.

What if I have questions?

If you have questions about this project or if you have research-related problem, you may contact the researcher, (Maud Low, email: [REDACTED]). Another resource is the researcher's faculty sponsor, Dr. Cynthia Jacelon (email: [REDACTED]). If you have any questions concerning your rights as a research subject, you may contact the

Volunteer Agreement

If you understand what this study involves and agree to participate, you can join this study as a participant. If you do not agree to participate, you do not need to give any information. Now, you can give your verbal decision if you understand the study procedures clearly. If you decide to participate in the study, you can check the box below.

____ I am agreeing to voluntarily enter this study. I have had a chance to read this consent form, and it was explained to me in a language which I use and understand. I have had the opportunity to ask questions and have received satisfactory answers. I understand that I can withdraw at any time and will retain the information on my pseudonym and provide it at the time of requesting to withdraw from this study.

Use of Voice for Data Discussion or Presentation

____ I agree that my voice, being audio recorded, may be used as a part of the data findings and discussion.

____ I do not want my voice, being recorded, to be used in the discussions of the study's findings.

By signing below, the participant indicates his/her willingness to participate in the research study as described and explained above

Availability to Check Findings

____ I agree to being available via email to read and comment on the findings of this study

____ I do not want to be contacted to read and comment on the findings of this study

By signing below, the participant indicates his/her willingness to participate in the research study as described and explained above

Signature of the Participant

Print Name (Participant)

Date

By signing below, an interviewer indicates that the participant has read and, to the best of my knowledge understands the details contained in this document.

Signature of Interviewer

Print Name (Interviewer)

Date:

Appendix C. Demographic Information

Please answer the following items by circling the appropriate response. Thank you for your participation.

Pseudonym _____

1. Number of years in Nursing Practice

- Less than 1 year
- 1-3 years
- 4-6 years
- 7-9 years
- 10-15 years
- 15-20 years
- More than 20 years

2. What is your area of specialty? _____

3. What is your current nursing position/or last one you held? _____

4. Gender:

- Male
- Female

5. Highest level of education.

- ADN
- BSN
- MS/MSN
- DNP
- EdD
- PhD

6. Length of time (in years) working in current position or last position.

- Less than 1 year
- 1-3 years
- 4-6 years
- 7-9 years
- 10-15 years
- 15-20 years
- More than 20 years

Appendix D. Semi-Structured Interview Question Guide

The following semi-structured interview questions were adapted from Charmaz's (2006) guide to grounded theory questions.

Introduction:

-Interested in understanding your experiences in relating to nurse peers in the workplace throughout your career and the meaning of these experiences to you.

1. Tell me about any official requirements of the "nurse peer relationship" where you work or have worked.
Follow-up probes:
Examples: orientation, education, peer review, teamwork.
What did/ does this mean to you?
2. Tell me about the nurse peer relationship(s) you encountered on your last day of work.
Follow-up probes:
What do they mean to you?
3. Tell me about a good relationship at work with a nurse peer.
Follow-up probes:
Can you give an example of what made it so positive?
What contributed to the success of the relationship?
What contributed to your reactions and responses within the relationship?
What contributed to the other nurse's reactions and responses within the relationship?
How did this relationship affect your subsequent interactions with workplace nurse peers?
How did the work environment and/or leadership affect this relationship?
What did/ does this relationship mean to you?
4. I'm trying to get the whole range of nurse peer relationships. So, tell me about a problematic workplace nurse peer relationship you have had.
Follow-up probes:
Can you give an example of what made it so problematic?
Does this fit your definition of "bullying"?
What do you think motivated the "bully" in this instance?
What contributed to the occurrence of those events?
What contributed to your reactions and responses during those events?
How did this relationship affect your subsequent interactions with workplace nurse peers?
How did the work environment and/or leadership affect this relationship?
What did/ does this relationship mean to you?
5. Looking back over your career, what general thoughts or feelings do you have about workplace nurse peer relationships?
Follow-up probes:
How have your thoughts and feelings on NPRs changed over time?
How do you see your future in dealing with NPRs?
6. Do you have any other thoughts, feelings, or comments about NPRs?

Appendix E. Collaborative Institutional Training Initiative (CITI)



Appendix F. Mental Health Resource Referral Guide

<i>Counseling Services</i>		
IF THIS IS AN EMERGENCY Call 911 or go to your local emergency room		
Toll-free, 24-hour hotline of the National Suicide Prevention Lifeline 1-800-273-TALK (1800-273-8255)		
ON-CAMPUS RESOURCES for UMass Faculty, Staff, and Students		
University Health Services (UHS) UMass student medical crisis	413-577-5000 http://www.umass.edu/uhs/	24 hours 150 Infirmary Way
Center for Counseling and Psychological Health (CCPH) UMass student mental health center	413-545-2337 http://www.umass.edu/uhs/counseling/	Weekdays 8am-5pm; or after business hours, call UHS and ask for CCPH clinician on-call
Faculty and Staff Assistance Program (FSAP) UMass faculty and staff	413-545-0350 http://www.umass.edu/uhs/services/fsap/	Weekdays 8:30am-5pm 150 Infirmary Way, UHS Ground floor
Center for Women & Community Counseling, Advocacy, Support Groups	413.545.0883 Rape crisis hotline (24/7) 413-545-0800 http://www.umass.edu/ewc/	Weekdays 8:30am-5pm 180 Infirmary Way, New Africa House
UMass Police Department	Emergency: 911 (campus phone) or 413-545-2121 (cell phone) http://www.umass.edu/umpd/	24 hours 585 East Pleasant Street
Disability Services UMass referrals and accommodations	413-545-0892 http://www.umass.edu/disability/	Weekdays 8:30am-5pm 161 Whitmore Administration Building
OFF-CAMPUS/COMMUNITY RESOURCES		
Clinical & Support Options Outpatient Services http://www.csoinc.org/outpatient/		
Cooley Dickinson Hospital http://www.cooley-dickinson.org/Main/Home.aspx		
Baystate Behavioral Health http://baystatehealth.com/Baystate/Main+Nav/Clinical+Services/Departments/Behavioral+Health+Services		
ServiceNet http://servicenet.org/		
NATIONAL RESOURCES		
Mental Health Services Locator http://store.samhsa.gov/mhlocator		

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