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Analyzing The Impact of Workplace Bullying on Nursing Practice and Patient Outcomes: Review

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Abstract

Background: Workplace bullying in nursing environments poses significant threats to both healthcare professionals and patient safety. Bullying behaviors can disrupt communication, collaboration, and overall team dynamics, leading to increased medical errors and diminished patient care quality. Understanding the multifaceted impacts of bullying is crucial for addressing these issues in healthcare settings.

Methods: This systematic review analyzed literature from 2000 to 2023, focusing on the relationship between workplace bullying and nursing practice mistakes, as well as patient outcomes. Databases including PubMed, CINAHL, and Scopus were searched for studies that examined the prevalence of bullying, its psychological effects on nurses, and its correlation with adverse patient events. Data were categorized into themes related to bullying behaviors and their consequences on nursing practice.

Results: The review identified that a substantial proportion of nurses (27%-82%) report experiencing bullying, which correlates with heightened stress, burnout, and decreased job satisfaction. Additionally, studies revealed that bullying negatively impacts communication and teamwork, leading to increased medication errors and adverse patient outcomes. The findings highlight a direct link between workplace bullying and nursing practice mistakes, with implications for patient safety.

Conclusion: Addressing workplace bullying is essential for improving both nurse well-being and patient care quality. Healthcare organizations must implement comprehensive strategies to mitigate bullying and foster a supportive work environment. Future research should explore the long-term effects of bullying on patient outcomes and the effectiveness of interventions aimed at reducing bullying behaviors.

Keywords: Workplace Bullying, Nursing Practice Errors, Patient Safety, Nurse Well-being, Healthcare Environment.

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1. Introduction

Medical mistakes impose significant financial burdens on hospitals and payer systems, affecting not just the expenses associated with patient morbidity and death but also diminishing patient happiness and eroding faith in the healthcare delivery system [1]. The projected societal cost of lost lives and incomes due to unfavorable medical occurrences in the United States ranges from $393 billion to $985 billion annually, representing 18% to 45% of total US healthcare expenditures in 2006 [2]. Moreover, medical blunders may elevate healthcare expenses for an individual patient's hospitalization by 17% and extend the patient's duration of stay by 22% [3,4]. Despite several regulatory, institutional, and accrediting initiatives after the release of this study, the incidence of fatalities attributable to medical errors remains elevated, with multiple studies suggesting that the mortality rate exceeds the figures presented in the Institute of Medicine report [5,6]. A 2016 analysis of death certificates indicated that healthcare mistakes, both at the individual and systemic levels, may be regarded as the third greatest cause of mortality in the United States [7]. 2019 research indicated a reduction in US death rates associated with medical mistakes or adverse events from 1990 to 2016; nonetheless, the authors observed in their secondary analysis that 63% of the unfavorable consequences of medical therapy are surgical or perioperative incidents [8].

Nurses frequently operate in a frontline acute-care role and oversee over 80% of patient care [9]. Most patient information is relayed among members of the patient care team, and inaccuracies during these communication exchanges significantly contribute to medical errors. Workplace bullying can adversely affect the dissemination of critical patient information, collaborative decision-making, and provider communication, thereby exacerbating medical errors and detrimental patient outcomes [10,11]. Health care professionals who experience bullying are less inclined to intervene or report medical errors and may resort to workarounds to evade the bully, potentially heightening the risk of direct patient harm through medical errors [12].

2. Harassment Among Nurses

Workplace bullying constitutes a recurrent pattern of adverse behaviors executed by one employee towards another, resulting in both immediate repercussions for the individuals involved and broader systemic effects, such as diminished job satisfaction among witnesses [13]. Bullying obstructs respectful, collaborative, and effective teamwork. Health care teams are more susceptible to disruptive behavior due to bullying compared to employees in other sectors. In 2008, The Joint Commission acknowledged the peril of bullying within the health care system and issued a sentinel event alert urging health care organizations to implement organizational-level interventions to combat bullying [14-16].

Workplace bullying is particularly prevalent among interprofessional health care teams, especially among nurses and physicians, leading to heightened stress, frustration, diminished focus, and impaired job performance [18]. The literature indicates that the percentage of nurses who self-report experiencing bullying, either as victims or witnesses, varies significantly, ranging from 27% to 82%. Bullying has been documented in various hospital environments, including the operating room, emergency department, and acute and critical-care units [19-22]. The adverse effects of workplace bullying on psychosocial factors at both individual and organizational levels—such as job satisfaction, emotional well-being, cognitive function, depression, burnout, intent to leave, and absenteeism—are well-established, ultimately undermining communication efficacy. Nevertheless, further research is necessary to elucidate how these stressors at the nursing level influence patient outcomes, whether directly or indirectly [23-27].

Numerous terms characterize workplace bullying, including mobbing, horizontal violence, lateral violence, incivility, and bullying, each with slight variations in conceptual application [28]. Some scholars have sought to distinguish these terms by examining modifiers such as power differential, intensity, and chronicity; however, the terminology associated with bullying is frequently employed interchangeably [18].

A literature review on lateral violence indicates that studies consistently defined behaviors and outcomes across all conceptualizations. Consequently, for this review, we will utilize the term workplace bullying or simply bullying. Nursing practice mistakes are widely described as any divergence from established norms in nursing practice and education, including medical errors, failure to rescue, missing care, and adverse events [29].

This study aimed to analyze the literature about the impact of nurse bullying on nursing practice mistakes and patient outcomes, categorizing the data into themes associated with bullying and nursing practice errors.

3. The Impact of the Work Environment on Errors in Nursing Practice

This review found seven papers examining organizational or unit-level impacts on nursing practice, including bullying. Two researchers used the Practice Environment Scale-Nursing Work Index (PES-NWI) instrument to assess different facets of the work environment. One study reported solely the overall PES-NWI score without subscale analysis, revealing that as the work environment improved, medication errors increased, contrary to anticipated outcomes [30-36]. Another study demonstrated a significant negative correlation between overall workplace environment ratings via the PES-NWI and all three categories of measured nurse-sensitive adverse events: central catheter-associated bloodstream infections, ventilator-associated pneumonia, and urinary tract infections [25]. Although the researchers performed a subscale analysis, they exclusively presented the individual t-scores for each subscale and did not conduct a regression analysis of the three types of adverse events. Both studies failed to analyze data at the organizational level to identify which elements of the nursing practice environment correlated with nursing practice mistakes.

One of the six articles examined data at the subscale level utilizing a modified version of the PES-NWI scale. This study demonstrated that elevated levels of depersonalization were indicative of a heightened self-reported incidence of various adverse patient outcomes associated with nursing care, such as falls, healthcare-associated infections, and medication errors. Nursing management at the unit level was similarly indicative of nurse-perceived quality of care, suggesting an implicit link between organizational-level connections, depersonalization, and worse patient outcomes [35].

The four subsequent investigations examined the association between the overall organizational-level practice environment and nursing practice mistakes, using various measures to emphasize distinct features of the environment. One study compared overall bullying levels across hospital units in the sample and discovered that mean subscale scores were significantly elevated for labor and delivery units in contrast to other women's health services departments ($F_{2,59} = 4.88$, $P = .01$) [33]. Another investigation assessed the correlation between safety culture, as evaluated by healthcare professionals, and perceived adverse events, revealing variations in this correlation among different professions. Nurses exhibited the most robust correlation rating for safety culture and diminished medical errors compared to physicians and operating room administrators (incidence rate ratio = 1.73, $P < .00001$) [24].

Two additional studies employed the Negative Acts Questionnaire-Revised (NAQ-R) to investigate the correlation between various bullying behaviors and perceived patient safety. Logistic regression analysis revealed that perioperative staff at one location were threefold more likely to experience bullying compared to their counterparts at another location ($P = .03$, 95% confidence interval [CI]). Furthermore, one study indicated a rise in errors and adverse events at non-critical-care sites relative to critical-care sites. The disparities between the sample locations in both studies suggest a potential organizational-level explanation for the variations in bullying and errors [34].

4. Connections at the Individual Level Between Bullying and Errors in Nursing Practice

The psychosocial repercussions of bullying include symptoms such as heightened stress, somatic complaints, frustration, absenteeism, and diminished focus. These aspects manifest at the individual worker level rather than at an aggregate or organizational level. Numerous studies have identified negative behaviors linked to bullying, which were subsequently correlated with additional metrics of patient error

[37,38]. A survey of 241 nurses in the Midwest revealed a significant positive correlation between individual-level bullying behaviors and psychosocial responses, including stress, somatic symptoms, and impaired concentration (F = 0.251, P < .001). Another study involving 508 nurses in South Korea indicated that verbal abuse was associated with job stress (r = 0.17, P < .001) and intentions to resign (r = 0.16, P < .001) [37]. Additionally, a separate study demonstrated a significant moderate positive correlation between the frequency and intensity of bullying and emotional exhaustion among affected participants (P < .001) [23].

Most studies on workplace bullying have concentrated on its impact on individual-level variables (e.g., stress, absenteeism) within the nursing population, yet they have not explored how bullying may influence patients and jeopardize patient safety due to nursing practice errors stemming from these individual-level psychosocial factors [37,38]. This systematic review identified three studies examining the impact of bullying on nursing practice errors via psychosocial consequences, rather than higher organizational-level factors. One study differentiated between two forms of bullying: work-related bullying stemming from the formal structure of a hospital unit and person-related bullying arising from informal personal relationships within the unit. Both forms of bullying were significantly associated with medical errors and psychological or behavioral responses; however, work-related bullying was mitigated by the recipient's psychological or behavioral response, while person-related bullying was only partially mitigated by such responses. A potential view is that medical mistakes escalate due to an individual's psychological or behavioral reactions (e.g., diminished morale, absence of acknowledgment) rather than the bullying conduct itself [17].

A separate study revealed that workplace bullying indirectly affected nurse-assessed patient safety via job stress and intent to leave. All subscale results of workplace bullying were significantly correlated with all examined variables, including patient safety for personal-related (r = 0.15, P < .001), work-related (r = 0.19, P < .001), and intimidation-related bullying (r = 0.17, P < .001). Additionally, other researchers evaluated the relationship between bullying and various psychological factors, contrasting it with respondents' perceptions of the connection between disruptive behaviors and adverse events. This connection was not statistically nor theoretically evaluated. Individual-level psychosocial characteristics may be a reaction to bullying and maybe a precursor to mistakes in nursing practice [17].

5. Obstacles to Collaboration

Health care is provided in interprofessional team settings that need teamwork, cooperation, and civility among individuals. Bullying may cause victims to shun their colleagues, thereby compromising the effectiveness of interprofessional teams [18]. Utilizing the Lateral Violence in Nursing Survey, researchers discovered that bullying adversely affects teamwork behaviors that jeopardize patient safety, such as lifting patients without requesting assistance (25.6%), employing unfamiliar equipment instead of seeking help (11.6%), and deferring order clarification to the subsequent nurse responsible for the patient (6.9%) [12].

Researchers investigated teamwork through the Collegial Nurse-Physician subscale of the PES-NWI survey and identified a positive correlation between teamwork and nursing error interception rates (β = 1.33, P = .001) [39]. One study revealed that horizontal violence exhibited a significant negative correlation with perceived peer relations (r = -1.084, P < .05) and a direct correlation with perceived errors and adverse events (r = 0.428, P < .05). Nonetheless, a multiple regression analysis of all factors indicated no significant perceived correlations between bullying and errors [34].

Two studies employed the NAQ-R scale to assess the frequency and severity of bullying behaviors, albeit with slightly divergent analytical approaches [23,40]. One study evaluated the impact of bullying and incivility on nursing perceptions of quality and the perceived frequency of adverse patient outcomes, revealing significant correlations between all forms of bullying and incivility and perceived negative outcomes [40]. Bullying exhibited the most robust association with perceived adverse events (β = 0.241, P < .05), while coworker incivility also demonstrated a strong correlation with perceived adverse events (β = 0.148, P < .05). The other study evaluated bullying in the operating room utilizing the NAQ-R alongside seven questions regarding near misses, errors, and safety, revealing that merely 3% of participants believed

bullying affected error rates. These two studies yielded divergent outcomes, necessitating an examination of the discrepancies in samples, conceptual frameworks, and research methodologies [23].

6. Communication Deficit

This systematic review indicates that all four studies concerning communication utilized subscales or specific inquiries or statements from established scales for their analyses. In an examination within the operating room context, perioperative nurses' responses to the Hospital Survey on Patient Safety Culture revealed correlations between significant surgical complications and the hospital safety culture subscale ($P = .002$, CI 95%), as well as the statements “problems often occur in the exchange of information across hospital units” ($P = .006$, CI 95%) and “hospital units do not coordinate well with each other” ($P = .013$, CI 95%) [17,24,41]. Researchers explored open communication as a component of patient safety culture within a critical transport team environment, employing the Hospital Survey on Patient Safety Culture subscale. A very positive correlation was identified between communication openness and patient safety grade ($r = 0.62$, $P = .0001$) [41].

In the emergency room, researchers examined the obstacles to successful communication at both the individual-value and situational levels and assessed the impact of certain contributory behaviors. The participants were requested to evaluate aggregate "disruptive behaviors," including the specific obstacles previously identified in the survey, in relation to perceived adverse events and errors: 32.8% of participants believed disruptive behaviors were associated with adverse events. In a separate study, 60% of participants reported experiencing horizontal hostility behaviors monthly, leading to unsafe practices, such as executing an illegible order (30%) and independently lifting heavy patients (25.6%) [17]. However, the direct correlation between specific individual and systems-level barriers and the incidence of adverse events, whether actual or reported, was not empirically tested, thereby constraining the conclusions that can be drawn from the analysis of these particular barrier inquiries [12].

Researchers conducted a survey of nurses in perinatal settings utilizing an adapted critical-care instrument featuring subscale items pertinent to workplace bullying, including inquiries regarding the adverse impact of bullying on communication. The study examined the correlation between bullying and behaviors influenced by it; however, it did not delineate the results at the specific question level, leaving the direct relationship between nursing practice errors and compromised communication ambiguous [33].

In the perioperative setting, effective communication is crucial as patients undergo critical operations managed by multidisciplinary teams; nonetheless, the operating room is a high-stress environment where disruptive behaviors and bullying often occur [23]. Both studies conducted in the perioperative setting included in this study identified bullying-type messages that undermined the safety culture of the respective units [23,24]. In the perioperative setting for bariatric surgeries, the communication and care coordination elements of the hospital's safety culture, as indicated by subscales of a comprehensive safety culture questionnaire, were strongly correlated with the rates of surgical complications [24]. Other researchers identified adverse communication behaviors, including "having one's opinion disregarded" and "being yelled at," which may adversely impact safety culture and correlate with frequent problematic occurrences in the perioperative environment related to perceived risks to patient safety [23].

An in-depth examination of the correlations between bullying behaviors and patient safety in this two research uncovers intricacies. In the perioperative context, 59% of participants reported observing bullying, while merely 6% acknowledged being victims of such behaviors [41]. In the setting of bariatric surgeries, nurses did not find a significant correlation between the overall operating room safety culture and complication rates, whereas surgeons believed that the safety culture was indeed linked to complication rates. These conflicting results underscore the necessity for further investigation into patient safety and errors concerning nurses' reactions to bullying, in order to comprehend the phenomenon and devise appropriate interventions [23].

This review analyzed several human and organizational repercussions of bullying, both alone and collectively, to comprehend their associations with nursing practice mistakes. Two studies concurrently

assessed the possible impacts of organizational-level and individual-level linkages on nursing practice mistakes, highlighting the need for further exploration of these correlations. Research examined the correlation between collaboration (i.e., peer interactions) and bullying concerning nursing practice mistakes and adverse events but yielded no significant results. These findings need more efforts to replicate and enhance the models linking these concepts [17].

Nursing has transitioned from mechanistic, simplistic cause-effect interactions to a knowledge-driven coordination of patient care within intricate, multifaceted, and dynamic healthcare organizations [35,37]. Bullying can lead to either deliberate counterproductive work behaviors aimed at undermining an organization or discord between a nurse's intended performance and actual performance due to constraints in the work environment. This conflict is referred to as structurational divergence (SD) and arises when nurses encounter contradictions that impede their capacity to comprehend and respond effectively in social or professional contexts. Structurational divergence frequently manifests as typical interpersonal conflict; however, it proves resistant to conflict resolution interventions, suggesting an alternative conceptual foundation. No studies in this review examined SD as an individual-level consequence of bullying to explore the correlation between nursing SD and nursing practice errors. Further elaboration of this notion is necessary to enhance the comprehension of the connections between the repercussions of bullying and mistakes in nursing practice [42].

To enhance the communication of patient information among nurses, it is crucial to delineate and recognize the extrinsic or individual attributes that contribute to or are affected by bullying, hence facilitating or obstructing communication. Following the publication of To Err is Human: Building a Safer Health System, healthcare organizations intensified their emphasis on safety culture, defined as the beliefs and values that underpin health and safety management [43-45]. A crucial element of safety culture is communication, which encompasses assertive language, clarification, and structured dialogue. Structured communication procedures enhance a safety culture by standardizing information exchanged among healthcare professionals, hence reducing variability and mistakes. Teamwork, another facet of safety culture, may also be adversely impacted by bullying [46-49]. In a safety culture, teamwork necessitates collaboration among caregivers founded on trust and respect for experience. This review confirms that bullying behaviors influence perceptions of safety culture, thereby impacting communication and teamwork, yet fails to elucidate the specific associations and relationships among these concepts.

Environmental antecedents (e.g., job characteristics, quality of interpersonal relationships, leadership styles, organizational culture) can affect both organizational and individual factors, creating environments that may either facilitate or hinder bullying behaviors [50]. In a proposed model outlining potential relationships between the antecedents and consequences of bullying, derived from a systematic review, researchers identified a knowledge gap regarding the individual-level and organizational-level consequences of bullying, which may mediate or moderate patient safety and quality of care through nursing practice errors. Their model suggests a potential mediating relationship between nurses' personal well-being and healthcare organization operations, emphasizing the need for further research. Further multilevel analyses and longitudinal research are required to clarify these links and explain how the repercussions of bullying at both organizational and individual levels may result in mistakes in nursing practice [51-53].

The nursing profession has historically been undervalued, and oppression theory posits that a deficiency in power and autonomy results in maladaptive behaviors, including bullying within the profession. The oppression of marginalized individuals fosters low self-esteem, anger, and fear, which can culminate in intra-group bullying over time. The adverse effects of bullying frequently persist beyond the workplace, impacting individuals at home. Nurses subjected to bullying may diminish their work efforts, leading to a decline in the quality of their output, which in turn compromises patient care. This review indicates that nurses endure individual-level repercussions (e.g., diminished self-esteem, frustration, fear) following bullying incidents; however, the correlation to subsequent patient outcomes remains speculative and inadequately elucidated in existing literature. Longitudinal study may be beneficial, since the enduring

impacts of bullying and the protracted healing process after a bullying incident may adversely impact patient outcomes via nursing practice mistakes [54].

7. Conclusion

This study aimed to assess the evidence about the impact of bullying on nursing practice mistakes and patient outcomes. Our investigation indicated that nurses perceive bullying as a factor that may directly or indirectly impact nursing practice mistakes and patient outcomes, while the mechanisms remain ambiguous. Bullying is linked to complex outcomes that may interact with one another. Comprehending the origins of bullying is crucial for formulating effective solutions. The majority of research has concentrated on adverse nursing professional outcomes, such as burnout, dissatisfaction, intent to resign, and dysfunctional teams; however, this emphasis has not resulted in cultural or systemic transformation within the sector. Researchers and facility executives must develop effective strategies to mitigate workplace bullying to prevent adverse patient outcomes resulting from changes in nursing practice.

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تحليل تأثير التنمر في مكان العمل على ممارسة التمريض ونتائج المرضى: مراجعة

الملخص

الخلفية :يشكل التنمر في بيئة العمل التمريضية تهديدات كبيرة لكل من المهنيين الصحيين وسلامة المرضى. يمكن أن تؤدي سلوكيات التنمر إلى تعطيل التواصل والتعاون وديناميكيات الفريق بشكل عام، مما يزيد من الأخطاء الطبية ويقلل من جودة الرعاية المقدمة للمرضى. من الضروري فهم التأثيرات المتعددة الأبعاد للتنمر لمعالجة هذه القضايا في بيئات الرعاية الصحية.

المنهجية :قامت هذه المراجعة المنهجية بتحليل الأدبيات من عام 2000 إلى 2023، مع التركيز على العلاقة بين التنمر في مكان العمل وأخطاء ممارسة التمريض، بالإضافة إلى نتائج المرضى. تم البحث في قواعد البيانات مثل PubMed و CINAHLو Scopusعن دراسات تناولت انتشار التنمر، وتأثيراته النفسية على الممرضين والممرضات، وعلاقته بالأحداث السلبية للمرضى. تم تصنيف البيانات إلى موضوعات تتعلق بسلوكيات التنمر وعواقبها على ممارسة التمريض.

النتائج :أظهرت المراجعة أن نسبة كبيرة من الممرضين والممرضات (27%-82%) أفادوا بتعرضهم للتنمر، مما يرتبط بزيادة مستويات التوتر، والإرهاق الوظيفي، وانخفاض الرضا الوظيفي. بالإضافة إلى ذلك، كشفت الدراسات أن التنمر يؤثر سلبًا على التواصل والعمل الجماعي، مما يؤدي إلى زيادة أخطاء صرف الأدوية ونتائج سلبية للمرضى. تسلط النتائج الضوء على وجود علاقة مباشرة بين التنمر في مكان العمل وأخطاء ممارسة التمريض، مع تداعيات خطيرة على سلامة المرضى.

الخاتمة :يعد التصدي للتنمر في مكان العمل أمرًا ضروريًا لتحسين رفاه الممرضين والممرضات وجودة الرعاية المقدمة للمرضى. يجب على مؤسسات الرعاية الصحية تنفيذ استراتيجيات شاملة للحد من التنمر وتعزيز بيئة عمل داعمة. ينبغي أن تستكشف البحوث المستقبلية الآثار طويلة الأمد للتنمر على نتائج المرضى وفعالية التدخلات الهادفة إلى تقليل سلوكيات التنمر.

الكلمات المفتاحية :التنمر في مكان العمل، أخطاء ممارسة التمريض، سلامة المرضى، رفاه الممرضين، بيئة الرعاية الصحية.