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RESEARCH ARTICLE

Creating respectful workplaces for nurses in regional acute care settings: A quasi-experimental design

Natasha Hawkins[1] | Sarah Yeun-Sim Jeong[2] | Tony Smith[3] | Jenny Sim[4,5] | Matthew Clapham[6]

[1]The School of Nursing & Midwifery, The University of Newcastle, Taree, New South Wales, Australia

[2]The School of Nursing & Midwifery, Faculty of Medicine and Health, University of Sydney, Sydney, New South Wales, Australia

[3]Department of Rural Health, The University of Newcastle, Taree, New South Wales, Australia

[4]The School of Nursing & Midwifery, The University of Newcastle, Ourimbah, New South Wales, Australia

[5]School of Nursing University of Wollongong, NSW Australia Associate Professor Australian Health Services Research Institute (AHSRI) University of Wollongong, New South Wales, Australia

[6]Hunter Medical Research Institute, Lot 1 Kookaburra CCt, New Lambton Heights, New South Wales, Australia

Correspondence
Natasha Hawkins, The School of Nursing & Midwifery, The University of Newcastle, Taree, New South Wales, Australia.
Email: tash.hawkins@newcastle.edu.au

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Abstract

Aim: To examine self-reported exposure and experiences of negative workplace behaviour and ways of coping of nursing staff before and after educational workshops.

Design: A Quasi-experimental design.

Method/Setting/Participants: Data were collected pre- /postworkshops using a structured questionnaire. Nurses ($N = 230$) from 12 units in four regional acute care hospitals were invited to complete a pre-intervention survey. Educational workshops were then implemented by the organization at two of the hospitals, after which, follow-up surveys were undertaken.

Results: There were 74 responses in the pre-intervention and 56 responses in the postintervention time period. There were 111 participants who attended the educational intervention, 20% ($n = 22$) completed the follow-up survey. Participants were more likely exposed to work-related bullying acts and they used problem-focused coping strategies and sought social support as a way of coping when exposed to the negative behaviours. Overall, there was a decrease in both bullying and incivility experienced by participants; however, our findings were unable to establish that a statistically significant difference was made due to the implementation of the intervention.

Study Registration: Australian New Zealand Clinical Trials Registry (Registration No. ACTRN12618002007213; December 14, 2018).

KEYWORDS
acute care, bullying, nursing workforce, staff development, workforce issues

[Correction added on 20 August 2022 after first online publication: The fifth author was added in this version.]

[Correction added on 4 October 2022 after first online publication: A second affiliation was added to the author Jenny Sim in this version.]

1 | INTRODUCTION

Despite the International code of ethics for nurses stating that nurses should maintain "a collaborative and respectful relationship with co-workers in nursing and other fields" (ICN, 2012), nurses often liken their workplace to that of a battlefield (Darbyshire, Thompson, & Watson, 2019; Farrell, 2001; Hawkins, Jeong, & Smith, 2019). The internal conflict related to hierarchical standing, status and power in nursing persist (Hawkins et al., 2019; Mikaelian & Stanley, 2016), with negative workplace behaviour noted to impact upon nurses' job satisfaction even more than salary (Simons, 2008).

2 | BACKGROUND

There are varying terms used interchangeably in the literature to describe the conflict and negative behaviours experienced by nurses (Hawkins et al., 2019). Terms include, but are not limited to bullying, incivility, horizontal violence, harassment and lateral violence (Clarke, Kane, Rajacich, & Lafreniere, 2012; Hawkins et al., 2019). Although used interchangeably, in reality the terms describe fluctuating levels of behaviour by different perpetrators (Hawkins, Jeong, & Smith, 2021a, 2021b). Most definitions emphasize that negative acts must be repeated in order to be classified as bullying and harassment; however, it is suggested that a single serious episode may also fit the definitions (Einarsen, Hoel, & Notelaers, 2009). Due to the lack of a universally accepted definition and the subjectiveness of bullying behaviours, the actual pervasiveness is difficult to assess (Hawkins et al., 2019; Healy-Cullen, 2017; Mikaelian & Stanley, 2016). Nevertheless, the subjective element of the victim's perception needs to be recognized alongside other discernible measures (Healy-Cullen, 2017).

Negative workplace behaviour has been described as a "silent epidemic" (Murray, 2009), with victims and witnesses often hesitating to speak up and report the behaviours (Mikaelian & Stanley, 2016; Salvador et al., 2021). Consequently, negative behaviours often go unreported and, in some cases, are accepted as the cultural "norm" in the profession (Darbyshire et al., 2019; Hawkins et al., 2019; Mikaelian & Stanley, 2016; Salvador et al., 2021). Despite the differences in the reported incidence and prevalence, research has consistently shown the adverse effects of such behaviour (Clarke et al., 2012; Hawkins et al., 2019). Negative workplace behaviours have been found to have damaging impacts upon individual nurses emotional and physical health (Mikaelian & Stanley, 2016; Salvador et al., 2021) and on quality of care and patient outcomes (McNamara, 2012; Roche, Diers, Duffield, & Catling-Paull, 2010). Research also indicates that ongoing negative behaviours impact on organizations, being associated with high staff turnover, burnout and increased absenteeism and having the potential to damage the reputation of organizations (Mikaelian & Stanley, 2016) and the nursing profession.

As noted previously (Einarsen et al., 2009), negative workplace behaviours can be classified into three categories: work-related bullying (e.g. unmanageable workloads or withholding information); person-related bullying (e.g. being humiliated or ignored); and physically intimidating bullying (e.g. being shouted at or even threats of violence). There are many organizational factors, such as culture, workload, stress levels and leadership styles that have been identified as contributing to the prevalence of negative behaviour in the workplace (Karatuna, Jönsson, & Muhonen, 2020; Wolf, Perhats, Delao, & Martinovich, 2021). Research also indicates there are various antecedents that place individuals at higher risk of exposure to negative workplace behaviour (Karatuna et al., 2020). These include: the area of employment (e.g. high-intensity areas); personality traits (e.g. low assertiveness); age; length of service; years of experience; and being part of ethnic minority (Karatuna et al., 2020).

2.1 | Ways of coping

Another antecedent that has been identified in the literature is the coping response of individuals when exposed to negative workplace behaviour (Brande, Baillien, De Witte, Vander Elst, & Godderis, 2016). Coping refers to a person's cognitive and behavioural responses to manage or reduce a problem or stressor (Folkman & Lazarus, 1985). These coping responses have been described as being either problem-focused (dealing with the problem) or emotion-focused (regulating emotions) (Folkman & Lazarus, 1985; Hewett, Liefooghe, Visockaite, & Roongrerngsuke, 2018). The degree to which an individual feels they can alter the problem or stressor influences the type of coping response in any given situation (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Hewett et al., 2018). Problem-focused coping is used when an individual feels the stressor can be altered, while emotion-focused coping is used when an individual acquiesces, accepting that nothing can be changed (Folkman et al., 1986; Hewett et al., 2018; Senol-Durak, Durak, & Elagöz, 2011). There can be negative psychological consequences for the individual when there is a discrepancy between their coping response and their actual ability to modify the stressor (Vitaliano, DeWolfe, Maiuro, Russo, & Katon, 1990).

2.2 | A regional perspective

The organizational impacts of negative workplace behaviour mentioned above are of particular concern in rural and regional health facilities, which are already facing shortages of nursing workforce (Jones, Rahman, & Jiaqing, 2019). With the disparity in the distribution of the nursing workforce between metropolitan and non-metropolitan areas, there is ongoing international concern about the future nursing staffing levels for rural and regional areas (Jones et al., 2019; Trépanier, Gagnon, Mbemba, et al., 2013). Recruitment and retention of nurses in those areas remains a challenge and, unfortunately, the effects of such nursing shortages have been shown to result in increased workloads, stress and difficult working conditions

for those employed (Jones et al., 2019; Trépanier et al., 2013). In a self-perpetuating cycle, increased workload and stress levels increase likelihood of exposure to negative workplace behaviour (Hutchinson, Wilkes, Jackson, & Vickers, 2010), which reduces staff retention.

2.3 | Justification for this study

Despite previous extensive research being undertaken, negative workplace behaviour among nurses continues to be problematic (Hartin, Birks, & Lindsay, 2019; Hawkins et al., 2019). This ongoing negative culture must be addressed, particularly in rural and regional areas, where staff recruitment and retention are challenging (Trépanier et al., 2013). There is a scarcity of research examining strategies implemented in acute care settings to address negative behaviour experienced by nurses. The existing knowledge about negative behaviour mitigation needs to be strengthened, with very few studies having included comparison or control groups (Olsen et al., 2020). Furthermore, very little evidence exists about the ways of coping of nurses when exposed to negative behaviours and whether this is associated to the types of negative behaviour they are exposed to.

2.4 | Study aim

Due to the different terms used, this study will use the term negative workplace behaviour to encapsulate both the higher-level behaviours of bullying and the lower level, often tolerated, behaviours of incivility. In response to the need for a comparative study, this study aimed to investigate the self-reported exposure to and experiences of negative workplace behaviours and ways of coping of nursing staff before and after an implementation of an educational intervention at four comparable-sized regional acute care hospitals with same Local Health District in New South Wales (NSW), Australia.

The null hypotheses are that:

- There will be no statistically significant difference in self-reported exposure to and experiences of negative workplace behaviours between nurses at intervention compared to control sites; and
- There will be no statistically significant difference in self-reported exposure to and experiences of negative workplace behaviours among nurses after compared to before the intervention.

3 | METHODS

3.1 | Study design

The overarching study used a mixed method, sequential explanatory design (Yu, 2009) with an embedded experimental component. The study protocol (IRRID: PRR1-10.2196/18643) is reported elsewhere (Hawkins et al., 2021a). This paper reports on the quantitative, experimental component and the implementation of the Respectful Workplace Workshops by the Local Health District. Figure 1 illustrates that component of the study design.

3.2 | Setting and participants

This study included 12 medical or surgical wards in the four regional acute care hospitals. The hospitals were selected due to being similar size, with similar provision of services and case mix. Their co-location in the same Local Health District meant that all four hospitals were under the same executive leadership and were subject to the same bullying and negative workplace behaviour policies and the same human research ethics governance. However, the sites chosen are geographically separated to minimize potential contamination due to study subjects communicating across sites during the intervention period. The total targeted population at the time of Strand 1 data collection was 230 nurses and included new graduate nurses in their first 12 months of practice, Registered Nurses who had been employed for more than 1 year at a minimum of 0.6 full-time equivalent and senior Registered Nurses in permanent leadership roles, comprising of nurse unit managers, clinical nurse educators and clinical nurse specialists.

During initial planning stages, nine employees across the four hospitals were identified as having previously attended the Respectful Workplace Workshops at other hospitals in the Local Health District. Due to the low number of previously exposed participants across the 12 wards; however, the risk of contamination bias at a site level was considered minimal (Hawkins et al., 2021a, 2021b). Nevertheless, these and any other participants who had previously attended the workshops were excluded by an initial survey screening question, "Have you previously completed the Respectful Workplace Workshops?" Remaining participants were allocated into clusters according to the hospital at which they worked, and the survey participants were a volunteer sample from each of the four hospitals. Preliminary sample size calculation assumed a 30% response rate ($n = 69$) with 5% type 1 error and 80% power to detect an effect size equivalent to 0.7 of the standard deviation, thus necessitating recruitment of a minimum of 35 participants for both the intervention and control arms of the study (see Figure 1).

3.3 | Data collection

After ethics approval and initial stakeholder consultation with Directors of Nursing, the principal investigator (NH) visited each ward to present about the research aims and hand out recruitment packages, which contained the participant information statement and the various questionnaires, as explained in detail elsewhere (Hawkins et al., 2021a, 2021b). The questionnaire included three parts, as follows

- Purpose-designed instruments to collect data about:
  - Demographic characteristics
  - Self-assessment of exposure to bullying and incivility

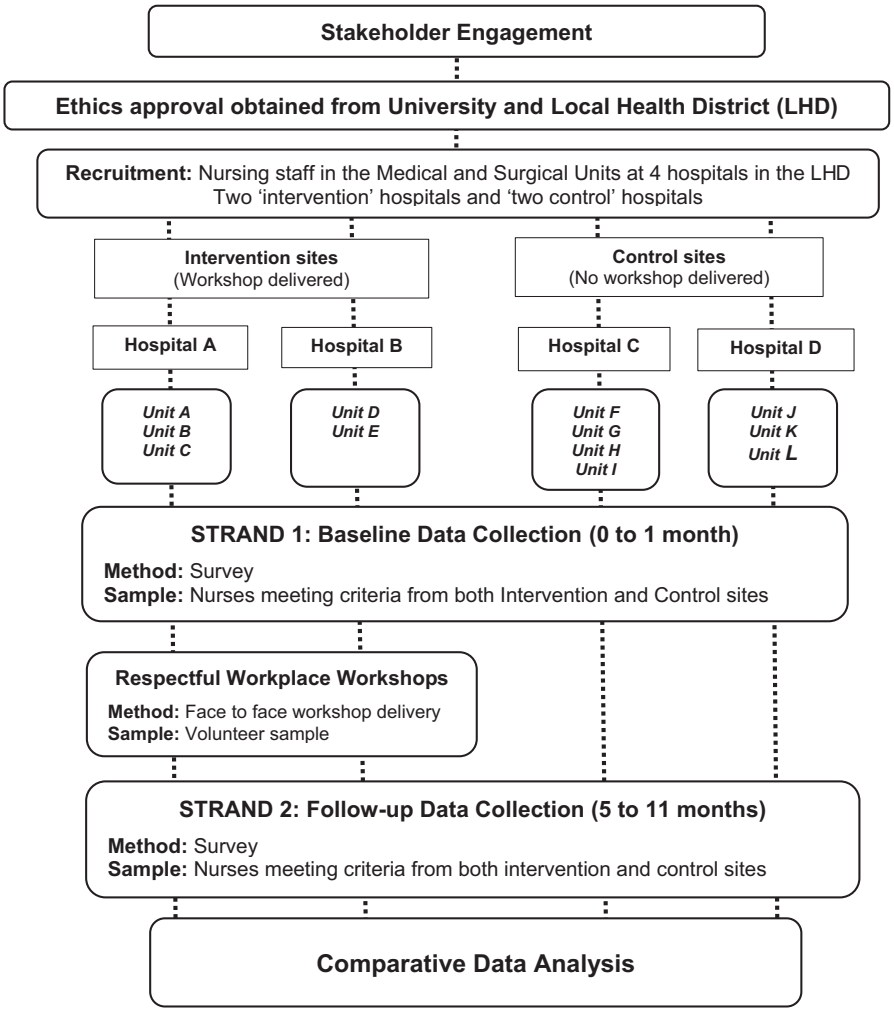

FIGURE 1 Flow chart showing the study data collection and analysis

- The Negative Acts Questionnaire—Revised (Einarsen et al., 2009), an instrument consisting of 22 items measuring exposure to negative workplace behaviours, with response alternatives on a 5-point Likert-type scale, where the higher the score, the greater the frequency of exposure to negative acts.
- The Ways of Coping Questionnaire (Folkman & Lazarus, 1985), a 66-item instrument designed to examine coping processes in stressful encounters.

Permission from the original authors was granted to use the instruments. The pre-intervention surveys were first distributed in March 2018 and postintervention surveys were distributed in August 2018. Participants need not have completed the pre-intervention survey to complete the follow-up. Questionnaires could be completed in either hardcopy or online via Redcap (Harris et al., 2009), a secure web-based application for building and managing web-based surveys and databases. The clinical nurse educators at each hospital were sent reminder emails to distribute to all potential respondents 2 and 4 weeks after the initial distribution of the survey. Completed hardcopies could be returned either by depositing them into brightly coloured boxes left in each ward's tearoom or by posting directly to the research team in reply-paid envelopes that were given.

3.4 | The intervention

The Respectful Workplace Workshops comprised of three copyrighted face-to-face training modules that were developed and delivered by the Local Health Districts' Respectful Workplace Team at the two intervention sites. The aim of the modules was to promote respectful workplace behaviour by improving communication between staff members for the purpose of recognizing, managing and mitigating negative workplace behaviour (HNELHD, 2016). Training occurred independently at each of the sites and all the facilitators were pre-trained and adhered to the proposed course outline to ensure standardized delivery of training across the two sites. The workshops were made available to staff on various days at each site over a three-month period, in order to increase attendance and minimize disruption to work rosters.

Modules 1 and 2 required 2 hours of contact time and, to assist with rostering, the team combined modules 1 and 2 into a single four-hour workshop. Module 3 was for nurse unit managers only and required a further 4 hours of face-to-face contact. The first two modules aimed to challenge participants and encourage reflection on responsibilities and contributions to support a respectful workplace. Those modules provided participants with a

structured conversation template to assist with clear, direct and respectful communication, allowing for role-playing of these conversations to assist the translation of theory into practice. The third module explored managers' roles in supporting the respectful workplace and aimed to improve managerial skills by using resolution pathways and coaching of other staff. The modules used a combination of training methods, including role-play, brainstorming, didactic teaching with PowerPoint presentations and workbooks. The use of a multicomponent intervention consisting of information sharing, skill application and reflective processing is supported in the literature to address incivility in nursing (Olsen et al., 2020).

3.5 | Data analysis

Statistical analyses were performed using SAS v9.4. Numbers and percentages of observations and, where relevant missing values, were tabulated. Due to low counts, nurse unit managers, clinical nurse educators and clinical nurse specialists were combined to form the leadership Registered Nurses' category. Fisher's exact test was used for categorical data instead of a chi-squared test due to low expected counts. Student's *t*-test was used for mean difference and Wilcoxon rank sum test for median to compare demographic variables between control and intervention groups in the postintervention time period and between pre- and postintervention. Age was included as an ordinal variable in all demographic association regressions. The parameter estimates for age can be interpreted as increasing from any age category to the next highest category changes the mean/median domain score by the parameter estimate.

Each question in the Negative Acts Questionnaire—Revised was answered on a scale of 1 to 5, where: 1 = never; 2 = now and then; 3 = monthly; 4 = weekly and 5 = daily; however, scores were dichotomized for the purpose of statistical analysis so that a score of 1 = no exposure to negative acts and 2 or above indicated some exposure. Negative act domain scores were calculated as the sum score from each set of items in the domains. The association between demographic variables and the negative act domains were assessed using quantile regression. Each domain score was regressed on demographic variables including parameters for the study design variables: intervention/control; pre− /postintervention; and the intervention time interaction. Parameter estimates with 95% confidence intervals and p-values were derived using the re-sampling method.

For the Ways of Coping Questionnaire, each item was answered on a scale of 0 to 3, where: 0 = not used; 1 = used somewhat; 2 = used quite a bit; and 3 = used a great deal. Each item was then dichotomized, with a score of 0 meaning the strategy was not used and 1 to 3 that it was used. Ways of Coping domain scores were calculated as the sum from each set of items in the domains, though not all items are used in calculating domain scores. The Ways of Coping domains were assessed with multiple linear regression, with each domain score regressed on demographic variables, including parameters for the study design variables, as for Negative Acts Questionnaire—Revised domains (above). Parameter estimates with 95% confidence intervals and p-values are given, with Huber–White standard errors and confidence intervals also given. If there was a relatively small number of responses missing in the domain, then those missing questions were replaced with the average score for that person; otherwise, that person was left out of analysis.

Changes in outcomes over the study were assessed with normal, quantile or logistic regressions where appropriate. Variables included time (pre−/post-) treatment (intervention/control) and treatment/time interaction. Parameter estimates or odds ratios, 95% confidence intervals, p- values for changes over time in intervention and in control were calculated.

4 | RESULTS

There were 74 responses (32%) in the pre-intervention time period, which included 28 in the control and 46 in the intervention group, and 56 responses (24%) in the postintervention time period, which included 19 in the control and 37 in the intervention group. A total of 28.5% of participants (n = 16) from the postintervention survey were matched as having also completed the preintervention survey.

4.1 | Demographics

Table 1 shows a summary of the demographic variables in both the pre- and postintervention data collection periods. The majority of participants were female (n = 115, 88%) aged under 35 years (n = 68, 53%) and had been working as a Registered Nurse for an average of 10.4 years, with an average of 73.8 hr of work per fortnight at the time of data collection. Participants included new graduate nurses (n = 38, 29%), Registered Nurses (n = 66, 51%) and leadership Registered Nurses (n = 26, 20%). The participants worked on medical wards (n = 81, 62%) and surgical wards (n = 49, 38%). Only one demographic variable was statistically significant between the pre- and postintervention surveys. Due to the time lapse between the two data collection points, the new graduate nurses had been employed for longer in the second survey (p = <0.001).

Over the three-month intervention period, a total of 13 workshops were held across the two intervention sites, with a total of 111 participants attending. This included 28 new graduate nurses, 3 nurse unit managers and 80 Registered Nurses. Out of those 111 participants, 20% (n = 22) completed the postsurvey. Those participants included 8 new graduates (36%), 7 Registered Nurses (32%) and 7 leadership Registered Nurses (32%) (See Table 1).

4.2 | Exposure to bullying and incivility

Table 2 shows the numbers and percentages of those participants who self-identified exposure to bullying and incivility in the month

TABLE 1 Demographics and descriptive characteristics of participants for both pre- and postintervention data collection

Variable	Category	Pre ($n = 74$)	Post ($n = 56$)	Total ($n = 130$)	p-Value
Gender	Female	68 (92%)	47 (84%)	115 (88%)	0.177
	Male	6 (8.1%)	9 (16%)	15 (12%)	
	Missing	0	0	0	
Age	18–25	20 (28%)	16 (29%)	36 (28%)	0.949
	26–35	19 (26%)	13 (24%)	32 (25%)	
	36–45	13 (18%)	8 (15%)	21 (17%)	
	46–55	10 (14%)	10 (18%)	20 (16%)	
	56–65	10 (14%)	8 (15%)	18 (14%)	
	Missing	2	1	3	
Aboriginal or Torres Strait Islander	No	72 (99%)	51 (93%)	123 (96%)	0.164
	Yes	1 (1.4%)	4 (7.3%)	5 (3.9%)	
	Missing	1	1	2	
Position	NGN	20 (27%)	18 (32%)	38 (29%)	0.115
	RN	43 (58%)	23 (41%)	66 (51%)	
	LNR	11 (15%)	15 (27%)	26 (20%)	
	Missing	0	0	0	
NGN Employed under TPP	No	2 (10%)	7 (39%)	9 (24%)	0.058
	Yes	18 (90%)	11 (61%)	29 (76%)	
Ward	Medical	46 (62%)	35 (63%)	81 (62%)	1.000
	Surgical	28 (38%)	21 (38%)	49 (38%)	
	Missing	0	0	0	
Months as a NGN	*n*	19	18	37	
	Mean (SD)	3.63 (2.03)	7.25 (2.44)	5.39 (2.87)	<0.0001[a]
	Median (min, max)	3 (1, 10)	7.25 (3, 10)	5 (1, 10)	0.0003[b]
Years in current position	*n*	67	56	123	
	Mean (SD)	9.49 (11.6)	6.31 (9.23)	8.04 (10.7)	0.100[a]
	Median (min, max)	6 (0.1, 44)	2 (0.17, 42)	4.5 (0.1, 44)	0.117[b]
Years as an RN	*n*	67	40	107	
	Mean (SD)	11.4 (12.8)	8.75 (11.9)	10.4 (12.5)	0.285[a]
	Median (min, max)	6.3 (0.2, 44)	0.92 (0, 36)	6 (0, 44)	0.124[b]
Work hours per fortnight	*n*	74	56	130	
	Mean (SD)	73.8 (9.4)	73.8 (7.79)	73.8 (8.71)	0.978[a]
	Median (min, max)	79 (48, 80)	76 (40, 80)	76 (40, 80)	0.324[b]
Workshop attendees	NGN	0	8 (36%)	22 (20%)	
	RN	0	7 (32%)		
	LNR	0	7 (32%)		

Abbreviations: LNR, RNs in leadership or management roles; NGN, New graduate nurse; RN, Registered Nurse; TPP, Transition to practice program.

[a]Students' *t*-test.

[b]Mann-Whitney U-test.

prior to the data collection points. Across the total sample ($n = 130$) 31% of participants ($n = 40$) had experienced bullying. Overall, there was less bullying experienced in the postintervention period, 27% compared to 34% in the pre-intervention survey (See Table 2). There was a decrease in both the intervention group and control group, from 37% to 31% and from 29% to 21%, respectively. The odds of having been bullied over the previous month were 33% less in the control (OR 0.67 95%CI 0.2 to 2.7) and 25% less in the intervention group (OR 0.75 95%CI 0.3 to 1.8). The intervention odds ratio was 13% higher than the control odds ratio (OR 1.13, 95%CI 0.2 to 5.8), meaning that, although not statistically significant, the intervention group experienced less of a reduction in bullying than the control group (See Table 2). Out of the 11 participants who indicated they had experienced bullying in the previous 1 month, 5

TABLE 2 Self-reported bullying and incivility exposure, intention to leave and policy awareness, together with the odds of a change in participants' responses for the control and intervention hospitals between baseline and follow-up

Statement	*n*	Response	Control		Intervention		Totals		Change from baseline odds ratio (95%CI)		*p*-Value
			Pre (*n* = 28)	Post (*n* = 19)	Pre (*n* = 46)	Post (*n* = 37)	Pre (*n* = 74)	Post (*n* = 56)			
Have you experienced "Bullying" at work over the last one month?	129	No	20 (71%)	15 (79%)	29 (63%)	25 (69%)	49 (66%)	40 (71%)	Control	0.67 (0.17, 2.69)	0.569
		Yes	8 (29%)	4 (21%)	17 (37%)	11[a] (31%)	25 (34%)	15 (27%)	Intervention	0.75 (0.31, 1.79)	0.518
		Missing	0	0	0	1	0	1	Interaction	1.13 (0.22, 5.83)	0.888
Have you experienced 'incivility' at work over the last one month?	128	No	12 (43%)	14 (74%)	25 (56%)	18 (50%)	37 (50%)	32 (57%)	Control	0.27 (0.07, 1.04)	0.057
		Yes	16 (57%)	5 (26%)	20 (44%)	18[b] (50%)	36 (49%)	23 (41%)	Intervention	1.25 (0.52, 3.00)	0.618
		Missing	0	0	1	1	1	1	Interaction	4.67 (0.93, 23.44)	0.061

[a]5/11 attended the workshop.

[b]11/18 attended the workshop.

TABLE 3 Negative acts and ways of coping differences in domain scores and changes from pre- to postintervention periods for intervention and control groups, adjusted for hospital (quantile regression)

Domains		*n*	Difference in Control group		Difference in Intervention group		Change from baseline between intervention and control	
			Estimate (95%CI)	*p*	Estimate (95%CI)	*p*	Estimate (95%CI)	*p*
Negative acts 1	Work-related bullying	130	−4.00 (−8.61, 0.61)	0.089	−2.00 (−5.54, 1.54)	0.266	2.00 (−3.69, 7.69)	0.488
Negative acts 2	Person-related bullying	130	0.00 (−2.64, 2.64)	1.000	0.00 (−2.73, 2.73)	1.000	0.00 (−3.82, 3.82)	1.000
Negative acts 3	Physically intimidating bullying	130	0.00 (−1.22, 1.22)	1.000	−1.00 (−1.96, −0.04)	0.041[b]	−1.00 (−2.63, 0.63)	0.226
Ways of coping 1	Problem- focused	121[a]	1.75 (−2.68, 6.18)	0.438	−1.27 (−4.27, 1.73)	0.407	−3.02 (−8.38, 2.33)	0.268
Ways of coping 2	Wishful thinking	122[a]	−0.78 (−3.33, 1.77)	0.548	−0.63 (−2.66, 1.39)	0.540	0.15 (−3.11, 3.41)	0.929
Ways of coping 3	Detachment	123[a]	0.46 (−1.42, 2.35)	0.631	−0.72 (−2.50, 1.05)	0.423	−1.19 (−3.78, 1.40)	0.369
Ways of coping 4	Seeking social support	122[a]	0.10 (−2.38, 2.59)	0.934	−2.49 (−4.56, −0.41)	0.019[b]	−2.59 (−5.82, 0.64)	0.116
Ways of coping 5	Focusing on the positive	122[a]	0.50 (−0.97, 1.97)	0.506	−0.83 (−2.13, 0.48)	0.216	−1.33 (−3.30, 0.64)	0.187
Ways of coping 6	Self-blame	123[a]	0.09 (−1.03, 1.22)	0.872	−1.03 (−1.82, −0.24)	0.011[b]	−1.12 (−2.50, 0.26)	0.110
Ways of coping 7	Tension reduction	121[a]	−0.57 (−1.96, 0.81)	0.418	0.31 (−0.64, 1.26)	0.524	0.88 (−0.80, 2.57)	0.304
Ways of coping 8	Keep to self	121[a]	0.89 (−0.53, 2.31)	0.220	−0.60 (−1.45, 0.25)	0.165	−1.49 (−3.14, 0.17)	0.078

[a]Missing values.

[b]Statistically significant at $\alpha = 0.05$.

were participants who had attended the workshops. For those who experienced incivility (n = 18), 11 were participants who attended the workshops (See Table 2).

Participants who indicated they had experienced bullying were asked to identify the perpetrators. They were able to select multiple answers to reflect their bullying experiences. There was a total of 42 responses from 25 participants who reported being bullied in the pre-intervention survey and 29 responses from the 15 participants who reported being bullied in the postintervention survey. Overall, in the pre-intervention period, 48% (n = 12) of participants identified managers as being the main perpetrator of bullying; however, in the postintervention period, 73% (n = 11) of participants identified Registered Nurse colleagues as the main perpetrators.

There was a total of 59 participants (46%) in the study who reported an exposure to incivility in the month prior to participating in the surveys. Overall, there were fewer participants who experienced incivility in the postintervention time period, 41% compared to 49% in the pre-intervention survey (See Table 2). There was a decrease in the number of participants who experienced incivility in the control group from 57% to 26%; however, the intervention group reported a rise from 44% to 50%. The odds of having experienced 'incivility' over the last month were 73% less in the control (OR 0.27, 95%CI 0.1 to 1) and 25% more in the intervention group (OR 1.25, 95%CI 0.5 to 3). The intervention group odds ratio was over 4 times higher than that of the control group (OR 4.67, 95%CI 0.9 to 23), meaning that the control group reported a greater reduction of incivility over the previous month, although again not statistically significant (See Table 2).

Similar to bullying behaviours, participants who indicated that they had experienced incivility were also asked to identify the main perpetrators of the uncivil behaviours. There was a total of 61 responses from 36 respondents in the pre-intervention survey and 32 responses from 23 respondents after the workshops. Registered Nurse colleagues were identified as being the main source of incivility in both the pre- (42%, n = 15) and postintervention (57%, n = 13) surveys. This was followed by managers, with 33% (n = 12) and 39% (n = 9), respectively, experiencing incivility from managers. Students were the only designation not identified as being perpetrators of either bullying or incivility across either survey.

4.3 | Types of negative acts experienced

The most commonly reported negative acts experienced by participants across all sites in both surveys included being exposed to an unmanageable workload (75%, n = 97), having opinions and views ignored (49%, n = 64), being given tasks with unreasonable targets or deadlines (48%, n = 63), being humiliated or ridiculed in connection with your work (47%, n = 61), someone withholding information, which affects your performance (44%, n = 57) and being ignored or excluded (44%, n = 57; See Table S1). The least commonly experienced negative acts across all sites in both surveys included having practical jokes carried out by people you do not get along with (8.5%, n = 11), threats or violence or physical abuse (13%, n = 17), hints or signals that they should quit their job (17%, n = 22), being the subject of excessive teasing and sarcasm (19%, n = 25) and being isolated from supportive peers (22%, n = 29; See Table S1).

TABLE 4 Correlation between negative acts and ways of coping total scores

Pre- /postintervention	N	Pearson correlation coefficient	p-Value
Pre-Intervention	71	0.25	0.035
Postintervention	50	0.12	0.409

About the pre- and postintervention periods. For Domain 1—Work-related bullying exposure, the intervention group had a median score change of −2 (95%CI = −5.5 to 1.5) from the pre-intervention time period (See Table 3). The difference between the intervention and control groups in postintervention for Domain 1—Work-related bullying exposure was 2 (95%CI = −3.7 to 7.7), meaning that the intervention group decreased less than the control group. There was also a statistically significant decrease in the postintervention period in Domain 3—Physically intimidating bullying in the intervention group (p = 0.041; See Table 3).

4.4 | Ways of coping

Participants used a variety of ways of coping when exposed to negative workplace behaviours. The most common ways of coping used by participants for both the control and intervention sites for pre- and postintervention surveys included concentrating on what they had to do next (91%, n = 113); Trying to analyse the problem in order to understand it better (90%, n = 110), Turning to a work or substitute activity to take their mind off it (80%, n = 98) and Talking to someone about how they were feeling (79%, n = 93; See Table S2). The least common ways of coping included; Finding a new faith or religion (9%, n = 11), Taking a big chance on something risky (20%, n = 24), Refusing to believe that it happened (20%, n = 25) and taking it out on other people (23%, n = 27; See Table S2). Across both the control and intervention sites, both before and after the intervention, Domain 1—Problem-focused coping strategies were the most commonly used, followed by Domain 4—Seeking social support. The 22 participants who completed the workshops and the postintervention survey, they were also more likely to use problem-focused coping (mean = 24.5, SD = 8.6), followed by seeking social support (mean = 13.7, SD = 5.6). Table 3 also shows the changes in mean scores for all Ways of Coping domains for the intervention and control group in both the pre- and postintervention surveys. For the intervention group there were statistically significant decreases in Domain 4—Seeking support (p = 0.019) and Domain 6—Self-blame (p = 0.011) as coping strategies after exposure to the Respectful Workplace Workshops.

4.5 | Correlations between negative acts and ways of coping

There was a weak positive relationship between negative acts and ways of coping total scores in the pre-intervention survey (Pearson's correlation coefficient; $r = 0.25$; $p = 0.035$), indicating that the type of negative act a person is exposed to may influence ways of coping. There was not enough evidence to conclude there was any correlation between scores at the postintervention time period ($p = 0.4$; See Table 4). When examining correlations between the Ways of Coping 8 domains and the Negative Acts Questionnaire-Revised 3 domains, most were weakly positive (See Table S3). The highest correlations were seen in the pre control group between Ways of Coping Domain 1—Problem-focused coping and Negative Acts Questionnaire Domain 2—Person-related bullying (0.66, $p = <0.001$) and between Ways of Coping Domain 2—Wishful Thinking and Negative Acts Questionnaire Domain 1—Work-related bullying, (0.60, $p = <0.001$). The postintervention group correlation between Ways of Coping Domain 8—Keep to self and Negative acts Questionnaire Domain 2—Person-related bullying (0.58, $p = <0.001$) was also statistically significant, indicating that those who reported to exposed to person-related bullying were more likely to keep to self.

5 | DISCUSSION

The 30% prevalence of exposure to negative workplace behaviour among nurses in this study was similar to results of comparable observational studies (Johnson & Rea, 2009; Simons, 2008). This study also aimed to investigate the effect of the Respectful Workplace Workshops on the prevalence of negative workplace behaviours; however, while study participants reported a decrease in both bullying and incivility overall, the reduction was greater at the control compared to the intervention sites. The intervention sites in this study also reported an increase in the levels of reported incivility from 44% in the pre-intervention time period to 50% in the postintervention period. Previous studies have also reported an increase in reporting of negative behaviours after the implementation of an educational intervention. A previous study (Chipps & McRury, 2012) reported an increase in negative acts from 13% to 25% in a pilot study that involved an educational intervention that was designed to improve coping ability in conflict situations. The proposed explanation was that the increase in reporting of negative behaviours could be attributed to a heightened awareness of previously covert behaviours (Chipps & McRury, 2012).

The improvements in the control group outcomes may be related to the participants' knowledge of being part of a study, known as, the "Hawthorne effect" (Bourbonnais, Brisson, & Vézina, 2011). Undertaking surveys of negative workplace behaviours at the control, and the intervention sites may have prompted consideration of current workplace behaviour and inadvertently led to behavioural changes. Furthermore, in this study, the reduction of negative behaviours at both the control and intervention sites may be partly attributable to maturation of the nursing workforce, particularly the new graduate nurses. As new graduate's skills develop, they are increasingly inclined to "fit in" and "get the job done", therefore, being less exposed and sensitive to negative behaviours (Lima, Newall, Kinney, Jordan, & Hamilton, 2014). Staff turnover during the period of the study, which was not monitored, may have also contributed to confounding, as observed in other studies (McIntosh-Scott, Mason, Mason-Whitehead, & Coyle, 2013). Another consideration in this study is that only a proportion of participants from the intervention sites attended the educational intervention, thereby limiting its effects in that cohort.

It has previously been reported that organizations generally do not have a good track record of managing or preventing negative workplace behaviours, with educational awareness campaigns and zero tolerance policies being the main avenue of mitigation (Georgakopoulos, Wilkin, & Kent, 2011; Hodgins, MacCurtain, & Mannix-McNamara, 2014). It has been suggested that it is futile to implement individually focused educational interventions in the belief that negative workplace behaviour will be mitigated if individuals' knowledge, ability to recognize and responses to bullying are addressed (Johnson & Rea, 2009). The findings from this study support that perspective, given that individually focused interventions have little or no influence on the most prevalent type of bullying identified in this study, which was work-related bullying through being exposed to an unmanageable workload. This suggests that no one intervention fits all circumstances and organizations should undertake diagnostic testing of the types of negative behaviours occurring in order to tailor interventions to address the negative acts being experienced by their employees.

As well as exposure to unmanageable workloads, the other common type of bullying experienced by participants in this study was being given tasks with unreasonable or impossible deadlines. [Correction added on 20 August 2022 after first online publication: The first word 'And' was changed to 'As well as' in the preceding sentence.] With many respondents indicating that they had been bullied by their managers, nurses in managerial and leadership roles are pivotal in reducing this type of negative behaviour. Safe Work Australia (2016) states that "senior management commitment in identifying, preventing and responding to workplace bullying is one of the key factors for preventing unreasonable behaviour". In a recent study undertaken by Al-Bsheish, Bin Mustafa, Ismail, Meri, and Dauwed (2019), it was identified that perceived management commitment to safety and quality empowered nurses and enhanced their commitment to safe work practices. However, the lack of training for nurse unit managers in the management of negative workplace behaviour has been reported as a barrier to mitigation (Hartin, Birks, & Lindsay, 2020). The Respectful Workplace Workshops intervention in this study included nurse unit manager targeted training in conjunction with individual coaching, although there was very little participation by nurse unit managers, with only 3 out of 12 nurse unit managers attending the workshops and only 1 completing the postintervention survey. Whether attendance at educational workshops would improve the confidence and competence of nurse unit managers in managing negative behaviour warrants further investigation.

It is evident that negative workplace behaviour in nursing is a complex phenomenon, as are individuals' coping responses with "constantly changing cognitive and behavioural efforts to manage stressors" (Folkman et al., 1986). The nature of individuals' unique coping responses when exposed to stressors cannot be accounted for in the randomization of participants. It was found that study participants used various coping mechanisms and both the intervention and control groups were more likely to implement problem-focused coping strategies and sought social support when exposed to negative workplace behaviour. This suggests that participants viewed negative workplace behaviour as a modifiable stressor. Previous studies have alluded to the concern for the participants' wellbeing when there is a mismatch between coping styles and the modifiability of the stressor (Folkman et al., 1986; Senol-Durak et al., 2011). With participants in this study reportedly using problem-focused strategies in an effort to change persistent negative workplace behaviours, there needs be consideration of the impact of these behaviours remaining despite the action-orientated attempts by participants to alter the situation.

The pre-intervention control group had the strongest correlations between problem-focused coping and person-related bullying, and between wishful thinking and work-related bullying. This indicates that the participants viewed person-related bullying as a modifiable stressor but viewed work-related bullying acts as non-modifiable. It has been reported previously that nurses often feel powerless and that they have no control over their workload or resources (Hutchinson et al., 2010). Unfortunately, these workplace conditions remain a strong predictor of negative workplace behaviour in the nursing profession (Hutchinson et al., 2010). There is a need for consideration as to who is accountable for the modification of such organizational conditions.

5.1 | Limitations

While findings from this study have strengthened evidence related to organizational interventions to mitigate negative workplace behaviour among nurses, there are some limitations to be noted. A major difficulty in intervention studies that rely on behavioural changes is to ensure that the intervention actually produces the anticipated outcome. Unfortunately, there was insufficient evidence to indicate the Respectful Workplace Workshops were the source of changes in the levels of negative behaviours experienced by participants in this study. Due to the nature of quasi-experimental research design, true randomization of participants was not possible and it is not possible to be certain that the differences noted in the postintervention survey were due to the intervention or to uncontrollable variables, such as staff changes and skill development or even perhaps pre-existing differences among the participants in the groups. Although, no demographic variables were noted to be statistically significant between the control and intervention groups, the nature of studying individuals with their own subjective views of negative behaviours and unique coping responses is fraught with confounding factors. That combined with the small sample size of this study, and limited time and resources, limits its generalizability of the findings. The response rates in the surveys were also less than optimal; however, this is a common limitation in organizational research (Biggs, Brough, & Barbour, 2014) and the responses are comparable to similar interventional studies in healthcare settings (Biggs et al., 2014; Hopkinson, Dickinson, Dumayas, Jarzombek, & Blackman, 2020).

5.2 | Recommendations

Though the sample size was small, the intervention used in this study did not produce a detectable effect. It is recommended that further consideration be given to the best approach to mitigate negative workplace behaviour. As these behaviours have such a prolific and persistent existence in nursing, the delivery of a once off, one size fits all workshop in an organization is not sufficient as a standalone measure to modify workplace culture. Regular monitoring of workplace culture through staff consultation should be priority. In addition, the findings from this study suggest a need for assessment of negative behaviours in an organization prior to tailoring of any intervention to mitigate these behaviours. The consideration of the effect of work-related bullying, such as workloads and lack of resources upon individuals, also needs to be forefront in the minds of hospital administrators when aiming to develop a respectful workplace culture (Hutchinson, Jackson, Wilkes, & Vickers, 2008). Future research should examine how interventions could be individually tailored to the types of negative behaviours occurring in organizations in order to greater influence the civility norms. Those studies should include larger sample sizes and nurses of varying levels, such as nurse administrators and executives, nurse unit managers, Registered Nurses, Enrolled Nurses and assistant nurses, to give a more holistic picture of hierarchical standing and its influence upon behaviours.

6 | CONCLUSIONS

Negative behaviours are a statistically significant workplace stressor and there appears to be no easy fix. Organizations have a duty of care to their staff to give a safe working environment free from negative behaviours. The use of educational interventions and zero tolerance policies continue to be the mainstream approach; however, there is limited evidence supporting the use of educational interventions as a standalone means to address the problem, particularly when zero tolerance policies are not enforced by management. The findings from this study support that a one size fits all approach is not sufficient to mitigate negative workplace behaviour and that using education as a "tick box approach" is unlikely to be effective in developing sustainable cultural changes in organizations. The interplay of various personal, professional and organizational workload factors make for a complex problem requiring a multifactorial solution.

AUTHOR CONTRIBUTION

All the listed authors meet the authorship criteria and are in agreement with the content of the manuscript.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Due to the sensitive nature of the questions asked in this study, survey respondents were assured raw data would remain confidential and would not be shared. Data not available/The data that has been used is confidential.

ETHICAL APPROVAL

Ethics approval was from the local Human Research Ethics Committee (NSW HREC Reference No: HREC/17/HNE/596). All participants were assured of their anonymity and were informed that participation was voluntary and they were able to withdraw from the study at any time without giving an explanation. Consent was implied by completion of the questionnaire.

ORCID

Natasha Hawkins https://orcid.org/0000-0003-4265-884X

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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