Collegian (2017) 24, 125—133

Available online at www.sciencedirect.com

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journal homepage: www.elsevier.com/locate/coll

Australian nursing students' experience of bullying and/or harassment during clinical placement

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Received 11 June 2015; received in revised form 10 November 2015; accepted 15 November 2015

KEYWORDS
Bullying;
Harassment;
Incivility;
Nursing students;
Workplace violence;
Clinical placement

Summary Bullying and harassment in nursing are unacceptable behaviours in the workplace. There is a large body of evidence relating this problem, however little of it focuses on the experiences of nursing students. This prospective cross-sectional survey investigated Australian undergraduate nursing students' ($N = 888$) experiences of bullying and/or harassment during clinical placement. Half (50.1%) of the students indicated they had experienced this behaviour in the previous 12 months. Younger students were more likely to be bullied/harassed than older students ($p = 0.05$). Participants identified perpetrators of bullying/harassment as registered nurses (56.6%), patients (37.4%), enrolled nurse's (36.4%), clinical facilitators (25.9%), preceptors (24.6%), nurse managers (22.8%) and other student nurses (11.8%). The majority of students reported that the experience of being bullied/harassed made them feel anxious (71.5%) and depressed (53.6%). Almost a third of students (32.8%) indicated that these experiences negatively affected the standard of care they provided to patients with many (46.9%) reconsidering nursing as their intended career. In the face of workforce attrition in nursing, the findings of this study have implications for education providers, clinical institutions and the profession at large.

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http://dx.doi.org/10.1016/j.colegn.2015.11.004
1322-7696/

1. Background

Bullying and harassment are unacceptable in any setting, especially in the workplace. This public health issue can lead victims to experience serious psychosocial and physical morbidities (World Health Organization, 2010) such as burnout (Allen & Holland, 2014) fatigue, anxiety and depression (Reknes et al., 2014). In Australia there have been increased (6.8%) reports of bullying in the workplace (Dollard et al., 2012). Most workplaces in the western world have policies and procedures to prevent and manage bullying and harassment involving their employees. Employers have a legal responsibility to provide safe workplaces for employees (Australian Human Rights Commission, 2013). Educational institutions also have a duty of care to protect students of the health professions from workplace violence during clinical placement.

Bullying in the workplace can be described as, ''verbal, physical, social or psychological abuse by your employer (or manager), another person or group of people at work'' (Australian Human Rights Commission, 2013). It has been estimated that workplace bullying/harassment costs between 6 and 36 billion dollars annually to the Australian economy (Parliament of the Commonwealth of Australia, 2012). Many other definitions exist and one by Hewett (2010) described workplace violence as ''aggressive behaviour towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence, such as verbal abuse, incivility, bullying and intimidation'' (p. 10).

There are numerous papers in the literature regarding the issue of bullying in nursing (Birks, Budden, Park, Simes, & Bagley, 2014; Cleary, Hunt, & Horsfall, 2010; Croft & Cash, 2012; Etienne, 2014; Hutchinson, Jackson, Haigh, & Hayter, 2013; Hutchinson, Vickers, Wilkes, & Jackson, 2010; Khadjehturian, 2012). The sources of bullying in nursing (sometimes called workplace violence, aggression or incivility) can be other health professionals, nurses (Cooper & Curzio, 2012), or patients and their families (Hutchinson, 2013). Major changes such as decreased health funding, increased hospital bed waiting times and increasingly demanding roles in nursing have led to a more stressful working environment (Hegney, Tuckett, Parker, & Eley, 2010). As nursing students are vulnerable (Bowllan, 2015) they are particularly susceptible to the effects of a changing healthcare workplace and increased aggression by patients and staff.

Some studies indicate that at least 30% of nurses have experienced bullying in their workplace (Farrell & Shafiei, 2012; Spector, Zhou, & Che, 2014). Other studies report a much higher figure of more than half (Cleary et al., 2010; Hegney et al., 2008; Hutchinson, 2014) to 72% (Berry, Gillespie, Gates, & Schafer, 2012) of nurses reporting workplace violence or aggression. Australian studies have also cited similar figures relating to the prevalence of bullying experienced by nurses (Hegney, Eley, Plank, Buikstra, & Parker, 2006; Hegney et al., 2010; Hutchinson et al., 2013). Many of these nurses may decide to leave their job, which can lead to an increased shortage of younger nurses in the workforce (Laschinger, Grau, Finegan, & Wilk, 2010).

Baccalaureate students spend considerable time in clinical settings to gain nursing skills and are vulnerable to experience workplace aggression. One recent Australian study (Hopkins, Fetherston, & Morrison, 2014) of 154 second and third year nursing students reported that over 57% of students had experienced non-physical violence while in the clinical setting. Also in this sample it was found that more than 33% of second year students had experienced some form of physical violence such as being punched, kicked or slapped and the perpetrator had been a patient, colleague or registered nurse. What is also concerning is that many nursing students underreport bullying behaviours such as verbal abuse (Ferns & Meerabeau, 2009) and thus the incidence could be much higher.

While the serious nature and incidence of bullying in nursing is well documented, it is only recently that international researchers have begun to explore the issue of bullying of students and the personal, organisational and professional implications (Magnavita & Heponiemi, 2011; Stevenson, Randle, & Grayling, 2006). In spite of this increased interest, there is still little known about the experiences of Australian nursing students and the impact that bullying has on them personally and professionally. The purpose of this study was to fill this gap in knowledge. The aim of the research reported in this paper is to identify the incidence and nature of bullying and/or harassment experienced by nursing students during clinical placement. Ultimately, the research team seeks to establish a clear picture of the problem and thus facilitate the identification of recommendations to improve future placement experiences for students of nursing.

The specific questions for the research were:

1. What is the incidence of bullying and/or harassment experienced by nursing students during clinical placement?
2. Who are the perpetrators of bullying and/or harassment towards nursing students?
3. What types of bullying and/or harassment are experienced by nursing students?
4. What is the impact of bullying and/or harassment on nursing students?
5. Do students report bullying and/or harassment and how are reports managed?

2. Method

This study employed a cross-sectional survey design, utilising an instrument adapted from the work of Hewett (2010), who developed and tested the tool with 218 undergraduate nursing students in South Africa. Content validity of the original tool was established via a pilot study. The original survey comprised five sections with 66 individual items based around workplace violence including intimidation, bullying or verbal abuse, non-physical violence, and reporting and management of workplace violence. The questionnaire used mainly closed-ended questions that were rated using a 4-point response scale on frequency, with opportunity for respondents to provide textual descriptions.

For the study reported in this paper, minor changes were made to language for the Australian context and several items were added. The revised survey (the *Student Experience of Bullying During Clinical Placement* (SEBDCP) survey) comprised 13 main questions with a total of 83 items, most using the same response scale on frequency of [1] 'Never' (0 times); [2] 'Occasionally' (1—2 times); [3] 'Sometimes' (3—5 times) and [4] 'Often' (>5 times). Each question offered an 'other' response category and an option to provide details. There were also 10 socio-demographic questions that sought information such as age, gender, program of enrolment and year. Respondents were not required to answer all questions.

A key addition to the original survey was a question asking respondents whether or not they had been bullied and/or harassed ('yes'/'no'/'unsure'). The research team chose not to include a definition of bullying or harassment in order to seek an understanding of what students deemed to be behaviour of this nature. Further questions asked whether students had experienced specified behaviours during clinical placements in the previous year, the clinical setting where this had occurred, the discipline or work role of the perpetrator, details of the nature of the behaviour, its affect, whether the experience had been reported and the outcome of that reporting.

The questions were uploaded in the format of a commercial Internet survey provider (SurveyMonkey.com). The survey was then extensively tested by a panel of recently graduated registered nurses, nurse academics and laypersons to ensure content validity, flow and precision of data collection. Following approval by the institutional ethics committee, the survey was launched and was accessible between October and December 2014. Recruitment occurred via heads of schools of nursing across Australia, who was asked to pass on the link to students enrolled in undergraduate nursing programs.

Analysis was conducted using IBM-SPSS 21 (IBM Corp., Armonk, New York, 2011). Numerical and categorical data were summed and then subjected to inferential statistical tests. The response set was tested for association (age, year of course, experience of bullying or non-physical harassment, experience of physical violence) using *t*-tests or equivalent non-parametric tests, or Pearson's Product Moment correlation — as appropriate. $p < 0.05$ was set as the significance level. Survey subscales were reliable with the following Cronbach alpha coefficients: Non-violent behaviour 0.93; physical behaviour 0.66; sexual harassment 0.72; impact on feelings 0.94 and work impact 0.84.

3. Results

A total of 888 participants completed the survey. Given the nature of the questions posed, no item was compulsory and thus all nursing students who provided data on their experiences of bullying or harassment were included in the analysis. The majority of respondents were female (89%), and the overall median age was 26 years. There was no significant age difference between females and males (Means: 29.6, SD 10.9; 31.0, SD 9.7 respectively). Participants resided in one of the eight Australian states or territories and were enrolled in an undergraduate professional entry-level nursing degree, either a bachelor degree or nursing-midwifery double degree. Most participants were enrolled in first year (23%), second year (31%) or third year (43%), with very few in fourth year or in dual years (3%). English was the primary language for 85% and the majority (77%) were Australian-born. Two percent of respondents identified as Aboriginal and/or Torres Strait Islander.

3.1. Incidence of bullying and/or harassment

Participants were asked whether they had been bullied or harassed in the past year while on clinical placement. Half the students (50.1%; $n = 446$) affirmed this experience. Over one-third (37.5%; $n = 333$) claimed they had not experienced bullying/harassment and the remainder were unsure (109; 12.3%).

It was noted that at least 20 participants who denied being bullied or harassed subsequently indicated that they had experienced some form of behaviour that could be deemed bullying/harassment. It was also important to include the group who were 'uncertain'. In keeping with the aim of exploring the nature of bullying and harassment, all these responders were included in the overall analysis of the survey.

A fairly high proportion of participants (67%; $n = 545$ of 808) had witnessed bullying/harassment of another nursing student, 10.3% ($n = 83$) had witnessed this event 'often', 17% ($n = 141$) 'sometimes' and 40% ($n = 321$) 'occasionally'.

3.2. Effect of personal and demographic variables

The demographic characteristics of participants who had been bullied versus those not bullied were examined. Chi-square tests for independence indicated that participants being born in Australia or having English as their first language had no significant effect on their experience of bullying/harassment (in answering this single generic question Q11: 'yes'/'no'/'unsure'). Of 22 indigenous participants, 12 experienced bullying/harassment, which, was not significantly different to the overall rate of 50%. While no significant difference was found between gender and bullying/harassment χ^2 (2, $n = 882$) = 4.07, $p = 0.13$, these figures suggest that significance may have been reached with a larger proportion of males.

Participants' age was significantly inversely correlated with bullying/harassment experience,: $r = -.06$, ($n = 877$) $p = 0.05$. Younger age participants were more likely to experience being bullied or harassed. In addition, course advancement was significantly associated with increased experience of bullying/harassment: χ^2 (8, $n = 883$) = 73.41, $p = 0.000$. Of those currently enrolled in first year, 26% (52/199) had experienced bullying/harassment during the past year; 52% ($n = 143/273$) in second year; 60% ($n = 227/381$) of those in third year, and 13 of 17 in fourth year. This pattern appeared to be repeated when participants' year of first enrolment in the nursing program was examined, as those enrolled in 2012 and in 2013 experienced the highest rates of bullying/harassment over the enrolment period 2010—2014.

Table 1 Sources of bullying/harassment by frequency ($n = 785–821$).

Source	Frequency				Mean/SD
	Never *n* (%)	Occasionally *n* (%)	Sometimes *n* (%)	Often *n* (%)	
Registered nurse(s)	356 (43.4)	208 (25.3)	161 (19.6)	96 (11.7)	2.0 (1.05)
Patient(s)	498 (63.2)	199 (25.3)	76 (9.6)	15 (1.9)	1.50 (0.75)
Enrolled nurse(s)	503 (63.6.)	138 (17.4)	107 (13.5)	43 (5.4)	1.61 (0.91)
Clinical tutors/facilitator(s)	588 (74.1)	98 (12.4)	61 (7.7)	46 (5.8)	1.45 (0.86)
Patients' relative(s) or friend(s)	597 (76.7)	138 (17.7)	33 (4.2)	10 (1.3)	1.30 (0.61)
Preceptor/mentor	601 (75.4)	87 (10.9)	75 (9.4)	34 (4.3)	1.43 (0.83)
Nurse manager(s)	606 (77.2)	102 (13.0)	51 (6.5)	26 (3.3)	1.35 (0.75)
Other health professional(s)	611 (77.7)	121 (15.4)	39 (5.0)	15 (1.9)	1.31 (0.65)
Doctor(s)	632 (80.3%)	107 (13.6)	40 (5.1)	8 (1.0)	1.27 (0.59)
Assistant(s) in nursing	679 (86.6)	58 (7.4)	35 (4.3)	13 (1.7)	1.21 (0.59)
Other nursing student(s)	787 (88.2)	57 (7.3)	18 (2.3)	17 (2.2)	1.18 (0.57)
Other health professional student(s)	701 (90.2)	47 (6.0)	24 (3.1)	5 (0.6)	1.14 (0.47)
Administrative staff	716 (92.0)	37 (4.8)	19 (2.4)	6 (0.8)	1.11 (0.45)
Auxiliary staff e.g. food services, cleaning	719 (92.8)	39 (5.0)	9 (1.2)	8 (1.0)	1.10 (0.42)
Other (other people, carers, orderlies)	535 (98.5)	2 (0.4)	1 (0.2)	5 (0.9)	1.03 (0.30)

Scale: [1] Never (0 times); [2] Occasionally (1—2 times); [3] Sometimes (3—5 times); [4] Often (>5 times).

3.3. Bullying and/or harassment experience by clinical setting

The greatest proportion (60%; $n = 516$) of bullying/harassment occurred in hospital settings. Bullying/harassment had occurred in hospital 'sometimes' or 'often' for one-third of participants (32%; $n = 275$), 'occasionally' for 28% ($n = 241$) and 'never' for 40%. Males reported a higher incidence of bullying/harassment in hospital than females χ^2 (1, $n = 850$) = 9.01, $p = 0.03$ ('often': males 19%; females 11%). In contrast, there was a low proportion of bullying/harassment experienced in community settings where 84% ($n = 640$) reported 'never' being bullied or harassed. Around 15% had experienced bullying/harassment in these settings 'sometimes' or 'occasionally', with very few experiences ($n = 11$) being 'often'.

A range of other settings was mentioned as being environments where bullying/harassment had occurred, although the overall frequency was very low ('sometimes'/'often' experienced by 4.5%). Additionally, aged care facilities were the most frequently named 'other' setting, described in open-ended responses (1%; $n = 44$) and mental health units were also mentioned.

3.4. Sources of bullying and/or harassment

Participants were asked about the source of bullying/harassment, via a list of those staff they would have contact with in the clinical environment. As can be seen in Table 1, registered and enrolled nurses were the main sources of such distress. Twenty-five percent of students had experienced bullying/harassment by preceptors/mentors at some stage. Assistants in nursing were also implicated. While other nursing students and health professional students were less likely to bully or harass nursing students, about one in 12 students did report bullying/harassment from these sources 'occasionally', 'sometimes' or 'often'.

Patients, and, to a lesser extent, patients' relatives, were sources of bullying/harassment, although around two-thirds of students had never experienced behaviour of this nature from these sources. The lowest sources of bullying/harassment appeared to be those individuals who were less likely to have a direct supervisory role for nursing students. The majority of participants reported they had never been bullied or harassed by doctors, other health professionals, administrative or auxiliary staff, or other students, although approximately 1% reported this experience had occurred 'often'.

3.5. Physical abuse

The incidence of physical abuse of nursing students was low. Of 825 participants, between 1 and 10 participants reported some form of physical abuse 'often' or 'sometimes'; being either punched, slapped, kicked, shoved, or hit with an object or a weapon. However, 79 participants had at least one experience of being 'pushed' or 'shoved' ('occasionally'). Over 91% of participants reported 'never' having experienced physical abuse. There was a greater incidence of being *threatened* with physical violence, however, as 62 participants of both sexes (7.6%) 'occasionally' had this experience.

3.6. Sexual harassment

A total of 11.6% ($n = 96$) of participants reported that unwanted sexual harassment of various types had occurred 'often'/'sometimes', and, additionally, 35% ($n = 278$) less often ('occasionally'). Respondents reported 'occasionally'/'sometimes'/'often' having 'Had a sexist remark directed at me' (experienced by 15.0%, 122); 'Had a

Table 2 Type and frequency of non-violent behaviour ($n = 788–806$).

Behaviour	Frequency			
	Never *n* (%)	Occasionally *n* (%)	Sometimes *n* (%)	Often *n* (%)
Exposed to a racist remark	639 (81.4)	76 (9.7)	30 (3.8)	40 (5.1)
Unfairly treated regarding rostering schedules	624 (79.2)	90 (11.4)	33 (4.2)	41 (5.2)
Verbally abused e.g. sworn, shouted or yelled at	507 (64.0)	164 (20.7)	78 (9.8)	43 (5.4)
Given unfair work allocation	493 (63.6)	143 (18.2)	88 (11.2)	63 (8.0)
Ridiculed	475 (60.3)	159 (20.2)	89 (11.3)	65 (8.2)
Denied acknowledgement for good work	355 (44.7)	219 (27.5)	122 (15.3)	99 (12.5)
Denied learning opportunities	323 (40.6)	230 (28.9)	127 (16.0)	116 (14.6)
Harshly judged	300 (37.4)	227 (28.3)	160 (20.0)	115 (14.3)
Unfairly criticised	284 (35.2)	252 (31.3)	165 (20.5)	105 (13.0)
Neglected	282 (35.4)	232 (29.1)	154 (19.3)	129 (16.2)
Treated as though I am not part of the multidisciplinary team	268 (33.8)	249 (31.4)	141 (17.8)	134 (16.9)
Ignored	171 (21.2)	257 (31.9)	191 (23.7)	186 (23.1)
Shown negative non-verbal behaviour e.g. raised eyebrows, rolling eyes	159 (19.7)	253 (31.3)	222 (27.9)	174 (21.5)

suggestive sexual gesture directed at me' (13%; 103); 'Been inappropriately touched' (11%; 86); 'Had unwanted request for intimate physical contact' (6.6%; 53); and 'Been threatened with sexual assault' (1.0%; 9). There were 8 open comments that indicated that unwelcome attention could include harassment by a patient or a member of staff.

3.7. Non-violent behaviour

Participants were asked about the type and frequency of non-violent bullying/harassment behaviour (see Table 2).

There was a low incidence of gender-based or sexual orientation based remarks, although one fifth of respondents had experienced racist remarks. There was also a low incidence of being unfairly treated regarding rostering or work allocation. However, issues that might negatively impact the students' learning environment were experienced by 60–80%. These included being harshly judged or unfairly criticised, as well as being neglected, ignored, or denied learning opportunities.

3.8. Impact of bullying and/or harassment

Over 60% of participants reported that bullying/harassment resulted in a negative impact on their personal feelings during clinical placement (including all respondents, even those who may have denied they were ever bullied). This centred mainly on feeling anxious, inadequate, or angry (all experienced by 60–63%), with around 15% reporting these feelings resulted 'often'. Others reported feeling embarrassed or humiliated, confused, depressed or fearful. Of these, the highest proportion that suffered negative feelings was 21% who 'often' felt inadequate and 13% who 'often' felt fearful. Feelings described included frustration, disappointment, and loss of confidence at unjust treatment, leading to ''questioning my preferred area of practice'' or even ''whether nursing is really a field I want to work in''.

Participants were asked about the impact and frequency of bullying/harassment on clinical work (see Table 3). While half the participants (50.2%) thought their experience of bullying/harassment negatively affected the way they worked with others and might make them consider leaving nursing, a much smaller proportion (20%) had ever absented themselves from the workplace as a result of these feelings.

3.9. Management of bullying and/or harassment

Many participants were aware of the existence of an organisational policy directive around limitation of bullying/harassment in clinical settings (69%; $n = 484$ of 807) or in the university (65.5%; 525 of 800) although there were suggestions that such policy was not made clear to students.

Of 811 respondents, almost three-quarters (71.3%; 577) had never reported an episode of bullying/harassment, while one-quarter 234 (29%) had done so. The majority (58%) of reports had been made to the clinical facility, with 46% made to the university. Respondents were able to select more than one response and 47 students indicated reporting to both the clinical facility and hospital, while 2 reported to the clinical facility and 'other'. Open text comments about 'other' modes of reporting reveal that around 20% ($n = 50$) of reports were made to a senior staff member in the clinical environment, such as the clinical facilitator, supervisor or unit manager.

Participants were asked about outcomes of their reporting. Forty-five percent of the students who made reports said that action had been taken to resolve their complaint, with nearly two-thirds of these resolved to the complainant's satisfaction. For 26% ($n = 61$) no known action was taken, and for the remaining 29%, participants were unsure whether any action was taken.

Students who indicated that they had not reported bullying/harassment were asked why they chose not to make a report. Nearly half (45.5%, $n = 251$) of those who responded

Table 3 Effect of bullying/harassment on clinical work by frequency ($n = 791–796$).

Behaviour	Frequency			
	Never *n* (%)	Occasionally *n* (%)	Sometimes *n* (%)	Often *n* (%)
Negatively affected the way I worked with others	396 (49.9)	231 (29.1)	95 (12.0)	71 (9.0)
Made me consider leaving nursing	423 (53.1)	167 (21.0)	103 (12.9)	103 (12.9)
Made me afraid to check orders when I wasn't sure	484 (61.2)	165 (20.5)	82 (10.2)	63 (8.2)
Negatively affected the standard of care I provided to patients	534 (67.2)	165 (20.8)	55 (6.9)	41 (5.2)
Caused me to call in absent	634 (80.2)	91 (11.5)	39 (4.9)	27 (3.4)
Other (see open comments)	413	10	8	10

indicated that they had never been bullied or harassed. For the remainder, the main reason for not reporting an incident was fear of 'being victimised' (53.3%, $n = 292$), having an attitude that 'nothing will be done' about it (45%, $n = 243$), not knowing 'where/how to report it' (31.0%, $n = 167$), that it was 'not important enough to me' to report it (26%, $n = 139$), or 'it is part of the job' (24%, $n = 129$). In addition, 75 participants gave other reasons via the open text option that mainly related to bullying/harassment by staff. These reasons fell into the two categories: worrying about the consequences (''I'm scared of getting a bad report''; ''may affect future placements/job opportunities''; ''will turn staff against me'') and second, that it was best to just ignore it (''Nursing is a profession that is aided by having a thick skin''; ''I don't think it will be considered very important'' (just a ''rite of passage''), and further comments suggesting that the respondents did not want to revisit the experience.

4. Discussion

Bullying in nursing is not a new phenomenon and is historically embedded. Nursing is primarily a female-dominated profession, which demonstrates a culture of same-sex bullying. Nurses' bullying behaviour has been described as 'oppressed group' behaviour that is fuelled because of personal low self-esteem and group identity in a profession (Roberts, Demarco, & Griffin, 2009). In spite of major changes that have occurred in nursing education, healthcare and nurses' scope of practice, the problem of bullying persists.

The prevalence of bullying/harassment experienced by nursing students as revealed by this study is alarming. Students spend a limited amount of time in clinical settings and yet over 50% of respondents in this study reported that they had experienced bullying/harassment behaviours. This finding is comparable to a smaller study of 154 Western Australian nursing students, which also reported that more than 50% of students experienced non-physical violence and aggression (Hopkins et al., 2014). Students are vulnerable and often feel powerless to question registered nurses about concerning behaviours. Unfortunately workplace violence is so prevalent in the health industry that staff can make light of others' behaviour and not provide the support required by students.

Further to the definitively identified experience of bullying/harassment in this study, an additional 10% of participants indicated they were unsure if they had been bullied. The problem may lie in the limitations of existing definitions of bullying and harassment. For example, many definitions of bullying and harassment make reference to frequency and duration of behaviours (Australian Human Rights Commission, 2013). The authors of this study, however, believe that single events should not be dismissed as they can cause serious psychological and long-term consequences for students (Einarsen & Nielsen, 2015).

Much of the negative behaviour experienced by participants in this study was non-violent. While the lower incidence of physical or sexual harassment is reassuring, any activity of this nature is unacceptable, particularly towards those more vulnerable to its effects and less well positioned to defend themselves or respond effectively. The most frequently reported negative behaviours are those that have an element of subjective interpretation such as being judged, criticised or denied learning opportunities. The authors acknowledge that words such as 'bullying' and 'harassment' can be overused in the workplace and students may resort to these terms when legitimately challenged while on placement. Nonetheless participants in this study responded to the numerous behaviours that are considered unacceptable in the workplace and that meet the criteria for the definition of bullying and harassment (Australian Human Rights Commission, 2013).

It is concerning to note that many of the perpetrators of bullying/harassment in this study were registered nurses, consistent with other findings (Hopkins et al., 2014). Even more disturbing is the finding that often it was those in position of leadership and authority that were the source of this behaviour. This study identified that younger students were more likely to be bullied than older students. The majority of students of nursing are school leavers and many have few life skills and experiences to help them cope with adversity. This socio-demographic profile alone makes students vulnerable when confronted with unacceptable behaviour from those seen to be in positions of authority and power.

As a case in point, clinical facilitators are expected by universities to be the students' advocate, mentor, protector and role model in healthcare facilities. However, students identified that the perpetrators of bullying/harassment included their clinical facilitators, reflecting the experiences of participants in Clarke, Kane, Rajacich, &

Lafreniere's (2012) study of bullying in one institution in Canada. This finding raises serious questions for universities relating to how these facilitators are chosen, prepared, monitored and evaluated in clinical workplaces. Changes to healthcare and education funding and increasing numbers of nursing students have led to universities losing much of the control of students' off campus learning experiences. In many cases universities pay health facilities for their nurses to take on the role of clinical facilitators, with these staff often having divided loyalties, a lack of commitment and dual roles.

Sadly, many students indicated they did not report bullying/harassment because they were frightened of possible negative consequences instituted by staff. Therefore it can be concluded that the incidence of bullying/harassment experienced by nursing students is underreported and the findings presented in this paper may in fact be the tip of the iceberg. Of particular concern was that some students indicated that they thought incivility was part of the job, or that an incident was too minor to report. It would appear that respondents see bullying on a continuum of seriousness and have a threshold of when the situation needs to be formally reported. Similarly, many bystanders may be concerned about the consequences of 'whistle blowing' on colleagues particularly in risk-adverse organisations that have policies in place, but are reluctant to deal with a problem when it occurs. This culture again increases the vulnerability of nursing students and the potential for being bullied within the health organisation.

The study is the first of its type to explore the experiences of bullying and harassment of nursing students in Australia from a national perspective. The findings provide a snapshot of the treatment experienced by some nursing students in clinical settings. The issues raised by this study are concerning for the nursing profession and have implications for education providers, clinical institutions, policy makers and workforce planning.

Implications and recommendations

The impact of being exposed to bullying and harassment is well documented as a cause of major health problems to victims (Clarke et al., 2012; Decker & Shellenbarger, 2012; Magnavita & Heponiemi, 2011). The findings presented in this paper reinforce the negative impact that experiencing bullying and/or harassment in the workplace can have on the nursing student. Aside from the consequences that such behaviours can have on the student personally, there are clear implications for patient safety and the quality of care and the long-term issues faced by the profession — as students are driven away from this career path. The economic and workforce impact of uncivil behaviour in nursing cannot be overestimated.

The problem is, however, complex and multifaceted (Seibel, 2014) and thus requires a multi-pronged solution. Universities and clinical partners need to work together to provide a safe environment for students in all learning spaces. To this end a number of recommendations are made to address the issues identified in this study. In the first instance, students need to be educated about types of workplace violence; behaviours that constitute bullying/harassment and the reporting options available to them. Strategies to develop skills in communication and to build resilience (Pines et al., 2011) need to be integrated into the undergraduate nursing curriculum to prepare students for potential exposure to uncivil behaviours in the workforce (Lee, Bernstein, & Nokes, 2014). Indeed, Adam and Taylor (2014) identified these skills as being core to students' professional development. Policies, processes and procedures must be clearly explained and any reports of bullying/harassment need to be managed (Birks, Budden, Stewart, & Chapman, 2014) in a way that addresses the requisite duty of care and protects students (Bowllan, 2015). Adequate preparation of clinical facilitators is equally critical, and should include a requirement to complete an accredited program of study. These individuals should be the first point of contact for students requiring support, rather than being part of the problem, as has been reported in this study. Finally, strategies to address these issues must also be directed at bystanders who witness such events.

While this study has drawn a sizable representative sample from across Australia, some limitations are acknowledged. It is possible that the title of the survey attracted only those participants who felt they had an experience to report, therefore biasing the sample. Alternatively, it may have deterred those who did not wish to revisit a prior negative experience. Furthermore, the decision not to define the terms 'bullying' or 'harassment' may have proven constraining for some respondents. While the list of potential behaviours was considered exhaustive for the purposes of this study, the limited context for each behaviour afforded by the use of an online survey may have influenced respondents who may or may not have considered a behaviour to be bullying or harassment in a given situation.

Further research should address the identified limitations and seek to extend the findings of this study. There are opportunities for greater exploration of students' experiences, such as through the use of interviews. The proportion of male respondents in the sample was too small to permit an extensive exploration of the relationship of this variable with the behaviours examined in this study. Future research may investigate how the issue of gender influences the frequency and type of bullying/harassment experienced by nursing students. Most significantly, any further work should aim to identify and evaluate strategies to prevent bullying and harassment of nursing students and seek to reduce the impact of such behaviour when it does occur.

5. Conclusion

Bullying and harassment of nursing students on clinical placement is unacceptable and requires zero tolerance by the profession. The findings of this study have implications for education providers, clinical institutions and the nursing profession more broadly. Universities must develop transparent policies and procedures to manage this critical problem. Undergraduate students should be adequately prepared for their clinical placement experience, including being made familiar with the policies and procedures that aim to promote their welfare. Healthcare facilities also need to acknowledge the prevalence of this unacceptable behaviour and its impact on prospective health care

professionals. Ultimately the nursing community needs to recognise the long-term impact that bullying and harassment has on both individuals and the profession. Bullying and harassment of nursing students can no longer be spoken about as a thing of the past; it clearly persists and it is continuing to affect the potential workforce of the future.

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