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Workplace violence experienced by nursing students: A UK survey

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ABSTRACT

Aims: To appreciate the nature and scope of workplace violence amongst a sample of the UK nursing student population during clinical placement and to recommend strategies universities can implement to successfully manage the impact.
Background: Workplace violence is defined as a violent act(s) directed toward workers and can include physical, psychological or verbal behaviour. It is prevalent in nursing and causes victims work-based stress that can affect not only the individual but also the quality of care. Similar negative experiences amongst students can have a direct impact on the development of future professional skills.
Design: This study employed a cross-sectional survey design. Questions were uploaded in the format of a commercial internet survey provider (SurveyMonkey.com) and distributed across a sample of nursing schools in the UK. The survey was voluntary and employed a validated tool to assess workplace violence and was based on a similar study in Australia. The number of respondents was 657. This paper reports on the quantitative results.
Findings: Nearly half of the students (42.18%) indicated they had experienced bullying/harassment in the past year while on clinical placement. One-third (30.4%) had witnessed bullying/harassment of other students and 19.6% of incidents involved a qualified nurse. The unwanted behaviours made some students consider leaving nursing (19.8%). Some respondents said the standard of patient care (12.3%) and their work with others (25.9%) were negatively affected.
Conclusions: Workplace violence can influence nursing students' attitude toward the profession and their level of satisfaction with the work. Whilst it was reassuring to note that the majority of the participants knew where/how to report, only one fifth had actively reported an episode of bullying/harassment. Current students are the nurses and leaders of the future and have a key role in shaping the culture of generations to come. Universities and clinical providers need to work together to reduce the incidence and impact of workplace violence in order to improve the culture of practice.

1. Introduction

Bullying is a major problem in nursing in the United Kingdom (UK) (Lowenstein, 2013; Carter et al., 2013). Workplace violence is defined as violent act(s) directed toward workers and can include physical, psychological or verbal behavior (Gacki-Smith et al., 2009). Violence against nurses has been an increasing problem in many societies (Jackson et al., 2002) often because nurses on the frontline are more at risk of workplace assault than other health professionals. Bullying is perhaps the most frequently encountered form of work-related violence (Cooper et al., 2011) and is a form of harassment reported by nurses, including students, all over the world (Cooper et al., 2011; Ozturk et al., 2008; Randle, 2003; Magnussen and Amundson, 2003). The psychological impact is not limited to a particular culture or context. A point illustrated in a recent systematic review of studies into aggression showing that despite differences in countries, cultures and settings, nurses' responses to aggression were consistent (Needham et al., 2005).

Bullying causes victims work-based stress that effects not only individual nurses but also the quality of patient care (Cooper et al., 2011). It is behavior that makes someone feel intimidated or offended. The nature of bullying means it can cause not only physical but also psychological harm (Cortine and Magley, 2003; Kivimaki et al., 2003) and can result in increased staff turnover, lowered morale and reduced loyalty (Quine, 1999). In some cases the effects of bullying for the person may lead to short or long-term mental health issues (Birks et al., 2014;

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Gregor, 2004). The resultant psychological distress can include anxiety, depression, loss of confidence, mood swings, irritability and post-traumatic stress disorder (Birks et al., 2014; Cortine and Magley, 2003; Gregor, 2004). These psychological responses can appear immediately after the event or can persist for months or years after the event has occurred (Gerberich et al., 2004).

Given the prevalence of the problem, nursing students on clinical placement, who are learning about professional behaviors are likely to be exposed to such workplace violence. Exposure to this behavior could have a detrimental effect on their professional identity, values and expectations if inadequate support is provided. The professional and academic literature on this subject has tended to focus on the qualified workforce with little attention being paid to the experience of students. This is a significant gap given the potential impact on the individual student, the attrition rate from the program and the financial costs of such failure. This study therefore sought to highlight the current prevalence of workplace violence through a national survey exploring student experiences in practice in order to identify and strengthen support strategies within organizations involved in nurse education.

2. Background

Bullying, harassment and violence have gained increasing importance in nursing literature, partly because they are so widespread but also because they have become normalized as acceptable (Hutchinson et al., 2006). When bullying is instigated or goes unchecked by nurses, such activities and behaviors become culturally normalized (Steven, 2002). Although single acts of aggression or harassment occur in the workplace, bullying is a form of repeated behavior that occurs over time (Einarsen and Mikkelsen, 2003). Although there is no legal definition of workplace bullying in the United Kingdom (UK), ACAS (2014) state that 'Bullying may be characterized as offensive, intimidating, malicious or insulting behavior, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient'.

Harassment is however unlawful in the UK under the Equality Act 2010, being defined as 'unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating and intimidating, hostile, degrading, humiliating or offensive environment for that individual'. Recent literature indicates that bullying can be seen both in the nursing workplace and academic settings. Thus, it has a negative impact on nurses and nursing students and the culture of practice and education (Cooper et al., 2011; Jackson et al., 2002; Kolanko et al., 2006; McKenna et al., 2003, Randle, 2003). Many nurses consider themselves powerless as a result of bullying (Anderson, 2001).

Student nurses and new graduates entering the workforce are particularly vulnerable and at high risk as they are often younger, less experienced and less aware of cultural norms and care (Lewis, 2006). They do not have a well-defined and approved social role, a salary, a career and a stable bond with a specific type of nursing work. Thus, bullying whatever the type, can easily undermine their self-esteem and morale (Magnavita and Heponiemi, 2011). In the UK the Nursing and Midwifery Council (NMC) stipulate that 50% of an undergraduate student nurses program must be in clinical practice therefore they can be exposed to this type of uncivil behavior on clinical placement in healthcare facilities. Nursing students can be victims of this aggression and this may be one reason for nurses leaving and the subsequent shortage of younger nurses in the workforce (Laschinger et al., 2009). Some studies show that nursing students are exposed to physical, sexual and verbal abuse in clinical settings (Celik and Bayraktar, 2004; Curtis et al., 2007; Grenade and MacDonal, 1995). Whilst others have found that aggressive behaviors like bullying, violence, and harassment can come from a range of sources including educators, patients, patients' kin, other nurses and health care providers (Bartholomew, 2006; Celik and Bayraktar, 2004; Thomas and Burk, 2009). Also a study undertaken by Randle (2003) with nursing students found that 95% perceived themselves as anxious, depressed and unhappy at the end of the 3-year nursing education period (Randle, 2003).

Such negative experiences can have a direct impact on the development of future professional skills and may determine whether an individual victim decides to remain within the profession. In fact it is likely that the experience of bullying and uncivil behavior leads directly to the attrition of students during their degree or from the profession as new nursing graduates. As there are currently around 60,000 student nurses in the university system in the UK at this time with 21,000 new students enrolled each year and with each costing a minimum of £50,000 to train a nurse on a three-year program this must be an issue of concern. Universities have a clear duty of care to support students during their studies, indeed the NMC (2008) has published standards for mentorship establishing a set of competences to mentor and assess students in practice. Universities must ensure regular updating of clinical mentors and quality-assure placement settings to see that standards are maintained. However implementation of standards relies on people recognizing there is a problem.

Considerable effort has been targeted at workplace cultures in recent years, with initiatives that include awareness raising and the introduction of new policies on harassment and whistle-blowing. This might suggest that the situation is improving however anecdotal evidence from student evaluation of clinical placements and the variety of blogs maintained by students would suggest that workplace violence remains a problem. Whilst there have been no recent studies in the UK, Australian studies have indicated that more than 50% of nursing students have witnessed or have been bullied and/or harassed in the workplace (Birks et al., 2014; Cleary et al., 2010, Queensland Nurse Union, 2012).

In order to understand the scope and nature of the issue in the UK, this paper reports on a national survey conducted across a sample of nursing schools/faculties and mirrors a similar study conducted in the Australia (Budden et al., 2015).

2.1. The Study

This study uses a survey approach to identify the incidence, type and effect of bullying and other uncivil behaviors experienced by UK nursing students during their clinical placements in healthcare settings. It also provides indications of impact and as such lays the foundation for future work addressing the problem of bullying and/or harassment of nursing students to enable universities and placement providers to fulfill their duty of care.

2.2. Study Objectives

The aims of this study are:

- To explore and describe the incidence and experiences of uncivil behaviors such as bullying and/or harassment of undergraduate nursing students during clinical placement on programs in 2015
- To recommend strategies universities can implement to successfully manage uncivil behaviors, minimize the effects on students and increase their professional resilience.

3. Method

This study employed a survey design with questions being uploaded in the format of a commercial internet survey provider (SurveyMonkey.com). A convenience sample of UK Higher Education Institutions with nursing schools/faculties was identified and invitations to participate were send to the Heads of Schools asking for their participation. Once agreed, an email was sent containing a brief explanation of the research and a link to the survey.

On accessing the survey, the student participants were presented with a Participant Information Sheet (PIS). The PIS facilitated a process of informed consent by asking participants to confirm that they had read the statement. Consent was therefore assumed by their submission of the survey. Participation was entirely voluntary and students could choose not to participate or withdraw without any impact on them or their studies. Completing the survey took no longer than 15 min.

3.1. Ethical Considerations

Ethical approval was obtained from King's College London (KCL) Research Ethics Committees (CREC). The participants received an information sheet detailing the scope and purpose of the study with clear guidance indicating they could proceed with the survey or exit at that point. No individually identifiable data was requested in the survey and where participants included any such data, such as names of organizations or individuals, all data was anonymised.

3.2. Survey Design

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. 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 (Hewett, 2010). Content validity of the original tool was established via a pilot study and adapted by researchers in James Cook University, Australia (Birks et al., 2014). Minor changes were made to language and several items were added. The revised 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). 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.

3.3. Participants

Whilst the total student population enrolled in a nursing degree in the UK across 72 schools of nursing is approximately 60,000 students, time and cost constraints prevented inclusion of all schools and so a convenience sample of one third of the total were contacted. Of those contacted, several declined to support participation but of those that agreed this allowed access to approximately 12,000 students.

3.4. Selection Criteria

The research team sought to ensure there was a sample of universities across all four nations of the UK. The instruction to each Head of School was that ii should only be targeted at current nursing students.

3.5. Data Analyses

Data coded and analyzed using a computer-based data management system and then exported to the SPSS 21 statistical software (IBM SPSS Statistics v21); figures and percentages were used in the presentation of the findings depending on the data.

4. Results

This article reports on the quantitative data including descriptive statistics to reveal trends and relationships.

4.1. Demographic Findings

Table 1 below reveals that 657 nursing students responded to the survey. The majority were female (88.3%), 65.9% were 18–27 years old. Most were attending university in the southeast (45.7%), the majority were UK-born (84.8%), 75.6% of the respondents ethnic group was white (English/Scottish/Northern Irish/British), and their first language was English (89.6%). Most were enrolled on BSc Nursing (86.6%) with 38.4% enrolled in 2014 and 36.2% were in their 2nd year (see Table 1).

4.2. Experiences of Bullying and/or Harassment

In the past year while on clinical placement, 42.18% (n = 232) of the participants reported feeling personally bullied and/or harassed with a further 16.55% (n = 91) being unsure whether it was bullying or harassment. One quarter has witnessed such incidents in a hospital setting (25.4%; n = 167). One-third (30.4%; n = 200) had witnessed bullying/harassment of other nursing students and 19.6% reported that incidents involved a registered nurse (n = 129) (see Table 2).

Table 1
Demographic variables.

Source	Frequency	
	n	%
Gender		
Female	580	88.3
Male	77	11.7
UK-born		
Yes	557	84.8
No	71	10.8
English is the first language		
Yes	589	89.6
No	40	6.1
Ethnic group		
White: English/Welsh/Scottish/northern Irish/British	497	75.6
White: Irish	46	7.0
Any other white background	20	3.0
Asian/Asian British: Indian	4	6.0
Asian/Asian British: Pakistani	8	1.2
Asian/Asian British: Bangladeshi	5	0.8
Asian/Asian British: Chinese	1	0.2
Any other Asian background	7	1.1
Black/African/Caribbean/Black British: Caribbean	12	1.8
Any other Black/African/Caribbean background	3	0.5
Black/African/Caribbean/Black British: African	26	4.0
Other ethnic group: Arab	8	1.2
Geographical area of attend university		
North East	14	2.1
Midlands	68	10.4
South East	300	45.7
South West	81	12.3
Scotland	24	3.7
Wales	2	0.3
Northern Ireland	104	15.8
Enrolled program		
BSc	568	86.5
Other (Midwifery, PG)	56	8.5
First enrolled year of the current program		
2010	4	0.6
2011	10	1.5
2012	150	22.8
2013	211	32.1
2014	252	38.4
Enrolled year of the current program		
1st year	219	33.3
2nd year	238	36.2
3rd year	161	24.5
4th year	3	0.5

Table 2
Sources of bullying/harassment by frequency.

Source	Frequency	
	n	%
Registered nurse(s)	129	19.6
Healthcare assistant(s) (nursing)	50	7.6
Other	35	5.3
Preceptor/mentor	34	5.2
Patient(s)	32	4.9
Nurse manager(s)	28	4.3
Doctor(s)	13	2.0
Auxiliary staff e.g. food services, cleaning	12	1.8
Patients' relative(s) or friend(s)	8	1.2
Other health professional(s)	4	0.6
Clinical tutors/facilitator(s)	3	0.5
Other nursing student(s)	2	0.3
Other health professional student(s)	2	0.3
Administrative staff	2	0.3
Total	354	53.9

4.3. Types of Bullying and/or Harassment

Students reported having experienced different types of bullying/harassment including physical, sexual, verbal and nor-verbal abuse, with 7.6% being related to class, 5.8% sexually related, 5.8% race related and 7.6% gender related (see Table 3).

4.4. Impact on Work/Care

The unwanted and negative behaviors made some students consider leaving nursing (19.8). Some called in absent (10.2%) whilst others were afraid to check instructions when they were not sure (20.1%) with the consequent risk to patient safety. 12.3% reported that the standard of patient care was negatively affected and that their work with others was also negatively affected (25.9%) (see Table 4).

4.5. Impact on Feelings

There were also significant impacts on the feelings and mood of the students with respondents feeling angry (26%), embarrassed (28.3%) and anxious (26.8%) (see Table 5).

4.6. Reporting Bullying and/or Harassment

Whilst it was reassuring to note that the majority of the participants knew where/how to report bullying (51.4%), only one in five (19%) had actively reported an episode of bullying and/or harassment. Those that did report did so to the university (12.8%), to the clinical facility (11.1%) or to the police (0.2%). After reporting, some indicated that no action was taken (10.8%). When asked about the cause of not reporting, one fifth (21.3%) thought that bullying was a necessary part of the job or an occupational hazard (see Table 6).

5. Discussion

The data reveals almost half of the sample had experienced what they believed to be bullying or harassment with a further significant number being unsure. Even if the incidence has been over exaggerated, the results still suggest an unacceptable prevalence and should raise alarm bells for those delivering nursing programs, as an area in need of attention.

Given the incidence of workplace violence reported by qualified staff around the world it is perhaps not surprising that such a significant number of students on placement, experience similar events. The fact that students encounter such bullying or harassment against themselves will inevitably impact on the retention of students trying to develop professional skills in order to become members of a respected profession.

Not surprisingly the workplace violence encountered caused a range of reactions among students. They reported feeling vulnerable and unsafe, embarrassed and humiliated, confused, anxious, angry and depressed. If sustained it is highly likely to lead individuals to question their commitment to their training and profession and may even cause them to project

Table 3
Type and frequency of bullying and/harassment.

Behavior	Frequency			
	Never n (%)	Occasionally n (%)	Sometimes n (%)	Often n (%)
Exposed to a racist remark	469 (71.4)	38 (5.8)	14 (2.1)	10 (1.5)
Exposed to a gender remark	451 (68.6)	50 (7.6)	18 (2.7)	14 (2.1)
Exposed to a class related remark	453 (68.9)	50 (7.6)	16 (2.4)	13 (2.0)
Exposed to sexuality related remark	473 (72.0)	38 (5.8)	12 (1.8)	10 (1.5)
Unfairly treated regarding rostering schedules	349 (53.1)	88 (13.4)	56 (8.5)	43 (6.5)
Verbally abused e.g. sworn, shouted or yelled at	354 (53.9)	118 (18.0)	44 (6.7)	22 (3.3)
Given unfair work allocation	278 (42.3)	128 (19.5)	81 (12.3)	49 (7.5)
Ridiculed	363 (55.3)	97 (14.8)	42 (6.4)	29 (4.4)
Denied acknowledgement for good work	236 (35.9)	153 (23.3)	83 (12.6)	63 (9.6)
Denied learning opportunities	217 (33.0)	155 (23.6)	90 (13.7)	70 (10.7)
Harshly judged	232 (35.3)	160 (24.4)	86 (13.1)	55 (8.4)
Unfairly criticised	217 (33.0)	165 (25.1)	94 (14.3)	59 (9.0)
Neglected	214 (32.6)	125 (19.0)	120 (18.3)	71 (10.8)
Treated as though I am not part of the multidisciplinary team	179 (27.2)	196 (29.8)	96 (14.6)	70 (10.7)
Ignored	104 (15.8)	175 (26.6)	138 (21.0)	122 (18.6)
Pushed	504 (76.7)	27 (4.1)	6 (0.9)	0 (0.0)
Showed	506 (77.0)	23 (3.5)	0.6 (0.9)	0 (0.0)
Kicked	517 (78.7)	12 (1.8)	5 (0.8)	1 (0.2)
Slapped	512 (77.9)	18 (2.7)	7 (1.1)	0 (0.0)
Punched	510 (77.6)	18 (2.7)	4 (0.6)	0 (0.0)
Hit with an object/weapon	523 (79.6)	10 (1.5)	0 (0.0)	0 (0.0)
Threatened with an object/weapon	511 (77.8)	17 (2.6)	4 (0.6)	0 (0.0)
Threatened with physical violence	481 (73.2)	43 (6.5)	11 (1.7)	1 (0.2)
Shown negative non-verbal behavior e.g. raised eyebrows, rolling eyes	93 (14.2)	200 (30.4)	146 (22.2)	101 (15.4)

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

Table 4
Effect of bullying/harassment on clinical work by frequency.

Behavior	Frequency			
	Never n (%)	Occasionally n (%)	Sometimes n (%)	Often n (%)
Negatively affected the way I worked with others	271 (41.2)	170 (25.9)	55 (8.4)	30 (4.6)
Made me consider leaving nursing	274 (41.7)	130 (19.8)	66 (10.0)	58 (8.8)
Made me afraid to check orders when I wasn't sure	284 (43.2)	132 (20.1)	72 (11.0)	39 (5.9)
Negatively affected the standard of care I provided to patients	405 (61.6)	81 (12.3)	26 (4.0)	14 (2.1)
Caused me to call in absent	401 (61.0)	67 (10.2)	34 (5.2)	23 (3.5)

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

their feelings onto the delivery of nursing care, negatively impacting on patient outcomes.

The personal impact of workplace violence on the individual, in terms of mental wellbeing, should not be underestimated, as students will often need additional support to cope with and manage challenging situations. As well as the personal cost, there are also resource implications for higher education having to devote time and effort to resolve these complex issues.

Perhaps the most concerning finding was the proportion of respondents who did not consider it worth reporting of believing nothing would happen if they did. This may suggest something about the culture of nursing that tolerates such incidents going unchecked. It has been known for some time that student or novice nurses may come up against high rates of negative behavior during their time in practice (McKenna et al., 2003). Laschinger et al. (2009) suggest negative work experiences may result in new graduates assimilating such behavior and displaying the same toward others.

One theory that helps illustrate how such practice behavior, irrespective of whether this is positive or negative, becomes embedded into the day-to-day work of an organization is Normalisation Process Theory (NPT). NPT has three core elements; 1, bringing a practice into action (implementation), 2, practice become routinely incorporated in everyday work (embedding) and 3, practice being reproduced and sustained among the social matrices of an organization (integration) (May and Finch, 2009, May et al., 2009). The prevalence of workplace violence and failure to address the problem revealed in this study might suggest that bullying and harassment has become routinely embedded and accepted and sustained as 'normal'. Whilst, as Papp and Von Bonsdorf (2003) point out, clinical placements remain the most effective environment for developing nursing students' clinical skills it may also be a breeding ground of negativity and disturbing team dynamics leading to increased burn out and alienation and potentially poorer patient outcomes (Becher and Visovsky, 2012).

Critical to addressing bullying and harassment in practice is to raise awareness of its existence and for university's delivering nursing programs and placement providers to work together to develop systems and processes for reporting and investigating the problem. This should include a joint strategy that conveys a clear message that bullying and harassment will not be tolerated, with details of how to raise concerns contained in each student program handbook. The strategy should be comprehensive and include the following five elements:

1. A shared commitment to acknowledging the problem and awareness raising
2. A joint and consistent message that incidents of workplace violence will not be tolerated
3. Effective policies and procedures that will ensure incidents are fully investigated and addressed in a timely manner.
4. University support mechanisms including counseling and mentorship for students experiencing bullying and harassment
5. Training for mentors, supervisors and teams who are providing placements for students to include self-awareness skills, student-centered approaches and managing difficult conversations

For the student the process of awareness raising needs to start when they are being prepared for their clinical placements. This should include information to help them understand and identify workplace violence and to have access to clear information on how to report incidents. Students will need to have confidence that incidents will be handled appropriately with post-incident support being provided to include counseling and debriefing. Universities and placement providers should also provide training to mentors, assess the learning environment through audit and post-placement evaluation and provide debriefing sessions with students to explore their experiences.

Partnerships between academic institutions and service providers are critical to creating excellent learning environments for students and building capacity for tomorrow's workforce (Beal, 2012). Nurse education institutions and health service providers need to work together to better prepare nursing students and develop shared policies and

Table 5
Feelings about bullying/harassment by frequency.

Feelings	Frequency			
	Never n (%)	Occasionally n (%)	Sometimes n (%)	Often n (%)
Angry	176 (26.8)	171 (26.0)	100 (15.2)	82 (12.5)
Depressed	242 (36.8)	133 (20.2)	78 (11.9)	74 (11.3)
Humiliated	229 (34.9)	142 (21.6)	84 (12.8)	68 (10.4)
Embarrassed	176 (26.8)	186 (28.3)	100 (15.2)	65 (9.9)
Anxious	154 (23.4)	176 (26.8)	85 (12.9)	112 (17.0)
Fearful	304 (46.3)	108 (16.4)	54 (8.2)	53 (8.1)
Confused	270 (41,1)	124 (18.9)	70 (10.7)	61 (9.3)
Inadequate	180 (27.4)	163 (24.8)	81 (12.3)	103 (15.7)
Unsafe	378 (57.5)	85 (12.9)	33 (5.0)	28 (4.3)

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

Table 6
Reporting about bullying/harassment by frequency.

Reporting activities	Frequency	
	n	%
Have you ever reported an episode of bullying and/or harassment?		
Yes	125	19
No	404	61.5
Who did you report the episode of bullying and/or harassment to?		
To the university	84	12.8
To the clinical facility	73	11.1
To the police	1	0.2
Was action taken in response to your reporting?		
Yes, and the issue was resolved to my satisfaction	49	7.5
Yes, but the issue not resolved to my satisfaction	33	5.0
No action was taken	71	10.8
Unsure if action was taken	35	5.3
I have never reported an episode of bullying and/or harassment because		
I have never been bullied or harassed	204	31.1
It is part of the job	86	13.1
Nothing will be done about it	183	27.9
I am afraid I will be victimised	232	35.3
It is not important enough to me	94	14.3
I do not know where/how to report	65	9.9

procedures which can increase understanding and awareness of the consequences and management of bullying/harassment (Birks et al., 2014). Only then will we achieve a shared culture of zero tolerance toward such behaviors and build learning environments in which everyone feels valued.

6. Conclusions

The unpalatable truth revealed by this UK survey is that an unacceptably high proportion of nursing students experience bullying and harassment whilst on clinical placement. Throughout a nursing student's training many factors will influence their professional aspirations and their level of satisfaction with the work but undoubtedly negative experiences, such as bullying and harassment, will cause doubt and disillusionment and may ultimately lead to students leaving the profession.

The negative impact of bullying and harassment on personal welling and clinical learning needs to be acknowledged and addressed by nurse education providers in partnership with organizations providing clinical placement opportunities. The incidence revealed may expose symptoms in an organization of a wider problem culture of bullying and intimidation that has become normalized and accepted. By working together organizations can develop a joint strategy that acknowledges and raises awareness of the problem as well as providing effective policies and procedures to manage this unacceptable behavior. Targeted training for individuals and teams that help challenge negative cultures, raise awareness of the impact and management of bullying/harassment, as well as building student resilience so that they have the confidence to act against such behavior, will go some way to addressing the problem.

It needs to be acknowledged that those entering nurse education are the nurses and leaders of the future and will have a key role in shaping the culture and expectations of generations to come. Nurse educators and placement providers have a responsibility to tackle this problem in order to avoid bringing the nursing profession into disrepute. Whilst recognizing the limitations of a self-reported survey method, we do believe that the results are significant enough to raise real concerns for UK nurse education providers to increase vigilance for this phenomena in order to challenge and demonstrate that such behaviors are not tolerated in a caring profession.

Conflict of Interest

None declared.

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