A Quantitative Study on the Factors that Promote and Hinder Nurses' Willingness to Report Wrongdoing to Healthcare Leadership

Reem Azhari

A Dissertation Submitted to the Faculty of
The Chicago School of Professional Psychology
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Organizational Leadership

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2014

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I am grateful to Dr. Lisa Black for permission to reproduce her survey, the Registered Nurses' Workplace Support for Patient Advocacy Questionnaire (Black, 2011). See letter of permission from Dr. Black in Appendix F.

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Abstract

A Quantitative Study on the Factors that Promote and Hinder Nurses' Willingness to Report Wrongdoing to Healthcare Leadership

Reem Azhari

As healthcare becomes more complex, patients need nurses who can advocate for their safety. This quantitative study on patient advocacy sought to understand if significant relationships existed amongst factors contributing to nurses' willingness to report wrongdoing. Factors measured were management support, knowledge of the reporting process, and experiencing and witnessing retaliation after reporting wrongdoing. Three hundred and forty one nurses from the Association of Perioperative Registered Nurses (AORN) were surveyed using a 45 question survey consisting of closed ended questions, as well as Likert-type statement questions. Inferential statistical data analysis was performed and confirmed that significant relationships do exist amongst the factors measured. Due to these findings this study may be used to further explore empirical evidence linking those factors to nurses' willingness to report wrongdoing. The outcomes of this study also confirm that healthcare leadership must focus on increasing emotional intelligence as well as the communication strategies of their healthcare leadership teams. This is evident in the data showing that nurses know how to report wrongdoing, yet fear doing so due to lack of confidence on the part of their management team as well as fears of retaliation. Further studies may be warranted in the area of patient advocacy to determine if this data can be replicated across a multi-cultural and multi-generational workforce.

Table of Contents

Copyright ii

Signature Page iii

Permission to Reproduce Copyrighted Material iv

Acknowledgements v

Abstract vi

List of Tables xi

List of Figures xii

Chapter 1: Nature of the Study 1

Background of the Problem 2

The Practical Problem 3

The Research Problem 3

Problem Statement 4

Purpose Statement 4

Central Research Question 5

Potential Significance of Study 6

Delineations and Limitations 7

Assumptions 7

Definition of Terms 8

Ethical climate 8

Ethics committee 8

Moral distress 8

Whistleblower…… 8

Lateral violence…….....8

Horizontal violence…… 8

Oppressed group…….. 8

Wrongdoing in nursing…… 9

Culture of silence…….9

Retaliation……..... 9

Patient advocate…….....9

Methodology…….....9

Summary…….12

Chapter 2: Review of the Literature 14

Poor Ethical Climate.....15

Moral Distress.....19

Dysfunctional Teams.....22

Unethical Leadership…….33

Summary……39

Chapter 3: Methodology.....42

Design of Study 42

Strengths of Design 43

Weaknesses of Design.....44

Population/Sample…….44

Instrumentation…….. 45

Independent Variables……... 46

Dependent Variables……..... 46

Research Hypotheses…… 46

Data Collection…….. 47

Privacy and Confidentiality……... 48

Risks and Benefits……. 48

Ethical Considerations……... 49

Data Analysis…….49

Summary……... 50

Chapter 4: Results.....52

Overview of Study.....52

Participant Demographic Data.....54

Method of Analysis 59

Analysis Using Inferential Statistics.....59

Hypothesis 1 59

Hypothesis 2 61

Hypothesis 3 62

Hypothesis 4…….. 62

Hypothesis 5…….. 62

Summary.....64

Chapter 5: Summary and Conclusions 66

Conclusions 67

Limitations……69

Implications for Future Research 70

References 73

Appendix A: AORN Email Invite 80

Appendix B: E Consent and E Survey....81

Appendix C: IRB Forms....92

Appendix D: IRB Approval Letter 104

Appendix E: Permission to Use Survey Letter....106

Appendix F: AORN Database Guidelines 107

Appendix G: AORN Permission to Use Database Letter…… 110

List of Tables

Table 1*: Types of Lateral Violence and Their Manifestations*…….. 23

Table 2: *Demographic Data*…….. 56

Table 3: *Descriptive Statistics* 58

Table 4: *Regression Descriptives* 64

List of Figures

Figure 1: *Oppression and the Quality of Care*……. 25

Figure 2: *The Process of Whistleblowing*……..38

Chapter 1: Nature of Study

Organizational learning in healthcare is a critical component in promoting a culture of patient safety (Dodds & Kodate, 2011). Developing organizational policies that prevent patient negligence as well as promoting disclosure of wrongdoing is necessary to drive risk regulation in the healthcare industry (Dodds & Kodate, 2011). Once policies are in place, it is imperative that healthcare leaders support nurses' in their monitoring of patient safety and quality care.

Nurses are obligated by their professional standards and the American Nurses Association's (ANA) Code of Ethics to raise concerns regarding witnessed unethical practices (ANA, 2001). The literature has shown that nurses do not come forward and report witnessed unethical behavior due to fear of retaliation by colleagues and healthcare administration (Mansbach & Bachner, 2010). Types of retaliation include job loss and deliberate isolation from co-workers (Jackson et al., 2010a). The use of hospital ethics officers is also underutilized as both nurses and doctors are not comfortable or familiar with the process of ethical reporting (Hoffman, Neill, & Stovall, 2008).

This study has presented the factors that both promote and inhibit nurses' willingness to come forward and report wrongdoing to their healthcare leadership team. It is the aim of the researcher to share these findings with healthcare organizations in order to assist their leadership in understanding any significant relationships associated with factors that may hinder nurses' willingness to report wrongdoing as well as ways that may promote the reporting of wrongdoing. Understanding these correlations may lead to the development of healthcare ethics protocols and other programs which may be used by healthcare leaders to encourage nurses to come forward and report wrongdoing.

Background of the Problem

The literature has shown that nurses have struggled with reporting ethical dilemmas to their respective leadership (Attree, 2007) and go against their better judgment due to the fear of their management team (Black, 2011). Nurses are responsible for acting as the patient's advocate and as such it is their duty to report any unethical practices they witness. These unethical practices include healthcare workers deviating from hospital protocol, patient negligence, impaired nurses or physicians on duty, using patients in research without their consent, and false billing practices. It is imperative that healthcare organizations support and encourage nurses to report any unethical behavior they may witness. Nurses who fear reporting any witnessed perceived unethical practices may not act on reporting any perceived wrongdoing which may place the patient at risk.

The literature shows that the majority of nurses will not come forward and report any misconduct on the part of administration, physicians, or their colleagues for fear of retaliation (Peters, Hutchinson, Wilkes, & Jackson, 2011). Studies have also shown that nurses who report unethical behavior suffer physical and emotional illnesses throughout their ordeal (Kayoko, Yumiko, Atsushi, & Shinji, 2008). This is problematic for healthcare administrators who are suffering from the inability to recruit experienced nurses due to the nursing shortage which may be caused by high stress levels suffered by nurses (MacKusick & Minick, 2010). Healthcare leadership may also suffer when the quality of care decreases due to a lack of reporting on the part of the nurse. Nurses who fear reporting wrongdoing may not come forward thus continuing the cycle of unethical patient care.

The Practical Problem

With the onset of managed care in the 1980s, hospitals and healthcare organizations have had to work with limited resources which may affect the quality of care provided to their patients (Gaudine, LeFort, Lamb, & Thorne, 2011). Administrators fear damaging relationships with the high revenue generating physicians who are often employed by the hospital. Because of this, nurses are discouraged from reporting unethical behavior, and in many instances are retaliated against (Jackson et al., 2010a). This presents a problem in that nurses realize they may not be supported thus this inhibits them from coming forward and reporting unethical behaviors.

Nurses are required by their profession to raise concerns regarding the standards of practice they witness. Healthcare leadership has failed to create an open culture and in doing so risks a decrease in the safety and quality of patient care (Attree, 2007).

It is estimated that as many as 50% of nurses exit or change their professional roles within the first 3 years of clinical practice (Aiken, Clarke, Sloan, Sochalski, & Silber, 2002). It was postulated that nurses leave the profession due to burnout, emotional distress, and lack of support during reporting of grievances (MacKusick & Minick, 2010).

The Research Problem

A systematic review of literature to identify ethical dilemmas experienced by nurses has revealed that little research was conducted on the ethical climate of healthcare settings in the past 20 years (Suhonen, Stolt, Virtanen, & Leino-Kilpi, 2011). It also identified that a theoretical framework on healthcare ethics is absent from empirical literature (Suhonen et al., 2011). The problem with an absent definition of ethical climate

is that organizations are not able to operationalize the definitions of poor or positive existing climates. This quantitative study has asked nurses to answer questions regarding the factors that inhibit or promote the reporting of wrongdoing. It has analyzed significant correlations amongst those factors which may be used to assist healthcare leadership in understanding necessary leadership behaviors that may support patient advocacy.

Problem Statement

There is a problem with nurses failing to report unethical behavior in their practice (Mansbach & Bachner, 2010). Current nursing research on reporting wrongdoing lacks the quantitative studies necessary to establish solid empirical data (Black, 2011). Studies regarding nurses and whistleblowing have mainly been qualitative (Peters et al., 2011) and as such, cannot provide healthcare organizations with metrics that can be used for process improvement.

As technology increases, reductions and restructuring occur, and regulatory systems increase, nurses are at the forefront of witnessing these changes and how they affect the ethical climate of healthcare. It is their obligation to support patients' rights and support sound organizational ethics (Suhonen et al., 2011). Considering the current nursing shortages and the need for providers who are ethical, it is the duty of healthcare organizations to encourage nurses to report unethical behavior (Ulrich, Taylor, Soeken, O'Donnell, & Farrar, 2010).

Purpose Statement

The purpose of this study was to identify if significant relationships existed amongst the factors that both promote and those that inhibit the reporting of wrongdoing

by nurses working in healthcare organizations. This study contributed to the body of knowledge needed to address this problem by understanding what inhibits nurses from disclosing harmful behavior. It will increase the awareness of the types of nurses who are likely to report unethical behavior. By determining the factors that lead to nurses taking action or ignoring issues, the outcome of this research may assist healthcare leaders in overcoming those barriers. By understanding why nurses fail to report wrongdoing, healthcare organizations can attempt to foster systems that encourage open cultures that promote the culture of learning. A learning culture is necessary for an organization by removing the factors that limit growth and creating solutions (Senge, 2006).

Leaders must possess a moral compass in order to promote a culture of ethics and safety in nursing (By, Burnes, & Oswick, 2012). Leadership strategies must be able to create the necessary changes that can influence the moral compass of nurses who will then align their values with the actions of the leader (By et al., 2012). This research study will assist in further developing healthcare leaders by adding to the scholarly research needed to assist them in creating and maintaining a positive ethical climate in healthcare.

Central Research Question

What are the factors that inhibit and those that promote nurses' willingness to report wrongdoing in the workplace?

The theoretical assumptions of this study were as follows: having a defined ethical culture that promotes reporting of unethical behavior through open dialogue, ethical leadership, hospital ethics hotlines, and hospital ethics compliance policies will promote nurses who are willing to come forward and report unethical behavior. On the contrary, organizations that do not have policies or hotlines for reporting unethical

behavior, as well as having leadership teams that do not support the nurse who reports unethical behaviors, will cultivate nurses who will be reluctant to come forward. It was also hypothesized that experiencing and witnessing retaliation are significantly related to reporting wrongdoing.

Potential Significance of the Study

This study is important to healthcare leadership in that it provides data determining factors that both inhibit and promote the willingness of nurses' to come forward and report unethical behaviors. Healthcare organizations may utilize the outcomes of this study to educate their leadership on ways to both promote and support their nurses when faced with ethical dilemmas in their practice.

This study has addressed the willingness of nurses to report wrongdoing utilizing a cross sectional survey. The study has asked nurses to answer a series of closed ended, yes or no questions, along with Likert-type statements. These questions addressed perceived support by management and healthcare leadership. Data from the questions asked may be used to gather information on organizational culture and operational processes. In addition, data generated from the questions were converted to a numerical format used to make correlations amongst the variables measured. Significant correlations were identified regarding the relationships of these factors. Quantitative methods allow for complex statistical analysis by the researcher thus strengthening the correlation of the study variables (Babbie, 2010). This quantitative study has contributed to the scholarly literature by addressing specific factors that prevent or promote nurses from reporting unethical behaviors. As this is a quantitative study, healthcare organizations will be able to gather empirical data necessary for tracking any

improvements in their potential safety programs. The added information is necessary for healthcare organizational leadership to increase its scholarly work on nurses and patient advocacy utilizing a quantitative approach.

Delineations and Limitations

This study was limited to nurses belonging to the Association of Perioperative Registered Nurses (AORN). Nurses belonging to this specific specialty may have easier access to reporting protocols, have greater patient risk when they choose not to report wrongdoing, and may be prone to speaking out more so than other specialty area nurses. The results of studying one type of nursing specialty may not be generalizable to other specialty areas.

Nurses who choose to join professional organizations are intent on having their voices heard (ANA, 2001). This may be a limitation in that the participation may be skewed toward nurses that feel strongly about their professional practice. The more timid nurses may not be apt to join professional nursing associations and may be apathetic toward their profession. Another potential limitation in this study concerns the nurses' understanding of retaliation and wrongdoing.

Assumptions

There was an assumption that the study will have a medium effect size. It was also assumed that ANOVA, chi-square testing, and multiple regression analysis will be conducted with 4 independent variables and the power will be set at .8 (Cohen, 1988). Based on those assumptions, a sample that exceeds 325 will provide significant power (Cohen, 1988).

Definition of Terms

The following are conceptual and operational definitions of terms that are provided for the purpose of this study:

Ethical climate. The practice which an organization engages in that determines the way ethical issues are handled (Hart, 2005).

Ethics committee. A committee usually chaired by a physician that is responsible for conducting ethics consultations for healthcare staff (Gaudine, Lamb, LeFort, & Thorne, 2011).

Moral distress. Painful feelings and psychological distress that occurs when nurses find themselves in situations where they feel powerless and are unable to do the right thing (Gallagher, 2010).

Whistleblower. A person who identifies an illegal, incompetent, or unethical situation in the workplace and reports it to a person of authority (Moore & McAuliffe, 2010).

Lateral violence. A theory that maintains that oppressed groups feel the need to become violent and oppress others in order to lessen their feelings of oppression (Sheriden-Leos, 2008).

Horizontal violence. A synonym of lateral violence which may be used interchangeably (Sheridan-Leos, 2008).

Oppressed group. A group that believes they have no voice and therefore no power (Milgram, 1983).

Wrongdoing in nursing. Defined as going against the ANA code of ethics and not adhering to protocols, employee behavior standards, patient safety issues, or appropriate billing practices (ANA, 2001).

Culture of silence. An organizational culture that does not promote dialogue or encourage their associates to report unethical behavior (Verhezen, 2010).

Retaliation. Retribution or a counter attack in response to an unwanted act (Peters et al., 2011).

Patient advocate. A person who acts as a liaison between the patient and healthcare institution ensuring patients receive ethical and safe care (Davis & Konishi, 2007).

Methodology

This study employed a non-experimental research design using a closed ended, cross-sectional survey. The quantitative method of analysis was used to make correlations amongst questionnaire items and measured their scores for interrelationships. Quantitative analysis is a method used to convert data into numerical forms (Babbie, 2010). The data was then subjected to statistical analysis which confirms the strengths of the relationships of all variables measured (Babbie, 2010). Statistical analysis can be conducted through the use of computer programs. For the purpose of this study, the author utilized the Statistical Package for the Social Sciences (SPSS), a statistical software package for data analysis. This package allowed for data analytics including descriptive statistics such as frequencies, plots, and charts. It also had the ability to analyze highly complex inferential statistics such as multiple regression analysis, chi-square testing, and categorical analysis used in this study.

The aim of this study was to determine whether correlations exist between the factors that influence nurses' willingness to report wrongdoing. This cross sectional quantitative study utilized the Registered Nurses' Workplace Support for Patient Advocacy Questionnaire developed by and used with the permission of Dr. Lisa Black (Black, 2011). This questionnaire was developed for a study on nursing and their support for patient advocacy. In 2007 and 2008, 115 patients were found to have hepatitis C through the reuse of contaminated medication vials at 2 clinics in Nevada (Black, 2011). Further joint investigations conducted by their federal and state agencies found additional breeches in infection control practices as well as other unsafe conditions. Items that were to be used for single procedures and then disposed of were re-sterilized and used over. Nurses stated that on many occasions they were told that they needed to use items designated for single use only up to four times. Items such as disposable bite blocks were being sterilized against the protocols of the companies and reused. Items that are labeled for single use are unable to be sterilized, thus truly clean, and pose an infection risk to the next patient (Black, 2011). Anecdotal evidence by the nurses suggested that nurses did not report these unsafe conditions due to their fear of retaliation (Black, 2011). Due to these findings, the Nevada legislature's Legislative Committee on Health Care requested a study be conducted on Nevada RN's experiences with workplace attitudes toward patient advocacy activities. Dr. Black developed this questionnaire as a way to gather data regarding the factors that influence nurses' willingness to report wrongdoing (Black, 2011).

The questionnaire contained 45 questions ranging in yes no format as well as Likert-type questions. This questionnaire has been validated and tested by the Nevada

Nurses' Research Counsel. The tool as written has previously been examined by an expert panel to demonstrate construct validity. While post-hoc reliability testing demonstrated a high level of internal consistency among the Likert scaled survey items (r = 0.93), it is important to note that the remainder of the tool was untested.

Participants were recruited from the Association of Perioperative Registered Nurses (AORN) national database. Following Cohen's (1988) conventions for power at .8 with a medium effect size a minimum N to achieve acceptable power is 325. Historically the surveys given to members of AORN yield a 10% response rate therefore request for participation was sent out to 3250 members via email.

Survey questions were housed using SurveyMonkey. A link using the SurveyMonkey system contained the survey, a consent form, and an IRB disclosure form. This link was sent out via personal email to defined members of AORN that fit the criterion set by the researcher. Participants' criterions were that they were members of the AORN who have practiced as clinical nurses in the United States. The researcher supplied AORN with the SurveyMonkey link which was then sent out to select members of the database. Surveys were available for 11 days and closed after a sample size of 379 was reached.

Once completed, the results of the questionnaires were sent back to the researcher via the SurveyMonkey database. Once returned the data was analyzed using Statistical Packages for Social Science (SPSS 20.0) produced by IBM. Multiple Regression Analysis (MRA) was used for testing the differences between more than two groups. As there were many variances being measured in this study, MRA allowed cases that were under study to be grouped into variables and analyzed. It is a regression model with

multiple variates (Creswell, 2007). The data analysis method of ANOVA can be used to analyze the extent in which the groups differed from one another in terms of their independent variables (Babbie, 2010). This method was to be used to analyze hypothesis one; however, it was not necessary to analyze the data due to an overwhelming response to one answer. For simple yes and no answers, a chi-square test was utilized to analyze the data concerning hypotheses two and three chi-square tests are simple regression models which take on only two values (Creswell, 2007). Pearson correlation analysis was used to analyze the results of hypothesis four.

Summary

This chapter explored the need to further study nurses and their willingness to report wrongdoing. The information presented indicated that minimal empirical data existed in the examination of factors involving nurses and the reasons they do or do not report perceived unethical behavior. Nurses, as the front line to patient advocacy, are required by their code of ethics to report wrongdoing. This chapter showed the importance of supporting nurses in doing so thus promoting patient safety and quality of care. This chapter also outlined the method of analysis used to gather data on the factors that promote and influence nurses' willingness to report wrongdoing. This quantitative study utilized a tested questionnaire that was distributed to members of AORN through an electronic link distributed by SurveyMonkey.

The next chapter will provide a review of literature concerning nursing and nursing ethics. Themes found in the literature consist of poor ethical climate, moral distress, dysfunctional teams, and unethical leadership. Themes were examined to

determine potential reasons as to why nurses' willingness to report wrongdoing may by hindered or promoted.

Chapter 2: Review of Literature

The current review of literature on nurses' willingness to come forward and report wrongdoing will be presented into four themes. These themes are: 1) poor ethical climate, 2) moral distress, 3) dysfunctional teams, and 4) unethical leadership.

In order to fully understand the world of the professional nurse, the review of literature will present information on the ethical climate that nurses are exposed to as well as the moral distress they feel while witnessing, and often addressing, patient care issues. Concepts presented will include the theories of lateral violence, cultures of silence, and nurses as an oppressed group. The challenges for healthcare leaders will be to address these barriers and promote a culture of open communication led by emotionally intelligent leaders (Dodds & Kodate, 2011).

The experiences of nurse whistleblowers presented will show that the emotional, physical, and social sequelae of coming forward and reporting wrongdoing have cost nurses their jobs. The research also shows that, in addition to retaliatory discharge, nurse whistleblowers also suffered from emotional and physical distress (Jackson et al., 2010b).

The need for nurses to function as patient advocates is critical in maintaining the safety and well-being of the patients. The literature presented will show that the willingness of nurses may be dependent on the support received by their healthcare organization. When healthcare organizations create mission statements regarding patient safety they are espousing their intent to create safe and ethical environments. In some organizations however, the espoused values may only be written on paper and the actual values modeled by the leaders may not be aligned with those espoused values (Schein, 1985).

When espoused values are not supported by an organization, it creates an unethical climate which causes many nurses to leave the profession (Attree, 2007). The literature shows that while nursing ethics have been examined over the last few decades, the profession has yet to establish a theoretical framework on the concepts of ethical climate (Suhonen et al., 2011). The following theme of poor ethical climate will be explored in relationship to poorly created climates which may lead to burnout, stress, and turnover in the profession of nursing (Aiken et al., 2002).

Poor Ethical Climate

Ethical climate is defined as the practice an organization engages in that effects the way ethical patient care issues are dealt with (Hart, 2005). Hart (2005) studied the effects of ethical climate on nurses' turnover rate and concluded that unethical climates will decrease the job satisfaction of staff nurses and their ability to maintain job stressors. Hart (2005) also concluded that when nurses do not feel they are supported by an organization, or that the organization does not value the professional conduct of its employees, the organization is viewed as possessing an unethical climate which in turn causes nursing staff turnover. According to the Joint Commission on Accreditation of Health Care Organizations, the current nursing turnover is between 18-26% (Aiken et al., 2002).

Although the term *ethical climate* exists, a meta-analysis literature review of healthcare organizations that was conducted over a 20 year period revealed that a clear theoretical framework or definitions regarding the term ethical climate in the healthcare sector still do not exist (Suhonen et al., 2011). This meta-analysis also showed that the

study of healthcare lacks theoretical conceptualizations of the terms moral distress and ethical culture.

Ethical climate is developed by the leadership of organizations. The educator, philosopher, and economist Handy has addressed the phenomena of organizations by identifying four cultures which provide a framework for analyzing an organization's culture (Kane-Urrabazo, 2006). Most hospitals fall into his notion of the bureaucratic culture and as such encourage their staff to fall into established roles based on policies and procedures. If hospitals do not create policies and procedures for nurses that encourage patient advocacy and open communication, the organization creates a climate of ambiguity which further contributes to poor ethical decision making on the part of the nurse advocate. Healthcare organizations operating as bureaucratic cultures need to eliminate the red tape culture by creating seamless protocols that encourage the reporting of wrongdoing and promote a healthy work environment. A healthy workplace promotes an open culture of communication which is essential in empowering nurses (Lucas, Spence Laschinger, & Wong, 2008).

In a study on the development of 20th century nurse leaders, the authors found that nursing leadership must foster the development of team building skills as well as the ability of their leaders to create positive cultures (Huston, 2008). Research on leadership out of Hong Kong showed that managers possessed higher levels of ethical perception (Siu & Lam, 2009). The findings of this study showed the need for organizations to hire and cultivate ethically aware leaders. Having ethical leaders will allow nurses to align themselves with ethical standards. As nurses begin to fill higher executive positions,

nursing leadership development must therefore exert its influence at the board level in order to maintain positive ethical climates (Jumaa, 2008).

Sorta-Bilajac et al. (2011) chose to explore the ethical dilemmas experienced by doctors and nurses in their practice. The secondary purpose of the study was to assess whether they are satisfied with the resolution when they report wrongdoing. A questionnaire was given to nurses and doctors practicing at a hospital in Croatia. The questionnaire contained questions regarding ethical dilemmas. The results showed that the most frequently occurring ethical dilemmas confronted by both doctors and nurses were: 1) near the end of life decisions, 2) justice, and 3) professional misconduct. The study showed that when doctors and nurses reported their dilemmas, the men (who comprised the majority of physician responses at 81%) had a higher satisfaction with attaining solutions than women (who comprise the majority of nurse respondents at 89%) did. Additional data showed that only 5% of physicians and 4% of nurses stated that they utilize their hospital ethics committee. This lack of utilization of an ethics committee shows the need for healthcare organizations to develop protocols and educate staff on the use of ethics committee process.

Caldwell, Hayes, and Long, (2010) in their study on leadership and trust found that when organizational members do not view their leaders as trustworthy, the gap of trust between the employee and their manager dissipates. Without trust in leadership, nurses' willingness to report wrongdoing will be hindered as the lack of trust will promote fear. Faith and trust in leadership may allow nurses to openly communicate any concerns without fear of retaliation.

It is current standard for hospitals in the United States to have an ethics officer on staff. This officer is responsible for the compliance of the hospital's standards of practice. Ethics officers also exist in the business sector. In spite of employing ethics officers, organizations still engage in unethical behavior (Hoffman et al., 2008). In healthcare, ethics officers are used as liaisons for nurses who experience ethical conflicts or need guidance in their quest for patient advocacy. In the business sector, ethics officers are hired to internally investigate unethical practices, however, due to their alliances with their origination may face dilemmas in pursuing misconduct (Hoffman et al., 2008). Ethics officers who are on the payroll of healthcare organizations may not support nurses' claims of wrongdoing as they may be biased in their need to defend the organization's practices. This creates a dilemma for nurses who understand that their claims may not be pursued based on the ethics committees' willingness to investigate wrongdoing. It is imperative that healthcare organizations support nurses' willingness to report wrongdoing by providing non biased reviews of their claims.

Ethics committees exist to foster communication and maintain ethical practices. In spite of the existence of ethics committees, studies have shown that nurses and doctors do not consult them as often as they should (Gaudine et al., 2011a). Gaudine et al. (2011a) presented the findings on the perspectives of doctors and nurses regarding ethical conflicts within the hospital setting. In this qualitative study, nurses and doctors were asked what ethical conflicts they experience in their practice. Nurses and doctors shared five themes on ethical conflicts within healthcare organizations. Themes shared were lack of respect for professionals, insufficient or scarce resources, disagreement with hospital policies, feeling that administration turns a blind eye when confronted with

ethical dilemmas, and lack of organizational transparency. The nursing group generated a separate theme which stated that nurses feel the organization does not support their professional development. Nurses stated that they are uncomfortable with the ethics committee reporting process and have little knowledge of the workings of the ethics committee. Physicians generated a separate theme which was identified as administration having a lack of preventative focus. Physician participants stated that organizations value curing the patient rather than preventing disease. Gaudine et al. (2011b) found that doctors do not report issues to ethics committees because they did not feel they were useful and worried that the ethics officers may disagree with their stand on the dilemma.

Positive ethical climates are created and supported by emotionally intelligent leaders (Lucas et al., 2008). In order to continue to support these climates, healthcare leaders must foster the learning and growth of future nursing leadership (Lucas et al., 2008). If these climates are not supported, they may cause moral distress for nurses who strive for patient advocacy.

The next theme to be explored is moral distress. Moral distress occurs when nurses want to do the right thing for patients but feel helpless and unsupported due to organizational constraints (Pauly, Varcoe, Storch, & Newton, 2009). These feelings may be exacerbated by fears of retaliation from healthcare leadership.

Moral Distress

The concept of moral distress was first described as something that occurs when an individual knows the right thing to do; however, they are hindered by lack of knowledge or fear (Pauly et al., 2009). In nursing, this can occur when a nurse understands what his or her code of ethics dictates, however, feels that his or her hands

are tied due to fear of retaliation, lack of knowledge on the reporting process, or little support by management.

It is estimated that 30-50% of new Registered Nurses completely leave or change their professional roles within the first 3 years of clinical practice thought to be due to moral distress (Aiken et al., 2002). These statistics are important to healthcare leaders in that the need to develop strong leadership must occur in order to maintain moral satisfaction in the field of nursing (Fairchild, 2010). Moral distress occurs when nurses face the daily challenge of making ethical decisions on behalf of their patients. Moral distress increases when nurses are confronted with ethical situations they feel are not reflective of their own moral values. When nurses feel their climate of work is unethical, they will experience a greater deal of moral distress, which leads to nurses leaving the profession (MacKusick & Minick, 2010).

This type of distress is associated with feelings of anger and helplessness. These feelings of anxiety are heightened when nurses are not encouraged to take the correct course of action they feel they need to take to remain true to themselves (Zuzelo, 2007). Nurses who left their profession stated that they did so due to fatigue, lack of management support, and sexual and verbal harassment which created feelings of moral distress (MacKusick & Minick, 2010). Based on these reasons, it is critical that healthcare leaders strategize to minimize these events and create supportive work environments that fully address nurses' grievances.

Several studies on the physical and emotional stressors of nursing have been documented in literature throughout the last two decades. The terms emotional and moral

distress, however, have only recently been explored with respect to the nursing profession (Pauly et al., 2009).

Lutzen, Blom, Ewalds-Kvist, and Winch (2010) examined the connection between moral distress and moral climate in psychiatric nurses. The authors examined the concept of moral burden and moral climate as experienced by a group of psychiatric nurses practicing in central Sweden. They discovered that the more the nurse experienced moral burden the more they experienced moral distress. They also discovered that the more support a nurse received the less likely they were to experience moral distress. The final outcome of the study determined that perceived moral climate was linked to moral stress experienced by the nurse. In order to minimize moral distress, healthcare organizations must remove the burden of fear by establishing supportive healthcare management teams.

Extending the study of moral distress, Ulrich et al., (2010) studied the frequency and level of distress nurses encounter on a daily basis. The authors studied 422 nurses. They asked them to identify stressors and their daily frequencies. The nurse participants indicated that their most frequently occurring ethically challenging incidences included protecting patients' rights, negative staffing patterns, autonomy and informed consent, advanced care planning, and surrogate decision making. They stated that because these incidents occur most frequently, they cause them the most stress.

A meta-analysis study was conducted to understand the reasons why nurses decided to leave the profession. The authors reviewed 31 studies to determine the root cause and the results varied. Upon literature review, it was discovered that nurses will leave the profession due to stress, burnout, work and family conflict, and their perception

of poor public image. The study also found that nurses who had a childhood desire to become a nurse were less likely to leave the profession than those who chose the nursing profession as adults. The results indicated that nursing withdrawal from the profession begins as a process. They often choose to leave their department, then the organization, and eventually the profession. The authors recommend that more research be conducted to drill down to the root causes of the above mentioned factors (Flinkman, Leino-Kilpi, & Salantera, 2010)

Nurses experience moral distress when they are unable to provide optimal patient care. These stressors are caused by limited staff, poor time management, and little knowledge on how to reason through ethical dilemmas (Zuzelo, 2007). Ethical dilemmas cause teams to become dysfunctional as they breed an environment of fear and distrust. Team dysfunctions cause a great deal of harm to organizations and leave employees with a sense of apathy and feelings of burnout (Lencioni, 2002). The next section will explore the theme of dysfunctional teams.

Dysfunctional Teams

The literature on lack of trust in the field of nursing has shown that nurses often engage in many types of dysfunctional behaviors (Sheridan-Leos, 2008). In order for a team to function in a healthy way, leaders must work to create an environment of trust that nurtures commitment and communication (Lencioni, 2002). Group dysfunction occurs when there is an absence of trust, fear of conflict, lack of commitment, no personal accountability, and a lack of attention of results (Lencioni, 2002). Lateral violence, also called *horizontal violence*, is a theory that suggests that oppressed groups feel the need to bully or act aggressively toward their own in order to make themselves

feel less oppressed. Types of lateral violence may include verbal abuse, scapegoating, and other overt passive-aggressive behavior (Sheridan-Leos, 2008). See Table 1.

Table 1: *Types of Lateral Violence and Their Manifestations*

Table 1. Types of Lateral Violence and Their Manifestations

TYPE	MANIFESTATION
Nonverbal cues (covert and overt)	Raising eyebrows, rolling eyes, or making faces in reply to a question
Verbal remarks (overt)	Snide, rude, and demeaning comments Abrupt responses to honest questions
Actions (overt)	Actions that undermine the victim's ability to perform in the healthcare setting (e.g., hiding or hording limited patient care items from other nurses). Not being available to help the other nurse with difficult care issues Refusing or continually being too busy to help during difficult care issues
Withholding information (covert and overt)	The information can be about a patient or a procedure (e.g., deliberately not telling another nurse that a patient has limited sight on the right side, that the suction set up in an outpatient room is not working).
Purposefully sabotaging (overt)	This serves to set up the other nurse for negative situations. A circulator does not tell a new nurse who is scrubbed that she knows the shunt the surgeon has selected has fallen to the floor (Anonymous, 2007).
Group infighting (overt)	Nursing cliques Excluding other staff members
Scapegoating (overt)	Blaming negative outcomes on one identified nurse
Passive-aggressive behavior (overt)	Failure to resolve conflicts directly Complaining to others about a person but not speaking directly to that person
Broken confidences and not respecting privacy (covert)	Also characterized as gossiping; sharing information that is meant to be private. For example, a nurse has failed the Oncology Nursing Certification and plans to sit for the test again but does not want her coworkers to know that she failed. She tells her mentor in confidence that she failed the certification test and this has caused her great pain. The mentor shares this story with coworkers during downtime on the unit.

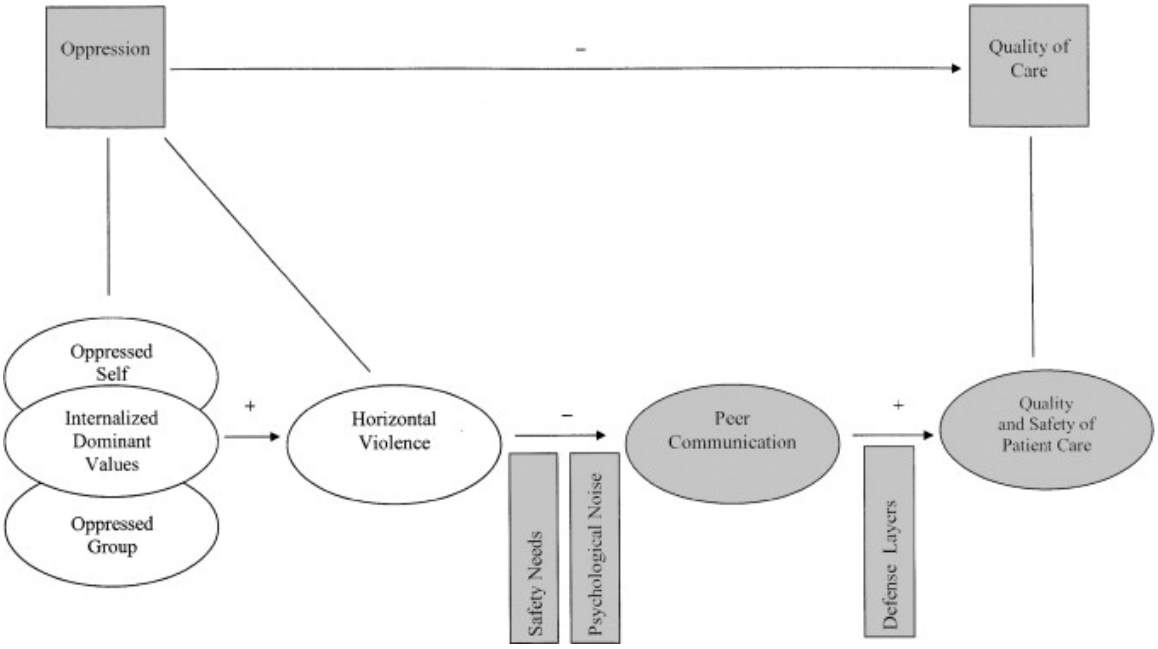
Note. Based on information from Freshwater, 2000; Griffin, 2004.

A study conducted by McKenna, Smith, Poole, and Coverdale (2003) addressed lateral violence in new graduate nursing students. The authors studied 551 new nurses and asked them if they experienced any type of lateral violence their first year of employment. The data showed that the majority of those surveyed had experienced interpersonal conflict and that overt lateral violence, identified as racial slurs, blocked opportunities, sexual harassment, verbal abuse, and humiliation, had been experienced by 34% of the respondents. The authors note that the distress from this lateral violence resulted in absenteeism and in nurses leaving the profession. The authors go on to point out that feelings of powerlessness will prevent nurses from reporting wrongdoing and that nurses fear confronting the oppressor. This study clearly shows the need for healthcare organizations to create and sustain a culture of open communication and support nurses' willingness to report wrongdoing. If unable to, healthcare organizations will continue to lose professional nurses thus adding to an already burdened nursing shortage.

The earliest studies on horizontal violence come from Heal's oppressed group model. Freire coined the term horizontal violence and supporters of this theory believe that nurses are prone to this based on their suppression by the medical establishment (Coursey, Rodriguez, Dieckmann, & Austin, 2013). Freire believed that oppressed group behavior stemmed from one group feeling devalued by a group that possessed a higher level of power. Freire went on to note that these feelings of oppression occurred when the powerful group promoted themselves while the less powerful felt inferior (Roberts, DeMarco, & Griffin, 2009). According to Freire's theory, the oppressed group developed self-hatred and their feelings of worthlessness caused them to loathe each other (Roberts et al., 2009).

In the case of healthcare, the physicians may be seen as the powerful group due to their level of status and education relative to that of nurses. Horizontal violence in the healthcare industry affects the quality of patient care. If nurses are not supported when they voice their concerns they will fear doing so. This oppression will cause the nurse to remain silent thus allowing potential safety needs to go unheeded (Purpora & Blegen, 2012). See Figure 1.

Figure 1: *Oppression and the Quality of Care* (Purpora & Blegen, 2012)



Roberts et al. (2009) reviewed the current literature on oppressed group behavior in nursing and determined that the unequal power bases between doctors and nurses has caused the nurse to feel powerless. They also go on to point out that nurses who support the dominant view of physicians or administration are the nurses that get rewarded. On

the other hand, nurses who go against the dominant view of the powerful are often not rewarded and may be further suppressed. The authors further state that oppression of nursing as a group has been theorized to have occurred due to the predominately female profession having to work under the direction of the predominately male medical profession.

The notion of the nurse as handmaiden to the doctor has perpetuated the feelings of suppression by nurses. Nurses are not seen as having as much control or power over situations as their male physician counterparts. This sense of powerlessness creates a feeling of dominance by the physician over the nurse, thus the hierarchy of suppression begins (Roberts et al., 2009). Nursing leadership can change this system by encouraging their nurses to speak up. This can be accomplished through the support of ethical reporting protocols. The balance of power may be shifted if nurses are conditioned to understand their worth and are supported by healthcare administration (Roberts et al., 2009).

The intimidation of the male-female power play was identified by authors Celik and Celik (2007) in their study on the sexual harassment of nurses in Turkey. The authors studied 622 nurses practicing in 8 ministries of health hospitals. When asked if they had ever been sexually harassed, 37.1% of the nurses stated that they were. Of those sexually harassed, 80% did not come forward to report their harasser. According to the results of the study, the primary instigators of sexual harassment were physicians. Due to the nurses' lower working status than physicians, insufficient healthcare leadership support, and poor government regulations, the reports of harassment against physicians would continue to go unreported (Celik & Celik, 2007).

The literature has shown that over the years oppressed groups will succumb to authority without question. The classic example of oppressed group behavior comes from Stanley Milgram and his study on obedience (Milgram, 1983). In his study, Milgram took a group of people, placing them in the teacher role, and mandated that they give the subject who they believed to be a learner (in reality the subject was an actor) an electric shock for each answer they got wrong. Although the punishment was incredibly severe, the test subjects were told to continue. At one point in the experiment, a learner (again this was a trained actor) claimed to have a heart condition. Several learners (actors) banged on the doors when being artificially shocked to show their distress. Milgram reported that the subjects who were unaware that the learners were actors asked to stop and became nervous. When they were told they could not and that they would not be held accountable for the condition of the learners, many continued. The results indicated that although people were strained and experienced conflicting emotions about harming another person they continued to obey the authority that told them to continue. In the commentary on Milgram's work researchers Reicher and Haslam point out that in the face of authority, people will tend to lose sight of their own personal goal and become fixated on the goal that was given to them by that authority figure irrespective of how they ethically feel about the goal (Reicher & Haslam, 2011).

Nurses are on the front line of patient care and as such are ethically responsible for reporting ethical wrongdoing and not carrying out orders which they feel may harm a patient. In a study conducted by Attree (2007) a group of nurses were asked the factors that influenced their decision to raise concerns regarding patient care. The study found that nurses were well aware of their responsibility to their profession; however, they felt

that the repercussions of reporting ethical wrongdoing outweighed the need to report. The findings concluded that nurses feared retribution, labeling, and apathy by healthcare administration. They also found that nurses perceived reporting unethical behavior as a high-risk and low-benefit action. The apathy expressed by the nurses in the study stemmed from the fear that it would limit their career advancement.

Although hospitals have implemented anonymous hotlines to report unethical behavior, the data yielded by a study conducted at the East Carolina University School of Medicine showed that these reports by nurses often go unfounded (Goettler, Butler, Shackleford, & Rotondo, 2009). Presented in this study were the findings collected by the Division of Clinical Effectiveness, Department of Surgery at East Carolina University. The purpose of the study was to determine the prevalence and type of reported physician behavioral issues generated over 2 years. These reports were generated via an anonymous hotline, written risk management reports, or direct complaints to administration. Close to 200 behavior issues were reported. Of the 199 reports, 114 were physician issues. Incidences regarding physician behavior ranged from rudeness, poor communication, swearing, throwing things, and failure to follow hospital protocol. The reports were reviewed by the quality department and only 1% of the reported incidences were considered disruptive.

If organizational change is to occur, leaders must understand their team dynamic and work to create trust and foster communication through shared experiences and respect (Lencioni, 2002). Communication cannot occur in a culture that breeds distrust and silence (Lencioni, 2002). Studies have shown that a culture of silence is perpetuated

out of many factors. Fear of blame, retribution, and loss of peer relationships, are a few of the reasons why nurses remain silent (Jackson et al., 2010a).

A culture that is laden with integrity is far different than a culture that merely goes along with compliance (Verhezen, 2010). Healthcare organizations must pass accreditations set forth by government and private inspection agencies. These inspections are often scheduled and healthcare personnel are prepped for their arrival months in advance. Institutions often comply with set standards to remain in good standing legally. Cultures that maintain standards in order to pass inspection only often become mute when challenged ethically. To remain an ethical organization, an organization must strive for dialogue and promote ethical behavior. In doing so an organization leaves behind a legacy of moral excellence (Verhezen, 2010).

Taylor and Curtis (2010) studied practicing senior accountants and the factors that influence their likelihood of whistleblowing. Participants were shown three vignettes representing various situations in which ethical violations occurred. After watching the vignettes the participants were asked to if they would likely report that violation. The data showed that participants reporting intentions increased when the witness to the event had a higher professional identity. Reporting intentions also increased when the witness to the event aligned their locus of commitment with the company rather than their colleague. Finally, the data showed that as moral intensity (one's commitment to their moral judgment) increased, so did moral intent. This study concluded that organizations that foster a culture of commitment to top management, as well as to increasing professional identity of their employees, are more likely to have employees that are willing to speak up.

Keil, Tiwana, Sainsbury, and Sneha (2010) addressed the concept of whistleblowing by conducting a benefit-to-cost analysis of a whistleblowing event. The authors questioned why some employees remain silent while others are intent on reporting ethical wrongdoing. The benefit-to-cost differential looks at how an individual decides on whether they should or should not blow the whistle. The authors presented five areas which encouraged whistleblowing. Those areas that promoted whistleblowing were personal responsibility, trust in supervisor, reporting anonymity, responsive management, and organizational climate that was conducive to reporting. The ability to hide information and senior management attachment to a project did not play a role in the intention to whistleblow.

The reasons that nurses choose to remain silent were explored in a study conducted on the perpetuation of silence in hospitals (Moore & McAuliffe, 2010). The authors surveyed 152 nurses working in Ireland and asked them if they had observed poor care in the past 6 months and whether or not they reported their findings. The data showed that 80% of the respondents had witnessed poor care in the last 6 months; however, only 70% reported it. Of the 70% who reported the poor care, only 25% of those nurses were satisfied with the way the organization handled those concerns. The nurses stated that due to fear of retaliation and lack of faith in the organization's ability to handle issues, the reporting of wrongdoing will continue to be hampered.

Nurses are often reluctant to report adverse events. Moumtzoglou (2010) studied specific factors that impede nurses from reporting adverse events in Greece. The findings showed that there were five main reasons why nurses would not come forward and report. These reasons were fear of the press, fear of losing their license, difficulty in

handling an adverse event, lack of confidence, and complaints by patients. The study findings showed that the management structure did not support the structure of reporting adverse events. Data also showed that Greek nurses felt they would be blamed for coming forward and reporting an adverse event. They feared they would be perceived as incompetent and poor nurses. The results of this study show the need for management support and the need to dissolve the culture of blame that occurs in healthcare settings.

A connection between power and silence was observed while studying communication in the operating room amongst nurses and doctors (Gardezi et al., 2009). Nurses are responsible for overseeing the quality monitoring of the patient in the operating room. They are required to clarify the patient's diagnosis and procedure by conducting a surgical pause or time out. During a time out in surgery, the nurse asks all team members, including the surgeon and anesthesiologist to agree on the type and site of surgery in unison. Often times, the doctors did not adhere to the protocol and the nurses either repeated the request softly or turned to the anesthesiologist for confirmation (Gardezi et al., 2009). This fear of raising their voices to the surgeons and allowing them to deviate from protocol may be contributed by nurses' fear of retaliation and lack of management support. Nurses in the study also commented that when they attempted to control the surgical environment through the strict monitoring of the sterile environment and surgical protocols, the surgeons would refer to them as drill sergeants and became agitated. The authors concluded that much of the silence occurring in the operating room stemmed from broader issues dealing with institutional power relations.

The culture of silence may emanate from the fear of being punished. In a study conducted on blame culture, authors studied nursing students, senior nurses, medical

students, and physicians. The purpose of the study was to understand why healthcare workers do not report their own medical errors (Gorini, Miglioretti, & Pravettoni, 2012). The results of the study indicated that the reasons healthcare workers did not report medical errors varied amongst their seniority and position. Data indicated that the fear of being viewed as incompetent by leadership and co-workers was greater than the fear of being punished. The fear of being punished, however, was greater amongst nursing students and senior nurses than that of medical students and senior physicians. Punishment included retaliation in the form of loss of respect or suspension. This information is important to healthcare leaders by showing that communication and trust are critical components in establishing a culture that is free of fear and promotes patient safety. In order to successfully promote change and create an open culture, leaders must understand their shortcomings and work on becoming stronger leaders who promote dialogue and trust (Lencioni, 2002).

The culture of silence by nurses was further explored in a study on workplace communication. A descriptive, qualitative study, utilizing semi-structured interviews, was conducted using 33 registered nurse participants (Garon, 2011). The aim of the study was to explore the perceptions of nurses and their feelings about their ability to speak up. Three themes emerged from the interviews. The first theme noted that culture was a great influence in the ability to speak up. Nurses who were raised in passive cultures where the female was known to be quiet and not challenge authority did not speak up. Other cultures where women were taught to speak up during their education and family life had an easier time doing so. The second theme dealt with the tone that was set by administration. Nurses stated that if their managers or the organization's

administrative team set the tone for fear and silence, then they were most likely to remain silent. If the manager set the tone for open communication, then the nurse was able to speak up more freely without fear of repercussion.

The final theme dealt with the history of the outcomes of previously reported events. If a unit manager had a history of not attaining resolution on reported problems, or if no timetable is given for resolution, then the nurse will not come forward and report issues in the future. Overall, this study showed that a major influence in nurses choosing to remain silent is the support they perceive they will or will not receive by their nurse manager. By creating a culture of open communication, organizations will foster nurses who are willing to speak up, thus increasing quality of patient care. When leadership does not support these types of open cultures, they create behaviors that foster unethical practices.

Unethical Leadership

Although ethical leadership has been studied at great length over the years, there is still disagreement on how to operationalize the definition (Yukl, 2009). Ethical leadership, however, has been defined as leadership behavior that sets examples for others and criticizes unethical behavior (Yukl, 2009). Types of ethical leadership include servant leadership, spiritual leadership, and authentic leadership.

Servant leadership is a concept that was developed by Robert Greenleaf in 1970. He postulates that leaders have the job of elevating their employees and empowering them. The purpose of these types of leaders is to nurture and lead with integrity. These types of leaders are required to be humble, empathetic, and fair (Yukl, 2009). Like servant leaders, ethical, spiritual, and authentic leaders lead by example. They do not

retaliate against their employees, but rather, they have the goal of creating a meaningful work environment filled with people who are supportive of each other. Based on the notions of ethical leadership, nurses who are retaliated against are victims are unethical leadership.

Hannigan (2006) examines the factors that are involved in deciding to blow the whistle on healthcare fraud. The participants were nurse practitioners and data was gathered via government websites, healthcare management, and ethics and nursing journals. The article cited research which stated that due to the emotional stress of whistleblowing, the nurse meets strict conditions that establish the need to whistleblow prior to doing so. These conditions include seeing a grave injustice, appealing to ethical theories, understanding the facts, loyalty to client, understanding that blowing the whistle will cause more good than harm, and being ready to assume responsibility for the seriousness of their actions. Although the Qui Tam statute has been put in place to protect individuals who blow the whistle on healthcare fraud, the government cannot protect the anonymity of the whistleblower. The authors concluded that the decision to blow the whistle must be weighed carefully. Whistleblowers have experienced loss of job, threats against their families and themselves, and emotional stress. The positive outcomes, however, include feelings of morality and diminished psychological stress by doing the right thing.

Ethical behavior needs to be modeled by nurse leaders. Along the continuum of their nursing education, nurses begin to model their behavior after their nurse mentors. Mentorship plays a large role in creating favorable experiences and positive career growth (McCloughen, O'Brien, & Jackson, 2009). Mentorship also allows nurses to feel

more confident and have stronger identities. By having strong mentors, nurses are more confident and are able to promote ethical leadership behavior (McCloughen et al., 2009).

Jackson et al. (2010b) explored the reasons why nurse whistleblowers choose to come forward and report unethical behavior. Data was collected from interviews conducted on 11 nurse whistleblowers. The themes generated were categorized into three themes. The first theme was the reason for whistleblowing: I just couldn't advocate. The second theme was feeling silenced: Nobody speaks out. The final theme was climate of fear: You are just not safe. Nurses fear coming forward due to the negative backlash by healthcare administration and colleagues. This article supports this study by identifying factors such as the above mentioned three themes that promote the nurses' willingness to report unethical behavior. A similar study showed that nurse whistleblowers in the United Kingdom suffered emotional distress ranging from sleep deprivation, depression, headaches, GI disturbances, and thoughts of suicide (Peters et al., 2011).

Author Susan Ray reviews an event that occurred in which she, a nurse, was forced to report a whistleblowing event externally after all efforts to report the event internally failed. She points out that the whistleblowing event occurs due to a misalignment of values between the whistleblower and the organization. The author gives the account of her personal journey during her whistleblowing event. She gives an overview of her hospital and describes it as being laden with cover-ups, status quo, inactive, and controlled paternalistically. The lack of support during her attempt to internally blow the whistle forced her to do it externally to her union and human rights grievance board. The outcome of the external whistleblowing incident was favorable.

The nurse who she reported for inappropriately touching patients was required to take a leave of absence and obtain psychiatric help.

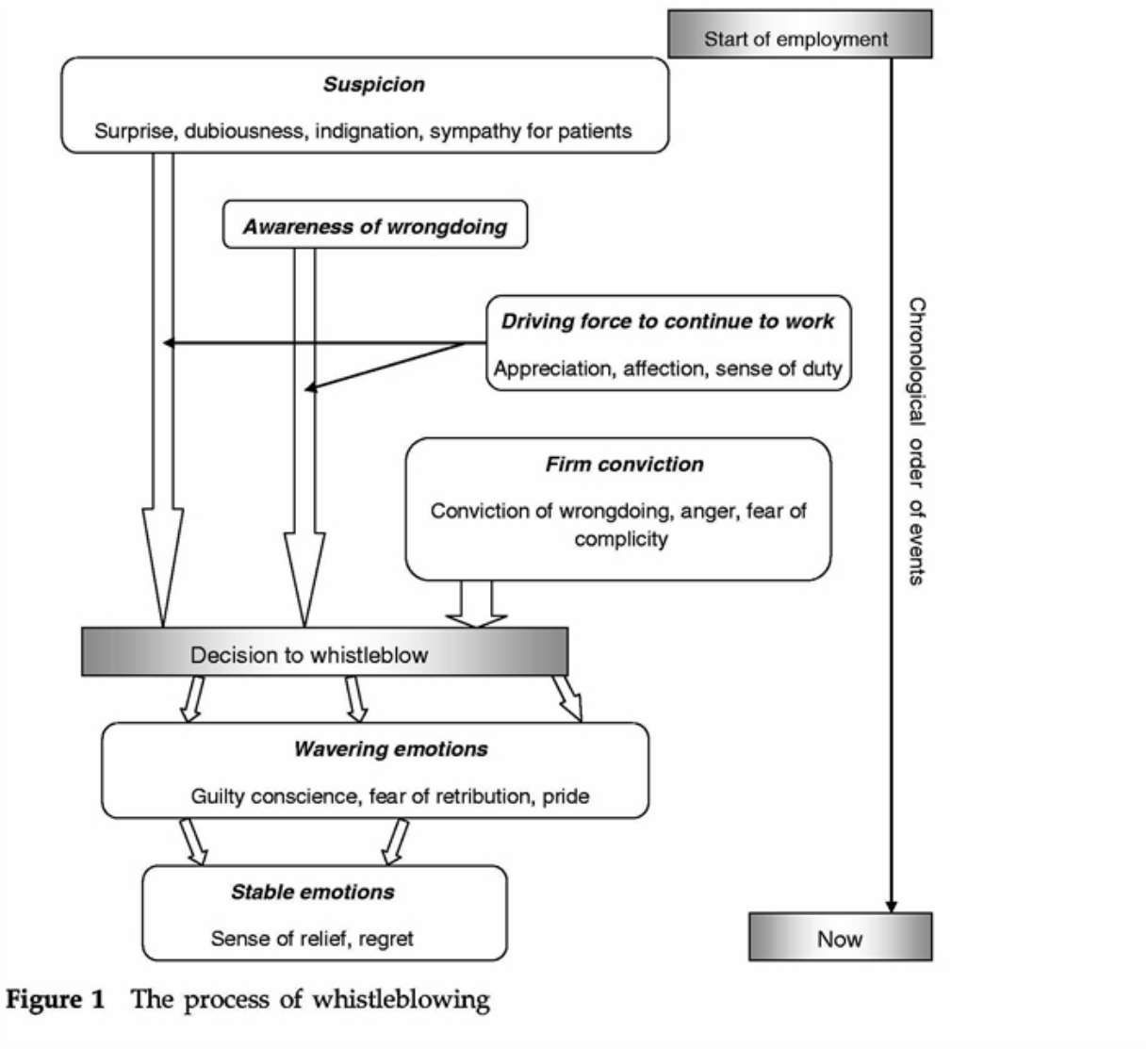
Nurse whistleblowers have also experienced broken relationships with colleagues and believe that they are no longer liked by their work mates. They also lose trust in their physician colleagues and have reported being bullied after reporting wrongdoing (Jackson et al., 2010b). These studies support the need for organizations to support their nurses in upholding the code of nursing code of ethics; otherwise nurses may turn to outside help to expose the organization (Ray, 2006).

A culture such as Japan values loyalty and saving face. In this study conducted by Davis and Konishi (2007) on Japanese nurses and whistleblowing, 24 Japanese nurses were asked why they would choose to blow the whistle on their colleagues. Of the 24 nurses, 10 had reported fellow nurse colleagues while 12 had reported physicians for some form of ethical wrongdoing. Nurses who reported their colleagues experienced burnout and a great deal of internal conflict.

To further the understanding of nurse whistleblowers in Japan, Ohnishi, Hayama, Asai, and Kosugi (2008) studied the lived experiences of two Japanese nurse whistleblowers. These two whistleblowers had taken their story to the media to report misconduct they both observed at a psychiatric hospital. After they told their stories, 6 categories and 16 subcategories were identified. The first was the suspicion of wrongdoing by the organization subcategorized into surprise, dubiousness, indignation, and sympathy for patients. The second was awareness of wrongdoing with no subcategory. The third was the driving force to continue working subcategorized into appreciation, affection, and sense of duty. The fourth category was firm conviction

subcategorized into conviction of wrongdoing, anger, and fear of complicity. The fifth was wavering emotions subcategorized into guilty conscience. The final category was stable emotions subcategorized into sense of relief and regret. This study relayed the emotions that nurses experience while involved in a whistleblowing event. The gamut of emotions nurses experience may contribute to their reluctance to come forward and report unethical behavior (Ohnishi et al., 2008). See Figure 2.

Figure 2: *The Process of Whistleblowing* (Ohnishi et al., 2008)



It is estimated that in Taiwan 6,000 to 20,000 patients die each year due to medication administration errors (MAEs) which result in 10% of all medical lawsuits in that country (Taiwan Joint Commission on Hospital Accreditation [TJCHA], 2004). Because it is the nurse that administers medication and is responsible in coming forward and self-reporting, administrators need to work on removing the barriers that may exist.

A study of 597 nurses in Taiwan asked nurses what their perceptions were regarding MAEs (Chiang & Pepper, 2006). The findings indicated that the greatest perceived barrier was fear. Nurses reported being fearful of administration placing blame on them and also fearful of the consequences they may receive. They also reported being afraid of physician reprimand and being seen as incompetent. The administrative barrier was described as getting no positive feedback by their administrators and blaming the nurse, rather than the system, for the MAE. This study supports the need for creating voluntary reporting systems as well as changing the way administrators perceive these mistakes as learning experiences and near misses rather than punishable offenses. Ethical and supportive leadership in healthcare alleviates the fear of reporting wrongdoing thus allowing the nurse greater freedom to come forward and report.

Nurses who have been involved in whistleblowing events find it safer to remain silent rather than report wrongdoing (McDonald & Ahern, 2000). These reasons ranged from feelings of fear, anxiety, and intimidation. Many stated that they were intimated by their own colleagues immediately after reporting what they perceived as wrongdoing by members of the healthcare team (McDonald & Ahern, 2000). By creating a safe environment, nurses will feel comfortable reporting wrongdoing to their healthcare leadership teams. These types of ethical dilemmas can be avoided with the promotion of ethical leaders who can influence healthcare organizations (Hickman, 2010).

Summary

When healthcare organizations create mission statements regarding patient safety they are espousing to create safe and ethical environments. In some organizations however, the espoused values may only be written on paper and the actual values

modeled by the leaders may not be aligned with those espoused values (Schein, 1985). This chapter has summarized the review of literature on healthcare leadership's response to the reporting of wrongdoing and the factors that contribute to nurses' decisions to report wrongdoing. Themes such as fear, retaliation, and oppression of the profession were examined and supported by current literature. The need for nursing and healthcare leadership to explore empirical data was evident in the review as well as the need for further exploration on the definitions of ethical climate. The review presented many articles on nurses' reporting of wrongdoing, however, quantitative studies offering empirical data were limited. In order to effectively plan organizational change it is imperative that change is measurable and data is transparent (Burke, 2011).

The review of literature also shows that there are deficiencies in the understanding and promotion of ethical leadership, positive moral climates, and creation of functional teams in nursing and healthcare leadership. The literature review also shows the need for the promotion of nurse leaders with emotional intelligence in order to support an ethical climate (Morrison, 2008). By understanding the need to develop nursing and healthcare leaders, organizations can improve poor relationships between management and staff as well as develop leadership competencies necessary for effective conflict resolution (Morrison, 2008). A decrease in conflict resolution as well as the creation of an open culture can inspire nurses to do the right thing by encouraging communication and decreasing burnout (Lee et al., 2010). By creating open cultures of communication, trust, commitment, and accountability, organizations can develop functional teams that pay attention to detail (Lencioni, 2002). These details, such as being able to freely and safely report wrongdoing without fear of repercussions from healthcare leadership, will

continue to promote patient safety as well as a supportive working environment for nurses.

The next chapter will introduce the measurements and research methodology that was used to conduct the study on nurses and the factors that are involved in their decision to report wrongdoing. Data gathering and participant involvement will be discussed as well as the process of data analysis. The next chapter will also highlight the ethical considerations necessary for conducting a study of this nature.

Chapter 3: Methodology

The purpose of this study was to identify significant relationships in factors that both promote and inhibit the reporting of unethical behavior by nurses working in healthcare organizations. By understanding if any significant correlations exist amongst these factors, healthcare leaders can take action to support nursing leaders in overcoming any barriers and creating a positive culture that promotes patient advocacy. Understanding these factors will encourage open cultures that promote the culture of learning. A learning culture has the ability to remove the factors that limit growth while encouraging solutions that promote positive organizational cultures (Senge, 2006).

This chapter will present the statistical methods that were utilized in this study. A presentation of the study design, participants, instrumentation, variables, and statistical analysis will be reviewed. An overview of ethical considerations will be discussed along with the risks and benefits to the participants. The protection of participant confidentiality will also be addressed.

Design of Study

The purpose of this quantitative cross-sectional survey study was to assess the factors that promote and hinder nurses' willingness to report wrongdoing. The study further showed if any correlations existed amongst the variables measured. Independent variables such as knowledge of the process of reporting wrongdoing, perceived management support, and fear of retaliation were assessed and measured for significant correlations with the dependent variable of willingness to report wrongdoing.

This quantitative research was conducted using the post-positivist world view. This worldview is most often utilized for quantitative research studies in that it is used for

empirical observation and measurement (Creswell, 2007). This non-experimental, cross-sectional design utilized a tool that has been validated in previous research on nursing and patient advocacy (Black, 2011). The tool utilized was the Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire developed by Dr. Lisa Black (2011). Utilizing a cross-sectional quantitative study design, the survey Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire was distributed electronically to a defined audience consisting of members of the Association of Perioperative Nurses. Permission to use the tool was granted by Dr. Lisa Black Thomas (See Appendix F for permission letter).

Strengths of Design

As the purpose of this study was to determine numerical observations to describe the phenomena of the factors that promote or hinder nurses' willingness to report wrongdoing, the study utilized the quantitative approach. Studies have been conducted on nurses' attitudes toward reporting wrongdoing utilizing the qualitative approach. Minimal studies have utilized the quantitative approach, thus, limiting empirical data for healthcare leadership to utilize (Black, 2011). A quantitative study allows the researcher to utilize an instrument based questionnaire which will measure nurses' attitudes and find correlations and/or significant relationships amongst the measured variables (Creswell, 2007).

Online surveys are excellent tools necessary to measure a large population and can be an effective way to gather large amounts of data (Babbie, 2010). Questionnaires are completed in privacy and due to the use of email they are cost effective (Babbie, 2010). Surveys that are given orally may not generate an honest response from

respondents on sensitive and personal issues; therefore, online surveys allow a larger degree of honesty by the participant (Babbie, 2010). Cross-sectional surveys utilizing convenience samples save time, money, and effort, thus enabling the researcher to gather data in a timely fashion (Creswell, 2007).

Weaknesses of Design

The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire was employed in this study. Cross-sectional designs utilizing a convenience sample may not generalize to the entire population depending on the homogeneity of the cohort group (Creswell, 2007). Questionnaires are often not mandatory; therefore, there is potential risk of a low response (Babbie, 2010). This design also required participants to be competent enough to answer written questions. The researcher must also steer clear of asking complicated questions that the respondent may not understand (Babbie, 2010).

Population/Sample

The population of interest for this study was a convenience sample of registered nurses who were members of the Association of Perioperative Registered Nurses (AORN). AORN is an autonomous accredited organization that supports the scholarly advancement of nurses specializing in the care of surgical patients. According to Cohen (1988) the power of a statistical test is the probability that the null hypothesis will be rejected when false. He also notes that statistical power depends on the significance criterion, sample size, and population effect size. Following Cohen's (1988) conventions for power at .8 with a medium effect size with 4 independent variables, for the full research model that we will utilize in this study, a minimum N to achieve acceptable

power is 325. Historically the surveys given to members of AORN yield a 10% response rate; therefore, request for participation was sent out to 3250 members via email. The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire was sent out to 3250 nurses based on a 10% response rate to achieve the anticipated sample size of 325. The AORN database is comprised of all active and non-active operating room registered nurses, first assistants, recovery room nurses, and nurse educators. Members of the AORN database are both international as well as national members. For the purpose of this study, only nurses practicing in the United States were included. The survey was open for participation for approximately 2 weeks to give the participants the chance to complete the study questionnaire. At the request of the researcher, AORN sent out 2 follow up reminder emails to potential participants. A survey response of 379 nurses was achieved at the completion of the study.

Instrumentation

The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire was used in this study to measure the variables of interest. The instrument was developed for a study by Dr. Lisa Black of the University of Nevada- Reno with the input from the Nevada Nurses Association Legislative Committee and the Board of Directors of the Nevada Nurses Association. Content validity of this instrument was determined by a review panel of experts and the survey tool was pilot tested with acute care nurses from the state of Nevada (Black, 2011). The tool as written has previously been examined by an expert panel to demonstrate construct validity. While post-hoc reliability testing demonstrated a high level of internal consistency among the likert

scaled survey items (r = 0.93), it is important to note that the remainder of the tool is untested.

This tool was useful for the purposes of this study as it assessed the nurses' attitudes for reporting wrongdoing. It also assessed the variables that affected nurses' willingness to report wrongdoing. This study was in response to the Nevada State Board of Nursing's report which suggested that nurses have a fear of retaliation when reporting breech of safety practices they witness.

The questionnaire was comprised of 45 questions. Sixteen of the questions were answered with a yes or a no and 14 questions were likert type statements. The remaining questions concerned the participant's demographic data. The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire is located in Appendix A.

Independent Variables

Independent variables measured were: a) knowledge of the reporting process of wrongdoing, b) experiencing retaliation after reporting wrongdoing, c) witnessing retaliation of others who report wrongdoing, and d) feeling supported by management.

Dependent Variable

Dependent variable measured was the predictor for reporting wrongdoing.

Research Hypotheses

H1- There is a statistically significant relationship between knowledge of the reporting process and reporting wrongdoing.

H2- Experiencing retaliation is significantly related to reporting wrongdoing.

H3- Witnessing retaliation to others is significantly related to reporting wrongdoing.

H4- Feeling supported by nursing management is significantly related to reporting wrongdoing.

H5- Knowledge of the reporting process, experiencing retaliation, witnessing retaliation, and feeling supported by nursing management are predictors for reporting wrongdoing.

Data Collection

Data was collected from the AORN members with permission from the AORN research committee. AORN sent out 3250 invitation emails at the request of the researcher. This study was not advertised on the AORN website as this is not the protocol of the organization.

A link was established via SurveyMonkey. The researcher then sent out the link to the AORN research liaison who then distributed the email invitation to participate in the study to the personal email accounts of 3250 members (See Appendix B for email invitation). The link contained the survey and the electronic consent form (See Appendix C for consent form).

The criterion for selection was that the nurses were members of AORN and had practiced clinical nursing at one time in their careers. SurveyMonkey then housed the data and sent it back to the researcher via a secure and encrypted website. Participants had approximately 2 weeks to consent to and complete the survey. A reminder email was sent out at the request of the researcher 2 times to encourage participation.

Privacy and Confidentiality

Email addresses of AORN participants of the study were not shared with the researcher. AORN directly sent the link provided by the author to the nurse participants. Participants were able to log into a password protected account. Participants' surveys were numbered and all data was sent back to the researcher. SurveyMonkey did not collect any names, email addresses, or IP addresses. All data was stored in a password protected electronic format. Survey Monkey houses its data with enhanced security channels and SSL encryption. SSL encryption is a protocol that was developed for transmitting documents in a secure manner. This encryption assured that there was a secure connection between the client and the server. The results of the study will only be used for scholarly research. No personally identifiable information was shared with any third party groups. Only aggregate data was shared with scholars in the form of the dissertation and may be shared in the form of scholarly articles and presentations.

Risks and Benefits

Risks and benefits were explained to the participants in the consent form. The risks in this non-experimental study were minimal. The only risk foreseen was that nurses who recalled uncomfortable situations they dealt with regarding wrongdoing may have become distressed. To offset this potential risk, participants were told that they may discontinue participation in the study at any time. Participants were also reminded that they suffered no penalty or consequences if they withdrew early or chose not to participate after agreeing to join the study.

There was no individual benefit to the participant other than knowing that this research will contribute to the body of nursing and healthcare leadership. Nurses who

have had little support involving patient advocacy may view their participation as a way to benefit future nurses and help educate healthcare organizations on the need to support their nurses' efforts in reporting wrongdoing. Nurses who participated may also increase their awareness on patient advocacy nurses' willingness to report wrongdoing.

Ethical Considerations

The Institutional Review Board (IRB) process was adhered to per the protocol of the Association of Perioperative Registered Nurses as well as the IRB guidelines mandated by The Chicago School of Professional Psychology. A letter outlining the research and its adherence to the guidelines can be found in Appendix D. Upon adherence to the IRB protocol, a letter of approval to conduct research was granted. See Appendix E for IRB approval letter.

The participants needed to answer questions which were taken from The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire. This questionnaire may have reminded participants of uncomfortable events that may have provoked stress and anxiety. Participating in a survey may have taken time away from the participant in the workplace thus causing a decrease in potential income.

Data Analysis

The analyses of the variables were accomplished through inferential statistics. Unlike descriptive statistics, inferential statistics determined correlations amongst variables. The goal of inferential statistics is to discover patterns amongst small groups of people that can then be generalized to a larger population (Babbie, 2010).

The SPSS version 20.0 (SPSS Inc., Chicago, IL, USA) was used to analyze the data. SPSS is a statistical package for the social sciences which allows a large number of

data points to be input into its system (Babbie, 2010). The analysis of the data showed the factors that contribute to nurses reporting or ignoring incidents of wrong doing. Variables such as sex, gender, marital status, and income levels were not measured using inferential statistics and were merely reported as descriptive statistics.

Statistical analysis for this study utilized multiple regression analysis (MRA) and chi-square testing. Multiple regression analysis (MRA) will test for significant correlations of the factors measured. MRA seeks to find the impact of two or more independent variables on a single dependent variable (Babbie, 2010). Chi-square tests will allow the researcher to measure yes-no questions containing only two measured variables (Babbie, 2010). Chi-square testing is based on the null hypothesis which assumes that there is no relationship between two variables (Babbie, 2010).

Summary

This study was carried out using a quantitative approach which is applicable in describing empirical relationships that exist amongst variables (Creswell, 2007). The Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire was utilized to gather data. This data provided information on the factors that promote or hinder nurses' willingness to report wrongdoing and also provided information regarding the existence of any correlations. Factors studied were nurses' perceived support by management, fear of retaliation, and knowledge of the reporting process. Participants were gathered via the Association of Perioperative Nurses national database. Full disclosures of the study along with consent to participate were implemented. Participant information remained confidential through the association's secure database. Data was analyzed using the SPSS version 20.0 statistical analysis package.

The following chapter will present the data analysis and findings of the study. The questionnaires were gathered and participants' information was examined. Correlations were made amongst the variables and the data was presented in statistical form. Strengths in statistical variances were examined and assumptions were made based on the strengths of the relationships.

Chapter 4: Results

The purpose of this quantitative cross sectional study was to determine if significant relationships exist amongst factors that both promote and factors that hinder nurses' willingness to report wrongdoing to healthcare leadership. The relationships assessed were familiarity with the process of reporting wrongdoing, witnessing the retaliation of others who reported wrongdoing, or personally being retaliated against for reporting wrongdoing. Management support was also studied to determine whether there is a correlation between management support and reporting wrongdoing.

Overview of Study

The study conducted involved a close ended survey administered to members of the Association of Perioperative Registered Nurses (AORN). This survey was designed and tested by Dr. Lisa Black and contained 45 close ended questions. They ranged from yes-no questions to Likert-type statements. Guidelines for the use of the database were given to the researcher and the appropriate protocol was followed. In order for permission to be granted for database usage, the researcher adhered to all of the guidelines presented by AORN. The criteria for request to use database included providing a cover letter, contact information of the requestor, an abstract of the study, and a letter outlining the significance of the research as it relates to perioperative practice. Further information necessary for the use of the database included a request for the literature review and a section on methods used for the study. Methods questions included but were not limited to a justification of sample size, research design, data collection methods, and copies of all instruments. All written communication inviting subjects to participate were presented and approved for final usage of the database.

AORN guidelines also mandated that the researcher discuss data analysis, limitations, ethical considerations, and documentation of IRB approval (see table Appendix G for Guidelines for the use of AORN's Membership Database). Upon providing the above mentioned information to the AORN research committee, the research committee met and approved the use of the database (see Appendix H for AORN approval letter to conduct research using their member database). Chi-square testing was conducted on the yes-no questions. ANOVA was to be used for hypothesis one, however, the data showed an overwhelming response to one answer, therefore that hypothesis was not tested and no inferential statistics were run. Multiple regression analysis was conducted with four independent variables. Assuming medium effect sizes and following Cohen's (1988) formula for power analysis, a sample size of 325 was targeted. The historical response rate for members of AORN via an electronic survey is 10%; therefore the researcher asked and received permission to sample 3250 members. Members were sent an invitation to participate in the survey via email along with a link containing the survey.

Invitations to participate, along with the survey link which included an electronic consent form, were sent out electronically on March 3, 2014. Follow up email reminders were sent on March 10, 2014 and March 17, 2014. The total response rate was at 397 on March 18, 2014. Participants who agreed to the study were instructed to sign an electronic consent form. After achieving an N of 397 the study was closed that afternoon. After a review of surveys, casewise deletion was used to eliminate partially filled out surveys. The final total N was set at 341.

Participant Demographic Data

Participants were members of AORN who had at one time practiced perioperative nursing. The majority of participants were female (96%) with male participation at 4%. It was reported that 78% of the participants worked in an acute care hospital while 22% stated that they do not. The largest group to participate in this study was within the age ranges of 51-65 years old (81%). The second largest group to participate in this study was in the over 66 years old category (11%). The 36-50 year olds comprised the smallest range of participants (8%). No nurse under the age of 35 participated in the study. Basic programs of nursing education were completed between 1950-1959 (1%), 1960-1969 (9%), 1970-1979 (46%) and 1980-1989 (40%). A small segment was comprised of nurses who completed their nursing education between 1990-1999 (2%). An even smaller percentage (0.29%) completed their nursing education between 2000 and the present. The highest level of participant education was the Bachelor's Degree (45%). The second highest level of education was the Master's Degree (25%). Similar to Associate's Degree nurses (13%) participating, the number of Diploma nurses was at 14%. Participants also held doctoral degrees (2%).

White/Caucasian nurses were the largest comprising ethnic sample (92%). Black or African American participants were reported as 1% while Asian nurses comprised 2% of the respondents. Hispanic or Mexican nurse participation stood at 1% while American Indian nurse participants comprised 0.29% of the survey population as did Hawaiian and Pacific Islander nurse participants. The rest of the participants stated *other* (0.59%) or checked off the option that allowed the participant not to answer (2%).

The majority of subjects were married or partnered (70%). Widowed, divorced or separated participants made up 22% of the respondents while the never married participants were reported at 8%. Respondent majority also have no dependents living at home (72%) while 24% stated that they have other adults living at their home. Children living at home between the ages of 6-18 years old comprised 9% of participants while a small minority (0.59%) had children under the ages of 6 living with them. The majority of participants worked over 40 hours a week (49%) while the second highest group worked between 33-40 hours a week (31%). Part time nurses working between 25-32 hours made up 8% of participants while 6% comprised participants who worked between 17-24 hours. Another small percentage of participants (6%) worked between 8-16 hours a week. Of these reported hours 47% of participants stated that none of these hours were unscheduled overtime hours. Participants reported that they worked 0-5 hours of unscheduled overtime (31%) while the participants working 6-10 hours of unscheduled overtime were reported at 15%. Participants working 11-20 hours of unscheduled overtime comprised 6% of the survey population while only 2% of participants reported working more than 20 hours of unscheduled overtime.

Annual individual salary for participants varied. The majority of participants earned over $100,000 a year (35%) while the second highest pay for participants was between $61,000-80,000 a year (23%). Participants earning $41,000-60,000 a year comprised 13% while those earning between $20,000-40,000 a year comprise 8%. Overall estimation of gross annual household income was reported as over $150,000 a year (34%), $101,000-150,000 a year participants comprised 29%. Combined household earnings for participants ranging between $76,000-100,000 a year was 22%. Households

included in this study earning $51,000-75,000 a year were at 11%. Participant households earning between $30,000-50,000 annually were the smallest majority at 3%. (See table 2 for demographic data).

Table 2*: Demographic Data*

Variable	N	%
Gender		
Female	**317**	**96**
Male	**19**	**4**
Age Range		
Under 35	**0**	**0**
36-50	**27**	**8**
51-65	**275**	**81**
Over 65	**39**	**11**
Highest Level of Education		
Diploma	**47**	**14**
Associate's Degree	**45**	**13**
Bachelor's Degree	**154**	**45**
Master's Degree	**86**	**25**
Doctorate	**8**	**2**
Race/Ethnicity		
White/Caucasian	**313**	**92**
Black/African American	**3**	**1**
Asian	**8**	**2**
Hispanic	**4**	**1**
American Indian	**1**	**.29**
Pacific Islander	**1**	**.29**
Other	**2**	**.59**
Prefer not to answer	**8**	**2**

When asked if they were satisfied with their current positions, 35% of nurses strongly agreed while 53% of nurses agreed. The remaining disagreed (9%) or strongly disagreed (4%). The majority of participants reported being satisfied with their nursing career (95% strongly agree or agree) while the remaining 5% disagree or strongly disagree. Participants reported that their facility was seeking Magnet recognition (45%) while 55% reported that their facility was not seeking Magnet recognition. Of the participants surveyed, 89% hold specialty certifications. Of the participants surveyed 83% were not represented by a union in the workplace while 17% were. (See table 3 for data on descriptive statistics).

Table 3: *Descriptive Statistics*

Variable	N	%
Current position satisfaction		
Strongly Agree	**117**	**35**
Agree	**179**	**53**
Disagree	**30**	**9**
Strongly Disagree	**12**	**4**
Overall Career Satisfaction		
Strongly Agree	**185**	**55**
Agree	**136**	**40**
Disagree	**14**	**4**
Strongly Disagree	**3**	**1**
Is your facility:		
Seeking Magnet recognition		
Yes	**153**	**45**
No	**185**	**55**
Unionized		
Yes	**58**	**17**
No	**281**	**83**

Method of Analysis

Survey was analyzed with SPSS version 20.0. Variables were coded and question four, the reporting of wrongdoing, was used as the criterion variable. Chi-square analysis was used for yes-no questions which related to hypotheses two, three, and four. Pearson chi-square tests allowed the researcher to measure yes-no questions containing only two measured variables (Babbie, 2010). The method of chi-square testing is based on the null hypothesis which assumes that a relationship does not exist between two variables. ANOVA analyzes cases that are being studied by combining them into groups that represent an independent variable. This analysis was to be used for hypothesis one, however, after reviewing the survey the overwhelming number of participants responded one way; therefore, the decision to analyze hypothesis one with the use of ANOVA or any type of inferential statistics was terminated. Relationships were assessed regarding management support, witnessing of retaliation, experiencing retaliation, and understanding of the reporting process. Multiple regression analysis (MRA) was used to analyze hypothesis five which assumed significant relationships amongst all factors studied. MRA was also used to test significant correlations amongst all of the factors being measured. It was used to determine impact of two or more of the variables on a single dependent variable. In this study, the dependent variable is the reporting of wrongdoing to healthcare leadership (See Appendix I for full survey results).

Analysis Using Inferential Statistics

Hypothesis 1. Upon data analysis of the survey review, it was discovered that less than one percent of participants were unfamiliar with the reporting event. It was decided that due to the overwhelming responses stating that participants were aware of

the mechanisms of reporting wrongdoing, an analysis would not be run on this hypothesis. Survey question 24, which asks if participants know how to report an unsafe condition, was compared to question 4 through 13 of the survey. These questions dealt with issues concerning the reporting of peers, managers, and physicians to various regulating bodies. These bodies included managers, state boards of nursing, medical directors, and the state board of directors. Of the participants surveyed, 88% reported that they had reported unsafe conditions to people they felt would be able to correct the situation. When asked to state to whom they would report the situation, the majority of participants would report these unsafe conditions to their nurse managers or nursing supervisors (77%). None of the participants reported unsafe conditions to collective bargaining associations while 11% reported these conditions to the medical director. Reporting to the state board of nursing accounted for 2% of the participants responses while no participant reported to the state board of medical examiners. The choice of other was reported by 10% of participants. When asked if they were aware of a situation that caused harm to a patient that they did not report, 16% stated yes while the majority (84%) stated that they had not. Of those that answered yes, the greatest reason was that they didn't think anything would come of it (36%) followed by concerns of retaliation after making the report (29%). No participant stated that it was none of their concern, while 2% stated they did not have the time as the reason for not reporting wrongdoing. Participants reported other reasons as this was allowed as a checkbox in the survey (25%) although no specific reasons were given. The majority of participants reported that they were involved in the reporting of the actions of a staff nurse to a supervisor (81%) while 19% reported they were not. When it came to reporting actions of nursing supervisors to

higher levels of management within the facility, 44% stated they had while 56% stated they had not. Participants who reported a nurse to the state board of nursing (21%) were outnumbered by those that had not (79%). When questioned regarding the reporting of a physician to their nursing supervisor 85% stated they had while the remaining 15% stated they had not. When asked if they had reported the actions of a physician to their medical director, 54% stated they had, while the remaining 46% stated they had not. The majority of participants (95%) have never reported or been involved in the reporting of actions of a physician to the state board of medical examiners. The remaining 5% state they have.

Hypothesis 2. This data was analyzed using chi-square testing. Questions used to analyze H2 sought to understand if any relationships existed between experiencing retaliation or knowing someone that experienced retaliation after reporting a physician or a nurse and reporting wrongdoing. After reporting a nurse, 16% of participants reported experiencing retaliation while 84% reported that they did not. After reporting the actions of a physician 22% of participants experienced retaliation while 78% reported that they did not. When asked if they had known of a nurse who experienced workplace retaliation after reporting the actions of another nurse, 46% stated they had while 54% stated they had not. Results of the chi-square test indicated no significant association between experiencing retaliation and reporting wrongdoing. The probability was .09. Therefore experiencing retaliation is not statistically significant to reporting wrongdoing, X^2 (1,341) = 2.82, p > .05

Hypothesis 3. This data was analyzed using chi-square testing. Questions sought to understand if significant relationships existed between witnessing retaliation to others and reporting wrongdoing. Survey questions 17 and 18 dealt with witnessing

workplace retaliation after having reported a doctor or a nurse. When asked if they had witnessed nurse colleagues experiencing retaliation after having reported the actions of a supervisor, 32% reported yes while the remaining 68% stated they had not. The majority of nurses (53%) did not know of a nurse who experienced workplace retaliation after reporting a physician while 47% did. Results indicated a significant relationship between witnessing retaliation and reporting wrongdoing, X^2 (1,341) = 11.38, p < .01.

Hypothesis 4. This data was analyzed using Pearson correlation analysis. The main question sought to determine if relationships existed between perception of management support and reporting wrongdoing. This question asked the participant to determine whether they could report wrongdoing without experiencing retaliation. The majority of participants stated that they would be able to report a situation that might harm a patient without experiencing workplace retaliation (87%) while the remaining 13% stated they could not. Results of the testing indicated a significant relationship between feeling supported by management and reporting wrongdoing, r (341) = .112, p < .05

Hypothesis 5. This final hypothesis sought to discover if any significant relationships existed amongst all of the independent variables being measured and the dependent variable of reporting wrongdoing. Question 4 which asked if the participant had ever reported an unsafe patient care condition to people that they felt would be able to correct the situation was compared to questions 22 through 32 of the survey. These questions dealt with management support, knowledge of reporting wrongdoing, and personal as well as observed retaliation. The majority of nurse participants (32%) strongly agreed or agreed (51%) that their facility was supportive of nurses with the

remaining stating they disagreed (14%) or strongly disagreed (2%) with that statement. Participants stating the facility they work at encourages them to report wrongdoing was measured at 53% strongly agreeing with or 40% agreeing with that statement, while the remaining participants disagreed (7%) or strongly disagreed (0.59%). When asked if they would be able to report the actions of another nurse to administration without fear of retaliation the majority strongly agreed (45%) or agreed (42%) with that statement while the minority disagreed (11%) or strongly disagreed (2%). The majority reported that they could report the actions of another nurse to the state board of nursing without experiencing retaliation (34% strongly agree) while 53% agree. Some participants, however, disagreed (13%) or strongly disagreed (1%) with that statement. The majority of participants reported being able to report the actions of a nursing supervisor without experiencing retaliation (28% strongly agreed, while 44% agreed). The remaining participants disagreed (23%) or strongly disagreed (5%). Nurses felt they could report a physician to their supervisor (33% strongly agree and 47% agree) without experiencing retaliation while the same held true for reporting a physician to the medical director (28% strongly agree, 49% agree). When asked if they would experience retaliation by reporting the actions of a physician to the state board of medical examiners the majority of participants agreed (51%) or strongly agreed (19%) while the remaining either disagreed (25%) or strongly disagreed (5%). When asked if they ever witnessed retaliation of a fellow nurse after they reported wrongdoing, 11% of nurses strongly agreed and 32% of nurses agreed they had witnessed such an event. The majority of nurses reported that they could report wrongdoing without experiencing retaliation (33% strongly agree while 50% agree). The remaining disagree (16%) or strongly disagree

(2%). Multiple regression analysis revealed significant relationships between the predictors and the criterion variable, $R^2 = .062$, $F\ (10,298) = 1.95$, $p < .05$. (See table 4 for Regression Descriptives).

Table 4: *Regression Descriptives*

Variable	Mean	Std. Deviation
WRW	.91	.29
SBM	16.57	5.43
WR	.41	.49
ER	.08	.27

WRW- Willingness to report wrongdoing. SBM- Supported by management. WR- Witnessing retaliation. ER- Experiencing retaliation.

Summary

This chapter presented the data collected during this quantitative study on the factors that promote and factors that hinder nurses' willingness to report wrongdoing to healthcare leadership. The data was collected utilizing the Registered Nurses' Workplace Support for Patient Advocacy Activities Questionnaire developed and tested by Dr. Lisa Black (2011). Study participants were sent invitations via email through AORN. The use of the AORN database was requested by the researcher and protocol for use of the database was followed with final approval for use given to the researcher in March of 2014. Data was analyzed using inferential statistics. Chi-square testing, Pearson correlation analysis, and Multiple Regression Analysis (MRA) were used to determine if

significant relationships exist amongst variables related to the factors that influence, promote, or hinder nurses' willingness to report wrongdoing to healthcare leadership.

Hypothesis one stating that a significant relationship exists between knowledge of reporting wrongdoing and reporting wrongdoing was not run through statistical testing due to the overwhelming number of participants stating they understood the process of reporting wrongdoing. Hypothesis two was rejected as no significant relationships were found between experiencing retaliation and reporting wrongdoing. Hypothesis three, which sought to determine if a significant relationship existed between witnessing retaliation and reporting wrongdoing, was found to be significant as it was measured at $p<.01$. Hypothesis four, which associated feeling supported by management to being able to report wrongdoing, was accepted with a $p<.05$. The final hypothesis, which used multiple regression analysis, was also accepted and found to be significant. The analysis of data presented showed significant relationships amongst all independent variables tested against the criterion variable of reporting wrongdoing. Independent variables measured were the knowledge of reporting wrongdoing and management support. Independent variables also measured were experiencing retaliation after reporting wrongdoing or witnessing a colleague being retaliated against after reporting wrongdoing. This study has shown that significant relationships exist amongst variables associated with nurses' willingness to report wrongdoing to healthcare leadership.

The next chapter will summarize this quantitative study in its entirety. It will review the relationships that exist amongst the variables studied and seek to understand their implications for healthcare leadership. The next chapter will also make recommendations for future studies.

Chapter 5: Summary and Conclusions

The purpose of the study conducted in this dissertation was to determine if significant relationships existed amongst variables that both promote or hinder nurses' willingness to report wrongdoing. The review of literature showed that nurses are unwilling to report wrongdoing due to fear of retaliation from healthcare leadership. Themes discussed in the review of literature were poor ethical climates, moral distress, unethical leadership, and team dysfunction. The literature review also presented much research on nursing and patient advocacy using the qualitative approach. The need for empirical data in healthcare leadership research was discussed in the literature review and as such supported the decision to conduct this research quantitatively (Black, 2011).

The study used a close ended survey which contained 45 questions related to nursing and patient advocacy. The survey was sent to members of the Association of Perioperative Registered Nurses (AORN) who were required to participate after signing an electronic consent form. Data was collected via an electronic survey and sent back to the researcher via the SurveyMonkey web development cloud. There were 379 participants in the survey; however, after casewise deletion the final number of participants totaled 341. SPSS 20.0 version software was then used to analyze the data. Inferences regarding relationships of the variables were made using chi-square testing and Multiple Regression Analysis. The criterion variable studied was the dependent variable of reporting wrongdoing. The data analysis supported the hypothesis that significant relationships exist amongst the independent variables measured.

Conclusions

The first hypothesis predicting that there would be a significant relationship between knowledge of the reporting process and reporting wrongdoing was not run through analysis. The data showed that an overwhelming number of participants were familiar with the reporting process as only two participants stated they were not aware. The literature shows that healthcare organizations spend millions of dollars annually on safety training and the development of tools and checklists. Although the hypothesis was rejected it is pertinent information. When analyzed with the other hypotheses this information shows that, although nurses are well versed on the how of reporting wrongdoing, many still do not due to fear of retaliation and lack of management support.

The second hypothesis theorized that experiencing retaliation is significantly related to reporting wrongdoing. This hypothesis was not significant; however it did approach significance as the probability was at .09. This data shows that although it was not accepted statistically, 18% of nurses did not report wrongdoing of another nurse for fear that they would experience retaliation. The number goes up when the nurse reports a nursing supervisor and the number escalates even higher when reporting a physician. This analysis shows that nurses fear retaliation when reporting their colleagues and the fear escalates when reporting people in higher positions of authority.

Hypothesis three presented the theory that witnessing retaliation to others is significantly related to reporting wrongdoing. This hypothesis was accepted as the data showed significance with $p<.01$. The findings in this hypothesis supported much of the ongoing concerns found in the review of healthcare leadership literature. If retaliation is

an issue in healthcare, the concern for poor ethical climates, moral distress, unethical leadership, and dysfunctional teams will continue to plague healthcare organizations.

Hypothesis four theorized that feeling supported by management was significantly related to reporting wrongdoing. This hypothesis yielded significant results and was accepted. There continues to be strong evidence in the literature which shows that management support is critical in developing trust and open communication. The literature continued to show that nurses struggle with reporting wrongdoing and as such this study has supported that notion using empirical data.

The final hypothesis sought to test significance amongst all independent variables being tested. The results after analysis were significant as knowledge of the reporting process, witnessing and experiencing retaliation, and management support were all significantly related as predictors for reporting wrongdoing.

The results of this study supported the literature review regarding the need for healthcare organizations to support their nurses and educate their management and leadership on the need for open communication. The review of literature in Chapter 2 also provided studies demonstrating that the majority of nurses will not come forward and report misconduct on the part of administration or the medical staff due to fear of retaliation (Peters et al.., 2011). This study was also able to provide empirical data necessary for healthcare organizations to measure the variables necessary for change. Nurses in this study overwhelmingly stated that they knew the how of reporting wrongdoing, yet fear and the lack of confidence on the part of management to do anything about it may have prevented many of them from doing so. The implications of having nurses' fear reporting wrongdoing are paramount. As patient advocates they are

the front line for patient safety. As healthcare systems become more complex, it is imperative that healthcare organizations have leadership that is responsive and sensitive to the fears and needs of their employees. There needs to be frameworks and models in place to not only help nurses understand how to report wrongdoing, which this study shows they already know how to do, but to have management support when they do so. The literature demonstrates that the cultures of silence, as well as the horizontal violence experienced in nursing, must be eradicated with strong and emotionally intelligent healthcare leadership.

This data adds to the body of leadership knowledge by helping organizations understand their roles in the promotion of patient advocacy as well as in promoting ethical organizational cultures. It also adds to the body of healthcare management by describing if significant relationships exist amongst management support, retaliation, and the predictors for reporting wrongdoing. This quantitative study provides healthcare organizations with solid data to continually assess the needs of their organization through their performance measurements. This data can also be used to develop future focused research on patient advocacy and healthcare leadership.

Limitations

Although empirical studies are necessary for organizations to measure their performances, the concepts of retaliation and management support may have been limited with the use of a survey. This survey did not allow the participants to specify which type of retaliation they experienced or witnessed. The survey also did not allow the participant to conceptualize their own definitions of retaliation and management support.

The survey did not allow the participant to type in any specific data under the answers that stated *other*. For example, question seven asked the participant to check off the reason why they did not report wrongdoing after witnessing it. The choices given were related to time constraints, knowledge, fear of retaliation, and feelings that management would not do anything about it. There was an additional choice to that question stated as *other*. Other was chosen by 25% of respondents as the reason they did not report wrongdoing. As the survey did not allow for nurse participants to write in answers, this potentially relevant information was lost.

Another potential limitation was the use of nurses that practiced only perioperative nursing. Studies have shown that nurses in the operating room have to deal with difficult surgeons. These types of physicians may not be as collaborative with their teams as other specialty physicians (Gardezi et al., 2009). The cultures of fear and silence are reported to be very prevalent in the area of surgery and as such this study is limited to that specialty area.

The final limitation to this study was the demographic data of participants. An overwhelming majority of participants were Caucasian females between 51-65 years of age (81%). This narrow demographic may not allow for generalizability for the large, multigenerational, and multicultural nursing profession.

Implications for Future Research

This data presented several implications for future research. Data presented shows a great need for healthcare leadership to support their nurses in reporting wrongdoing; due to these findings, future research needs to address leadership emotional intelligence and retaliation in healthcare. There may be an apparent lack of moral

understanding and compassion amongst healthcare leaders which must be addressed as well. Researchers should develop and operationalize definitions regarding management support, ethical climates, and moral distress to further quantify future studies.

This study can be replicated to include varied generations as well as cultures in order to gain more statistical insight into the factors that may influence nurses' willingness to report wrongdoing to healthcare leadership. Future research should include studying different specialty areas in nursing as well as studying other healthcare personnel. Although the purpose of this quantitative study was to provide empirical data, a small focus group after data analysis would provide greater insight into these issues and mixed methods studies that complement quantitative data with rich descriptions that conceptualize retaliation through participants' personal experiences.

As healthcare becomes more complex the need to understand the methods of supporting healthcare staff is critical. This study has shown that nurses understand the ways in which to report wrongdoing; however, the perceived lack of management support and fear of retaliation have created environments of fear and apathy that may be perpetuating a culture of silence. By understanding these issues, researchers can relay this message and educate healthcare leadership on becoming proactive in supporting their nurses. This data may also be used to support education on emotional intelligence and communication within healthcare organizations.

Patients are most vulnerable when they are sick. Having nurses feel supported in reporting wrongdoing allows the nurse to be the voice for the patient and as such continues to support an ethical and safe environment. As healthcare leaders are poised to enter this new era, this research will arm them with strategies they may use to support

their nursing staff as well as keep the lines of communication open in order to maintain safe environments and continue to allow their staff to advocate for patients.

References

Aiken, L., Clarke, S., Sloan, D., Sochalski, J., & Silber, J. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *The Journal of the American Medical Association*, *288*(16), 1987-1993.

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements.* Retrieved from http://www.nursingworld.org/ethics/code/protected_nwcoe303.html

Attree, M. (2007). Factors influencing nurses' decisions to raise concerns about care quality. *Journal of Nursing Management*, *15*(4), 392-402.

Babbie, E. (2010). *The practice of social research* (12th ed.). Belmont, CA: Wadsworth.

Black, L. M. (2011). Tragedy into policy: A quantitative study of nurses' attitudes toward patient advocacy activities. *The American Journal of Nursing*, *111*(6), 26-35.

Burke, W. (2011). *Organizational change theory and practice* (3rd ed.). Thousand Oaks, CA: Sage.

By, R. T., Burnes, B., & Oswick, C. (2012). Change management: Leadership, values and ethics. *Journal of Change Management*, *12*(1), 1-5.

Caldwell, C., Hayes, L. A., & Long, D. T. (2010). Leadership, trustworthiness, and ethical stewardship. *Journal of Business Ethics*, *96*, 497-512.

Celik, Y., & Celik, S. S. (2007). Sexual harassment against nurses in Turkey. *Journal of Nursing Scholarship*, *39*(2), 200-206.

Chiang, H., & Pepper, G. A. (2006). Barriers to nurses' reporting of medication errors in Taiwan. *Journal of Nursing Scholarship*, *38*(4), 392-399.

Cohen, J. (1988). *Applied multiple regression/correlation analysis for the behavioral sciences* (2nd ed.). New York, NY: Lawrence Erlbaum Associates.

Coursey, J. H., Rodriguez, R. E., Dieckmann, L. S., & Austin, P. N. (2013). Successful implementation of policies addressing lateral violence. *AORN Journal*, *97*(1), 101-109.

Creswell, J. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Davis, A. J., & Konishi, E. (2007). Whistleblowing in Japan. *Nursing Ethics*, *14*(2), 194-202.

Dodds, A., & Kodate, N. (2011). Accountability, organisational learning and risks to patient safety in England: Conflict or compromise? *Health, Risk and Society*, *13*(4), 327-346.

Fairchild, R. M. (2010). Practical ethical theory for nurses responding to complexity in care. *Nursing Ethics*, *17*(3), 353-362.

Flinkman, M., Leino-Kilpi, H., & Salantera, S. (2010). Nurses' intention to leave the profession: Integrative review. *Journal of Advanced Nursing*, *66*(7), 1422-1434.

Gallagher, A. (2010). Moral distress and moral courage in everyday nursing practice. *Online Journal of Issues in Nursing*, *16*(2). http://dx.doi.org/10.3912/OJIN.Vol16No02PPT03

Gardezi, F., Lingard, L., Espin, S., Whyte, S., Orser, B., & Baker, G. R. (2009). Silence, power and communication in the operating room. *Journal of Advanced Nursing*, *65*(7), 1390-1399.

Garon, M. (2011). Speaking up, being heard: Registered nurses' perceptions of workplace communication. *Journal of Nursing Management*, *20*(3), 361-371.

Gaudine, A., Lamb, M., LeFort, S. M., & Thorne, L. (2011a). Barriers and facilitators to consulting hospital clinical ethics committees. *Nursing Ethics*, *18*(6), 767-780.

Gaudine, A., LeFort, S., Lamb, M., & Thorne, L. (2011b). Ethical conflicts with hospitals: The perspective of nurses and physicians. *Nursing Ethics*, *18*, 756-766.

Goettler, C. E., Butler, T. S., Shackleford, P., & Rotondo, M. (2009, October). *Physician behavior: Not ready for 'never' land*. Paper presented at the American College of Surgeons Clinical Congress, Chicago, IL.

Gorini, A., Miglioretti, M., & Pravettoni, G. (2012). A new perspective on blame culture: An experimental study. *Journal of Evaluation in Clinical Practice*, *18*, 671-675.

Hannigan, N. (2006). Blowing the whistle in healthcare fraud: Should I? *Journal of the American Academy of Nurse Practitioners*, *18*, 512-517.

Hart, S. E. (2005). Hospital ethical climates and Registered Nurses' turnover intentions. *Journal of Nursing Scholarship*, *37*(12), 173-177.

Hoffman, W. M., Neill, J. D., & Stovall, O. S. (2008). An investigation of ethics officer independence. *Journal of Business Ethics*, *78*, 87-95.

Huston, C. (2008). Preparing nurse leaders for 2020. *Journal of Nursing Management*, *16*(8), 905-911.

Jackson, D., Perkins, K., Andrew, S., Edenborough, M., Halcomb, E., Luck, L.,...Wilkes, L. (2010a). Trial and retribution: A qualitative study of whistleblowing and workplace relationships in nursing. *Contemporary Nurse*, *36*(1-2), 34-44.

Jackson, D., Peters, K., Andrew, S., Edenborough, M., Halcomb, E., Luck, L.,...Wilkes, L. (2010b). Understanding whistleblowing: Qualitative insights from nurse whistleblowers. *Journal of Advanced Nursing*, *66*(10), 2194-2201.

Jumaa, M. O. (2008). The "F.E.E.L." good factors in nursing leadership at board level through work-based learning. *Journal of Nursing Management*, *16* (8), 992-999.

Kane-Urrabazo, C. (2006). Management's role in shaping organizational culture. *Journal of Nursing Management*, *14*(3), 188-194.

Kayoko, O., Yumiko, H., Atsushi, A., & Shinji, K. (2008). The process of whistleblowing in a Japanese psychiatric hospital. *Nursing Ethics*, *15*(5), 631-642.

Keil, M., Tiwana, A., Sainsbury, R., & Sneha, S. (2010). Toward a theory of whistleblowing intentions: A benefit-to-cost differential perspective. *Decisions Sciences Journal*, *41*(4), 787-812.

Kellerman, B. (2010). Making meaning of being bad. In G. R. Hickman (Ed.), *Leading organizations: Perspectives for a new era* (2nd ed., pp. 391-401). Thousand Oaks, CA: Sage.

Lee, H., Spiers, J., Yurtseven, O., Cummings, G., Sharlow, J., Bhatti, A., & Germann, P. (2010). Impact of leadership development on emotional health in healthcare managers. *Journal of Nursing Management*, *18*(8), 1027-1039.

Lencioni, P. (2002). *The five dysfunctions of a team: A leadership fable*. New York, NY: Free Press.

Lucas, V., Spence Laschinger, H. K., & Wong, C. A. (2008). The impact of emotional intelligent leadership on staff nurse empowerment: The moderating effect of span of control. *Journal of Nursing Management*, *16*, 964-973.

Lutzen, K., Blom, T., Ewalds-Kvist, B., & Winch, S. (2010). Moral distress, moral climate and moral sensitivity among psychiatric professionals. *Nursing Ethics*, *17*(2), 213-224.

MacKusick, C., & Minick, P. (2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *MEDSURG Nursing*, *19*(6), 335-340.

Mansbach, A., & Bachner, Y. (2010). Internal and external whistleblowing: Nurses' willingness to report wrongdoing. *Nursing Ethics*, *17*(4), 483-490.

McCloughen, A., O'Brien, L., & Jackson, D. (2009). Esteemed connection: Creating a mentoring relationship for nurse leadership. *Nursing Inquiry*, *16*(4), 326-336.

McDonald, S., & Ahern, K. (2000). The professional consequences of whistleblowing by nurses. *Journal of Professional Nursing*, *16*(6), 313-321.

McKenna, B., Smith, N., Poole, S., & Coverdale, J. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing*, *42*(1), 90-96.

Milgram, S. (1983). *Obedience to authority: An experimental view* (2nd ed.). New York, NY: Harper & Row.

Moore, L., & McAuliffe, E. (2010). Is inadequate response to whistleblowing perpetuating a culture of silence in hospitals? *Clinical Governance*, *15*(3), 166-178.

Morrison, J. (2008). The relationship between emotional intelligence competencies and preferred conflict-handling styles. *Journal of Nursing Management*, *16*(8) 974-983.

Moumtzoglou, A. (2010). Factors impeding nurses from reporting adverse events. *Journal of Nursing Management*, *18*, 542-547.

Ohnishi, K., Hayama, Y., Asai, A., & Kosugi, S. (2008). The process of whistleblowing in a Japanese psychiatric hospital. *Nursing Ethics*, *15*(5), 631-642.

Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perception of moral distress and ethical climate. *Nursing Ethics*, *16*(5), 561-573.

Peters, K., Hutchinson, M., Wilkes, L., & Jackson, D. (2011). The emotional sequelae of whistleblowing: Findings from a qualitative study. *Journal of Clinical Nursing*, *20*(19-20), 2907-2914.

Purpora, C., & Blegen, M. A. (2012). Horizontal violence and the quality and safety of patient care: A conceptual model. *Nursing Research and Practice*, *2012*, 1-6. http://dx.doi.org/10.1155/2012/306948

Ray, S. (2006). Whistleblowing and organizational ethics. *Nursing Ethics*, *13*(4), 438-445.

Reicher, S., & Haslam, S. A. (2011). After shock? Towards a social identity explanation of the Milgram "obedience" studies. *The British Psychological Society*, *50*, 163-169.

Roberts, S. J., DeMarco, R., & Griffin, M. (2009). The effect of oppressed group behaviours on the culture of the nursing workplace: A review of the evidence and interventions for change. *Journal of Nursing Management*, *17*(3), 288-293.

Schein, E. H. (1985). *Organizational Culture and Leadership*. San Francisco, CA: Jossey-Bass.

Senge, P. M. (2006). *The fifth discipline: The art and practice of the learning organization*. New York, NY: Doubleday.

Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing*, *12*(3), 399-403.

Siu, N., & Lam, K. (2009). A comparative study of ethical perceptions of managers and non-managers. *Journal of Business Ethics*, *88*, 167-183.

Sorta-Bilajac, I., Bazdaric, K., Zagrovic, M., Jancic, E., Brozovic, B., Cengic, T.,...Agich, G. (2011). How nurses and physicians face ethical dilemmas-the Croatian experience. *Nursing Ethics*, *18*(3), 341-355.

Suhonen, R., Stolt, M., Virtanen, H., & Leino-Kilpi, H. (2011). Organizational ethics: A literature review. *Nursing Ethics*, *18*(3), 285-303.

Taylor, E. Z., & Curtis, M. (2010). An examination of the layers of workplace influences in ethical judgments: Whistleblowing likelihood and perseverance in public accounting. *Journal of Business Ethics*, *93*, 21-37.

Ulrich, C., Taylor, C., Soeken, K., O'Donnell, P., & Farrar, A. (2010). Everyday ethics: Ethical issues and stress in nursing practice. *Journal of Advanced Nursing*, *66*(11), 2510-2519.

Verhezen, P. (2010). Giving voice in a culture of silence. From a culture of compliance to a culture of integrity. *Journal of Business Ethics*, *96*(2), 187-206.

Yukl, G. (2009). *Leadership in organizations* (7th ed.). New York, NY: Prentice Hall.

Zuzelo, P. R. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, *14*(3), 344-359.

Appendix A: AORN Email Invite

To ensure receipt of our emails, please addaorn@informz.net to your address book.

AORN

Dear AORN Member,

You have been invited to participate in a study due to your status as an AORN member. I am also an AORN member and doctoral candidate at The Chicago School of Professional Psychology. I am asking for your help in conducting a research study for my dissertation in Organizational Leadership.

The purpose of this study is to assist healthcare leadership in empirically analyzing the factors that promote and hinder nurses' willingness to report wrongdoing.

You will be asked to complete a closed ended survey consisting of 45 questions which include questions on reporting wrongdoing as well as demographic data. Questions will ask you to recall incidences in which you or a colleague may have witnessed wrongdoing and ask about specific mechanisms you may have used to report such events. The questionnaire should not take more than 15 minutes to complete.

Participation is voluntary and you may withdraw from participation at any time. If you have any questions or concerns regarding the study, please contact me atreemazhari@gmail.com to receive further details.

Thank you in advance for your scholarly contribution to the profession of nursing and healthcare leadership.

Take the survey now!

Sincerely,
Reem Azhari RN MS Ph.D. Candidate
The Chicago School of Professional Psychology

Appendix B: E Consent and E Survey

1. The purpose of this research project is to study the factors that influence nurses' willingness to report wrongdoing. This is a research project being conducted by Reem Azhari RN, Ph.D. candidate at The Chicago School of Professional Psychology.

You are invited to participate in this research project because you are a member of the Association of PeriOperative Registered Nurses. Your participation in this research study is voluntary. You may choose not to participate. If you decide to participate in this research survey, you may withdraw at any time. If you decide not to participate in this study or if you withdraw from participating at any time, you will not be penalized.

The procedure involves filling an online survey that will take approximately 15 minutes. Your responses will be confidential and we do not collect identifying information such as your name, email address or IP address. The survey questions will be about patient advocacy and factors that promote or hinder nurses' willingness to report wrongdoing to healthcare leadership.

Emotional distress may occur from having to recall wrongdoing in the workplace. This will be minimized by allowing participants to skip questions that may make them feel uncomfortable as well as allowing participants to discontinue the survey at any time. Breach of confidentiality may pose a potential risk however, this will be minimized by the use of an encrypted data base. AORN will also not release the names of the members and as such, anonymity will be maintained.

The results of this study will assist healthcare leadership in supporting nursing and their quest for patient advocacy. This in turn will serve to protect patients by providing interventions in any care that is perceived to be unethical. This study will also

contribute to nursing scholarship on patient advocacy as well as healthcare leadership. Nurses who participate in the study may also increase their personal knowledge base on nursing

and factors that promote and hinder their willingness to report unethical behavior.

We will do our best to keep your information confidential. All data is stored in a password protected electronic format. To help protect your confidentiality, the surveys will not contain information that will personally identify you. The results of this study will be used for scholarly purposes only and may be shared with The Chicago School of Professional Psychology representatives. All information will be destroyed after a minimum of 5 years as per APA guidelines.

If you have any questions about the research study, please email Reem Azhari at reemazhari@gmail.com. You may also contact the chairperson of the study Dr. Brandy Blount who can be reached at bblount@thechicagoschool.edu. This research has been reviewed according to The Chicago School of Professional Psychology IRB procedures for research involving human subjects.

ELECTRONIC CONSENT: Please select your choice below.
Clicking on the "agree" button below indicates that:

- **you have ready the above information**
- **you voluntarily agree to participate**
- **you are at least 18 years of age**

If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

AGREE

DISAGREE

2. Are you currently working in a position that requires a RN license?

YES

NO

3. In your primary nursing position, do you work in an acute care hospital?

YES

NO

4. Have you ever reported an unsafe patient care condition to people you felt would be able to correct the situation? If no, skip question 5.

YES

NO

5. If yes, who did you report that situation to?

a. Nurse manager/Nursing supervisor

b. Collective bargaining organization

c. Medical Director

d. State Board of Nursing

e. State Board of Medical Examiners

f. Other _____

6. Have you ever been aware of a situation that could cause harm to a patient that you did not report? If no, skip question 7.

YES
NO

7. If yes, please choose the most important reason that you did not report this concern (choose only one)?

a. I did not have the time
b. It was none of my concern

c. I didn't think anything would come of the report

d. I didn't know how or to whom to report the situation

e. I was concerned about experiencing retaliation for having made a report

f. Other _____

8. Have you ever reported or been involved in the reporting of the actions of a staff nurse to a nursing supervisor?

YES
NO

9. Have you ever reported or been involved in the actions of a nursing supervisor to a higher level of management within your facility?

YES
NO

10. Have you ever reported or been involved in the reporting of a nurse to the State Board of Nursing?
YES
NO

11. Have you ever reported or been involved in the reporting of the actions of a physician to your nursing supervisor?
YES
NO

12. Have you ever reported or been involved in the reporting of the actions of a physician to the medical director of your facility?
YES
NO

13. Have you ever reported or been involved in the reporting of the actions of a physician to the State Board of Medical Examiners?
YES
NO

14. If you have reported the actions of a nurse, did you experience retaliation for having done so? If you have not reported any nurse please skip this question.
YES
NO

15. If you have reported the actions of a physician, did you experience retaliation for having done so? If you have not reported the actions of a physician, please skip this question.
YES
NO

16. Do you know of a nurse who has experienced workplace retaliation after having reported the actions of another staff nurse?
YES
NO

17. Do you know of a nurse who has experienced workplace retaliation after having reported the actions of a nursing supervisor?

YES

NO

18. Do you know of a nurse who has experienced workplace retaliation after having reported the actions of a physician?

YES

NO

19. If you were to be aware of a situation that might harm a patient, could you report that situation without experiencing workplace retaliation?

YES
NO

20. Are you represented by a labor union in your nursing workplace?

YES
NO

21. Is the facility in which you work seeking recognition as a magnet facility?

YES
NO

22. The facility in which I work is supportive of nurses

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

23. The facility in which I work encourages nurses to report conditions that might cause harm to patients

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

24. I know how to report an unsafe patient care situation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

25. I could report the actions of another nurse to my facility's administration without fear of retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

26. I could report the actions of another nurse to the State Board of Nursing without experiencing workplace retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

27. I could report the actions of my nursing supervisor without experiencing workplace retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

28. I could report the actions of a physician to my nursing supervisor without experiencing workplaceretaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

29. I could report the actions of a physician to the medical director of my facility without experiencing workplace retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

30. I could report the actions of a physician to the State Board of Medical Examiners without experiencing workplace retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

31. I personally know or I know of a nurse who has been retaliated against for reporting a nurse

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

32. I could report a nurse staffing concern without experiencing workplace retaliation

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

33. I am satisfied with my current nursing position

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

34. I am satisfied with nursing as a career

STRONGLY AGREE

AGREE

DISAGREE

STRONGLY DISAGREE

35. How old are you?

18-25 years old

25- 35 years old

36-50 years old

51-65 years old

Over 66 years old

36. In what year did you complete your basic program of nursing education?

1950-1959

1980-1989

1960-1969

1990-1999

1970-1979

2000-PRESENT

37. What is your highest level of nursing education?

Diploma

Associate Degree

Bachelor's Degree

Master's Degree

Doctorate

38. Do you currently hold a specialty certification?

YES

NO

39. What is your gender?

Male

Female

Prefer not to answer

40. What is your racial/ethnic background?

American Indian

Asian

Black or African American

Hawaiian or Pacific Islander

Hispanic or Mexican

White/Caucasian

Prefer not to answer

Other

41. What is your current marital status?

Now married/partnered

Widowed, divorced, separated

Never Married

42. Describe the dependents in your home * (choose all that apply)

No dependents at home

Children less than 6 yrs old at home

Children 6 – 18 years old at home

Other adults living at home

43. On average, how many hours do you work each week?

8-16 HOURS

17-24 HOURS

25-32 HOURS

33-40 HOURS

OVER 40 HOURS

44. How many of these hours are unscheduled overtime hours?

NONE

0-5 HOURS

6-10 HOURS

11-20 HOURS

OVER 20 HOURS

45. Please estimate your annual gross income from your primary nursing position.

$20-$40K

$41-$60K

$61-$80K

$81-$100K

Over $100K

46. Please estimate your current gross annual household income

$30-$50K

$51-$75K

$76-$100K

$101-$150K

Over $150K

Appendix C: IRB Forms

TheChicagoSchool® of Professional Psychology

INSTITUTIONAL REVIEW BOARD

QUESTION & ANSWERS FORM

APPLICATION FOR APPROVAL OF A RESEARCH PROJECT

INVOLVING HUMAN PARTICIPANTS

***When providing information, please type your responses directly below each item*.**

Prior to submitting this file in the IRB Drop box on eGo or via email, please save it using the following file name:
First initial last name-QA
Example: acook-QA.

Failure to follow these directions will result in your application not being reviewed.

Title of Project: A Quantitative Study on the Factors that Promote and Hinder Nurses' Willingness to Report Wrongdoing to Healthcare Leadership

Principal Investigator(s): Reem Azhari

Dissertation/Thesis Chair: Dr. Brandy Blount

Research Personnel
Please describe the status and qualifications of research assistants and their role in the conduct of this study, if applicable:

No research assistants will be utilized in this study.

Collaborators in Outside Institutions:

1. Please list the name of the institution and the contact information for the collaborator(s) at any outside institutions where research procedures will be performed (i.e., recruitment, interaction with the subject, or data collection) and provide letter of IRB approval or a letter of support if applicable for review.

Information will be housed via the SurveyMonkey web cloud. Please see attached letter provided by SurveyMonkey outlining permission to conduct survey research.

All subjects will be invited to participate via a link sent by the researcher to select members of the Association of PeriOperative Registered Nurses (AORN). This invitation will be completed with the assistance of Mr. Brian Tepp, Director of AORN Membership.

Please see attached letter regarding the use of the Association of Perioperative Registered Nurses (AORN) database.

2. Please describe the role of this institution in this study.

   AORN will allow the researcher to use their database to gather research participants. All participants will be registered nurses practicing in the area of perioperative surgery. Study will cover the US as well as all levels of nursing education.

Purpose of the Study:

Please provide 3-4 paragraphs that will summarize the purpose of this study using **non-technical language** and include a statement to describe the research hypothesis or expected trends or findings to be investigated by the proposed research. In addition, please describe the expected starting and ending dates for the project. ***Please do not copy information directly from your dissertation proposal.***

Patients are most vulnerable when sick and under the care of healthcare professionals. As such, it is imperative that quality and ethical care be provided to all patients. The majority of care given to patients is provided by the registered nurse. Nurses act as the liaison to all members of the healthcare team as well as the patient advocate. The purpose of this study is to assist healthcare organizations and their leadership in understanding ways in which they may support nurses in their quest for patient advocacy.

Nurses must trust that they will be supported when they witness and report unethical or poor patient care. Unfortunately the research has shown that nurses fear reporting wrongdoing due to retaliation by supervisors and co-workers. Many do not feel supported by their supervisors or healthcare organization when it comes to reporting wrongdoing. Factors that hinder the reporting of wrongdoing also include the lack of knowledge in the hospital reporting protocol. This study hopes to add to the body of healthcare and organizational leadership in their understanding of ethical leadership and reporting wrongdoing.

This study hopes to gather empirical datasupporting the reasons perioperative nurses do or do not report wrongdoing and the factors that may contribute to them coming forward. The data generated will be published in nursing leadership and management journals as well as presented to healthcare leadership in order to better support nurses in their continued quest for ethical patient care. The expected start date of the study will be December 31, 2013 ending December 31, 2014.

Funding Source:
Please describe the source of funding for the project if applicable.

N/A

Subject Population:

As per 45 CFR 46, human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains:

(1) data through intervention or interaction with the individual, or

(2) identifiable private information (i.e., archival data, documents, or records, etc.)

Please specify the number of subjects (not a range) to be enrolled in this study and their age range. This is the number for which IRB approval will be granted, and any intention to enroll more than this number in the future will require IRB approval prior to enrolling further subjects.
Please note: Individuals who go through the consent process fall under the

protection of the IRB even if they have no further participation in the study. Therefore, when determining the appropriate number of subjects to enroll in your study, please consider the subjects who complete the consent process but may leave the study early and those who may not qualify after the screening procedures are complete. As such it is best to overestimate the number of participants needed to complete the study.

325

Please indicate the age range of the subjects to be enrolled.

all age ranges

Please describe the relevant characteristics (inclusion/exclusion) of the subjects that will be used to determine their eligibility to participate in this study.

Registered Nurses who are members of the Association of Perioperative Registered Nurses (AORN).

Archival/Existing Data:
Archival/Existing data is defined as data that is in existence at the time the study proposal is submitted to the IRB for review. Research using only archival data is considered a retrospective study. **Please complete this section only if archival data will be used (case files, etc.) for your study.**

1. To ensure that only retrospective data will be used, please provide the dates in which the data was originally collected.

   N/A

2. Please provide the name of the database or dataset and describe the information that will be specifically culled from the dataset.

   N/A

3. When the data was originally collected was it labeled in such a manner that the subjects could be identified? **If so, please**

indicated whether or not you will have access to the identifiers or codes that link the subject to the data collected.

N/A

4. If appropriate, please enclose a letter from the original researcher, or data collector or their representative, giving permission to use the data. ***Where relevant, the writer of the letter should indicate whether or not informed consent was collected, and describe all efforts that were made to guard the confidentiality of participants.***

Vulnerable Populations:

Please describe any vulnerable populations to be **targeted** for participation in the research (please check all that apply) as they require special consideration by the IRB:

☐Pregnant women – Please complete and submit Supplemental Form P

☐Minors under age18 – Please complete and submit Supplemental Form C

☐Wards of the state may be included

☐Prisoners- Please complete and submit Supplemental Form J

Special Populations:

Please describe any special populations to be targeted for participation in the research.

☐ Non-English Speaking ***A translated consent form or oral script must be submitted as appropriate***.

☐Illiterate* ***Please provide a rational for enrolling these subjects and describe the consent process for these subjects below.***

☐ Decisionally Impaired Adults* ***Please provide a rational for enrolling these subjects and describe the consent process for these subjects below.***

Recruitment/Screening:

1. Will The Chicago School Directory Information be used to recruit subjects for study participation? If yes, please contact the IRB Office and the Office of Institutional Research (OIR) after IRB Approval of your study has been granted to assist you with the recruitment message.

   ☐ Yes ☒No

2. Describe how the participants will be recruited for study participation. If advertisements (flyers/brochures, internet, newspaper, recruitment letters, or media) will be used please attach a copy of the advertisement for review. If flyers will be used please specify the location where they will be posted.

AORN will allow this researcher to use their database pending full approval of TCSPP IRB committee. Coordination of this effort will be guided by Brian Tepp, Director of AORN Membership.

The steps are as follows:

1. Members of AORN will be sent an email with an invitation to participate in the study along with the consent and survey. This link will have already been sent to Mr. Tepp via the researcher.
2. Members will click on the email and once it is opened they will be given a welcome screen which contains the description of the study along with the consent form containing terms and conditions that state risks and benefits.

3. They can participate by accepting the terms and clicking on "accept terms."
4. Upon accepting the terms they will be directed to the survey. The survey should not take longer than 15 minutes. Participants will have up to 3 weeks to complete the survey. They may discontinue at any time by hitting a discontinue button. If they choose to do so, they will be redirected to a thank you screen.
5. AORN will send out a reminder to complete the survey via email only one time during survey collection per their protocol.
6. The researcher will keep the survey open for 3 weeks or until the desired number of responses is reached.

7. If they choose to stop participating they will be redirected to a screen that will allow them to discontinue and a thank you prompt will be displayed.

8. Participants may save their answers and return to the survey at any time without losing their data. They may return to previous survey questions and update existing responses until they exit the survey.

9. The survey does not have to be completed at one sitting; however it must be completed on the same computer.

10. Upon survey completion a screen will thank the participant and exit them out. Once submitted, a survey cannot be re-entered and taken again. Answers will remain as is and the participant locked out of the survey.

3. If subjects will be verbally invited to participate, please indicate who will make initial contact with the potential subject and attach a copy of the Recruitment Script for review.

No verbal contact will be made with potential participants.

Screening: Describe how the participants will be selected for participation in this study. For example will subjects be asked to complete any screening procedures (i.e., questionnaire, survey, etc.) prior to the research intervention to determine study eligibility? If so, please attach a copy of the document that will be used. ***Please note standardized questionnaires and surveys do not need to be submitted for IRB review.***

No screening will occur prior to the research. Subjects who consent electronically will be accepted into the study.

Informed Consent: Informed consent is a not just a document but a conversation or process that informs the research subjects about the purpose of the study, the risks, potential benefits, and alternatives. It allows the potential subject to make an informed decision about whether or not to participate based on their goals or ideas.

Please select the consent method proposed for this study.

☐***Waiver/Alteration of Consent:*** The IRB may approve a waiver of consent for studies in which the investigator will have not physical, verbal, or electronic

contact with potential subjects. For example retrospective studies using archival data could be eligible for a waiver of consent. To request a waiver of consent, please address the following questions in the section below:

- Please describe, why the research presents no more than minimal risk
- Please include a statement to clarify why the waiver will not adversely affect the rights of the subject
- Please include a statement to explain why the study could not be practicably carried out without the waiver of consent.
- In addition, if appropriate please confirm the subjects will be provided with additional pertinent information after study participation.

☒***Waiver of Consent Documentation/Oral Consent:*** Waiver of consent documentation is appropriate for studies in which subjects are given an opportunity to accept or decline participation by responding to a verbal or electronic request. The IRB may approve an oral consent/waiver of documentation of consent provided that the study is minimal risk and the consent document would be the only record linking the subject to the research. In this process an oral script or electronic document containing the elements of written consent will be used to inform subjects of their rights. To request approval of an oral/waiver of documentation of consent please address the following questions in the section below.

- Please describe why this study presents no more than minimal risk to the subject
- Please include a statement to confirm that the only record linking the subject and the research would be the consent document
- Please include a statement to confirm that the principal risk would be potential harm resulting from a breach of confidentiality.

Please include a separate copy of the oral script/electronic consent request with your application for review.

This study presents no more than minimal risk as it contains basic yes, no, questions along with demographic information. Nurses will not be subject to physical or verbal contact in any scenarios.

Nurses may, however, be asked to recall situations which may trigger emotional distress by recalling incidences of reporting wrongdoing. Nurses may withdraw from the study at any time and will not suffer any consequences for any early withdrawal. Researcher will not be given the names of the participants per the protocol of the Association of PeriOperative Registered Nurses.

A potential for risk may also result from breach of confidentiality, however, given the nature of the encrypted and secure database utilized by SurveyMonkey this should threat should not be present.
The threat should also be minimized by the participants using their own personal computers with their own personal protected passwords.

☐***Written Consent:*** A written consent form serves as signed documentation that the consent process has occurred and is appropriate for studies in which the researcher will have direct contact with the subject; and it is necessary to maintain a link between the subject and the data that will be collected during the study. Consent forms should be written at a twelfth grade reading level using simple declarative sentences. **The current consent form template containing the required elements of consent/authorization is available on the IRB web site and must be used to develop the written consent form. Please include a separate copy of the written consent form to be used in this study for review.** Foreign language versions should be prepared for applicable research.

To request approval of written consent please describe when and who will conduct the consent process.

Description of the Study:

1. Using non-technical language, please provide a step-by-step description of what the subject will be asked to do during their study participation. In your description, please include the expected duration of the subject's participation and the frequency of the study visits if applicable. (Attach any questionnaires and/or testing instruments, as well as cover letter instructions to participants). ***Please note standardized screening tools do not need to be submitted for IRB review.***

   Subjects will be asked to fill out a survey on nursing advocacy using closed ended questions involving nurses' willingness to report wrongdoing.

   Demographic data will also be gathered at this time.

   Please see attached survey.

2. Please clarify whether or not the subjects will be exposed to deception, contrived social situations, manipulation of the participants' attitudes, opinions, or self-esteem, psychotherapeutic procedures, or other psychological influences. If so, describe procedures for follow-up and/or debriefing.
   Questionnaire is straightforward. No deceptive situations will be utilized.

Risks of the Research: Please outline potential risks to participants **and** the measures taken to minimize such risks.

Emotional distress may occur from having to recall wrongdoing in the workplace. This will be minimized by allowing participants to skip questions that may make them feel uncomfortable as well as allowing participants to discontinue the survey at any time. Breach of confidentiality may pose a potential risk; however, this will be minimized by the use of an encrypted data base. AORN will also not release the names of the members and as such, anonymity will be maintained. Risk will also be minimized by the use of participant's personal computer which will allow them to use their own personal password.

Benefits of Participation:

Please outline the potential **direct benefits** of this project to the subject. Alternatively, please describe the potential benefits to society in general. ***Please note remuneration should not be described as a benefit to subjects.***

The results of this study will assist healthcare leadership in supporting nursing and their quest for patient advocacy. This in turn will serve to protect patients by providing interventions in any care that is perceived to be unethical. This study will also contribute to nursing scholarship on patient advocacy as well as healthcare leadership. Nurses who participate in the study may also increase their personal knowledge base on nursing and factors that promote and hinder their willingness to report unethical behavior.

Compensation for Participation:
If applicable, please describe any remuneration to be received by the study participants, the source of this remuneration, and when the subject will receive this compensation.

None

Confidentiality:

1. Please indicate the personal identifying information about the study subject that will be accessed/collected **during** their study participation.

☐Name ☐Address
☐Telephone Number ☐Email Address
☐Social Security Number ☐Other (please describe)
☐Medical Information ☐Academic Information (such as grades, etc)

2. Please describe the steps taken to guard the anonymity of the subjects and/or the confidentiality of their responses.

Database identifiers through AORN will not be shared with the researcher. In addition, SurveyMonkey utilizes secure and encrypted databases.

3. Please describe procedures for storage and ultimate disposal of information.

Information will be housed by the researcher in their personal computer and destroyed (permanently deleted) after 5 years.

Certification of Application Readiness ***(for student researchers only)***

All Dissertation and Thesis Chairs are asked to complete this section to ensure that only complete, ready-to-review applications are submitted.

By typing your name on the signature line below, you are verifying that you are the Chair/primary advisor of the student's dissertation/thesis/research project and have reviewed the present application and approved it for IRB review. You understand that typing your name will serve as an electronic signature and initiate the review of this application. This electronic signature gives the Institutional Review Board of The Chicago School of Professional Psychology permission to review this application.

As chair/primary advisor of the student's dissertation/thesis/research project, I have reviewed the present application and approve it for IRB review.

Chairperson/Primary Advisor Signature: Brandy Blount, Ph.D.

Date: 10/25/13

Principal Investigator Signature

[☒] By checking this box and typing your name on the signature line, you are verifying that you are the author of this application. You understand that typing your name will serve as an electronic signature and initiate the review of this application. This electronic signature gives the Institutional Review Board of The Chicago School of Professional Psychology permission to review this application.

Author Signature Reem Azhari Date 10-25-2013

Appendix D: IRB Approval Letter

INSTITUTIONAL REVIEW BOARD

January 8, 2014

NOTICE OF EXPEDITED APPROVAL

Principal Investigator:	**Reem Azhari**
Research Advisor:	**Brandy Blount, Ph.D.**
Project Title:	**A Quantitative Study on the Factors that Promote and Hinder Nurses' Willingness to Report Perceived Unethical Behavior to Healthcare Leadership**
Risk Level:	**Minimal**
Special Populations:	**N/A**
Consent:	**Oral (version 11/10/13)**
IRB Renewal Date:	**1/8/15**

This notification certifies that the proposed study, as described in the revised application 12/21/13 submitted to the IRB committee, has been approved by the IRB committee and has been found to fulfill all necessary ethical requirements for human subjects research.

We have granted this approval from **1/8/14** to **1/7/15. Any proposed changes to this proposal during this approval period must be submitted to the IRB for review via the Addendum Request form located on the IRB website.** Should the data collection and analysis phase of your study extend beyond the approval period indicated above please submit the Continuing Renewal form located on the IRB website no later than **12/7/14**. This review is required should your *data collection and analysis phase* exceed the stipulated time limit. You need *not* submit a Continuing Renewal form if the data analysis is completed but you are still preparing a document (thesis, dissertation, or publication) based on the data.

Researchers are required to always follow the American Psychological Association's ethical principles and code of conduct, especially in regards to Section 8 of the ethical code ("research and publication"). Failure to conform to the APA ethical code may result in revocation of IRB approval.

Christoph Leonhard, Ph.D. January 8, 2014
Chicago Campus Chair, The Chicago School
IRB Committee

cc: Brandy Blount, Ph.D., Dissertation Chair
IRB Assistant

Rev. 1/13/10

Appendix E: Permission to Use Survey Letter

January 27, 2014

Reem Azhari Ph.d. Candidate
The Chicago School of Professional Psychology

Dear Ms. Azhari,

I am pleased to grant permission for you to use the *Registered Nurses' Workplace Support for Patient Advocacy Questionnaire* to support your doctoral research. You are welcome to use the tool as written, or to edit the tool to better suit your individual project. The tool as written has previously been examined by an expert panel to demonstrate construct validity. While post-hoc reliability testing demonstrated a high level of internal consistency among the likert scaled survey items (r = 0.93), it is important to note that the remainder of the tool is untested.

Please cite the following in your work:

Black, L.M. (2011). Tragedy into policy: A quantitative study of nurses' attitudes toward patient advocacy activities. *American Journal of Nursing, 111*(6), 26-35.

Sincerely,

Lisa M. Black Thomas, PhD, RN, CNE Assistant Professor
Orvis School of Nursing University of Nevada, Reno

Orvis School of Nursing
1664 N. Virginia Street
University of Nevada, Reno/0134
Reno, Nevada 89557-0052
(775) 784-6841 office
(775) 784-4262 fax
www.unr.edu/nursing

Appendix F: AORN Database Guidelines

Guidelines for use of AORN' s Membership Database

Purpose: AORN supports the conduct of nursing research. AORN does allow access to the membership database for identifying potential subjects for research studies, evidence based practice projects or other scholarly endeavors. Approval is granted by the AORN's Nursing Research Committee provided the following criteria are met:

Criteria for requests:

1. Cover letter
2. Contact information of requestor
3. Summary of study (abstract)
4. Significance of study to perioperative nurses and or perioperative nursing practice
5. Literature review
6. Methods
    a. Appropriate to generate valid and reliable, unbiased results
    b. Justification for the sample size (e.g. power analysis)
    c. Research design
    d. Data collection methods
    e. Copy of all instruments
    f. Copy of all written communication inviting potential subjects
7. Data management methods
8. Data analysis
9. Limitations
10. Ethical considerations
    a. Is the content appropriate for perioperative nurses?
    b. Consider if members would be offended by the content of

the survey

c. Documentation of IRB approval

i. This protects human subjects

ii. The IRB must be from a university or facility. If the applicant does not have access to an IRB in his/her facility, an IRB service (e.g. Western IRB) may be used.

iii. AORN does not require a national IRB for survey studies in which members are subjects.

11. Copy of requestor's CV

12. Faculty contact information if applicant is a student

13. Letter of support from facility if applicable

Additional Information:

All requests must be submitted to Dr. Lisa Spruce, Director of Evidence Based Practice at AORN: lspruce@aorn.org

Requests will not be considered until all documents have been submitted. Completed documents will be reviewed by AORN's Nursing Research Committee at the next scheduled monthly meeting. Decisions will be communicated to the requestor by Dr. Spruce.

Appeals to the decision of the Research Committee will be considered by contacting Dr. Spruce.

Appendix G: AORN Permission to Use Database Letter

AORN
Association of periOperative Registered Nurses
2170 South Parker Road, Suite 300 Denver, CO 80231-5711 (303) 755-6300 or (303) 755-6304 http://www.aorn.org/

October 25, 2013

Principle Investigator: Reem Azhari

Dear Reem,

This letter is to acknowledge the willingness of the Association of periOperative Registered Nurses (AORN) to collaborate with you as you proceed with your research study on factors that influence nurses' willingness to report wrong doing.

AORN's role in this study is to provide support and guidance as needed, and upon IRB approval, submission of all required documents, and AORN Nursing Research Committee approval; provide membership access for purposes of conducting an on-line survey.

Together, as a team, we will address issues that are foundational to patient safety in the perioperative environment. Through identifying gaps in knowledge we will be able to develop appropriate educational offerings that will increase compliance with evidence-based practice recommendations and improve patient outcomes related to surgical safety and the importance of reporting patient safety issues.

Your research project focuses upon questions of importance to perioperative nursing and I am enthusiastic about AORN's participation.

Sincerely,

Lisa Spruce, RN, DNP, ACNS, ACNP, ANP, CNOR
Director, Evidence-Based Perioperative Practice
Association of periOperative Registered Nurses (AORN)