IMPACT OF STRESS ON QUALITY OF CARE: THE MODERATING ROLE OF WORKPLACE SPIRITUALITY

Ph.D. THESIS

by

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CANDIDATE'S DECLARATION

I hereby certify that the work which is being presented in the thesis entitled **"IMPACT OF STRESS ON QUALITY OF CARE: THE MODERATING ROLE OF WORKPLACE SPIRITUALITY"** in partial fulfilment of the requirement for the award of the Degree of Doctor of Philosophy and submitted in the Department of Management Studies of the Indian Institute of Technology Roorkee, Roorkee is an authentic record of my own work carried out during a period from January, 2013 to February, 2016 under the supervision of Dr. Rajib Lochan Dhar, Assistant Professor, Department of Management Studies, Indian Institute of Technology Roorkee, Roorkee.

The matter presented in this thesis has not been submitted by me for the award of any other degree of this or any other Institute.

(JYOTI)

This is to certify that the above statement made by the candidate is correct to the best of my knowledge.

Signature of Supervisor

The Ph.D. Viva-Voce Examination of **Ms. Jyoti**, Research Scholar, has been held on **12 April, 2016**.

Chairman, SRC **Signature of External Examiner**

This is to certify that the student has made all the corrections in the thesis.

Signature of Supervisor **Head of the Department**

Dated: 2016

ABSTRACT

There is nothing more important for any country than the health and well-being of citizens for which committed health services of public healthcare institutions are necessary. Nursing staff is a vital channel whose assistance is needed for fulfiling the dream of universal healthcare in India. The increase in attrition rate, aggression, conflicts, anxiety, and medical errors of nursing staff has put a serious question mark on their working environment. This study has find out the significant causes of decreasing quality of care in light of the above said issues of nursing staff working in public healthcare institutions. This century is marked by significant changes in the social and demographic structure of the country like increased number of female professionals, working couples, increased divorce rates, maternal employment and single parents. These changes have altered the family structure due to which the quality of life is eloping. Also, the disparity of demands and scarcity of time has increased the conflict between family and career life. Furthermore, death and dying, chronic diseases, scarcity of material and human resources, emotionally and physically taxing situations, and aggressive patients are integral to the nursing profession. In order to work in such a demanding profession, nurses need family and colleagues support to provide effective and efficient services.

Nursing care requires the coordination and cooperation of each and every member because teamwork is emphasized and valued; so that nurses can better meet the requirements of the patients and can achieve the common goal, that is, health and well-being of patients. However, the ground reality seems to be different for nurses providing bed side care to patients. Multiple tasks along with the shortage of manpower have clustered the major burden of patient care on nursing staff, and lack of interpersonal relations at workplace has worsened the situation further. Moreover, long hierarchical structure restrains the open communication; hampers the team works and psychosomatic situations create aggression among team members. Nursing staff acts as a mediator between patients, doctors and healthcare institutes, and they face the aggressive behavior of patients and all other stakeholders of healthcare services. All these causes create strain among nursing staff and affect their quality of care services. Stress is the disparity of demand and resources at workplace even job itself can become the sources of transcendence and joy when nurses feel sense of community with

organizational goals. This study considers workplace spirituality as a coping mechanism for stress and also as a buffering variable in between stress and quality of care.

Descriptive research was used as a precursor of quantitative research design and survey method was adopted for the purpose of data collection. Nursing staff working in public healthcare institutions of Uttarakhand region were selected as the samples of the study. Convenience sampling technique was adopted for selection of sample, and accordingly, questionnaires were distributed to the selected sample. Finally, 872 questionnaires were used for analysis. Data analysis techniques like confirmatory factor analysis (CFA) and regression analysis using Hayes SPSS macro named 'PROCESS' were used to test the hypotheses. The results indicated that significant and positive relationship exists between independent variables and stress, and there is negative relationship between stress and quality of care. The results of the study supported the mediating role of stress between independent and dependent variables. Further, the results confirmed the buffering influence of workplace spirituality on relationship between stress and quality of care.

The results showed high mean value of work-family conflict, bullying, patient incivility and stress and low mean value of workplace spirituality and quality of care. The mean values indicate high conflict and aggression at workplace which results in exhaustion of psychological and emotional resources. Transformational resource like workplace spirituality can play a vital role in expanding the conscious periphery of nurses. This study provides recommendations that will help the management and nursing leaders to better understand the ground causes of stress among nursing staff and to make better decisions about policies and procedures for better job outcomes. The limitations of this study have opened new avenues for future research in the nursing profession.

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AUTHOR'S RESEARCH CONTRIBUTION

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Conference Details

1. Presented a research paper titled "Servant leadership and Service Quality of Indian police officers" in the conference titled "International conference on Research and Business Sustainability" held on 4-6 December, 2015 at IIT Roorkee - Greater NOIDA Campus.
2. Presented a research paper titled "Organization Culture and its relationship with public trust mediated by service quality: A study of elite hotels of Uttarakhand region" in the conference titled "International Conference on Evidence based Management" held on 20-21 March, 2015 at BITS Pilani.
3. Attended a conference titled "Creative Consciousness and Energy at Workplace: Insights from Adi Shankaracharya" organized by Vedic Foundation of Indian Management, in collaboration with Copenhagen Business School, Denmark and IIT Roorkee, India held

on 28-30 November, 2014 at Department of Management Studies, IIT Roorkee, Uttarakhand.

4. Presented a research paper titled “Stress as a mediator between work-family conflict and psychological health among the nursing staff: Moderating role of emotional intelligence” in the conference titled “Sixth International Conference on Excellence in Research and Education” held on 8-11 May, 2014 at Indian Institute of Management, Indore, Madhya Pradesh.
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LIST OF ABBREVIATIONS

The abbreviations used in the text have been defined at appropriate places, however, for easy reference, the list of abbreviations are being given below.

Abbreviation	**Stands for**
AGFI	Adjusted Goodness of Fit Index
AMOS	Analysis of Moment Structures
ANOVA	Analysis of Variance
AVE	Average Variance Extracted
CFA	Confirmatory Factor Analysis
CFI	Comparative Fit Index
CI	Confidence Intervals
CMIN	Minimum Discrepancy
DF	Degree of Freedom
EQ	Emotional Quotient
ERI	Effort Reward Imbalance
GFI	Goodness of Fit Index
GLM	General Linear Model
H1	Hypothesis 1
H2	Hypothesis 2
H3	Hypothesis 3
H4	Hypothesis 4
H5	Hypothesis 5
H5a	Hypothesis 5a
H5b	Hypothesis 5b
H5c	Hypothesis 5c
H6	Hypothesis 6
HCI	Healthcare Institutions
IBM	International Business Machines

ICR	Internal Consistency Reliability
ICU	Intensive Care Unit
IFI	Incremental Fit Index
INC	Indian Nursing Council
IOM	Institute of Medicine
IQ	Intelligence Quotient
JDC	Job Demand-Control
JDCS	Job-Demand Control-Support
JD-R	Job Demand-Resource
NFI	Normed Fit Index
NHS	National Health Service
NIOSH	National Institute for Occupational Safety and Health
NSS	Nursing Stress Scale
OLS	Ordinary Least Squares
OPD	Outpatient Department
PHCI	Public Healthcare Institutions
PI	Patient Incivility
PSTD	Post-Traumatic Stress Disorder
QC	Quality of Care
RAM	Roy Adaptation Model
RMSEA	Root Mean Square Error of Approximation
SEM	Structural Equation Modeling
SPSS	Statistical Package for the Social Sciences
SQ	Spiritual Quotient
TLI	Tucker–Lewis Index
TNAI	Trained Nurses Association of India
VIF	Variance Inflation Factor
WFC	Work-Family Conflict
WHO	World Health Organization
WS	Workplace Spirituality

CHAPTER 1

INTRODUCTION

1.1 Overview

The present thesis strives to analyze the work scenario of nursing staff working in public healthcare institutes. The purpose of the research is to investigate the elements that influence the level of stress experienced by Indian nurses. The current research aims for a comprehensive examination of complexity of job that causes stress amongst nursing staff. Further, the present study investigates the composite influence of job stressors on quality of patient care. A significant and dynamic perspective of workplace, which governs the conscious thoughts and actions of individuals, has been studied by means of workplace spirituality for assessing its buffering role in the relationship between stress and quality of care.

1.2 Development of Research Problem

It is well acknowledged that healthcare system is changing rapidly and nature of nursing in India is becoming far more complex and complicated. India's health care system is facing epidemiological transition from infective to chronic health problems. In developing countries, the government plays a leading role in the development and growth of healthcare system (Berman, 1998). Public healthcare institutions play a significant role in healthcare services in developing countries like India, where 72% of the population lives in rural, urban and hilly areas (Dummer & Cook, 2008), 22% of the population lives below the poverty line and 135 million citizens are deprived of even primary healthcare services (Sharma & Dhar, 2016). Public healthcare institutes are facing challenges of manpower shortage, deficient infrastructure, medical equipment, unmanageable patient load and equivocal patient care (Bajpai, 2014) as well as imbalance of job demands and available resources.

Employees respond as per their perception and experience of work demands (Swider & Zimmerman, 2010) which may coalesce around the notion of job stress. Stress is a psychological syndrome involving long term piling up of chronic emotional, psychological and interpersonal stressors that employees experience at their workplace. The prevalence of stress results in

multitude of adverse outcomes for employees as well as for organizations (McVicar, 2015). As per Maslach & Leiter (2008), employees working in client based professions are more likely to experience job stress.

Nursing is considered as one of the most stressed professions, as nurses' deal with human sufferings and psychosomatic condition of patients and of their relatives (Albrecht, 1982). The nature of nursing profession itself is considered one of the most significant stressor amongst nurses. Stress is a multidimensional phenomenon which includes occupational, organizational and individual stressors. Occupational stressors such as chronic, accidental, psychiatry and drug addict patients, death and dying, chaos in emergency and intensive care unit (ICU), nurse patient relations, job demands, long working hours, work load and night shifts creates a stressful working environment for nurses. Organizational stressors such as unsupportive working environment, lack of communication, unfair policies and procedures, exaggerate the level of nurses' stress. Individual level stressors play the most significant role as experience of job stress more or less depends on the personality and perception of an employee related to the ways in which they perceive the organizational and occupational stressors (Cordes & Dougherty, 1993). Teamwork is an integral part of nursing and interpersonal relations at workplace play a significant role in this profession.

Increased complexity and contemporary demands have made working environment more stressful for nurses, where adverse interpersonal relations with colleagues have created a high degree of stress in healthcare environment. Moreover, the behavior of patients and their relatives is not kind enough in return to noble services of nurses, as the patients show aggressive, hostile, intimidating and undesirable behavior, which augment the level of stress experienced by nursing staff. Work related stressors are the most contributing elements among the stress factors that have impact on nurses, and the empirical research has proved that work load, interpersonal relations, time pressure, duties and role of nurses and diversified job tasks are the most recognized stressors among healthcare professionals (Sharma & Dhar, 2016; Sharma, Dhar, & Tyagi, 2015). These stressors not only affect the performance of nurses at organizational domain, but also interrupt in functioning of family related responsibilities. Complex combination of stressors have shown the catalogue of outcomes like higher absenteeism and turnover, lower job satisfaction, morale and motivation, and decreased quality of care.

Nurses are required to deal with human suffering as well as grief and loss on a daily basis, but still they ensure the safety of patients in complex working environment. Research has ascertained that nurses show physiological and psychological syndrome while working in physically, psychologically and emotionally strenuous profession (Adib-Hajbaghery, Khamechian, & Alavi, 2012). In totality, all these factors deplete the physical and psychological energy of nurses and lead to lower concentration level and higher probability of medical errors (Swaminath & Raguram, 2010). Nurses going through traumatic stress experience various psychosomatic pressures, and they sometimes even take extreme steps of committing suicide (IANS, 2014). Moreover, nurses have even died because of violence and harassment by patients for whom they spend their entire life to provide healthcare (Yadav, 2007). Nurses juggle between multiple patients and other administrative tasks, while experiencing aggression and incivility because of which they suffer from never ending spiral effect of emotional and cognitive dissonance at workplace (Nurse, 2014). In-spite of hard emotional labor, nurses hides their emotions, as they are supposed to be polite, cheerful as well as positive in their emotions towards patients. Long term control of emotions adversely affects the emotional and psychological wellbeing of nurses, and they became victims of stress related diseases while working in high risk profession. Psychosomatic condition of nurses leads to low morale, loss of concentration, feeling of inadequacy, depersonalize, and jeopardize patient's safety (AbuAlRub, 2004). The combination of above said elements may be the source of various medication and medical errors which may results in decreased level of quality of care. However, in nursing profession there is no scope of errors because patient's life is involved in nursing care.

Empirical research has highlighted that great number of nurses are under stress (Sharma et al., 2015), and they strive for either positive coping strategies such as music, exercise and psychiatry help or adopt negative coping strategies such as drug addiction, smoking and other hostile activities. In extreme conditions of stress, nurses may involve in counterproductive work behavior and this can drive nurses towards post-traumatic stress disorder (PSTD) in which nurses witness anxiety and depression. Empirical researchers need to focus on significant stressors that are affecting the quality of nursing care as well as highlight the need to investigate the substantial moderator to buffer the impact of stress on nursing care. To handle multifarious characteristics and demands of nursing profession, nurses need physical, psychological, emotional, and most importantly spiritual energy. Same has been explained with dual process of Job demand resource

(JD-R) model (Schaufeli & Bakker, 2004) involving job demands and resources. Process is initiated with job demands at workplace, as employees need to expand efforts to meet the job demands which may results in enervation of physical, emotional, and psychological energy (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Sonnentag, Binnewies, & Mojza, 2010). To cope up energy loss, they need motivational resources that help in alleviating the physical and psychosomatic cost of job demands by intrinsic motivation (Schaufeli & Bakker, 2004). Nursing needs conservation of energy resource to cope up with continuous depletion of energy in order to handle traumatic situations of patients. Spirituality at workplace provides an opportunity for nurses to manage their intellect and emotions by finding meaningfulness and consensus in their purpose of life as they do a noble job of saving others' life being angels on earth.

Trauma and stress are an integral part of nursing profession, which can't be changed or improved much, but what can be altered is the approach to handle the challenges at workplace. It's not always the stressful conditions that infuse pressure, but more important is the perception and attitude towards viewing the challenges and availability of resources to handle challenges. Being conscious and thinking beyond self can be a catalyst to protect the thoughts and behavior of nurses from being adversely affected by stress due to patient care.

1.3 Statement of the Problem

Human resources are the key elements in service sector for delivering the required quality of services. Past research has highlighted the importance of healthcare professionals because the quality of patient care more or less depends on them (Sharma & Dhar, 2016). Nursing staff services are considered important for patient care and safety, as they are actively involved in the care process. Nursing is considered as one of the most stressed profession, and nurses are the most stressed professionals in healthcare. Stress is a complex phenomenon and various organizational and individual factors act as contributors in alleviating the stress level. However, few stressors are part and parcel of nursing profession which further contributes to worsen the exiting problem of stress among nurses. On the basis of the pilot study and literature review, it was observed that organizational stressors act as vital reasons of stress for nurses. Nurses feel frustration because of the lack of sufficient time to fulfill the multiple tasks in professional as well in personal life, and the lack of interpersonal relations at workplace act as important stressors that have been considered for the present study. These stressors develop stress among

nursing staff which eventually affect their quality of patient care services. Kane (2009) identified that the causes of stress among nurses differ between developed and developing nations, so this research is conducted considering this issues of developing countries.

Various sociologists and psychologists have suggested stress coping strategies for nurses considering the organizational role to deal with workplace stress. However, they have overlooked the individual aspect while framing the coping strategies for nurses. Stress is the consequence of organizational stressors and employees approach to perceive the stressful situations. Individual can handle adverse situation with his or her intelligence that works at three levels; that are intelligence quotient (IQ), emotional quotient (EQ), and spiritual quotient (SQ). IQ relates with the ability to think as per norms, logic, and knowledge to take the right decision, and EQ related to awareness of emotions associated with self and others which facilitate thoughts and actions. Spiritual quotient is fundamental to IQ and EQ, as it is related to being insightful; connecting with other's soul and thinking beyond self, which guides the cognitive and emotional intelligence to take rational decision. The present study has considered the third level of intelligence that is spiritual quotient as a significant and positive coping strategy for the issue of stress among nurses. Stress has been recognized as occupational hazard among nurses that has a crucial impact on their abilities to cope up with stressful demands and their patient care. Various professional as well as personal factors accumulate and increase stress among nursing staffs which further impact the quality of patient care. The issue of stress among nurses needs attention of researchers and management for more subtle solution of this problem with the third level of intelligence at workplace, that is, workplace spirituality.

1.4 Need and Importance of the Study

India is growing from under developed to developing country (Thomson, Sharma, & Kong, 2014), and healthcare sector has an inevitable role in the growth of a nation. Healthcare indices signify the development of nation and the delivery of qualitative healthcare services is the foundation of healthcare institutes. With the growth of healthcare sector, the structure and working style of healthcare institutes is becoming more and more complex. In addition, it is evident that the nature of nursing tasks is changing and health care is becoming more complex and challenging for nurses (Hughes & Jennings, 2008). Various factors such as government

policies for health awareness, communication technology, and growing percentage of middle class have contributed towards increased number of patients' admissions in public healthcare institutions (PHCI) (Balarajan, Selvaraj, & Subramanian, 2011). Healthcare professionals provide health care in working environment of intricate interaction of various factors such as scare resources, manpower, infrastructure, technology, and complex disease procedures. In totality, all these factors along with emotionally charged situations of human service professionals have significantly affected the nursing staff.

Various research articles have highlighted that stress among nurses is a silent killer, which is weakening the foundational basis of this profession (Adams, 2014). These causes are indicating an alarming situation for PHCI as nurses are leaving this noble profession because of their difficulty in handling the traumatic stressors without adequate resources. Stressors from diverse spheres like organizational, personal, and professional take a toll on the physical and psychological well-being of nurses. The relationship between work–family conflict and stress has been studied in the past, but the research on impact of bullying and patient incivility on stress experienced by nurses and eventually on the quality of care provided by PHCI nurses working in developing and culturally diverse country like India is scant. Moreover, the spirit of serving people is gradually missing among the nursing staff because being individuals they come with mind, body, emotions, and spirit at workplace. So, it's significant for the concerned departments and officials to understand the healthcare environment and psychology of healthcare stakeholder to optimally utilize the existing human resources and make human resource policies to provide better care to masses (Andreassi, Flory, Villibor, Teixeira, & C., 2010). The present study examines the existing work conditions of nurses along with stressors that adversely affect the healthcare services of nursing staff working in public healthcare institutions of Uttarakhand region. Further, this study aims to provide the implications of spiritual aspect for improving the existing stressful working condition of nurses. Therefore, it is important for the management to understand the human behavior at workplace and to help nurses in handling their psychosocial situations in a better way. Furthermore, the present study examines the diverse factors affecting their performance in terms of the quality of patient care because of the high level of stress amongst nursing staff of Uttarakhand region. Therefore, the suitable measures have been discussed for improving the existing situation of nursing staff.

1.5 Scope of the Study

The present study used cross-sectional, non-experimental research design and self-report data from sample representing the public healthcare institutions. Because of time constraints, convenience sampling was used and scope of the present study was limited to nursing staff working in public healthcare institutions of Uttarakhand region only. Nursing staff included nursing sister [grade one (1) & two (2)], staff nurse, and assistant nursing superintendent. Varied organizational, individual and occupational stressors may affect the nursing staff, but based on the literature review and pilot study, the present study confined on stressors such as work family conflict, bullying and patient incivility. For statistical analysis, univariate statistical techniques such as correlation analyses and multivariate procedures such as regression using SPSS macro named PROCESS has been used.

1.6 Key Definitions of Constructs Used in the Study

Work–family conflict:

Work–family conflict is “a form of interrole conflict in which the general demands of time devoted to and strain created by the job interfere with performing family-related responsibilities” (Netemeyer, Boles, & McMurrian, 1996, p.401).

Work–family conflict can be defined as, ‘‘a form of inter-role conflict in which the role pressures of the work and family domains are mutually incompatible, so that participation in one role [home] is made more difficult by participation in another role [work]’’ (Greenhaus & Beutell, 1985, p. 77).

Bullying:

Vartia (1996) defined bullying as, “long-lasting, recurrent, and serious negative actions, and behavior that is annoying and oppressing. It is not bullying if you are scolded once or somebody shrugs his/her shoulders at you once. Negative behavior develops into bullying when it becomes continuous and repeated. Often the victim of bullying feels unable to defend him/herself” (p. 205).

Einarsen, Raknes, & Matthiesen (1994) defined bullying as “situations where a worker or supervisor is systematically mistreated and victimized by bullying fellow workers or supervisors through repeated negative acts like insulting remarks and ridicule, verbal abuse, offensive teasing, isolation, and social exclusion, or the constant degrading of one's work and efforts” (p.383).

Patient Incivility:

Patient incivility is “Uncivil treatment from the patients one cares for is an additional source of workplace conflict that can result in negative effects on nurses” (Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010, p.178).

Hahn et al. (2008) defined patient incivility as “some organizational procedures, such as prolonged waiting times and difficult interactions between professionals and patients/ visitors, can be considered customer unfriendly and therefore increase the likelihood of patient incivility” (p. 439).

Stress:

Selye (1946) defined stress as “the nonspecific reaction of the body to any type of demand” (p. 32).

As per Folkman (1984), stress is, “any situation in which internal demands, external demands, or both, are appraised as taxing or exceeding the adaptive or coping resources of an individual or group” (p.19).

Workplace Spirituality:

Workplace spirituality is defined as “a framework of organizational values evidenced in the culture that promotes employees’ experience of transcendence through the work process, facilitating their sense of being connected to others in a way that provides feelings of completeness and joy” (Giacalone & Jurkiewicz, 2003, p. 13).

Rego and Pina e Cunha (2008) defined workplace spiritually as the “recognition that employees have an inner life which nourishes and is nourished by meaningful work taking place in the context of a community” (p. 55).

Quality of Care:

Quality of care addresses “all the dimensions of quality described earlier (i.e., effective, efficient, accessible, acceptable/patient-centerd, equitable, and safe) and will seek to improve outcomes by organizing integrated responses” (WHO, 2006, p.25).

Steffen (1988) defined the quality medical care as, “the capacity of the elements of that care to achieve legitimate medical and nonmedical goals” (p. 57).

1.7 Research Gaps

- Limited research has been conducted related to the varied perspective of work and family roles on the behavior and attitude of nursing staff.
- The contribution made by an organization in maintaining a psychological balance in service like nursing has not been explored in the Indian context.
- Few studies have been carried out on the mediating role of stress between the workplace environmental stressors of nursing staff and quality of care.
- There is lack of research on the moderating effect of workplace spirituality among the service professionals like nursing staff in Indian context.

The present research aims to highlight the harsh ground realities faced by nursing professionals from higher officials, management, nursing leaders and patients. Furthermore, the present study emphasizes on the environmental and individual stressors among nursing staff, stress coping mechanisms and its composite influence on the quality of care.

1.8 Research Objectives

1. To study the influence of work–family conflict, bullying, patient incivility on the stress level of the nursing staff.

2. To study the effect of stress on the quality of care provided by the nursing staff.
3. To study the mediating role of stress between the work–family conflict, bullying, patient incivility, and quality of care.
4. To examine the role of workplace spirituality in moderating the relationship between stress and quality of care provided by nursing staff.

1.9 Outline of the Thesis

The thesis is structured in seven chapters accompanied by supplementary information that are presented in the appendix at the end of thesis. Chapter one depicts the foundation of the thesis. In this chapter, the background of research is provided which helped in identifying the research gaps, rationale of the study, and further helped in the formation of the research objectives in Indian context. This chapter explains the need, importance, and contextual background of the research on nursing staff working in public healthcare institutions as well as briefly puts forth the research design and outline of the thesis. Chapter two provides the theoretical framework underpinning the conceptual model chosen for the present study. Chapter three provides detailed literature review and is divided in two subparts. Part one describes the context of the study in details based on the Indian nursing staff and part two provides the detailed information about the development and conceptualization of the constructs taken in this study; these constructs are work–family conflict, bullying, patient incivility, stress, workplace spirituality, and quality of care. This chapter defines the relationship amongst the variables selected for the study and provides literature review to justify the hypothesis for present study. Chapter four discusses the research methodology adopted for this study. This chapter provides the detailed information about the nature of study, data collection process, and measures of the study constructs and justification of data analysis techniques that have been used in this study. Further, chapter five presents the results and findings obtained from analyzing the data collected from the respondents. Chapter six discusses the results considering the findings of the study. This chapter explains the theoretical implications and suggestions / practical implications for the healthcare service sector. Further, limitations of the study and avenues for future research have been discussed in chapter seven.

1.10. Conclusion

This chapter started by presenting the background of the study and statement of problem in detail. Then chapter swiftly moved towards the need, importance and scope of the study. Further, the variables under study have been defined followed by the research gaps based on which research objectives are developed. The chapter brings forward the structure of complete thesis by describing the outline of thesis in form of different chapters.

CHAPTER - 2

THEORETICAL FRAMEWORK

2.1 Overview

This chapter focuses on the theoretical framework of the model representing the key aspects of the research variables. Stress and workplace spirituality have been considered as an essence of the present study, and the theories and models related to these concepts have been studied in this chapter. On the basis of the varied theories available on these two constructs, job demand resource (JD-R) model in the field of stress and self-identity theory for workplace spirituality was adopted to provide a foundation for understanding both the constructs and their dimensions.

2.2 Conceptual Framework

2.2.1 Job Demand Resource Model (JD-R)

A comprehensive model of stress that is JD-R model is used as the theoretical basis for the present study. Since the emergence of JD-R model in the 21st century, the model gained immense popularity among researchers. This model considers the diverse job characteristics for assessing its implications on employees' job outcomes (Demerouti, Bakker, De Jonge, Janssen, & Schaufeli, 2001). It was proposed as an alternative model to the then well-established models such as effort reward imbalance (ERI) (Siegrist, 1996) and job demand-control (JDC) model that were used in reference to employees' stress and well-being. JD-R model was used in the present study because both the ERI and JDC models had certain shortcomings like not considering individual job aspects and lack of universal application.

Siegrist, Siegrist, & Weber (1986) introduced the ERI model and predicted employees stress with the norm of reciprocity within the sociological framework. Though the ERI model was used in various studies, still there were certain issues relating to the components of this model. First, over commitment needs elaborated clarification because there seems to be an overlapping with allied (or related) psychological construct, that is, Type A personality. Second, the moderating role of over commitment needs further research for better understanding, as this

role is not studied much in the ERI model (Tsutsumi & Kawakami, 2004). Third, the ERI model still needs to explore the curvilinear outlook of imbalance, efforts and rewards, as crucial curvilinear effects are observed in Vitamin model (Warr, 1990). Fourth, the description of demand and rewards is limited to few variables only (Halbesleben & Buckley, 2004). As per the ERI model, the salary and status control are regarded as vital job resources without even considering the task identity and employee supervisor relationship (Bakker & Demerouti, 2007). All these reasons raise the important questions that are associated with universal application of the ERI model.

Later, the Job demand control model (JDC) model was introduced to predict the job stress which constituted three components that included job demands, job control, and job strain (Karasek Jr, 1979). Karasek Jr (1979) defined job demands as "the psychological stressors involved in accomplishing the workload, stressors related to unexpected tasks, and stressors of job-related personal conflict" (p.291)

Various researchers have pointed out certain shortcomings in the existing model. In the JD-C model, it is not clear whether employees experience stress because of higher job demands or low job control (Alfredsson, Spetz, & Theorell, 1985). The combination of high job demands and low job control causes job strain among employees (Karasek Jr, 1979).

Sparks & Cooper (2013) proclaimed that the JDC model ignores the social support and individual resources though it focuses on a probable psychosocial aspect. The job-demand control-support (JDCS) model is criticized because of various reasons like highlighting the psychosocial working environment without considering the individual job aspects (Loretto et al., 2005). As per job demand control and job-demand control-support models, the strain among employees can be modified by altering any of the three factors, which are, job demands, job control and job support. But both these models lack the sociological focus, as these are restricted to work related factors only. As per the JDC model, high job control and low job demands lead to low stress, but the level of motivation is missing in the process associated with strain and well-being (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001)

The present study has used the JD-R model because it is flexible and considers wider perspectives of job characteristics to better understand the antecedents of stress and its relationship with job performance in terms of nurses' quality of care. JD-R model was

introduced by (Demerouti, Bakker, Nachreiner, et al., 2001) as an alternative model of stress, which covers the shortcomings of job demand control (JDC) and effort reward imbalance (ERI) models. As per Bakker & Demerouti (2007), "JDC and ERI have been restricted to a given and limited set of predictor variables that may not be relevant for all job positions" (p.309). JD-R model concentrates on the psychosocial elements such as job resources. Job resources, "represent a broader category of 'positive' features of the work environment than job control in the demand control model" (Demerouti, Bakker, Nachreiner, et al., 2001, p. 280).

As per the JD-R model, stress is not only related to job control and job demands, but also to job resources for its adverse impact on health and well-being. JD-R model includes various working conditions based on varied occupations, and this characteristic distinguishes the model from the JDC and ERI models by taking into consideration both the negative and positive indicators of employees' stress and well-being (Demerouti, Bakker, De Jonge, et al., 2001). The JD-R model has expanded the scope of stress models with belief that every profession has specific indicators of job stress and these indicators have been categorized as job demands and job resources. Further, this model has classified the characteristics of work environment in two categories, that are, job demands and job resources. This model has widened its range of application on the diverse occupations by broadening the definition of job demands and job resources. Job demands can be defined as "those physical, psychological, social, or organizational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort or skills and are therefore associated with certain physiological and/or psychological costs" (Bakker & Demerouti, 2007, p. 312). Various examples of job demands are work overload, unfavorable working conditions, emotionally demanding job, and emotional dealing with clients. Demerouti, Bakker, Nachreiner, et al. (2001) defined job resources as "those physical, social, or organizational aspects of the job that may do any of the following: (a) be functional in achieving work goals; (b) reduce job demands and the associated physiological and psychological costs; (c) stimulate personal growth and development" (p. 501). Like social support, feedback and job control are few examples of job resources. Various theories put forth the motivational potential of job resources from varied perspectives rather than studying in contrast to job demands only.

As per the job demand resource (JD-R) model, extra efforts are deployed to meet the high demands of job and to prevent low performance. Employees may possibly restrict from

deploying the extra efforts, energy, and related cost by shifting towards less demanding tasks or by taking break from demanding tasks (Schaufeli & Taris, 2014). However, with insufficient mobilization of efforts and related cost, the process of sustained activation may exhaust employees both physically and psychologically (Schaufeli & Bakker, 2004).

The JD-R model is a psychosocial process which plays a significant role in the arousal of stress and motivation among people. The interaction between work environment and employees affect their psychosocial feelings. This model includes both the physical and emotional aspects of job demands. Job demands move towards job stressors only when these demands(job demands) surpass the physical, psychological, and social capacity of employees (Sonnentag, Mojza, Demerouti, & Bakker, 2012; Tims, Bakker, & Derks, 2013). Furthermore, this model considers the unique characteristics of work and task for defining job demand and resources that account for its growing applicability in both research and practice. Conservation of resource (COR) theory has also explained the tendency of people to accumulate, protect, and sustain the resources (Hobfoll, 1989).

Higher job demands may stimulate strain responses like stress and burnout, which in turn may result in adverse working outcomes such as absenteeism and low job performance. This pathway from stress to lower job outcomes is called strain pathway. Job resources stimulate positive job attitude similar to that of achieving objectives at workplace with decreased withdrawal behavior. This process is known as motivational pathway (Hoonakker, Carayon, & Korunka, 2013). Motivational process is associated with various organizational outcomes that directly support employee's psychological engagement with work and job performance (Brough et al., 2013).

The JD-R model has explained that the relationship between job demands and job resources is mediated by stress response and motivation (Bakker, Demerouti, & Verbeke, 2004; Lewig, Xanthopoulou, Bakker, Dollard, & Metzer, 2007). As per the JD-R model, stress may develop in two ways. First, the demanding job in the long term can deplete the physical and psychological energy and increase adaptive capability of employees. Further, the continual high job demands may be overtaxing for employees, when they are not able to recover from their depleted energy cost. The basic assumption of JD-R model is that stress occurs with the combination of high job demands and limited job resources (Demerouti, Bakker, De Jonge, et al.,

2001). High job demands exhaust physical and psychological energy and cause stress among employees. Second, the lack of appropriate job resource may have detrimental impact on employees' motivation and performance (Bakker et al., 2004). The importance of specific demand and resource depends on the characteristics of the job and working environment. The results of various cross sectional and longitudinal studies have shown that there exists both positive and negative relationship between job demands and job resources.

Past studies have shown that work–family conflict is related to job demand that exhausts the job resource of employees (Mauno, Kinnunen, & Ruokolainen, 2007). In past studies, the relationship between job demands and job resources has been studied keeping in mind the job outcomes that are based on two perspectives. One viewpoint focuses on organizational and job perspectives, and the other focuses on human resource practices of an organization (Lawler, 1996). Further, the cross sectional and longitudinal studies have shown that adverse job characteristics and conditions may have intense effect on job stress (Bakker, Demerouti, & Euwema, 2005). Basically, stress is an outcome of imbalance between job demands and job resources, and the availability of job resources may buffer the impact of job demands on stress. Job resources may sustain the employees' attitude and efforts to maintain his or her performance even in the situation of high job demand. Bakker, van Veldhoven, & Xanthopoulou (2010) explained that job resources support and facilitate work and play a significant role of moderator in the relationship between stress and various job outcomes (like commitment, job engagement, and job performance). As per Bakker et al. (2010), job demands are "the most crucial predictors of job strain, while job resources are the most crucial predictors of job motivation, learning, commitment, and engagement" (p. 4). Job resources can mitigate the influence of job demands on work outcomes by influencing the physical, cognitive, and emotional energy of employees (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003). The JD-R model has explained the impact of various job resources as well as its catalyst, job demands. However, it is vital to know the job demand that causes stress as well as the job resources that cause stress depends on the job characteristics prevailing in an organization.

Literature review depicts that the JD-R model has concentrated basically on various job characteristics (Van den Broeck, De Cuyper, De Witte, & Vansteenkiste, 2010), but still there is a scope to explore the significant moderating effect of personal resources on the diverse job outcomes. Active personal resources need to be studied to extend the scope of JD-R model.

Personal resources can be referred as the self-evaluation ability of employees to control the influence of varied environmental demands (Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007). The personal resources refer to those attributes of employees that motivate them to achieve their goal even in adverse and challenging situations (Hobfoll, 1989). The reason behind it is that personal resources determine the way employees understand the environment, adapt it, and react to those situations (Xanthopoulou et al., 2007).

Personal resources have been studied from the perspective of self-efficacy. Past literature has shown that personal resources can play diverse roles; specifically, it can work as a moderator between stress and job outcomes (Luthans, Lebsack, & Lebsack, 2008). By extending the scope of personal resources associated with the JD-R model, the present study has used spirituality as personal resource with which nurses can learn to control and manage job stress, and therefore, provide quality care to patients. Organizational, social, and emotional demand along with the diminished job resources may evoke stress among nurses which further may have adverse impact on their job performance. So, stress mediates the path between job demands and performance of nurses.

The core aim of the present study is to expand the JD-R model of stress on nurses working in public healthcare institutions. The JD-R model has made a crucial contribution by proving a broader outlook of job demands and job resources, which according to this theory differ across organizations. Various studies has supported the beliefs of JD-R model and indicated the mediating role of stress between job demands and job outcomes such as commitment, engagement, and job performance (Rothmann & Joubert, 2007). The present study has tried to observe the relation of job demand with stress as well as the relation of job resources with quality of care provided by nurses.

2.2.2 Self-Identity Model of Workplace Spirituality

2.2.2.1 Spirituality

In today's world of economic development and challenges, the quest for spirituality is at its upsurge. Spirituality is concerned with inner life; meaning to be conscious and linked to inner life. The word spirit is derived from a Latin word *spiritualis* which means connected to spirit. Spirituality can be defined as, "the search for meaning in life events and a yearning for connectedness to the universe" (Coles, 1991, p.37). Spirituality has been studied from two

dimensions; one at the individual level and the other at workplace which is referred as workplace spirituality. Empirical review by Goertzen & Barbuto (2001) has demonstrated various paradigms of individual spirituality, that is, self-actualization, purpose, meaning in life, health and wellness. An individual is made up of four components; that are, body, mind, emotions and spirit. Spiritual being can bring harmony in these four components by being conscious about the meaning and purpose of life.

Spirituality has its roots in India because India's infrastructure, scriptures, environment and aura assist in thriving and flourishing of spirituality, so India is called as Guru of spirituality (Bhawuk, 2003). Spirituality is a wider concept and has been studied from various dimensions and has often been confused with the concept of religion. Spirituality has been defined differently in different cultures, eras and religions. In Hinduism, spirituality has been defined in terms of Karma Yoga (Bhagavad Gita),which means doing efforts and actions objectively by not being attached to the outcome of efforts, whereas in Buddhism, spirituality has been defined as a mid-way path taken by an individual by rejecting the extremes (Ray, 2000). Past literature has shown that both religion and spirituality are distinct concepts. Religion is related to rituals as well as to be a member of particular formal organization, whereas spirituality is being connected to higher being and the feeling of community within the world (Zinnbauer et al., 1997).

2.2.2.2 Workplace Spirituality

Spirituality means being connected to oneself and finding meaning of life. In this fast challenging word, individuals try to connect to their consciousness through their job at workplace. Employees like to work in such places that can serve their spiritual purpose and can help them in achieving their ultimate goal of life (Zinnbauer, Pargament, & Scott, 1999). Kahnweiler & Otte (1997) described spirituality as, "perhaps the most connected to the concepts such as the search for meaning in what we are doing at the workplace" (Kahnweiler & Otte, 1997, p. 176). Spirituality at workplace is outline by organizational values and culture that facilitate employees to experience transcendence and offers a feeling of joy through sincere connection with their work (Jurkiewicz & Giacalone, 2004). The concept of workplace spirituality can be explained by placing attention on both the individual as well as organizational aspects along with examining their mutual relationship. It can be regarded as paying attention to the employees' experience of spirituality at workplace as well as organizational facilitation of

spiritual experience to employees through organizational values and culture. Another view about workplace spirituality can be described as a mutually nurturing relationship between employees' experience of spirituality and workplace facilitation (Ashmos & Duchon, 2000b). It is reflected in the concept of workplace spirituality that an employee's inner life "both nourishes and is nourished by" work aspects of meaningful work occurring in the context of community (Ashmos & Duchon, 2000a, p 137).

Workplace spirituality can be facilitated with inside-out and outside-in approach. The inside-out perspective focuses on the spiritual transformation of individual employees to facilitate spirituality in organization. In contrast, the outside-in perspective focuses on the organizational approach in facilitating employees' experience related to spirituality based on the incitement given by an organization. The present study has adopted self-identity theory to explain the concept of workplace spirituality. According to this theory, workplace spirituality can be defined based on the three levels of self-identity, that is individual, relational, and collective levels (Sedikides & Brewer, 2001). Spirituality at workplace is a continuum of inclusive levels that are individual, collective, relational, and transcendental self-identity (Liu & Robertson, 2010) as shown in Figure 2.1. Spirituality continuum starts with individual self-identity; that is, separating the individual self from others. This self-construal can be explained as, "the feeling individuals have about the fundamental meaning of who they are, what they are doing, the contributions they are making" (Vaill, 1998, p.218).

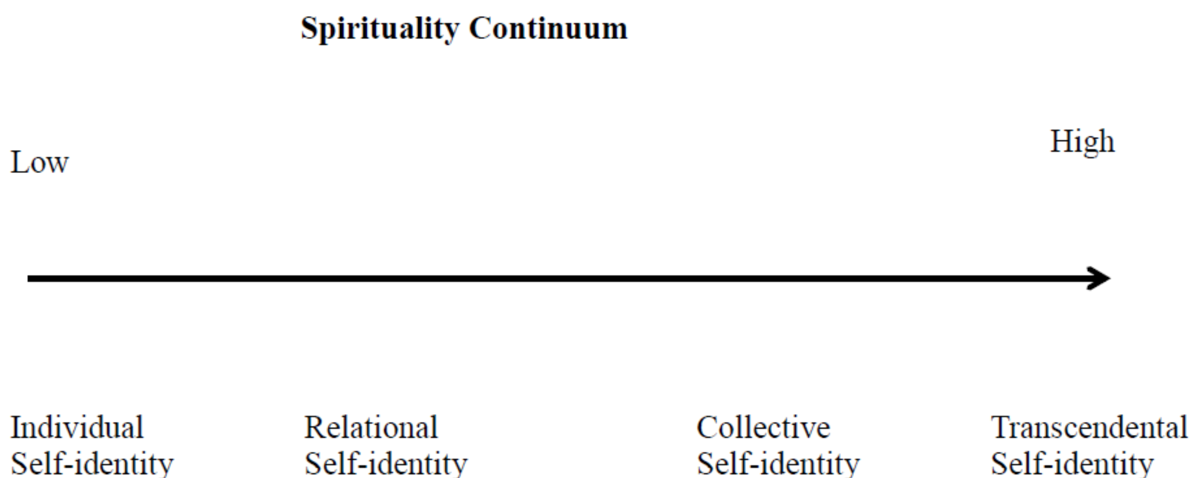

Figure 2.1: Concept of Workplace Spirituality [Adapted from (Liu & Robertson, 2010)]

Understanding spirituality at workplace begins at the moment when employees start differentiating inner and outer life and acknowledge that nourishment of inner self can lead to meaningful outer life (Ashmos & Duchon, 2000a). Individual level perspective emphasizes on the experiential inputs for facilitating the spiritual transformation of inner power among employees (Pawar, 2009). Individual focus approach can be applied to both pure and applied spirituality. Pure spirituality is the self-awareness and inner experience of an individual free from conventional thoughts and perceptions. Applied spirituality is practical application of pure spirituality which is associated with inner experience (Heaton, Schmidt-Wilk, & Travis, 2004). Spiritual awareness of an individual is considered an initiation of spiritual experience at workplace. The next level in continuum of spirituality is relational self-identity, which accentuates the adeptness and the personalized bond with others. Spiritual individuals nourish their inner self and connect to their beings for meaningful work (Wheatley, 2011). As per Mirvis (1997), "work itself is being re-discovered as a source of spiritual growth and connection to others." (p.193). Spirituality is ingrained in daily experiences through which employees want to connect to each other at work (Conger, 1994). Group level spiritual facilitation is reflected in the community building process. According to Mirvis (1997), "development of community in a group occurs on four cornerstones namely; consciousness of the self, consciousness of others, 'group consciousness, and organizing 'in harmony with...unseen order of things'" (p. 195–196).The next level is collective self-identity that is employees' stresses on common identification of unit and group (Andersen & Chen, 2002). A sense of community is vital for spiritual development, as employees connect with other stakeholders emotionally, psychologically, and spiritually. The feeling of community helps "both leaders and members to confront the loneliness, disappointment and pain of modern organization and to decide that these conditions should not continue to rot the spirit of an organization and the people in it" (Vaill, 1998, p.227). Organizational focused views emphasize on the organizational characteristics like human resources policies, organization's mission and vision, culture and spiritual values. These features facilitate employees in experiencing spirituality at workplace (Milliman, Czaplewski, & Ferguson, 2003).

The uppermost stage in continuum is transcendental self-identity, that is, expansion of intrapersonal, interpersonal, and transpersonal identity. The interconnection at this stage is deep rooted with coherent wholeness while expanding the boundary of individual self. Employees feel

the transcendence of harmony and congruence with employees, team, organization, and society at large (Chawla & Guda, 2013). These views need to be integrated for clear observation of the comprehensive model of workplace spirituality.

The theoretical foundation of the present study is stress and workplace spirituality that better represent the constructs under the study and the relationship that is shared between them. The JD-R model explains the causes and consequences of the stress and self-identity theory explains the ways in which an individual and organization can be a vital resource in handling the stress at workplace. So, both theories complement each other, and this combination best suited considering the conceptual model of this study. The model explains the ways in which the conflicting state of job demands and available resources like inter–role conflict at work and family domain accompanied by organizational factors like bullying and patient incivility causes stress. Further, the spiritual resources at workplace explain the ways of maintaining the balance between conflicting demands and resources situation with the self-identity theory of workplace spirituality.

2.3 Conclusion

Chapter three has presented the theoretical base of the present study, which provides the foundation for further research. The theoretical framework of present study is based on stress and workplace spirituality, that is, the JD-R model and self-identity theory, respectively, which supports in better understanding of the concepts and the relationships between the constructs of conceptual model. In the following chapter, the relevant literature has been discussed based on which the hypotheses have been formulated.

CHAPTER - 3

LITERATURE REVIEW

3.1 Overview

The chapter provides the brief historical background of nursing profession by describing the culture and history of its emergence along with the external and internal environment of public healthcare institutions. This eventually leads to discussion of the issues pertinent to nursing staff of public healthcare institutions, while identifying the causes and consequences of varied perspectives of this profession. Further, the constructs under study are described and literature on the hypothesized relations between antecedents of stress, work-family conflict, bullying, patient incivility and its job outcome, such as quality of care, are reviewed to support the hypotheses formulation. The moderating role of workplace spirituality in balancing stress and quality of care has been supported with help of the extant literature.

This chapter presents the relevant literature for supporting the conceptual model of the present study.

3.2 Context of the Study

3.2.1 Development of Nursing Profession

Nursing is as old as mankind and refers to nurture and care for all without any discrimination. The word nurse originates from Latin word *nutrica*, which means 'to care' and 'to nourish', and nurses cherish this word with their services towards the injured, sick and disabled persons for attaining, retaining, and maintaining health and wellbeing. Nursing services differentiates them from other healthcare professionals because of their approach and scope of practice and care. Literature shows that the ancient principles and practices of nursing are scientific in nature and therefore majority of them fit even in the contemporary world. Furthermore, the evidence related to importance of nursing was found in 700–600 before Christ. in scriptures such as Sushruta Samhita (Mhaske & Kadu, 2014). In India, the first nursing school was established during Maharishi Charka's time in 250 before Christ. (Russell Tranbarger, 2006)

reveal and show that nursing profession has deep roots in India. In addition to this, ancient civilizations such as Greeks, Egyptians, Hebrews, and Babylonians have given description of the nursing services. In early Christian era, women were also considered in nursing community. Phoebe, Fabiola, and Paula were first recognized as female nurses in 60 anno Domini and till that time the formal nursing school was not established to train nurses. Pastor Theodur Fliedner was the founder of first training institutes that provided training to female nurses in 1838. He transformed the male dominating profession of nursing to feminine one, and with time nursing has become female dominating profession. The most famous student of this school was Florence Nightingale also known as 'Lady with the Lamp'. Florence Nightingale is known as 'Mother of modern nursing' as she bestowed new heights and recognition for the nursing profession.

Nursing can be divided in intuitive or primitive, apprentice, educative, and contemporary period. Intuitive period was during the early Christian era, where nursing tasks were performed as a desire to help and as a part of religious orders. During apprentice period, the first training school was established in Kaisserwerth. The era of professional nursing starts from this period with the compilation of the first notes in nursing by Florence Nightingale, who became the first nursing theorist. During the educative period, a nursing school was established in St. Thomas Hospital, London, where the first course for formal education of nurses was designed. Clinical content was further increased in nursing education. Contemporary period is known for scientific and technological development in nursing profession. The 21st century is known for globalized and transcultural nursing services. Florence Nightingale with her efforts had ensured recognition of this noble profession and had implanted the seed of contemporary nursing.

3.2.2 Background and Development of Nursing Profession in India

The medical system in India dates back to pre-Vedic period. The contemporary medical system is based on one of the Vedas, that is, Atharvaveda. Public healthcare system can be traced back to the Vedic period and it has clear indication of well-developed sanitation system of the underground drainage and public bath. Further, Sushruta (known as the father of modern surgery in India), in his book *Sushruta Samhita,* mentioned that person with noble character can only serve as nurse. Medical education was introduced in the university of Taxila and Nalanda in

India. Medicine and nursing were considered as two indispensable and complimentary parts of the healthcare system.

Nursing is regarded as science and art of care, and nurses are considered as angels on earth who provide support to the patient and family as well as to assist the doctor. Nurses play a pivotal role in the efforts made by healthcare institutes to protect, promote, and optimize health of society. Professional nursing in India has its roots in the colonial era (Wilkinson, 1958) because the Royal Sanitary Commission on health recommended imperative need for adequate nursing care for the British army in India, and for this reason, the Indian nursing council (INC) was established.

The first school of nursing was started in the Government General Hospital, Madras, in the year 1871, and the training for professional nursing was started under the leadership of Catherine Grace Loch in 1888. Nurses worked in dangerous, dirty, and strenuous conditions in British rule. Mr. B.C. Roy worked for maintaining dignity and standard of nursing. In 1908, the trained nurses association of India (TNAI) was established to endorse honor to the profession as well as to provide international identity to Indian nurses. On the recommendations of Bhore Committee (1946), two colleges of nursing were started; one in Delhi and the other in Vellore.

During the post-colonial era, overseas experts in nursing were sponsored by international organizations like World health organization (WHO) for recreating the pillars of healthcare, that is, to raise the standard of nursing education and prevailing practices of nursing in India. Even after independence, the conditions of nurses were more or less the same as was in the Colonial era because Western nursing leaders followed the system that was conservative, problematic, and not as per the culture and economic condition of India. British systems have great influence in the economy, culture, and society of India.

Nursing in India was modeled according to the ideology of British nursing, which had its own advantages and shortcomings. Under the British rule, the vision of professional nursing was induced with ethos of formal and professional training, and organization structure and culture was placed for effective nursing services and international (Kumar & Arora, 2015) recognition of Indian nurses (Perry & Lev, 2007). Nurses are the backbone of healthcare institutes for delivering cost effective and quality care services.

3.2.3 Nursing and Indian Government

Valuable interest of government in nursing has been an integral part of the five–year plans of India. After independence, Shetty Committee under the supervision of first health minister recommended more training schools for nurses as well as suggested pay scale and representation of nursing superintendents in the state directorates of health services. The first five–year plan (1951–56) gave a spotlight to nursing profession in the national planning and highlighted the requirement of more nurses and tutors. The second five–year plan (1956–61) advocated the standardization of nurses training and promoted better facilities together with working part time and inclusion of nurses in the up-gradation of public health. The third five–year plan (1961–66) bore evidence of the weakened emphasis on nurses and nursing profession (Healey, 2014). In the fourth, fifth, and sixth five–year plan, the significance of nursing was neglected in health planning, as nurses were considered 'paraprofessional manpower' and separate identity of nursing services was ignored. The attention towards nursing profession was renewed from the seventh five–year plan (1985–90) by appointing high power committee on nursing. The revision of improvement in education and safety of nurses was recommended. The eleventh five–year plan (2007–12) emphasized on the programs related to the improvement of nursing skills in diverse areas, and the focus of twelfth five–year plan (2012–17) is to fill the gap of manpower in the field of nursing as well as to reduce attrition and periodical review of nursing program curriculum. The five–year plans have indispensable role in the development and growth of nursing profession.

3.2.4 Organization Structure

The organizational structure of nursing in India differs with regard to state, private, and autonomous hospitals. Furthermore, the structure differs among educator nursing and epidemiologist nursing professionals (Figure 3.1). In autonomous hospitals, the chief nursing officer is the head of nursing department and is responsible for management of the nursing department. The officer reports to the director through medical superintendent of the hospital. Nursing superintendent reports to chief nursing officer and is responsible for administration of the nursing services. Moreover, the three members (deputy nursing superintendent educator, deputy nursing superintendent epidemiologist, and nursing superintendent) are accountable to the nursing superintendent. Deputy nursing superintendent who is an educator and epidemiologist is

liable for education of nursing staff as well as for infection control. Deputy Superintendent is accountable for the administration and supervision of all the departments of a hospital such as Operation Theater, emergency, outpatient department (OPD), pediatric center, and all other blocks of the hospital. Assistant nursing superintendents are accountable for one or more than one wards of the hospital. Next Grade I is accountable of ward management and support Grade II provides bed side care to patients.

In private and state government hospitals, nursing superintendent works as head of the nursing department. In private and state government hospitals, subsequent to nursing superintendent is the deputy nursing superintendents and matrons, respectively. They are liable to manage the floor of the hospitals assigned to them. In private hospitals, the supervisor are accountable for managing their respective wards and report to nursing superintendent. Nursing sisters manage their respective wards and help the staff nurses. Auxiliary nurses support staff nurses in private hospitals. In state government and autonomous hospitals, the nursing department and college of nursing work independently, whereas in private hospitals both the departments work in association with each other (Figure 3.1).

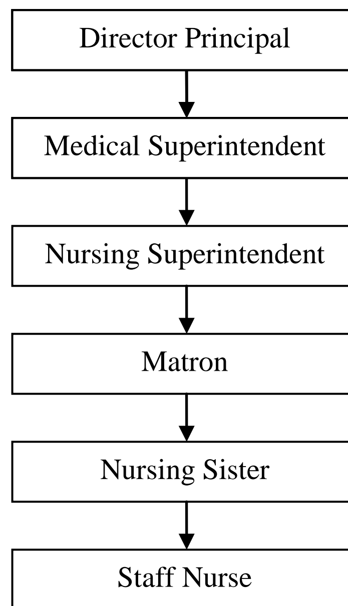

Figure 3.1: Hierarchy of nursing department of State or Central Government Hospital

3.2.5 Recruitment of Nurses

Nurses are vital healthcare professionals, and nursing services are cornerstone for the quality of patient care and efficiency of healthcare institutes (Rao, 2010). The recruitment policy plays a crucial role for employing efficient nurses to receive better healthcare services. Mixed method approach is adopted for recruitment of nurses. The rules of recruitment vary as per the designation and appropriate importance is given to education, experience, and promotion for each designation. The recruitment rules are depicted in Table 3.1 and 3.2 [Adapted from (Saini & Singh, 2008a, 2008b)].

Table 3.1: Recruitment rules of nursing staff for selected hospitals (Staff Nurse/Nursing Sister)

Designation	**Autonomous hospital**	**Private hospital**	**State Government hospital**	**INC Recommendations**
Staff Nurse				
Method of Recruitment	Direct	Direct	Direct	
Age Limit	18–30 years	18–35 years	18–40 years	
Qualification	Matriculation Certificate in General Nursing & Midwifery/ B. Sc. Nursing Registered 'A' Grade Nurse & Midwifery Test-cum-Interview	Matriculation Certificate in General Nursing & Midwifery/ B. Sc. Nursing Registered 'A' Grade Nurse & Midwifery Test-cum-Interview	Matriculation Certificate in General Nursing & Midwifery/ B. Sc. Nursing Registered-'A' Grade Nurse & Midwifery Interview	Matriculation Diploma in Nursing & Midwifery /B. Sc. Nursing Registered 'A' Grade Nurse & Midwife
Probation Period	2 years	1 year	2 years	

Nursing Sister				
Method of Recruitment	Promotion	Direct	Promotion	
Age Limit	Not Applicable	Not Applicable	Not Applicable	
Qualification	Matriculation Certificate in General Nursing & Midwifery/ B.Sc. Nursing Registered 'A' Grade Nurse & Midwife	B.Sc. Nursing Registered 'A' Grade Nurse & Midwife	Matriculation Certificate in General Nursing & Midwifery/ B.Sc. Nursing Registered 'A' Grade Nurse & Midwife	Diploma in General Nursing & Midwifery Diploma in education & Administration/ B.Sc. Nursing Registered 'A' Grade Nurse & Midwife
Probation Period	2 years	1 year		
Experience	5 years as Staff Nurse/ Sister Grade II	5 years as Staff Nurse	5 years as Staff Nurse	5 years as Staff Nurse

Table 3.2: Recruitment rules of nursing staff for selected hospitals (ANS/DNS/Matron)

Designation	**Autonomous hospital**	**Private hospital**	**State Government hospital**	**INC Recommendations**
ANS				
Method of Recruitment	Promotion 100%	Direct		
Age Limit	Not Applicable	Not Applicable	18–40 years	
Qualification	'A' Grade registered Nurse & Midwife Certificate in	M.Sc. Nursing		'A' Grade Registered Nurse & Midwife Certificate in

	General Nursing & Midwifery/ B.Sc. Nursing			General Nursing & Midwifery Certificate in Education and Administration/ B.Sc. Nursing
Experience	5 years as Grade I	5 years of teaching experience	Not Applicable	5 years as Nursing Sister
DNS/Matron				
Method of Recruitment	Promotion	Direct	Promotion	
Age Limit	Not Applicable	Not Applicable	Not Applicable	
Qualification	'A' Grade registered Nurse & Midwife certificate in General Nursing & Midwifery/ B.Sc. Nursing	M.Sc. Nursing 'A' Grade registered Nurse & Midwife	'A' Grade registered Nurse & Midwife certificate in General Nursing & Midwifery/ B.Sc. Nursing	'A' Grade registered Nurse & Midwife Certificate in General Nursing & Midwifery Certificate in Education and Administration/ B.Sc. Nursing
Experience	5 years as Assistant Nursing Superintendent	5 years as Assistant Nursing Superintendent	5 years as Nursing sister	5 years as Assistant Nursing Superintendent

3.2.6 Working Culture and Nursing

The role of nursing is expanding and becoming complex in the challenging work environment of healthcare institutes. Nursing care plays a principle as well as critical role in delivering quality of care to patients. However, the quality of nursing care depends on the amalgamation of individual employee aspects, interpersonal relations, team work, and work culture of an organizational. Professional ideology and culture was adopted from the West, but the East being different in cultural, social, and economic status, the professional culture in nursing proved to be ineffective and on marginal state since decades. Structural hierarchy has widened the gap between staff nurse, nursing superintendent, and director principle and this hampers the open communication and weakens the interpersonal relations at workplace. Because of the hierarchical gap, nurses at various levels are not able to convey the problems and issues they experience at workplace. Nurses providing bed side care to patients face various working issues and problems that need to be communicated to the higher officials, so that those issues can be addressed while drafting policies (Ojha, 2015a) and regulations for nurses. Nursing is a female dominated profession, where women are more susceptible to face incivility at workplace. Nurses have considered aggressive and violent behavior as an integral part of their profession which not only have a negative impact on the growth of such a noble profession but is also contributing towards deterioration of the problem related to attrition amongst nurses. All these reasons relate to the degradation of patient care.

3.2.7 Human Resources in Nursing Profession

Nurses are the pulse of healthcare because they take care of patients' life. Service sector depends on human resources for delivering the apposite service quality that is required specifically in nursing as face to face interaction is as important as medication (Pathak, Anindita, & Patwardhan, 2011). Nursing is service oriented, and nurses play a unique role in nurturing the health and well-being of patients (Rao, Rao, Kumar, Chatterjee, & Sundararaman, 2011). Nurses require intense motivation to give new life to the patients and to serve the humanity. Despite their noble service and in spite their being the building block of healthcare system, nurses are ignored as professionals. Working conditions of public healthcare institutes is becoming complex and intense, and these conditions create a traumatic environment which can leave either a positive or negative perception among new recruits. Fresh recruited nurses come with fresh energy and vision which need to be channelized to grow both the profession and professionals. In the first few years, nurses need to be nurtured and cared in order to make them ready for their profession, so that they can take good care of others. Public healthcare institutes have ignored

such a vital element for developing a satisfied and motivated workforce. A new nurse yearns for support and guidance from seniors, but belittling behavior from seniors infuses negative behavior because the new nurse has to compromise with his or her values to fit in the environment. Such conditions create inner conflict among freshly recruited nurses and referred to common phrase that ‘nurses are eating their young’. This type of beginning has a long term impact on nurses and their relation with seniors, which in turn affects team work, and in the long term this will adversely influence the nursing profession and patient care.

Nurses are noteworthy human resources who play a crucial role in providing care to the patients; however, they are ignored by the management while framing human resource policies of PHCI. There seems to be lack of effective human resource strategies for the overall improvement and development of nursing staff. Nurses are not provided adequate training opportunities for improving their nursing care and soft skills to handle patients and their relatives. Nursing staff works even with the lack of basic facilities like crèche, changing rooms, rest rooms, lack of proper lunch, and tea break and this even affects health of both the nurses and their patients.

3.2.7.1 Issues Related to Indian Nurses

Nurses handle and solve the health problems of patients, and it’s unfortunate that the professionals, who are problem solvers, actually face maximum problems and issues at workplace. The quantum of patient care and other administrative responsibilities along with ailing facilities and the status of paraprofessional manpower have weighed down Indian nurses. Nursing staff is surrounded with myriad of job tasks, and this huge work pressure adversely affect the psychosocial wellbeing of nurses, and it’s like a pie in the sky for them to think for their quality of life. Nurses are crippled by weak interpersonal relations, lack of support and respect from colleagues, seniors and patients in their profession. Nurses have a unique function of appreciating health and wellbeing of people, therefore, in the same way; they must be able to cherish their dream of living a happy and healthy life, so that they can help other for the same. Inadequate resources, unfair compensation and dividends (Gupta, Dogra, & Vashisht, 2013), weak support system, and feeble relations with diverse stakeholders at workplace are some of the stumbling block in nursing profession (Garg & Gupta, 2015). Fair compensation, good living

standards, strong support system, and adequate representation of nursing related issues (Pacoy, 2004) can insulate nurses from varied occupational menaces, and they can better concentrate on their services towards patients. Nursing care needs humane touch much more than just medication for physical, mental, emotional, and spiritual care of the patients (Priolcar, 2013). Administration needs to take care of the physical, emotional, and spiritual needs of the nurses for betterment of people (Ojha, 2015b) and society at large.

Working in close proximity with patients and their relatives and interacting with them can be stressful for nursing staff. The internal and external environment of public hospitals has an immense impact on patient care, so significant aspects of stressors and consequences of stress on nursing staff have been demonstrated carefully in the present study.

3.3 Identification and Selection of papers

For comprehensive and profound understanding of the past literature prevalent in the current research perspective the following electronic databases were used as the source: Science direct (1958–2015), EBSCO (1958–2015), Google Scholar (1958–2015), PROQUEST (1958–2015), SCOPUS (1958–2015), research reports and newspaper articles. Pertinent research papers till date along with those in 2016 were specifically selected for the present study. Relevant research papers were searched by using the keywords and text words for each of the construct under study, that are, patient incivility, work–family conflict, bullying, stress, workplace spirituality, and quality of care. Abstracts defining the constructs and their relationships were selected by the researcher. Research papers including all professions including nursing and all over the world including India were selected, however search was restricted to abstracts and research papers published in English only.

3.4 Description of Key Constructs

3.4.1 Work-Family Conflict

Work and family are the two indispensable parts and the central domain of anyone's life, where these two parts meddle with each other in many ways. Balancing work and family roles is becoming a challenging task, as the social systems and family structures are changing radically,

specifically in the developing countries like India. The impetus for research on the conflict between demands of work and family role stems from the continuous demographic changes that are reshaping the Indian society. For example, social systems like family characteristics are changing radically with the formation of nuclear families, changing composition of the workforce as the percentage of working women are on the increase, dual career couples, and late night work culture are witnessed in India. Moreover, the traditional division of family and work roles no longer exists in families where both husband and wife have their respective careers. These changes are influencing the work and family roles as both the roles are interdependent and dynamic in nature (Springer, 2014), and the need to maintain balance between work and family is becoming more intense in the changing scenario. In various situations, work and family roles can come in conflict with each other and intersection of both the roles can hamper the balance of work and family life.

As per Merriam–Webster's online dictionary, work can be defined as the activity which is done as a part of job to earn money.

Kozier (2008) defined family simply as a basic unit of society in which parents, grandparents, and children live under one roof and under one head.Rubin, Pruitt, and Kim (1994) explained conflict as the "perceived divergence of interest, or a belief that the parties' current aspirations cannot be achieved simultaneously" (p. 5).

Work and family are interconnected spheres, and work–family interference is bi-directional. Family demands sometimes interfere in the work domain, and this is termed as family-to-work conflict which is defined as, "form of inter-role conflict in which the general demands of, time devoted to, and strain created by the family interfere with performing work-related responsibilities" (Netemeyer, Boles, & McMurrian, 1996, p. 401). Alternatively, work demands at times restrains an individual from fulfiling family demands, and this is termed as work-to-family conflict which is defined as, "a form of inter-role conflict in which the general demands of, time devoted to, and strain created by the job interfere with performing family-related responsibilities" (Netemeyer et al., 1996, p.401).

Professions like nursing are based on human contact and so physical, psychological, and emotional job demands are more owing to challenging working environment, specifically in the

nurse to patient care (Dollard, Winefield, Winefield, & Jonge, 2000). The job profile of a nurse is demanding, as it comprises long working hours, night shifts, life challenging problems of patients and possibility of being deprived of leaves due to an emergency. Such work demands interfere with their family demands, and it becomes difficult for them to balance the both. Furthermore, the result of past studies have shown that the difficulty nurses face in balancing the work and family respondents create negative attitude and stress among them (Sharma, Dhar, & Tyagi, 2015). With changing time, the responsibilities of females at workplace are becoming more and more vital, and they are also giving equal importance to their career (Ahuja, 2002). Nursing is a demanding job and therefore, nurses are not able to devote sufficient time to their family (Sharma et al., 2015). Literature review supports that work family conflict is more significant among nurses than family work conflict (Happell et al., 2013), and focus of the thesis will be on the conflict between work and family as confronted by nurses.

Work family conflict evolved from the processes called role and inter-role conflict. Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964) defined role conflict as, “simultaneous occurrence of two (or more) sets of pressures such that compliance with one would make more difficult compliance with the other” (p. 19).Work family conflict can be defined as, “a form of inter-role conflict in which the role pressures of the work and family domains are mutually incompatible, so that participation in one role [home] is made more difficult by participation in another role [work]” (Greenhaus & Beutell, 1985, p. 77). In other words, the involvement in family role is made tougher by virtue of involvement in work role (Greenhaus & Beutell, 1985). Work family conflict can be explained as the pressure that is experienced owing to inter-role conflict in the domains of work and family, where demands of both domains are incompatible and conflicting in some respect (Jaga & Bagraim, 2014). By reviewing 25 research papers on the antecedents of work–family conflict, Greenhaus & Beutell (1985) highlighted three conceptually unique forms of work family conflict, that are, a) Time based conflict, b) Behavior based conflict, and c) Strain based conflict.

(a) Time based conflict: Time is a finite phenomenon, and one has to fulfill the demands of multiple roles in the limited tenure. Time based conflict occurs when time spent on fulfilling the demand of one role makes it challenging to achieve the demands of another role. Individuals compete within various roles of work and family, and conflict arises

when time and energy spent on one role can't be dedicated with same intensity on activities necessary for fulfilling the demands of another role (Greenhaus & Beutell, 1985). To accomplish the required roles of life, a person needs resources like time, energy, and attention, and conflict comes into picture when these finite resources are spent on one sphere and can't be utilized in other spheres. The perception about the extent of conflict rises as per the number of hours spent on both work and family roles (Gutek, Searle, & Klepa, 1991). Time based conflict can be explained in two ways: a) Owing to time constraint, it may be difficult for a person to fulfil the expectations of another role while participating in the other role; b) Time pressure may result in physical or psychological preoccupation with one role, even when one is physically present to accomplish the demands of another role.

Time based conflict can either be due to work or family related sources. Work related sources consist of work overload, irregular shift work, inflexible working environment, job complexity, and long working hours. Basically, time conflict is related to the intensity and amount of time spent in one role compared to another role (Goodman & Crouter, 2009). Family related sources of work–family conflict consists the responsibility of taking care of elder people, young children, and large family (Nomaguchi, 2009). Moreover, working mothers may confront WFC more than their male counterparts because of the cultural schema that mothers should take care of children and be more devoted towards their family life (Aycan, 2008). The findings of empirical studies are consistent with the belief that the time pressure of both domains contribute to work family conflict (Valk & Srinivasan, 2011).

(b) Behavior based conflict: Behavior based interference occur when the forms of behavior exhibited in one role may be incompatible to demand or expectations of another role (Edwards & Rothbard, 2000). Each role demands different behavior from a person, such as a person is expected to be less emotional and independent while fulfilling work roles, but is expected to be nurturing, emotional, and tender while fulfilling family roles. Conflict may arise if he/she does not alter the behavior as per the role demands.

(c) Strain Based Conflict: It involves the strain generated because of the varied roles played by an individual. It can be explained as the strain caused owing to participation in one role which in turn can make it tough to achieve the expectation of another role (Greenhaus & Beutell, 1985). Past literature has provided substantial evidence related to work stressors causing anxiety, depression, fatigue, and tensions. Conflict not only develop from the conflicting role demands, but also from the stress that arouse while performing multiple roles, which further lessen the physical, psychological, and emotional resources required for achieving diverse role demands. Employment quality (i.e., job satisfaction, job autonomy), time, quality of working environment (i.e., working hours, level of organizational support) can generate the physical as well as psychological fatigue and dissatisfaction.

3.4.1.1 Antecedents of Work-Family Conflict

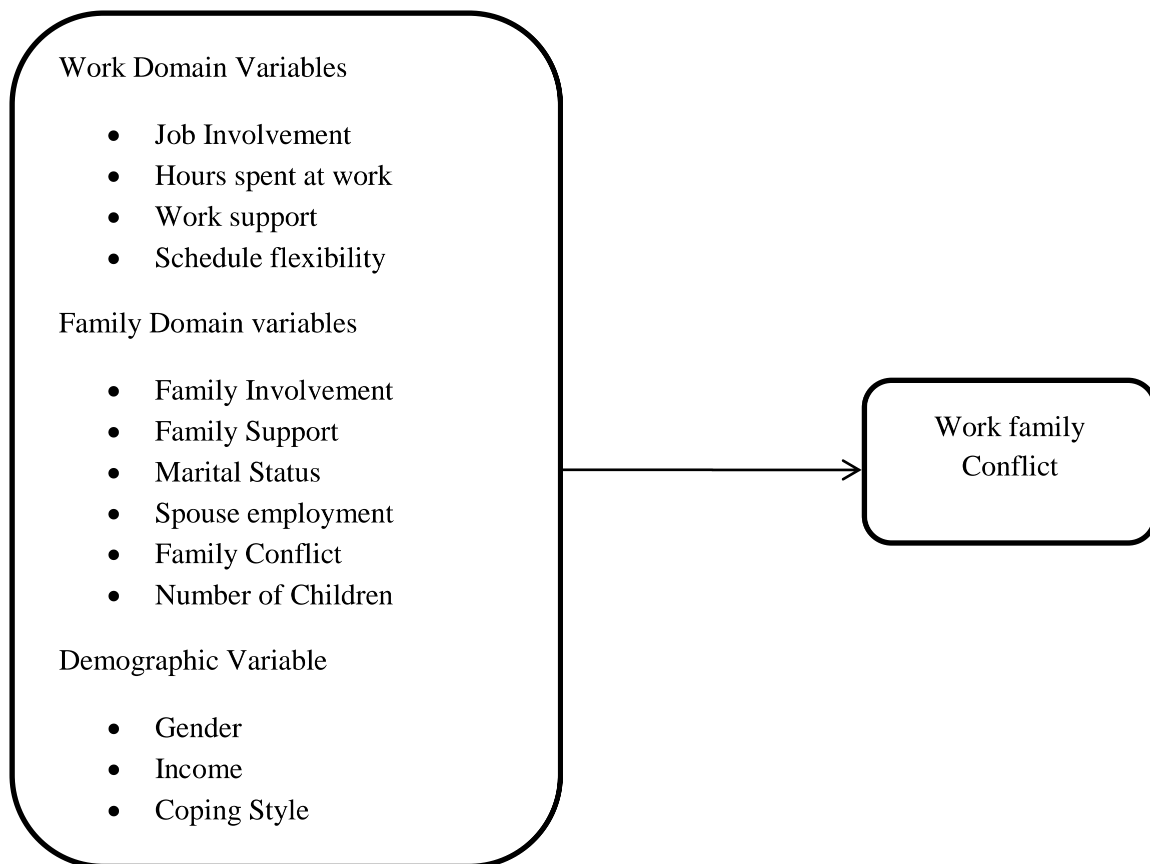

Figure 3.2: Antecedent of work-family conflict [Adapted from (Byron, 2005)]

Work related factors such as role ambiguity, rate of environmental changes, physical, psychological, and emotional demands of the job, can create strain in mental concentration that is required for fulfilling the requirements of both work and family domains (Pleck, Staines, & Lang, 1980). Even non-challenging and routine job profile can create strain among employees (Maguen et al., 2009). Mitchell, Eby, and Lorys (2015) suggested 'negative emotional spillover' from the work to family domain (Figure 3.2). Family resources such as poor interpersonal relations, unsupportive spouse, and others may become the reasons of strain in both the domains of life (Kendall-Tackett, 2005). Working mother and wives having different occupation from their husbands and working with complex job profile can experience strain while performing the dual role (work and family) (Beatty, Mayer, Coleman, Reynolds, & Lee, 1996).

3.4.1.2 Consequences of Work-Family Conflict

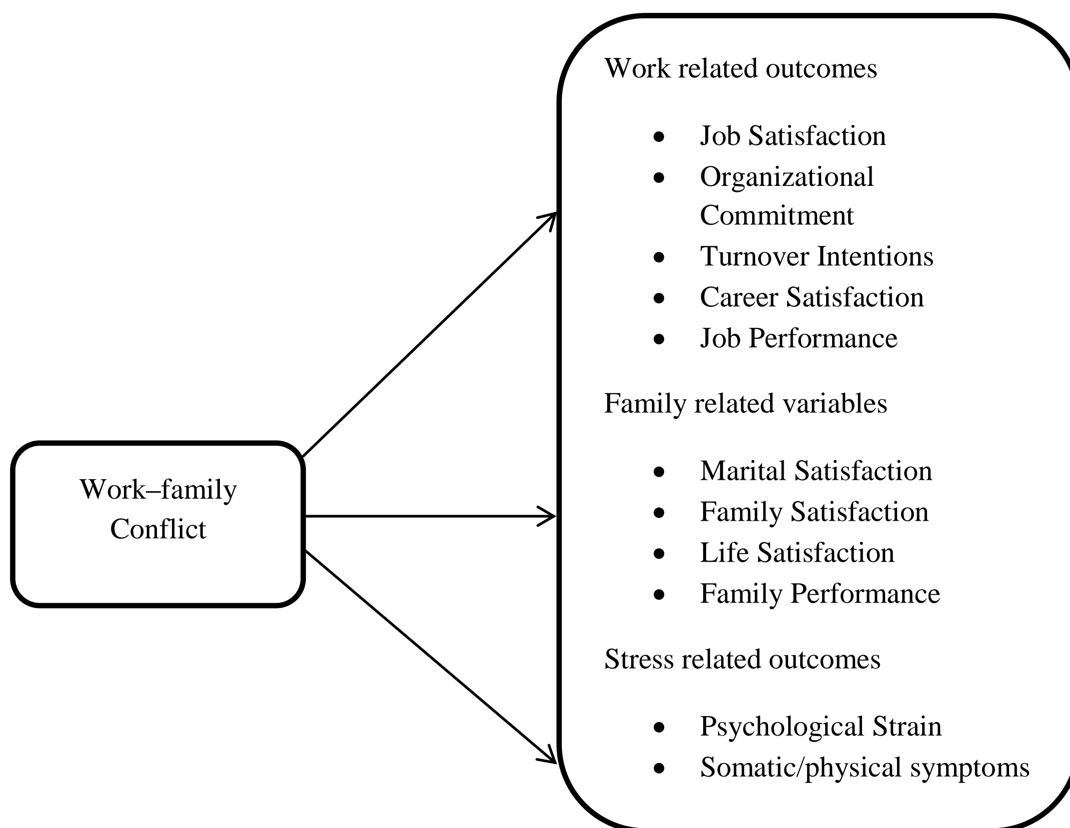

Figure 3.3: Consequences of work-family conflict [Adapted from (Allen, Herst, Bruck, & Sutton, 2000)]

Past literature suggests that work and family characteristics along with absence of support can create imbalance in available and required energy which may contribute in work family conflict (Figure 3.3). Competing demands between work and family roles arouse the conflict for employees. As per the role theory, employees try to balance the multiple roles within constant time and energy, thereby, increasing the possibility of conflict, overload, and negative outcomes like anxiety and depression (Grant-Vallone & Donaldson, 2001).

Further, the scarcity theory on human energy has explained work-family conflict as "any degree of commitment to one role will detract from commitment and chances of success, in the other, simply in terms of the availability of time and energy" (Edgell, 1970, p. 320). The consequences of work family conflict can be grouped in three categories that are related to work, family, and stress. Work-family conflict has an adverse impact on job related outcomes such as decreased job satisfaction, performance, career satisfaction, career success, increased absenteeism and attrition rate. In addition, this conflict in employees affects their marital and family life and eventually their life satisfaction. Furthermore, it affects stress related outcomes such as strain, anxiety, psychosomatic symptoms, depression, and psychological strain. All these factors in totality affect the mental state of employees and eventually their capability to perform their roles in either domain.

3.4.2 Bullying

Workplace behavior of employees decides the direction of the success or failure of an organization. Researchers are showing increased interest towards understanding the reasons and repercussions of aggressive and harmful workplace behavior of employees such as bullying (Robinson & Bennett, 1995). Past studies have suggested that bullying involves demeaning activities and hostile behavior. Bullying indicates the negative behavior and actions that occur between two persons or groups that may also be framed as corrupt behavior (Hutchinson et al., 2010). Workplace bullying can be considered as the subsection of aggression and a form of escalated conflict at workplace.

Research on workplace bullying started in the early 1980's (MacIntosh, 2005). The concept of bullying was first documented by Olweus (1973) and then introduced by Brodsky

(1976) in his book, ‘The Harassed Workers’. Leymann (1996) enquired about the conflicts that exist in workplace and explained the bullying phenomenon with a concept called mobbing in his book, “*Mobbing: Psychological Violence at work*”. Till 1990s, the research on bullying was focused more or less on European countries only. Adams and Crawford introduced the concept of bullying in UK (Adams & Bray, 1992). Earlier, both mobbing and bullying were considered as distinct terms, which only indicated the distinct focus of the same concept. Now both mobbing and bullying are used interchangeably in various studies, as this difference has blurred over the period of time (Branch, Ramsay, & Barker, 2013). With the passage of time, the studies on bullying have diverged from organizational psychology towards interdisciplinary field. In its earlier days, the research on bullying was focused on the intensity and the rate of occurrence of such behavior, the type of people involved in bullying behavior and its impact on the target (Ayoko, Callan, & Härtel, 2003). Since the last two decades, the focus of research has moved towards studying the impact of bullying on both individuals as well as on organizations.

Einarsen, Hoel, Zapf, and Cooper (2011) described bullying as, “. . . harassing, offending, socially excluding someone or negatively affecting someone’s work tasks. In order for the label bullying (or mobbing) to be applied to a particular activity, interaction or process, it has to occur repeatedly and regularly (e.g., weekly) and over a period of time (e.g., about six months). Bullying is an escalating process in the course of which the person confronted ends up in an inferior position and becomes the target of systematic negative social acts. A conflict cannot be called bullying if the incident is an isolated event or if two parties of approximately equal ‘strength’ are in conflict” (p.22).

Vickers (2006) described workplace bullying as, “persistent, offensive, abusive, intimidating, malicious or insulting behavior, abuse of power and unfair penal sanctions, making the target feel upset, threatened, humiliated or vulnerable” (p. 269).

Bullying involves three main actors, namely, the bully, the target, and the bystander. Bully is a person who degrades, intimidates and shows vicious and aggressive behavior towards the target because of power disparity and threat to his or her security and position. Bully can be of four types: a) screaming mimi, b) two headed snake, c) the gatekeeper, and d) the constant critic (Namie & Namie, 2004). Screaming mimi are loud and they insult the target in public to create a fear psychosis amongst others. Two headed snake is a dual personality person. He or she

praises and behaves like a trusted friend to the target, but in reality not only destroys the reputation of the target but also takes the credit of the target's work. Gatekeeper withholds the required information and resources, so that the target cannot fulfill his or her aim. Constant critic is the one who is continuously involved in unwanted criticism, as it will eventually lead to crumbling of the credibility and confidence of the target.

Target is the one who is bullied, and so faces the humility, psychological terror, and persistent social criticism (Einarsen et al., 2011). If the target is skilled and confident to fulfill his or her goals, then he or she can be a probable threat to the bully. Bully tries to kill the confidence of the target by focusing on his or her weakness. Bystander is the one who observes and witnesses the interpersonal workplace bullying and is usually a colleague and friend of the target and the bully. Bystanders can play significant and varied roles like comprising with the bully, supporting the target or taking a neutral position. They can also play a moderating role between the bully and the target. Bystanders observe the bullying behavior and can even become the victims of bullying which adds to the organizational cost (Hoel, Giga, & Davidson, 2007).

In the workplace, bullying can be of four types, that are, personal, work related, direct, and indirect. Personal bullying includes continuous criticism, passing insulting remarks and comments about personal life, and playing insulting pranks on the target. Work related bullying includes giving unrealistic targets, unachievable workloads or giving no work, and undue monitoring of the target (Einarsen et al., 2011). Direct bullying includes direct actions and behavior of the bully towards the target like giving personal comments to the target. Indirect bullying includes those behavior and actions of the bully that he or she performs behind the target, and the target generally came to know about the criticism through the grapevine (Lutgen-Sandvik, 2005). Further, Fox and Stallworth (2009) acknowledged six spheres of workplace bullying, which are threatening behavior, isolation, work disruption, demeaning behavior destruction of reputation, and abusive supervision. Bully with persistent and repeated behavior from these six domains tries to humiliate the target. Workplace bullying has three key components: (a) target's perception, (b) intent of the bully, and (c) the uniqueness of the conflict.

(a) Target's perception: Target may not realize that he or she is the target of workplace bullying at the time of bullying behavior, as self-identification of the target may be retroactive (D'Cruz & Noronha, 2010). Einarsen (1999) also claimed the subjective

nature of workplace bullying. Furthermore, literature supports that the target's perception plays a significant role in describing any behavior as bullying because it is, "its perpetrator that determines ultimately whether or not specific interactions are considered to be bullying" (Djurkovic, McCormack, & Casimir, 2005, p. 441).

(b) Intent of the bully: The other significant element is whether the behavior was intended towards the target or just perceived by the target as bullying behavior. Understanding of the bully's actual or the perceived intent can play an important role for the target to think about the protection mechanism. However, Neuman and Baron (2005) explained this element as, "although the perceived intent of an actor is important, it is the actual intent of the actor to inflict harms that is critical" (p. 17).

(c) Uniqueness of the conflict: Each workplace bullying behavior needs to be unique in a sense that each situation is exclusive, and the perceptual behavior of the target as well as the bully is also unique in each situation. The reason behind it is that each situation may be stimulated by a combination of various elements and may result in negative consequences of divergent frequencies for each target. Tracy, Lutgen-Sandvik, and Alberts (2006) presented the significant insight necessary for understanding of the relationship between workplace bullying and its adverse influence on individuals as well as on the organization. Prior understanding of bullying situation is significant as "once workplace bullying has become an entrenched pattern of negative interaction, it can be difficult or impossible to disrupt" (Tracy et al., 2006, p. 173).

3.4.2.1 Indicators and Antecedents of Bullying

Branch, Ramsay, and Barker (2007) demonstrated the four indicators of workplace bullying: (a) power imbalance amongst target and bully, (b) systematic nature of bullying behavior, and (c) repeated instances of workplace behavior over an extended period of time.

(a) Power imbalance amongst target and bully: Each and every conflict at workplace is directly or indirectly related to power (Deutsch, 2006). The power imbalance between target and bully makes it difficult for the target to defend himself or herself (Hutchinson, Wilkes, Jackson, & Vickers, 2010). Salin (2003) explained that power imbalance includes both formal as well as informal power as, "power imbalances can also be the consequence of other individual, situation, or societal characteristics" (p. 1216).

Imbalance of power can corrupt individuals in various ways such as using power for self -interest, thinking himself or herself superior due to power, forceful gain of power and holding power at any cost (Ashforth, 1994). The imbalance of power may decide the form of bullying, that is, upwards, downwards, and horizontal bullying (Branch, Ramsay, & Barker, 2007). In upward bullying, subordinate or group of subordinates may bully the superior because of their power of expertise (Branch et al., 2007). In horizontal bullying, colleague bully the other colleague as he or she can exert expert or referent power on the other (Branch et al., 2007). Most common is the downward bullying, where a superior bully the subordinate either because of his or her superior position or by exerting expert power (Casimir, McCormack, Djurkovic, & Nsubuga-Kyobe, 2012).

(b) Systematic nature of bullying behavior: Workplace bullying is systematic in nature, as the target is systematically identified by the bully to implement the bullying behavior on the target. Systematic workplace bullying can be defined as, "a series of calculated incidents that accumulate over time, carefully planned and executed by the bully to avoid legal grounds for grievance or disciplinary actions" (Wiedmer, 2011, p. 37). With systematic bullying, the bully easily gets involved in covert actions which mainly include psychological bullying than open physical behavior (Bond, Tuckey, & Dollard, 2010). Workplace bully focuses on one or group of individuals not on all the employees. Abusive and insulting behavior of the bully is directed towards one or specific group of individuals. Bully's deviant behavior is focused on that particular individual/s whom he or she desired to humiliate physically or psychologically (Salin, 2003).

(c) The repeated occurrence of bullying behavior: Bully has a repeated bullying behavior towards the target on various occasions and over a period of time(Nielsen, Matthiesen, & Einarsen, 2008). Workplace bullying becomes intensified over a period of time and is pervasive in nature which differentiates it from the other minor incidents of aggression (Fox & Stallworth, 2010).

3.4.2.1.1 Antecedents of Bullying

Attribution theory explained that the external and internal attributions influence the behavior of an individual in particular situation, as he or she attributes the cause of negative experience on other people (Rayner, Hoel, & Cooper, 2001). According to the past studies,

attributes shown at individual, group, and organizational level contributes to the prevalence of workplace bullying (Einarsen, 1999). At the individual level, employees' with personality traits such as high level of neuroticism, lower extraversion, and conscientiousness are passive, and so they are unlikely to reciprocate the negative behavior and attitude (Persson et al., 2009). Employees with negative affectivity show higher level of anxiety, anger, fear, guilt, and disgust (Watson & Clark, 1984). At the group level, task conflict, lack of communication, low autonomy, and self-managed teams are associated with higher level of bullying (Arthur, 2011). Leadership and management style is associated with bullying at workplace because abuse of power is one of the leading causes of bullying. Further, climate and culture of an organization can permit and trigger abusive and aggressive behavior at workplace (Lutgen-Sandvik, Tracy, & Alberts, 2007).

3.4.2.2 Consequences of Bullying

Continuous encounter of aggressive and bullying behavior have individual and organizational consequences. Bullying affects the cognitive process of individuals as well as their psychological and physiological well-being such as intent to leave, low job satisfaction, absenteeism, and even suicide in extreme cases. Bullying affects the culture of an organization, as aggressive behavior not only affects the target but also the bystanders. The target may even follow the aggressive behavior to protect himself or herself from being targeted in the future, and this may result in weak interpersonal relationships at workplace.

3.4.3 Patient Incivility (PI)

Incivility is a general form of social behavior in which the person lacks civil and good behavior or manners. Baron and Neuman (1998) in their study on workplace aggression and violence, introduced the concept of workplace incivility and explained that majority of violence in workplace environment is subtle, direct, and indirect action (Budd, 1999). Further, Andersson and Pearson (1999) defined incivility as, "low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect." Workplace incivility has been theorized as a particular form of employee deviance which can be defined as, "voluntary behavior that violates significant organizational norms and, in so doing, threatens the well-being of the organization or its members, or both" (Robinson & Bennett, 1995, p. 556). Workplace

incivility has been related with bullying, but there is a clear cut difference between the attributes of both the concepts. Bullying is a systematic and repetitive intent of the bully to harm the target, and there is clear imbalance of power between the bully and the target. However, workplace incivility is low intensity behavior, which is not planned or systematic, and no relationship of power exists between the perpetrator and the target.

Patient incivility is one of the forms of workplace incivility and has been considered as one of the factors for the present study. In context of nursing patient incivility is becoming a significant problem for PHCI. Patient incivility ranged from verbal abuse to physical assault. Cameron (1998) defined verbal abuse as, "any communication that attacks a person professionally or personally; it may refer to behaviors such as yelling, verbal insults, or threats of harm" (p. 34). World health organization (WHO, 2002) defined violence as, "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (p. 5).

Incivility is basically an exchange of emotions between two persons, which has been explained by the researchers through the social exchange theory. However, Lawler (2001) has explained 'an affect theory of social exchange' (p.321) for examining the role played by emotions within social exchange. Each social exchange between two persons involves the emotional component, and the intensity of emotions varies according to the kind of relationship and commitment shared by both of them. Emotions play a vital role in deciding the magnitude and direction of the exchange. He further explained that positive emotions lead to successful exchange, however, negative emotions result in unsuccessful exchange. Emotions lead to either social or unsocial behavior.

Affective event theory has explained, "(the) role of emotion and evaluative judgment in the relationship between an individual's experiences and his or her behaviors" (Carlson, Kacmar, Zivnuska, Ferguson, & Whitten, 2011, p. 298–299). Eminent scholar, Wallis (1987) proposed the schematic model of job satisfaction which states that negative workplace experience leads to stress among employees. Further, stress leads to lower job satisfaction, which eventually leads to poor performance of employees. Furthermore, incivility has been studied from the perspectives of ethology, psychology, and societal learning. From the report presented by WHO on violence

and health, the ecological framework needed for understanding the multidimensional nature of abuse and violence has been recognized (Moon, Patton, & Rao, 2010; WHO, 2002). On the basis of the ecological framework, the interaction of complex inter-relationship of social, cultural, environmental, and individual factors results in violent and abusive behavior (Duffy, Scott, & O'Leary-Kelly, 2005). Pearson, Andersson, and Wegner (2001) identified three characteristics of workplace incivility, which are psychological nature of the bully, ambiguous intent to harm the target and low intensity.

3.4.3.1 Antecedents of Patient Incivility

Gender plays a significant role in the problem of incivility experienced by nurses in healthcare institutions. Nursing is a female dominated profession, as 95 percent nurses are women in India. Incivility towards nurses is reflected in their interaction with patients and their families, and this shows the attitude of people towards them. Nurses face harassment such as eve teasing, staring, pinching, comments about clothes and appearance, sexual comments, yelling and undue touching of patients while performing their routine tasks. Female nurses consider these problems most vulnerable in the nursing profession. Organizational factors such as lack of supply, basic facilities, and manpower; and the characteristics of nursing profession such as overburdened with work, multi-tasking, inadequate security, and lack of instruments contribute to the problem of incivility of patients.

The factors related to patients like critical health status, non-availability of doctors result in aggressive and uncomfortable communication between nurses and patients. Combination of all these factors creates a level of dissatisfaction which leads to stress among nursing staff. Researchers have suggested various indicators prior to violent behavior. These indicators are anger, fidgeting, undue demands and attention, anxious behavior, assertive postures, and paranoid delusional comments (Presley & Robinson, 2002). Budd (1999) stated that, "there is something intrinsic in the nature of the work itself which results in high risks" (p.25). Interaction with public having health issues and furthermore giving bad news about death to patients' families are some of the intrinsic features of nurse's job which may trigger or arouse anger of patient and their relatives (Mark & Smith, 2012).

3.4.3.2 Consequences of Patient Incivility

The consequences of incivility are far reaching and have multifold impact on organization, employees, patients, and society. Patient incivility has a noteworthy impact on the organization in a sense that it loses its reputation because of aggressive episodes, high attrition rate of nurses, issues in recruitment of nurses, and financial loss to patient health care institutions (PHCI). Patient incivility mostly affect the nursing staff and they feel less motivated, less energetic, less attentive, and at times they even leave the nursing profession. The impact of incivility on nurses ranged from neurologic, orthopedic to traumatic situations. Incidents of patient incivility in PHCI give a negative view about the nursing profession, and so fewer nurses are attracted towards this profession. In totality, all these factors hamper the care provided to patients, increase the cost of healthcare, and seriously impact the society at large.

3.4.4 Stress

Stress is an indispensable part of mankind, and it has enormous impact on individuals as well on organizations. So, the interest of researchers is always inclined towards unfolding the layers of multidimensional and complex concept called stress. To better understand the concept of stress in modern times, it's imperative to study about stress from varied perspectives, as from centuries the concept of stress has been analyzed from varied context and form. After World War II, sociology started influencing the concept of stress and the probable reasons suggested are the issues related to marriage, health, growing up, etc. Cannon was amongst the first researchers to unfold the mystery of stress by acknowledging it with his fight or flight concept, that is, organisms' reacts to threat or strain with a general discharge of the sympathetic nervous system, which is based on the reaction of biological systems towards environmental stressors (Cannon, 1929). Later, it was considered as the first phase of 'general adaptation syndrome', which was recognized by Selye (1946). Anthropologist, Hoff (2001) developed crisis paradigm for explaining human reaction at the time of crisis and provided paradigm for managing stress during crisis. Lindemann (1944), the famous sociologist, has explained that the process of stress depends on the way people respond during crisis and critical situations. Earlier, psycho-biologists focus on physical stressors and found a link between stress and psychology. Holmes and Rahe (1967) contributed to the theory of stress from the psychiatrist point of view. He explained that the adjustment of life patterns owing to various life events causes stress among

individuals. Further, researchers have considered the adverse organizational working conditions as probable causes of stress (Cooper, Dewe, & O'Driscoll, 2001; Folkman, 1984). Bakker and Demerouti (2007) observed that disparity between job demands and job resources acts as a significant cause of stress and propounded the JD-R model of stress. Folkman (1984) validated the transactional perspective of stress, which explains that stress arouse when the situational demands surpass individual resources. Various researchers suggested that job conditions should also be considered to assess direct as well as indirect consequences of stress (Schaubroeck, Cotton, & Jennings, 1989). The National Institute for Occupational Safety and Health (NIOSH) defined stress as, "harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker" (2014, p. 6). According to Folkman (1984), stress is "any situation in which internal demands, external demands, or both, are appraised as taxing or exceeding the adaptive or coping resources of an individual or group" (p.19).

Nightingale (1860) observed that nurses suffer from something which is beyond their experience of illness and disease at workplace, and it is termed as stress. After more than seven decades, Selye, father of the modern concept of stress (Selye, 1936) described it as, "the nonspecific reaction of the body to any type of demand." Furthermore, he coined the term "GAS" (General Adaptation Syndrome) which explained the ways in which the body responds to environmental stimuli (demands) (Selye, 1946, p. 32) and explored the role of psychological stressors in the stress process. He defined stress as, "the non-specific response of the body to any demand for change" (p.32).

3.4.4.1 Antecedents and Consequences of Stress

Stress has been explained with four perspectives, these perspectives are: stimulus based, response based, transactional, and phenomenological (Watson, Fawcett, & Fawcett, 2003). Stimulus based perspective focuses on the environmental stressors that are external to an individual, and response based perspective deals with any stimuli that arouse stress and are considered as stressors; further this perspective focuses on the reaction of the individual towards the stressor. Transactional perspective views stress as an interaction between an individual's beliefs and objectives related to an environment. Further, phenomenological perspective views a

person’s perception and cognitive phenomenological discernment on an event that infuses stress among individuals (Watson et al., 2003).

McGrath (1976) suggested six dimensions of stress related to task, role, personality, and inherent behavioral setting, social environment, and physical environment. Organizational factors like management and leadership style, support system, emotional and psychological demands of the job and other facets of working environment induce stress among employees (Bhatt & Pathak, 2013). An organization comprises of various subsystems or dimensions, and these arouse stress through continually interact of dimensions with members of organization and with each other (Goyal & Kashyap, 2010). Bhatt and Pathak (2013) stressed primarily on acknowledging the sources of stress for understanding the probable consequences of stress (Dato & Abyad, 1996). They emphasized that the sources of stress can differ in both males and females, and the coping mechanism will also differ in accordance with the divergent causes of stress (Tarantola, 2009). Stress can be understood based on two perspectives, that are, eustress and distress, which depends on the perception, interpretation, and reaction of an individual. Eustress is an affirmative incongruity between the desires and perception of an event and is beneficial for better performance at the optimal level. However, physiological and psychological demands beyond the optimal level exceed the homeostasis level of energy and results in distress (Le Fevre, Matheny, & Kolt, 2003).

Literature review shows that stress has been studied from varied perspectives and in different organizational set-ups. Stress at workplace is the inconsistency between the demands and capacity of an employee to meet those demands which ultimately results in emotional, physical, and psychological consequences for employees (Li & Lambert, 2008). Past researchers have documented that nurses’ experience stress not only because of the occupational factors but also because of the organizational and environmental factors (McVicar, 2003; NIOSH, 1999). Nursing is a high risk profession (Hughes & Hughes, 2008) that includes job characteristics, exposure to chemicals, chronic diseases, complex environmental conditions, and the cumulative interaction of these factors, which arouses stress among nurses (Menzies, 1960). Stress among nurses has been neglected in spite of the fact that it not only affects the nurses’ but also the nursing profession (Gelsema, Van Der Doef, Maes, Akerboom, & Verhoeven, 2005).

Stress has been explained by using different theoretical models. Watson and Clark (1984) has explained stress with the help of emotional theory, which states that emotions like feeling of fear are activated only after the body changes as a consequence of an event. As per Agnew and White (1992) in the general strain theory focus on strain and its impact on behavior of an individual. Conservation of resource theory focuses on the fact that stress is related with resources that are either to conserve or to attain the new resources (Hobfoll, 1989). However, job demand resource model has been considered as theoretical framework for present study. The interaction of psychological, physical, emotional, and social aspects of working environment threatens the equilibrium of nurses. Various scales are present in literature for measure stress, however in this study; we used nurses stress scale developed by Gray–Toft and Anderson (Gray-Toft & Anderson, 1981). Nurses stress scale (NSS) has considered various aspects of nurses' stress that are physical, psychological, and social environment. This scale has considered the rudiments of nursing profession and working environment of nurses from varied perspectives, so it suits our study which is based on measuring the multifarious aspects of nurses' stress.

Past studies have linked stress with various outcomes such as adverse effect on health, reduced organizational effectiveness, and reduced job performance (Farquharson et al., 2012; Motowidlo, Packard, & Manning, 1986). Wolf, Pfeiffer, Ripley, Winter, and Wolff (1948) studied stress in relation to health and considered culture, living style, and goals of an individual based on which they proposed adaptive reaction pattern of an individual towards stress. Tyagi and Dhar conducted a study among 444 police officials and the results indicate that stress has a significant adverse impact on health of Indian police officials (Tyagi & Dhar, 2014). Kang and Sandhu studied the relationship between stress and health on 316 branch managers of public and private sector banks of India and observed that there are work place stressors like performance pressure and family stressors like insufficient time to fulfill family needs, and these stressors lead to low physical and psychological health (Kang & Sandhu, 2012). Yaşlıoğlu, Karagülle, and Baran (2013) focused on organizational outcomes like job satisfaction in relation to stress in logistic industry and observed that physically and psychologically demanding situations cause stress among employees which further reduce their job outcomes like job satisfaction, commitment, and job performance (Wallis, 1987). An organization consists of subsystems that constantly interact with each other and with organizational members in ways which can induce occupational stress in workers.

3.4.5 Workplace Spirituality

3.4.5.1 Spirituality

Spirituality is a commonly used term, yet it has diverse meaning for different people. Spirituality is an individualized approach which varies from person to person in relation to time and culture (Paul, Dutta, & Saha, 2015). According to Strack, Fottler, Wheatley, and Sodomka (2002), spirituality integrates all the energies which are parts of a human being and interconnect them to become a holistic being (Zohar, 2012). Mitroff and Denton (1999) considered several factors related to spirituality to congregate the key influencing elements which are: "a) Not formal, structured or organized; b) Non-denominational above and beyond denominations; c) Broadly inclusive, embracing everyone; d) Universal and timeless; e) The ultimate source and provider of meaning and purpose in life; f) The awe we feel in the presence of the transcendent; g) The sacredness of everything, the ordinariness of everyday life; h) The deep feeling of the interconnectedness of everything; i) Inner peace and calm; j) An inexhaustible source of faith and will power; k) The ultimate end in itself" (p. 88).

Spirituality can be explained on the basis of four connections, which are connection with self, with nature, with others, and with supreme power (Howard, 2002). This definition depicts the connection between spirituality and workplace. Individuals spend most of their time at workplace, and connection with work and other stakeholders' arouse feelings of fulfillment among them. Tischler (1999) connected spirituality with Maslow's need hierarchy theory, "as the majority of citizens in any society can be freed from the lower levels [food, shelter, security] of concern, they can, as a society, shift their concern to higher order needs [knowledge, self-fulfillment" (p. 274). Spirituality is generally confused with religion, but literature proposes that spirituality is beyond the rules and connotations of the religion. The basic property which differentiates spirituality from religion is its collective perspective; as religion is regarded as narrow and divisive, whereas spirituality is appreciated as universal and broadly comprehensive (Mitroff & Denton, 1999). Graber and Johnson (2001) explained the broader perspective of spirituality as it "avoids the formal and ceremonial connotations of religion; it is non-denominational, non-hierarchical, and non-ecclesiastical. Spirituality implies an inner search for meaning or fulfillment that may be undertaken by anyone regardless of religion" (p. 40).

3.4.5.2 Workplace Spirituality

Krishnakumar and Neck (2002) notes two prospects of workplace spirituality; one is intrinsic–origin view, and the other is existentialist view. The intrinsic–origin view of spirituality is "that which argues that spirituality is a concept or a principle that originates from the inside of an individual"; p.154). According to the intrinsic view, workplace spirituality involves sense of selfless service, morality, connection, forgiveness and empathy (J. Mahoney, 1999). Brandt (1996) explained "spirituality's goal is greater personal awareness of universal values, helping an individual live and work better and more joyfully" (p. 83). According to the existentialist view, "spirituality is perhaps the most connected to the concepts such as the search for meaning in what we are doing at the workplace" (Kahnweiler & Otte, 1997, p. 176). Further, they put forward few questions: "a) Why am I doing this work? b) What is the meaning of the work I am doing? c) Where does this lead me to? d) Is there a reason for my existence and the organization's?" (Kahnweiler & Otte, 1997, p. 179). Existential sickness occurs when employees don't find meaning and purpose in their work, and they feel alienated from work as well as from oneself (Litzsey, 2006). Employees, who specifically working in Asian countries like India, desire to work in such organizations where they can develop and connect the soul with work. Vivekananda (1947) rightly said, "You have to grow from inside out. No one can teach you, none can make you spiritual. There is no other teacher but your own soul" (p. 410).

Spirituality in workplace is gradually gaining significance, as in this challenging working environment; employees are keen to embrace the aspects of spirituality into their work (Wong, 2003).Workplace spirituality can be explained from employee's perspective as well as from organizational perspective. Ashmos and Duchon (2000a), defined workplace spirituality as the "recognition that employees have an inner life which nourishes and is nourished by meaningful work taking place in the context of a community" (p. 137). Giacalone and Jurkiewicz (2003) defined workplace spirituality from organizational perspective, as it is "a framework of organisational values evidenced in the culture that promote employees experience of transcendence through the work process, facilitating their sense of being connected to others in a way that provides feelings of completeness and joy" (p.13).

Spirituality is connecting with one's inner self, that is, their soul, and workplace spirituality is connecting soul with work without being affected by environment and end goals

(Kinjerski & Skrypnek, 2006). In *Bhagavad Gita*, it is stated that one has to focus on his or her efforts than thinking about the end results (Macrae, 1995). Buddhism has explained that hard work with devotion can not only transform the individual's life but can also transform the organization and the society as a whole (Jacobson, 1983). Workplace spirituality can be explained with regard to three perspectives, which are meaningful work, sense of community, and alignment with organizational value and goals (Sharma, Rastogi, & Garg, 2013).

Meaningful work: Sense of meaning and purpose in work are fundamental to workplace spirituality. Workplace spirituality represents the ways in which employees connect with their inner self by finding meaning and purpose in their work. By connecting to their work, they can give meaning to their life and search for deeper meaning and purpose of work Ashmos & Duchon, 2000).

Sense of Community: This dimension represents the mental, emotional, and spiritual connection of an employee with other stakeholders of an organization. Employees try to connect their inner self with their fellow workers and genuinely take care of them irrespective of all the workplace challenges (Neal & Bennett, 2000).

Alignment with organizational values and goals: According to this dimension, employees feel connected with the organization's purpose, mission, and vision. This aspect is based on the principle that purpose of life is to contribute in the organization and society, which is larger than one's self Ashmos & Duchon, 2000).

3.4.5.3 Drivers and Consequences of Workplace Spirituality

Workplace spirituality owes its existence to several motivations based on the values and goals of an individual as well as workplace. Global emphasis on human rights, economic and social changes, and need of mutual values of employees and employers are some of the motivators behind the growth of workplace spirituality in today's world. Employees like to do jobs in such environment which connect to their spirit and fulfill their inner-self.

Spirituality at workplace provides a framework to employees by means of which they experience transcendence being connected to their job. Enjoyment through fulfillment of job duties inculcates satisfaction among employees, and they can perform better in such environment. Spirituality at workplace links the organizational goals with employee's objectives

about finding the meaning and purpose of life through their work and infuses commitment as well as organization citizenship behavior of employees. Past research has indicated that spirituality at workplace helps to uncover creative potential and provide benefit related to improvement in customer service, trust, integrity, and serenity (Petchsawang & Duchon, 2012). Spiritual environment helps employees to spiritually connect to their work and experience inner strength, peace of mind, calmness, and positive attitude (Krishnakumar & Neck, 2002)

3.4.6 Quality of Care

Healthcare is an overarching umbrella under which patient safety and quality of care resides. Institute of medicine (IOM) has defined quality in healthcare as, "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" Lohr 1990, p.1). Earlier indicators of quality were composed of five (5) D's, which are disability, disease, discomfort, dissatisfaction, and death; and these components are believed to be more negative than the positive ones. The components associated with quality of care are positive and based on nursing care relate to the following: demonstration of attitude and behavior related to health promotion, perception of being well cared, symptom management of disease, and health related quality of life. However, the components of quality care in the 21st century are more conceptual and so are effective, patient centered, timely, equitable, efficient and safe (Mitchell, 2008).

Quality of care is a multidimensional concept, as it encapsulates three aspects: the care delivered by health professionals; care received by patients; and the environmental conditions within which care is delivered. According to Donabedian (1988), quality of care has two dimensions, that are, interpersonal and technical. Technical care denotes the clinical elements that are medical diagnosis, treatment, and cure. Interpersonal care denotes the quality of communication among patient and healthcare providers and the time spent with patient. Researchers have emphasized on the interpersonal care, as this is integral as well as fundamental part of delivering the technical care (Donabedian, 1988). Donabedian (1988) viewpoint encapsulates the varied qualities associated with care such as diagnosis, privacy, treatment, empathy, and compassion which is consistent with the definition of health given by World Health Organization (WHO). WHO (n.d.) states that holistic health does not only refers to

absence of disease, but also refers to the state of complete mental, social, and physical well-being (1948).

WHO (2006) provided six dimensions of the quality of care. The dimensions require healthcare to be:

"Effective: that is to deliver the healthcare services based on need and adherent to evidence.

Efficient: is optimal utilization of resources to avoid waste in healthcare services.

Accessible: delivering timely care and setting healthcare services in such a way that these are accessible geographically and skills and resources are suitable for medical needs.

Acceptable/patient centered: delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their community.

Equitable: delivering health care which does not vary in quality because of personal characteristics such as gender (Pacoy, 2013), race, ethnicity, geographical location, or socioeconomic status Safe: delivering health care which minimizes risks and harm to service users." (p.9)

3.4.6.1 Antecedents of Quality of Care

Various organizational and individual factors contribute in obstructing the quality of patient care. Organizational factors that act as hindrance in the quality of care provided are ineffective leadership and management, understaffing, stressful and anxious work environment (Milisen, Abraham, Siebens, Darras, & de Casterlé, 2006), patient acuity, work overload (Attree, 2005), and insufficient resources and time (Berland, Natvig, & Gundersen, 2008). These factors are deemed to hinder the smooth flow of the patient care and increase the chances of medical errors. Individual factors like the emotional and psychological state of the nursing staff have an adverse impact on the quality of nursing care. Moreover, the health condition, financial position, emotional state of patients and their relatives arouse anxiety and aggression amongst patients and their families which has adverse relationship with healthcare services provided to patients.

3.4.6.2 Consequences of Quality of Care

The outcome of low quality of care is like a dark shadow, as it involves the lives of patients. A small error of single person can have big and devastating effect on the lives of many, be it the families or the healthcare professionals (Landrigan et al., 2010). Low level of health

care can result in multiple chronic diseases, as one mistake can change the life of a patient (Bernes, 2000). Nurses also feel the heat of medical errors and experience emotional distress, anxiety, fear, guilt and loss of self-confidence (Castle & Anderson, 2011). A single mistake can become a tragedy for the patient and their relatives (Bernhard, 2013). Low quality of care has multidimensional impact on patients, their families, healthcare professionals, PHCI and on society at large. Degraded quality of care has an adverse impact on the reputation of the healthcare professionals as well as the PHCI.

3.5 Development of Hypotheses

3.5.1 Work-Family Conflict and Stress

Work family conflict can be defined as conflict in both work and family domain that takes place because of time, behavior and strain conflict. Such conflicts may create dissatisfaction, anxiety, depression, and fatigue which are considered as symptoms of stress. Stress can be defined as, “harmful physical and emotional responses that occur when job requirements do not match the worker’s capabilities, resources, and needs” (Park, 2007, p. 5). Furthermore, social culture plays an important role in work family conflict (Tyagi, Dhar, & Sharma, 2016). India has a collectivist culture where women are supposed to prioritize the children and the family rather than their job (Rao, 2013). The traditional division of work and family roles between men and women exists even in dual career couples. Women carry a dual burden across work and family more than men, so women are more susceptible to face stress because they experience conflict within work and family roles (Korabik, Lero, & Whitehead, 2011). Hopping between work and family reduces their level of energy and causes conflict between work and family.

Nursing is a woman centric profession; the representation of women in nursing is higher than men in India and all over the world. Women are more likely to experience conflict between work and family than men owing to the dual responsibilities, as they have to give equal importance to be work and family. Allen et al. (2000) tried to identify the causes of work family conflict, and the results of this study revealed that job requirements of nurses not only affect their personal and professional life but also arouse stress amongst them. Various researchers like Kossek and Ozeki (1999) found that eight out of nine studies have strong correlation between work family conflict and stress. Furthermore, the results of longitudinal studies have shown that

work-family conflict results in low vigor which could lead towards stress among healthcare professionals (Mauno, Kinnunen, & Ruokolainen, 2007). Inflexible work schedule, night shifts, long working hours, handling emergency situation of life and death are integrated in the job profile of nursing professionals which deplete their physical, psychological, and emotional energy (Trinkoff, Geiger-Brown, Brady, Lipscomb, & Muntaner, 2006). Because of depleted energy and finite time, nurses face conflict between the expectations associated with the family and professional role which fabricate stress in both the roles and affect their work–family balance (Wang, Liu, Wang, & Wang, 2012). Nurses are grappling in conflict because of the inability to match the physical, psychological, and emotional energy with the requirements of both family and work domains (Farquharson et al., 2012).

Adkins and Premeaux (2012) conducted a study on the time spent at the work place is positively related to work family conflict. Nurses work for long hours in order to meet the challenges at the work place, and devotion of more time at the job increases the imbalance in work and family life, which in turn raises the level of stress among them. Because of increase in the percentage of patients and decrease in nursing professionals, Indian nurses face role overload (Pal, 2014) and so they require to stretch their working hours. A continual experience of such working patterns has a spillover negative effect that causes fatigue, depression, and strain amongst nurses (Edgell, 1970).

According to the role stress theory, occupation with multiple roles job profile causes strain among employees. In a profession like nursing, nurses are required to fulfill multiple roles like handling Out Patient Department (OPD), in-patient care, medication, and discharge formalities of patients. So, they have to expand their energy to meet the requirements of the job. Role strain theory described that the tasks of family and work domains compete with each other for the availability of the limited resources such as energy and time. As energy and time are finite, they can expand their energy up to a certain level beyond which they feel helpless to perform the expected activities of another role (i.e., family). (Sharma et al., 2015; Singh & Patwardhan, 2012) recognized that work-family conflict is one of the major sources of stress among healthcare professionals owing to work intensification and overload (Kahn, 1973). Moreover, the emotional demands of the job and exposure to various occupational hazards, like coming in contact with infectious diseases along with shortage of resources, drain out the health and well-being of nursing professionals. With such health conditions, nurses may not be able to

fulfill both work and family requirements, and this conflicting situation generates stress among them. A study by Montgomery, Peeters, Schaufeli, and Ouden (2003) viewed work family-conflict as a significant antecedent of stress.

Nurses' job demands affect family life both directly as well as indirectly because it obstructs the time and energy required for family domain (Perrewé & Ganster, 2011). Stressful working conditions can cause a behavioral spillover on family such that disposition in one domain (i.e., work) can affect the activities of other domain (i.e., family). Various studies have demonstrated that the stressful conditions with superior, colleagues, and patients at workplace may enhance the depressive and angry behavior at work. Perceptual depressive and angry behavior can create tensions and conflicts in the family and inability to cope in such situations creates stress amongst nurses. Literature review depicts that conflict in both work and family domain are one of the probable causes of stress among nurses. The synthesis of commitment towards extensive and demanding responsibilities at job and family creates conflicts among nurses owing to strain, behavior, and time. On the basis of literature, it has been hypothesized that:

Hypothesis 1 (H1): Work–family conflict has direct relationship with stress.

3.5.2 Bullying and Stress

Bullying has become epidemic in all sectors, organizations, and professions; specifically in nursing because nurses are considered as 'oppressed group' in healthcare institutes (Hutchinson et al., 2010; Yildirim, Sertoz, Uyar, Fadiloglu, & Uslu, 2009). Abusive and aggressive behavior is gaining international notoriety (MacIntosh, 2005). Bullying is described as repeated, continuous, erroneous, and personalized behavior towards target over a period of time. Workplace bullying in healthcare institutes is identical with bullying behavior in other organizations like using abusive language, degrading and harming the reputation of the target, and withholding the resources required to accomplish a task. However, the impact of bullying behavior differs among healthcare institutes and other organizations because bullying behavior creates anxiety and stress among nursing professionals, which in turn may affect the healthcare services provided to the patients (Martin, 2008). Bullying in healthcare services being accompanied with demanding working environment for nurses enhances the probability of

medical error. The aggressive behavior of superior, subordinates, or co-workers along with challenges of providing individualized healthcare services may create stress among nursing professionals. Workplace bullying has direct influence on the attrition rate of nurses, which causes shortage of nursing professionals (Randle, 2003). The shortage of nursing professionals causes work overload and may result in compromising the quality of healthcare services to patients (Buerhaus et al., 2007). A study was conducted on medical surgical nurses for assessing the factors contributing to their stress level. The results explained that aggressive and violent behaviors along with harassment are some of the influential causes of stress among nurses. A study was conducted on nurses and clinicians for assessing the kind of abuse they face, their perception about abuse and the probable strategies needed for resolving abusive behavior in healthcare institutes (MacIntosh, 2005). Verbal abusive behavior by superiors and co-workers were recognized as the main forms of workplace bullying in healthcare institutes. Hutchinson, Vickers, Jackson, and Wilkes (2006) identified bullying and stress among the top five priorities that need to be addressed to reduce the attrition rate of nurses. Workplace bullying was strongly related with stress and rated on the priority list with 76% score as given by nurses (Mayhew et al., 2004). Aggressive behavior amongst nursing professionals is higher than any other occupation. Various studies focused on nursing professionals indicated that workplace bullying prompt the stress like anxiety, sleep disorder, and depression (Wright & Khatri, 2015). Further, nurses working in emergency, psychiatry units, and intensive care units have higher probability of becoming target in workplace bullying (Johnson & Rea, 2009).

Both horizontal and downward bullying is the most common type of workplace bullying behavior faced by nurses (Waschgler, Ruiz-Hernández, Llor-Esteban, & Jiménez-Barbero, 2013). Bullying includes both overt and covert behavior that consists of teasing and offensive behavior, criticism, provoking comments and creating unfriendly environment for nurses (Hoel et al., 2007). Bullying has both short and long term impact on nurses (OSACH, 2009); short term effects include headache, nausea, and anxiety, and long term effects include lower self-esteem, low confidence, and stress (Jackson, Clare, & Mannix, 2002). Hershcovis (2011) observed that workplace bullying is even more damaging and disruptive for nurses than any other work related stressors (Mikkelsen & Einarsen, 2002). Targets may experience nervousness as well as frustration, however, in extreme condition the target can even think of committing suicide (Yıldırım, 2009).

Bullying has an adverse impact on individuals as well as on the organization (Djurkovic, McCormack, & Casimir, 2005) and in healthcare sector the impact is even extended to the patients in terms of diminishing healthcare services (RACMA, 2013). Target who faces bullying behavior may feel low self-esteem, high propensity towards quitting job, less productivity, and low receptivity in comparison to those who have not faced workplace bullying (Lieber, 2010,, p.93). Bully has specific characteristics and plays an important role in workplace bullying. Bully seeks for domination, power and control, and bullying behavior satisfies the power need of the bully. Bullying behavior has an indirect cost on the organization in the form of high attrition rate, low morale of employees, and reduced performance (Samnani & Singh, 2012),in addition to these it may infuse inefficiency all over the organization (Wiedmer, 2011). Bullying has been considered integrated in nursing profession and exerts a dysfunctional relationship between nurses and negative as well as turbulent behavior at workplace (Randle, 2003). Phrase like nurses 'eat their young' (Bartholomew, 2006) describes the horizontal and downward bullying behavior encountered by nurses. Johnson (2009) in his study propounded that nurses' exhibit oppressed group behavior to bully the target nurses. Murray (2009) identified workplace bullying as interpersonal conflict in nursing. Farrell (1997) by interviewing 29 nurses of Tasmanian provided deeper insight about the concept of workplace bullying among nursing professionals. Respondents have reported about horizontal bullying, that is, nurse to nurse aggressive behavior and associated workplace bullying with professional terrorism which causes stress amongst the targets.

Nurses describe workplace bullying as, "ugly, demoralizing and divisive"(Alspach, 2008, p.16) and complained about the increased physical and psychological stress (Venkatesan, 2000) that one experiences owing to workplace bullying. Workplace bullying drain out the physical, psychological, and emotional energy of nurses due to which they are not able to concentrate on their professional and personal activities (Choudhary, Deswal, & Philip, 2013) because it causes anxiety, tension, and stress among them. Workplace bullying reduces self-esteem of nurses and adversely affects their ability to take right and quick decisions. This type of situation creates tension and anxiety; and the stress level increases among nurses when they experience prolonged condition of pressure (Lee, Lee, & Bernstein, 2013). Quine (2001) studied the impact of twenty (20) forms of bullying behavior on 1110 nurses working in national health service (NHS)

community centers of England, and the results reported that nurses experience lower job satisfaction, psychological health, and higher level of job induced stress because of workplace bullying. Makkar and Sanjeev (2013) conducted a study on 122 nurses in India and observed that nurses feel isolated, overburdened, denunciated, and mentally harassed which increase their stress level at workplace. Hence it is hypothesized that:

Hypothesis 2 (H2): Bullying has direct relationship with stress.

3.5.3 Patient Incivility and Stress

Emotions are considered fundamental to uncivil behavior. Past literature has shown that negative emotions like rudeness, anger, and frustration are increasing in workplace. Uncivil behavior and actions are the noteworthy occupational hazards that threaten the health, safety, morale, and performance of healthcare workers. Past research has also revealed that incivility is becoming the primal cause of stress amongst the people involved in such behavior. Incivility can be defined as "low-intensity deviant behavior with ambiguous intent to harm the target" (Andersson & Pearson, 1999, p. 455). Incivility violates the organizational norms and has a pervasive impact on all stakeholders (Andersson & Pearson, 1999). Lashley and de Meneses (2001) found that verbal abuse, anger, rudeness are common in public healthcare institutions. Incivility at workplace has an inverse impact on organization and on its employees. The problem of patient incivility has been flagged as "epidemic of abuse and violence" (Chapman & Styles, 2006; Pen, 2006).

Patient Incivility is well documented in the available literature and its adverse relationship with attendance productivity, patient safety, and satisfaction is also recognized in various studies (Benson, Blackburn, & Moehring, 2011). Kolanko et al. (2006) studied incivility in healthcare and found that healthcare professionals are more susceptible towards experiencing incivility. Nurses are amongst the most vulnerable professionals experiencing patient's violence and aggressive behavior in comparison to other healthcare professionals (Algwaiz & Alghanim, 2012). The results of past studies have shown that nurses deal directly and most frequently with the patients and are at higher risk of experiencing violent behavior from patients and their relatives (Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013). Specifically, in PHCI, nurses are the prime victims of patient incivility which inflicts stress amongst the nursing staff. Patient

incivility in healthcare has devastating impact on the workplace environment and on nursing staff (Clark, Farnsworth, & Landrum, 2009). Nursing staff being victims of patient incivility feels distressed from the aggressive and annoying behavior and actions of patients and their relatives. Nurses experiencing patient incivility show symptoms of stress like anxiety, depression, sleeplessness, and various health problems. Nurses manage multiple roles within limited time frame to provide the best services to the patients, so uncivil behavior of patients and their relatives towards nurses has more distressing impact on them than any other healthcare professionals.

Patient incivility is not only the major cause of frustration and stress among nursing staff, but it also causes economic and productivity losses of healthcare institutions (Strasser, Hutton, & Gates, 2008). The problem of patient incivility covers a wide range of behavior from verbal abuse to physical assault. Aggressive behavior of patients enters the arena of patient incivility when it crosses the verge of physical and psychological abuse. Patient incivility is becoming daily routine hassles of nursing staff and increasing the discontent among those who practice in high-liability working environment (Bogossian, Winters-Chang, & Tuckett, 2014). The concern over public behavior and violence towards healthcare workers is wide spread (Balamurugan, 2012). Issue of incivility is not new in healthcare, it was always been part of nursing (Balamurugan, 2012).

Various organizational and perpetrators factors contribute in the problem of incivility in PHCI. Organizational characteristics such as overcrowding, under staffing, nature of work, lack of basic amenities, and non-availability of the doctors as well as environmental factors such as lack of privacy, ward turmoil, lack of beds, and cleanliness aggravate the problem of incivility. Patients characteristics like aggressiveness, health status, lack of financial (Tandon & Vashisht, 2002) or family support as well as nursing staff conditions like work overload, conflict with doctors are some of the factors that cause patients incivility. Nurses' personality features such as external locus of control, anxiety, and nervousness also increase the likelihood of becoming victims of patient incivility. Researchers have suggested that the combination of above said factors are the causes of violent episodes by the patients (Algwaiz & Alghanim, 2012). Patient's aggressive behavior and actions have serious impact on nursing staff, as actions put the caregiver's role in question, resulting in the feeling of self-doubt and guilt of choosing nursing profession. Interaction between patients and staff is fundamental in initiating and further

development of aggression and violence (Krug, Mercy, Dahlberg, & Zwi, 2002). Thus, interaction is affected by various factors such as health status of patients, availability of resources, overcrowding and ward cleanliness (Arnetz & Arnetz, 2001; Farrell, Bobrowski, & Bobrowski, 2006). Patient's violent and insulting behavior causes negative attitude among nurses regarding their job tasks and profession and create negative climate at workplace. Such negative influencers have an adverse impact on the energy level of nursing staff, as they are not able to give appropriate time to patients and become less responsive to patient's needs. This behavior further creates a feeling of distress, as they feel guilty of not being able to give enough time to patients and feel dissatisfied with the quality of patients' care.

Nurses face both verbal abuse (Ward, 1988) and physical violence from patients as well as their relatives. Verbal abuse may not show any immediate symptom of physical injury but its emotional and psychological harm to inner core is devastating (Roby, 2011; WHO, 2005). Patient incivility has both short term and long term impact on nursing staff. The combination of short term impact such as increased absenteeism, headache, sleeplessness, irritation, and loss of appetite as well as long term impact such as distress, low morale, inattentiveness, health issues, and leaving the profession leads to stress, depression, post-traumatic stress disorder, and 'cognitive dissonance' (Oyeleye, Hanson, O'Connor, & Dunn, 2013). Patient incivility not only affects the target and the perpetrator but also the bystanders. Like newly graduate nurses may feel dissatisfied from the profession in their initial days because of in-civil episodes which can worsen the problem of nursing profession. Few studies have examined the long term impact of patient's behavior on nurses and found that patient reactions and actions results in fear, anger and cognitive disturbances among care givers. On the basis of the JD-R model, nurses tend to recover the potential loss of energy and vitality resulting from their ability to cope up with the demands and aggression of patients in absence of appropriate organizational resources. Consequently, they feel drained out with low self-esteem and motivation towards their profession and feel depression and stress owing to their job profile. On the basis of the above literature, it has been hypothesized that:

Hypothesis 3 (H3): Patient incivility has direct relationship with stress.

3.5.4 Stress and Quality of Care

The biggest challenge in front of healthcare institutes is to consistently provide the quality of health services in a rapidly changing and stressful environment. Nurses are the cornerstone of high quality health care services. Nursing staff contributes positively for better quality of care, however, this contribution depend on varied factors. The current shortage of nurses, high attrition rate, dissatisfaction, and stressful nursing staff are not unique phenomena in PHCI of India (Sharma & Dhar, 2016). The nursing staff is the life blood of healthcare services because they deliver quality care. Eminent scholar Freudenberger, inferred that employees working in the most dedicated and committed professions like nursing are more prone to fatigue and frustration, and therefore, display physical, psychological, and emotional exhaustion which is regarded as stress and dissatisfaction (Abushaikha & Saca Hazboun, 2009; Freudenberger, 1974; Humphries et al., 2014). The impact of stress on nurses results in physical, psychological, and emotional fatigue amongst them.

Because of lack of time, nurses are not able to do various tasks like comforting patients, counseling and educating them and their relatives which have significant impact on the satisfaction level of patients regarding quality of care. Many tasks are even left incomplete due to work overload and lack of time. Nurses feel anxious and stressed as they have to perform multiple tasks owing to shortage of staff and fixed time frame which in turn is leading to deteriorations in the quality of care provided in hospitals (Aiken et al., 2013). Adverse events and pressure ulcers are growing markedly for nurses working in general hospitals (Bredesen, Bjøro, Gunningberg, & Hofoss, 2015). Empirical literature has supported the intuitive adverse relationship between the psychological and emotional health of nurses and quality of patient care (Van Bogaert, Kowalski, Weeks, & Clarke, 2013).

Higher level of stress is associated with unfavorable job outcomes and complaints from patient and family, which emulates poor quality of care (Van Bogaert et al., 2013). The interaction of workplace environment and internal locus of control is complex in nature, and this causes emotional and psychological stress amongst nurses (Khamisa, Peltzer, & Oldenburg, 2013).

The relationship between stress and patient outcomes can be explained with a theory that higher level of stress among nurses impacts the emotional distance between the nurse–patient

relationship and diminishes the emotional resilience of the nurses. All these symptoms have a direct impact on the quality of care provided by nurses (Mitchell, 2008). The prevalence of stress and anxiety among nursing staff affect their concentration and performance due to which the quality of services provided to patients' get inversely affected. Nursing is a life saving profession, but the price of even one error of a nurse can costs a patient's life. According to the article, 'Nursing Mistakes Kill, Injure Thousands', 1725 patients were killed and 9584 were injured due to action or inaction of the nursing staff (Berens, 2000; Sinha, 2013). Nursing is rewarding, noble, and satisfying profession, but at the same time it is becoming extremely stressful (Bhatia, Kishore, Anand, & Jiloha, 2010). Nurses in India are highly overburdened as patient to nurse ration is too low (2250:1), and they are supposed to perform multitasks because they are not only caregivers but also the administrator and supervisor of the patients (Bhatia et al., 2010). All these responsibilities require high physical and emotional responses and mismatch of demands with physical capabilities and resources that arouse stress among nurses. Nurses facing mismatch of demands and energy resources show stress symptoms like hypertension, irritation, and lower mental and physical wellbeing of nurses. Past literature has highlighted that stressed nurses feel the inability to concentrate and handle patient care activities efficiently (Lombardo & Eyre, 2011).

Research has shown that nursing is high risk occupation and nurse's work in problematic and difficult environment, and such stressful elements impede the full capacity of nurses to provide the best care to patients (Van Bogaert, van Heusden, Timmermans, & Franck, 2014). Stress has indirect negative relationship with work engagement and direct relation with the job outcomes and performance such as quality of care (Pisanti et al., 2015). Past research shows that stressed nurses develop negative self-concept and job attitude, which lessen their concern towards patients and hinders the quality of healthcare services (Abushaikha & Saca Hazboun, 2009). The relation between quality services and stress experienced by nursing staff is self-evident, as stress depletes their energy and ability and intensifies the risk of medical errors. So, nurses are less likely to deliver high quality care to patients (Anthony Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011). Deteriorating working conditions is the underlying factor that threatens the quality of care and patient safety (Hoff, 2001). Furthermore, the quality of care depends on hygiene factors like the ward conditions and workplace environment in which the nursing staff delivers the services to patients.

The study focuses on quality of care and stress of nurses as both issues are considered significant in nursing profession (Klein, Frie, Blum, & von dem Knesebeck, 2010). Aiken, Clarke, Sloane, Lake, and Cheney (2008) asserted that nurses are like the surveillance system of HCI because they detect errors, complications, and adverse incidents, and if the surveillance system is under stress then the probability of medical errors and complications will be more (Hinami, Whelan, Wolosin, Miller, & Wetterneck, 2012). Various organizational factors are considered responsible for the problem of stress and poor quality of care delivered by nursing staff. These factors include stressful working environment, work overload, paucity of time and resources to provide quality care, poor management, and increased paucity (Billeter-Koponen & Fredén, 2005). All these factors are interconnected with each other and its composite effect leads to poor quality services of nurses. Nurses have neither time nor energy to attentively listen and meet the needs of the patients because they have to do their work at a fast pace being pressurized and pushed to carry out multiple tasks within a limited time (Berland et al., 2008). To handle the work overload, nurses don't take breaks, stay late at work to finish their job tasks and even after giving more than 100% they go home with the burden of unfinished work (Hall & Kiesners, 2005). These entire metaphors raise an issue of frustration and fatigue which is characterized by discontent and stress and under such conditions rather than enjoying their work they struggle hard to deliver the quality care that their patients require. A study by Cho et al. (2009) on nurses has shown that 33% are dissatisfied, 50% are stressed out and 25% are planning to leave the profession within one year. Chiang and Chang (2012) surveyed nurses and found that 41% are not able to provide care that they aspire for owing to time restraints and the primary reason behind it is that they are not able to listen and respond satisfactorily to the concern and needs of the patients (Milisen et al., 2006). The overburdened nurses try to complete their tasks within time frame and feel torn and stressed between everything, but in this process what they miss is inter-personal care which is fundamental to quality of care. In totality, stress increases the probability of medical errors and lowers down the quality of care provided by nurses.

Hypothesis 4 (H4): Stress has an inverse relationship with quality of care.

3.5.5 Stress as a Mediator between Work-Family Conflict, Bullying, Patient Incivility and Quality of Care

Stress has been studied in context to various antecedents and consequences. Every event in the workplace environment has some impact on employees and eventually on job outcomes. Stress causes considerable imbalance between the demands and response potential, and the inability to meet the demands significantly affects the consequences on employees and on their performance. Various environmental stressors reduce the energy, motivation, and enjoyment of employees, and they are not able to optimally and efficiently utilize their capacity and capability.

The whole process has been explained by McGrath (1970) in four stages:

a) Environmental Demands: Environment put physical, psychological, or cognitive demands, and these demands can be either based on job or task related activities;

b) Cognitive Appraisal: Demand does not only result in stress among individuals, but more important is the perception of demand and the ability to access the ways in which current resources and capabilities deal with the demands. Cognitive appraisal is a perception process in which an individual tries to understand whether a specific demand puts threat or challenge, and based on the perception they feel eustress or distress. High trait anxious people are more likely to believe that demands are extreme and threatening and feel anxiety at this stage (Matthews, Deary, & Whiteman, 2003);

c) Stress Response: This is the psychological interpretation of stage one and two as cognitive appraisal of resources, demand, and the outcomes will impact the physical and psychological reaction to the demand;

d) Behavioral Results: Actual behavior is expressed in this stage. High intensity of somatic and cognitive anxiety has an inverse relationship with the performance of employees (Blankenship, 2007). In addition, at this stage employees may even feel lack of motivation to participate and enjoy owing to disturbing behavior. Stress is considered a cyclic process because the results of fourth stage will give feedback to the first stage and will influence the perception of environmental demands (Blankenship, 2007).

The above said model of McGrath (1976) clearly indicated the intervening role of stress by considering role based stressors (work-family conflict), stress intrinsic to behavior setting (bullying), and stress arising from social environment (patient incivility) and job outcomes

(quality of care) (p.1369). Past studies have also recognized the mediating role of stress in physically and emotionally demanding professions like nursing (Sharma et al., 2015). In the study, work-family conflict is one of the antecedents of stress, and past studies have shown that higher the work family conflict higher would be the level of stress among employees (Panatik et al., 2012). Work-family conflict has been considered the most pervasive and challenging stressor among nurses. Nursing job can be characterized to be physically as well as emotionally demanding, long working hours, and work overload which consumes the energy and time required for fulfilling the family roles. Nurses are exposed to various stressors at their workplace like accidents, chronic diseases, death and emotional and painful condition of patients and their families (Lindemann, 1944). These stressors are part and parcel of nursing job and while dealing with all these factors their families suffer which causes imbalance and dissatisfaction among nurses. Working for long hours in such intense working conditions and environment arouse stress amongst nurses.

Time spent while fulfilling the professional duties interferes in the amount of time available to perform the family related responsibilities, and this imbalance creates discord between work and family which eventually causes stress (Netemeyer et al., 1996). Women may suffer higher work family conflict than men because family responsibilities are more on women in collectivist cultured countries like India. Nursing is represented by women (80%) and female employees (Pacoy, 2009) generally have fewer resources (Hobfoll, 1989) to meet the demands of both domains and their family life suffers owing to their demanding job, which leads to stress among them. The role theory has explained that the interference of work role in the family role or inter-role conflict causes stress (Wolfe, Quinn, Snoek, & Rosenthal, 1964) to those who attempt to fulfill the multiple roles (Boles, Howard, & Donofrio, 2001; Hammer, Bauer, & Grandey, 2003). Nurses while balancing the work and family roles try to stretch their capacity and energy, and in an effort to deal with imbalance of work and family (Parasuraman & Greenhaus, 1999) they themselves experience anxiety, depression, insomnia, and various health issues (Steinisch et al., 2013). All these symptoms lead to low morale, loss of concentration, low performance (Thomson, 2015), which in turn increase the probability of medical errors and diminish quality of care. Thus, it shows that stress mediates between work family conflict and quality of care. Another significant stressor among nurses is the workplace relationships. Team work with juniors, seniors, and physicians is the fundamental requirement necessary for

providing better care to patients (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Workplace bullying is a deliberate effort to humiliate and offense the target either by senior or the colleague. Bullying has a dramatic impact on the performance of the employees. Bullying induces differences in the team which causes stress among team members and affects their ability to perform their tasks.

Bullying not only affects the target, but also the bystanders owing to which nurses can make negative image of this profession and contribute to the problem of shortage of nurses. Bullying has a detrimental impact, and it can directly as well as indirectly affect the distressed employees in addition to the negative consequences that it will have on the organization and on patient at large (Aquino & Thau, 2009). As per stressor emotion model, workplace bullying induces negative emotions among the targets which causes stress, and in turn leads to decrease in motivation and job performance of employees (Spector & Fox, 2005). Workplace bullying results in psychosomatic effect like irritability, depression, and impaired interpersonal functioning of nurses (Mayhew et al., 2004). Einarsen and Mikkelsen (2003) found that exposure to negative interaction at workplace like bullying may elicit stress symptoms like psychological hyperarousal, avoidance of people, intrusions like flashbacks and nightmares, shattered self-confidence, and core beliefs (Tehrani, 2004). All these stress symptoms in totality increase absenteeism, turnover, productivity, and performance of nurses. Bullying affects target, bystander, the patient, organization, as well as the nursing profession. Bullying engender negative work environment which is unsafe for employees as well as for patients. Bullying results in battering of communication and teamwork, which in turn makes target nurses scared of workplace, they also face frustration and become unable to think and take rational decisions (Sousa, 2012). In this type of situation, a nurse being stressed can make error in patient care, which in turn will adversely affect quality of care (Hansen et al., 2006). From the literature review, it can be inferred that stress mediates the relationship between bullying and quality of care.

Other significant yet surprising stressor for nursing staff is attitude and behavior of patients and their relatives. Nurses act as mediators between physicians and patients, and they mostly handle the medical and emotional requirement of the patients. Nurse–patient relationship carries a noteworthy importance in the recovery process of patients, but most of the time nurses face aggressive and violent behavior from patients and their relatives. Patients make unusual

demands, insult them, and pass sarcastic comments on their dress; all these arouse strain symptoms in nurses. As per cognitive activation theory of stress (Ursin & Eriksen, 2004), stressful experiences may result in persistent cognitive activation in the form of strain and anxiety which may cause persistent physiological and psychological activation resulting in deterioration of health. Further, the inability to cope up with stressful situation exaggerates the level of stress among nurses (Spector, Coulter, Stockwell, & Matz, 2007).

The burgeoning literature on incivility has shown that coalesces of internal and external factors of patients leads to patient incivility. Internal factors consist of a patient's personality, emotional and physical condition, whereas external factors consist of cleanliness, availability of physicians, and ward environment. The interaction of internal and external factors leads to harassment, verbal abuse, and aggressive behavior and actions from patients and their relatives (Farrell & Shafiei, 2012). In spite of experiencing such actions of patients, nurses display positive emotions and try to give adequate care to patients while suppressing their emotions, and due to emotional dissonance they experience conflict of experienced and expressed emotions. This conflict may not be visible but have long term impact, as it works as a silent killer for the sufferers of emotional dissonance. This conflicting situation depletes the energy and emotional resources of nurses, owing to excessive physical, psychological, and emotional demands; and so they experience work related strain and stress (Felblinger, 2009). Stressful work experience may results in adverse job outcomes such as poor job performance of nurses.

Patient incivility affects the dynamic nurse–patient relationship which is essential for patient care (Williams, 2001). Nurses become terrified about providing care to aggressive patient, and they try to distance themselves from emotional needs of patients and so could not respond to the patient's needs attentively which encumber the quality of service provided to patients (McVicar, 2003). Patient mistreatment can increase absenteeism, attrition rate, health issues, decreased ability of emotional regulation, and overall productivity of nurses. Stress among nurses can increase the probability of medical errors that can have serious adverse consequences on patients. Stressed nurses will not be able to give their best, so it will negatively impact the quality of patient care. Literature review depicts the mediating role of stress between patient incivility and quality of care.

Stress is a multidimensional phenomenon, and various workplace environment and individual factors contribute towards stress of employees. Stress is the result of imbalance of demands and depleted available resources which has a long term psychological and physical impact on employees. Stress among nursing staff diminishes their ability to handle patients' needs effectively and adversely affect the quality of care. On the basis of the above literature, it has been proposed that:

Hypothesis 5a (H5a): Stress mediates the relationship between work-family conflict and quality of care.

Hypothesis 5b (H5b): Stress mediates the relationship between bullying and quality of care.

Hypothesis 5c (H5c): Stress mediates the relationship between patient incivility and quality of care.

3.5.6 The Moderating Role of Workplace Spirituality

Spirituality is the way of living life, and one can feel its presence in every sphere of life. So, it has been studied from varied perspectives in relation to various individual and work outcomes. It has been studied as exogenous variable for behavioral outcomes of employees like positive attitude, affective commitment, team work, motivation, creativity (Milliman, Czaplewski, & Ferguson, 2003), and job performance (Gavin & Mason, 2004). Furthermore, it has been studied as endogenous variable in relation with commitment, organization citizenship behavior (Choudhary, Kumar, & Philip, 2013), creativity and job performance. Workplace spirituality is an individualized phenomenon and nature of it relation depends on personal perspective because it can act as independent, dependent or mediator variable within specific parameters. Another significant feature associated with the dynamic nature of workplace spirituality is its moderating perspective, as empirical evidence supports that spirituality works as a moderator between stress and job performance (Kumar & Kumar, 2014). Stress is the perceived imbalance of demands and resources, and as per transactional model of stress (Cummings & Cooper, 1979), negative influence of stress can be moderated through self-consciousness and by understanding and wining the inner self (Rarick, 1988). On the basis of intelligence model, an individual go through three stages of intelligence, that is, intelligence quotient (IQ), emotional quotient (EQ), and spiritual quotient (SQ) (Emmons, 2000; Zohar,

2012). SQ is the state of self-awareness that manages the EQ and IQ because SQ is related to conscious action of employees in which the employee must perform the work honestly, dedicatedly, sincerely but should be indifferent to the outcomes or the results (Srivastava & Misra, 2012).

Spirituality at workplace facilitates employees to achieve self-transcendence and to cultivate inner self (Giacalone & Jurkiewicz, 2003). Such cultivation helps in nurturing patience, team work, positive interpersonal attitude (Kumar, Philip, & Sharma, 2014) and in overcoming psychological and emotional fatigue as well as enhancing self-control (Hoppe, 2005). Employees come at workplace as a physical, emotional, psychological, and spiritual being, and healthcare system affirm the concept of 'holism' because patients' needs are a blending of physical, psychological, emotional, and spiritual care.

Nursing profession has a 'spiritual heritage' because nurses show selfless dedication for the betterment of others that denotes sense of community towards workplace spirituality (McSherry, 2006). Nurses have to spend disproportionate time on administrative tasks at the expense of listening to patients needs as well as providing care to them. All this has three facet effects that is on the nurses in terms of less job satisfaction, on patients on terms of low quality of care (Leiter, Harvie, & Frizzell, 1998) and in totality on the health care institutions.

Empirical evidence has shown that negative relationship exists between stress and job performance (Jex, 1998),that is, with increase in the level of self-consciousness, the level of stress decreases. Spillover theory explains the influence of workplace spirituality on stress and job performance of employees through horizontal spillover and vertical spillover. Vertical spillover helps in achieving the ordinate dimension of spiritual well-being (Lee, Sirgy, Efraty, & Siegel, 2003),whereas horizontal spillover show service orientation, positive work interrelationship, group cohesion and deep concern for others (Garcia-Zamor, 2003). All these dimensions will help in positively handling the challenges nurses face while providing patient care (Delgado, 2007).

Employees working in spiritual workplace have lower level of stress because employees relate to their workplace values. Workplace spirituality facilitates meaningful insight (Thomson, 2015) towards work, connectedness and transcendence of self. Employees enjoy and feel satisfied with job which serves purpose and fulfilment in their work (Mitroff & Denton, 1999).

Employees perform their duties with integrity and devotion and feel connected with their job irrespective of any expectation about rewards and results. Spirituality makes employees feel interconnected with inner self of others and perceive their work greater than self, which foster positive feelings among them (Neal & Bennett, 2000).

The dimension of spirituality at workplace aligns the values of employees with an organization and respect the individuality and wholeness of each employee. Spirituality expands the frontiers of consciousness, which gives feeling of personal fulfillment and commitment and owing to these attributes employees perform better to achieve the organization's goals (Miller & Ewest, 2013). Workplace spirituality has specific importance for health care institutions (HCI), as healthcare professionals specifically nursing staff deal with suffering, illness, and death because these are integral part of their profession, and they need to perform their duties irrespective of being emotionally attached to the workplace environment for the betterment of the patients (Bolton, 2000). Puchalski (2001) described empathetic care "that involves serving the whole person—the physical, emotional, social, and spiritual. Such service is inherently a spiritual activity" (p. 352).

Nurses work in environment of heavy pressure because they have to be efficient and accurate in their services with limited available resources (Corley, 2002). Long term exposure to stressful working conditions results in depletion of physical, psychological, and emotional resources and inability to deal with such situation causes stress among nurses (Sharma & Dhar, 2016). Spirituality at workplace is a source of eternal energy that helps in conservation of energy and emotional resources as well as provides assistance in handling the challenges at workplace. Workplace spirituality provides an opportunity to nurses to develop their inner self and to connect with their job and have sense of community. Such feelings give motivation to nurses to face the challenges with positivity, and they sacrifice for the betterment of others. Spirituality gives a vision to find solution and not problem at workplace. Spirituality at workplace creates a culture of help, team work, and happiness, and lastly, openness within which all stakeholders try to help each other to achieve the goal. Spirituality is only a coping strategy that sustains life time because it focuses on bringing harmony between body and mind considering the external environment and inner self. Nurses functioning in positive working environment broaden their vision to handle the challenges within available resources. Probability of medical errors becomes less where nurses work with serenity, happiness, and satisfaction. Affective commitment among

nurses working in spiritual environment is higher and eventually provides better care to patients. Workplace spirituality works as a catalyst to buffer the negative impact of stress on nursing staff and ultimately on their quality of care. On the basis of the empirical and theoretical evidence, nursing services are multidimensional which includes physical, emotional, psychological, and spiritual care of patients. To give holism mantra in nursing services, they need to develop themselves to a level of inner consciousness.

Hypothesis 6 (H6): Workplace spirituality moderates the relationship between stress and quality of care such that workplace spirituality weakens the effect of stress on quality of care.

3.6 Conceptual Model

From the above discussion conceptual model has been presented to test the relationship between independent, dependent, and moderator variables (Figure 3.4). The conceptual model presents the relationship between work-family conflict, bullying, patient incivility, stress, and quality of care. Further, stress may act as a mediator amongst the relationship between independent variables (work-family conflict, bullying, patient incivility) and dependent variable (quality of care), and workplace spirituality may moderate the relationship shared between stress and quality of care provided by nursing staff.

Research objectives describe the purpose of the present study that is: a) How does work-family conflict relate to stress level of nursing staff? b) How does bullying relate to stress level of nursing staff? c) How does patient incivility relate to stress level of nursing staff? d) How does stress level of nursing staff relate to quality of care provided in public healthcare institutions? e) How does stress mediate the relationship between work-family conflict, bullying, patient incivility, and quality of care? f) How does workplace spirituality moderate the relationship between stress and quality of care?

These research objectives are the pattern to review the literature for the development of conceptual model in this study as depicted in Figure 3.4. This conceptual model will provide a framework to empirically test the validity of the relationship among variables selected for the-study. Job Demand Resource model in the field of stress was adopted to provide a foundation for

understanding the variables and its dimensions. Conceptual model proposed work-family conflict, bullying, and patient incivility as predictors of stress; and quality of care as an outcome variable; and stress as mediator between predictors and quality of care. Further, based on the theoretical framework, workplace spirituality was proposed as a moderator between stress and quality of care.

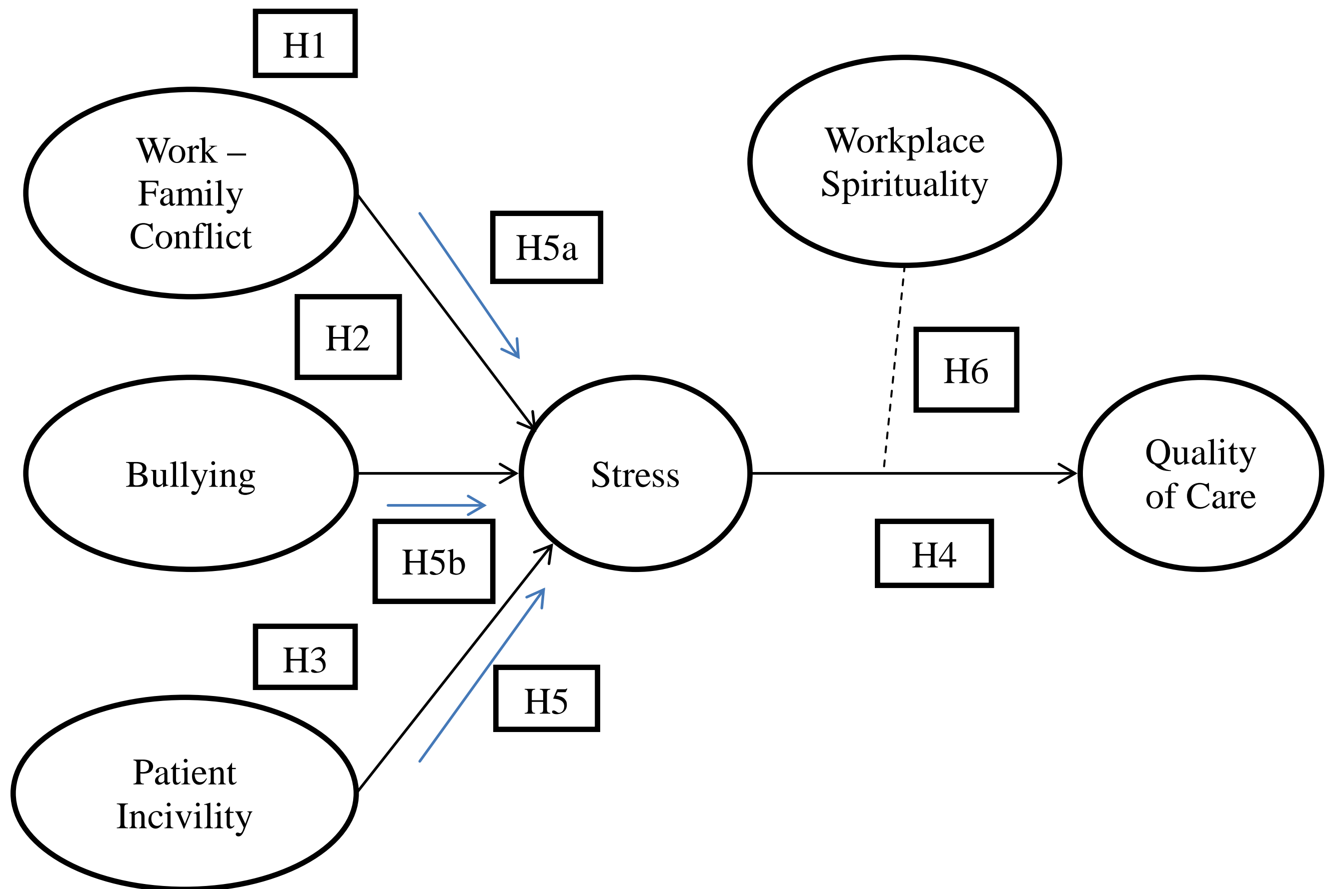

Figure 3.4: Hypothesized Model

3.7 Conclusion

This chapter has covered the background of population, that is, the nursing staff. This study deals with the concept and development of nursing, organizational structure, their working

environment, nursing as significant human resources and various issues pertaining to nurses. Further, in this chapter, relevant literature related to describing the constructs and their hypothesized relationship with other constructs as proposed in the conceptual model has been discussed. Six hypotheses have been formulated based on the conceptual framework, the pertinent literature, and relationship amongst constructs. In the following chapter, research design and the methodology for carrying out the further research has been described.

CHAPTER-4

METHODOLOGY

4.1 Overview

The chapter outlines the research design, participants in the study, instruments used in the data collection, procedure used to collect the data, technique and methodology used to analyze the data for the purpose of this study.

Research design gives direction and systematizes the research work. This chapter presents the research design used for the study, which describes the adequacy of research method for testing the proposed hypotheses. A quantitative approach with cross sectional data technique was implemented to have better understanding of the relationship between constructs depicted in the conceptual model. The research methodology of the present study explored the relationship between stress and its antecedents and consequences by focusing on the mediating influence of stress and moderating influence of workplace spirituality. Further, the sample characteristics, data collection procedure, and measures executed in the study are presented in details. The statistical analysis used for studying the reliability and validity of the questionnaire along with the statistical techniques used for data analysis in order to test the hypotheses have been discussed in details. Six measures used to test the hypothesis are work-family conflict (WFC), bullying, patient incivility (PI), stress, workplace spirituality (WS) and quality of care (QC).

4.2 Research Paradigm

As per Taylor, Kermode, and Roberts (2006), paradigm is a comprehensive outlook of procedures and the theoretical points. Paradigm guides the way to do the things, and in same manner, it can guide and affect the way research works. Paradigm can be defined as, "patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished" (Weaver & Olson, 2006, p. 460). Paradigm outlines the philosophical foundation of the research which is a fundamental part of investigation, both ontologically and epistemologically. Guba (1990) explained that paradigm can be described through ontology, epistemology, and methodology. These characteristics can

provide a blueprint to view knowledge and methodological approach for execution of the information available in order to conduct the research (Guba & Lincoln, 1994). Research paradigm is a cohesive group of fundamental concepts, variables, methodological approach, and tools of research. It explains the structure of inquiry, methods, methodology, processes and research design adopted for the study. As per past literature, the research tends to be directed by various paradigms like, positivism, post positivism, critical theory, and constructivism. Detail of the paradigms is given below in Table 4.1 and 4.2 [Adapted from Creswell (2013)].

Table 4.1: Detail of Paradigms

Positivist/ Post-positivist	Experimental Quasi-experimental (Cook, Campbell, & Day, 1979) Correlational Reductionism theory verification Causal comparative Determination Normative
Interpretivist/ Constructivist	Naturalistic Phenomenological Hermeneutic Interpretivist Ethnographic Multiple participant meanings Social and historical construction Theory generation
Critical Theory	Neo-marxist Feminist Critical Race Theory Freirean Participatory Emancipatory Advocacy Grand Narrative Empowerment issue oriented Change-oriented Interventionist Queer theory

Table 4.2: Research Paradigms, approach and methods

Research paradigm →	Positivist	Interpretivist/ Constructivist	Critical Theory	Postpositivist
Research Approach	Quantitative and Scientific method	Qualitative methods with subjective and objective research methods	Mixed methods (Qualitative and Quantitative methods). Contextual and historical factors and value based subjective inquiry	Objective data Quantitative and Qualitative method
Research Method	Experiments, scales and verification of hypotheses; Survey, Longitudinal and Cross-sectional research	Observation, case study and interviews	Action Research (Hope & Waterman, 2003); Varied tools to avoid discrimination	Quasi-experimental, correlational and ex-post facto research

Positivist research paradigm being one of the significant paradigms in nursing research (Weaver & Olson, 2006) has been adopted for the study. Further, explanation and justification for adoption of positivist research paradigm has been discussed.

4.2.1 Positivist Paradigm

Positivist research paradigm is related to the scientific evidence, theory, and methodology for understanding and conducting social research. According to Mertens (2005), positivist paradigm is "based on a rationalistic, empirical philosophy that originated with Aristotle, Francis Bacon, John Locke, August Comte and Emmanuel Kant" (p.8). This philosophy has strong propensity about using the experimental and statistical methods for measuring the phenomenon. Moreover, for testing the relationship among constructs, positivist philosophy relies on the

quantitative methods and collected data. This theoretical proposition revolves around the deterministic approach, which is based on the presumption that causes ascertain and clarify the impact on the outcome (Creswell, 2013). Positivist philosophy proceeds with explicit methods to achieve the procedural objectivity. This philosophy is best suitable in social science research as, "the social world can be studied in the same way as the natural world, that there is a method for studying the social world that is value free, and that explanations of a causal nature can be provided" (Mertens, 2005, p.8). This philosophy is further based on transparent methods and the belief that the research results can be tested to find out whether the results are distorted by bias or can be replicated. Further, positivist philosophy was replaced by post-positivist philosophy after World War-II. According to post-positivism, "What might be the truth for one person or cultural group may not be the 'truth' for another" (O'Leary, 2004, p.6). Post-positivist philosophy is based on the positivist paradigm because both the philosophies consider quantitative research design, that is, quantitative methods for collecting and analyzing the data.

Positivism emphasizes the objectivist approach for studying the social phenomena that gives importance to research methods like quantitative analysis, surveys and experiments.

The question arises about the ways through which a researcher selects a research paradigm and corresponding methodology. The following questions may be raised by the researcher:

1. What is the nature or essence of the social phenomena being investigated?
2. Is social phenomenon objective in nature or created by the human mind?
3. What is the basis of knowledge corresponding to the social reality, and how knowledge can be acquired and disseminated?
4. What is the relationship of an individual with her environment? Is she conditioned by the environment or is the environment created by her?

Positivism paradigm is based on the ontology that both researcher and respondents to be investigated are independent of each other. In positivism approach, the results are quantifiable and the part played by researcher is limited to data collection and statistical analysis of the data with objective approach. Positivist paradigm is based entirely on facts and covers wide range of conditions and environments. So, positivist paradigm was chosen because of its applicability considering the nature of the study. On the basis of this philosophy, the quantitative research

design provided better clarification in the nature and outlook of relationship between variables. The quantitative methodology was adopted for the research based on these views. Considering the nature of variables and past literature, the quantitative methods best suits to test the conceptual model (Bryman, 1988). Further, based on the research questions and objectives, this philosophy and technique was chosen for this study (Baum, 1995).

4.3 Research Design

Research design refers to the structure and broad strategy of research work that provides guidelines for achieving the objectives. Descriptive research design is scientific and conclusive in nature. Descriptive research gathers quantifiable data without influencing the target respondents, and the data further can be used for statistical analysis. Descriptive research design based on the quantitative method for data collection and analysis was adopted for the study. Further, considering the time and resource constraints, convenience sampling method was used for the study. Convenience sampling is non-probability technique for selecting respondents with ease of access and availability. The sample population for this study was nursing staff, who are working as nursing sister [grade one (1) & two (2)], staff nurse, and assistant nursing superintendent in the public healthcare institutions of Uttarakhand, namely, Rishikesh, Mussories, Haridwar, Haldwani, Manglore, Naianital, Bahadrabad, Laksar, Bagwanpur, Roorkee, Haldwani, Dehradun, and Khanpur.

4.4 Quantitative Methods

Quantitative research design has been well accepted in social sciences research because this is the structured way of revealing the interesting facts and direction of relationship between variables (Anisimova & Thomson, 2012). Quantitative methods can be survey, laboratory experiments, structured observation, secondary data analysis, content analysis, and mathematical modeling (Bryman, 1988). Considering the research design, the survey method was adopted to collect data for the present study.

4.4.1 Survey

Survey has long been the primary research strategy in quantitative social research because data is collected through survey method for statistical accuracy. The survey method is widely considered as internally quantitative and positivist and is most widely used method in social sciences research (De Vaus, 2013). This method has three distinguishing characteristics: its content, form of data, and the technique of analysis employed (Marsh, 1982).Content is the foundation of survey research which is based on the structured set of valid and reliable questionnaires. Data collected using survey method is structured, systematic, and centered on variables, and the analysis technique depends on comparison made across variables and groups.

In quantitative research design, survey method is significant because the essence of this type of research is to study relationship and the reasons of relationship between variables. The survey method describes the way variables relate to each other and the way variables vary and co-vary with each other (Punch, 2003). Three common modes of survey method are: a substitute for observation, a way to assess the attitudes, a measure of perceptions, intensions, values and beliefs (Sackett & Larson Jr, 1990). Survey method has an added advantage of collecting data from large sample, and it provides an opportunity to test the conceptual model and analyze the direction of relationship between constructs considered for the study. The most common method for survey is cross sectional design, and based on this design, the data is collected at a specific time period for descriptive purpose and for assessing the nature of relationships specifically when sample size is large.

Survey in the form of questionnaire is adopted because this study focuses on the attitude and behavior of employees. Standard questionnaires were adopted related to constructs used for the study and further the pilot study was conducted to test these questionnaires in the Indian context. The results obtained from the pilot study proved that these questionnaires were valid and reliable for further data collection. Survey in social research basically deals with knowledge, beliefs, attributes, and human behavior. So, for this study, survey method was used to have an insight into the working experience and environment of nursing staff, specifically to understand their perception about the patient incivility, bullying, work family conflict, stress, workplace spirituality and quality of care. In addition, survey helped in describing the nature of relationship between the above said constructs.

4.5 Pilot Study

A pilot study was conducted before the intended study in order to evaluate the content of questionnaire, time, and feasibility of the collected data. The questionnaire was pretested on nursing staff working in public health care institutions (PHCI) of Uttarakhand, India. These nursing staffs belonged to five cities which are Haridwar, Roorkee, Laksar, Dehradun, and Bagwanpur. The objective of pilot study was to test the instruments before starting the data collection with survey method. Before finalizing the measures, the initial instruments under consideration were reviewed by the experts and representatives from administration and nursing staff of PHCI. The focus of this pre-test was to ensure that the questions were easily understandable, no error is present related to issues addressed, and time required for completion of the survey questionnaire is properly estimated. Researcher was open to incorporate any useful feedback from the respondents and even ensured that measures are appropriate for the nursing occupation within the Indian context. Respondents were selected randomly from the selected PHCI which have given approval for the survey. Valuable feedback of respondents, experts and nursing administrators was considered and incorporated in the study to make it more practical and suitable in the Indian context. The results of the pilot study reflected the appropriateness of the scales and then these measures were implemented for the study.

4.6 Sample and Data Collection (Main Study)

The focus of study is on nursing staff working across public healthcare institutes of Uttarakhand, India. Seventy one (71) PHCI were selected randomly from various cities of Uttarakhand such as Rishikesh, Mussories, Haridwar, Haldwani, Manglore, Naianital, Bahadrabad, Laksar, Bagwanpur, Roorkee, Haldwani, Dehradun and Khanpur. The sample for study was selected randomly from wards of public health care institutes across Uttarakhand. Permission was granted from the concerned chief medical officer for conducting the survey from various wards of the public healthcare institutions. Participants represented various wards of PHCI including emergency, ICU, oncology, gynecology, surgical and psychiatry.

The target population of the study was nursing staff working in public healthcare organizations of Uttarakhand, India region. The population involved both male and female (20.07% and 79.93%, respectively) employees who are working as nursing staff. Nursing staff

includes nursing sister [grade one (1) & two (2)], staff nurse, and assistant nursing superintendent.

4.6.1 Distribution of Questionnaire

To conduct the survey, researcher contacted the concerned medical officer and nursing head to solicit their participation in the study. The purpose and significance of the research was explained to them and assurance of confidentiality was given to the concerned officials and participants. To ensure anonymity of the nursing staff, they were asked not to write their names on questionnaires and it was clarified that data will be used for academic purpose only. A meeting was organized where nursing head introduced the researcher to their respective nursing staff and gave an opportunity to the researcher to explain that the survey would cover issues regarding patient incivility, bullying, work-family conflict, stress, workplace spirituality, and quality of care. Cover letter contained thorough explanation of the purpose and importance of the research. For conducting the survey, cover letter, questionnaire, and stamped self-addressed return envelope were distributed to the respondents for their voluntary participation. As explained earlier, respondents were selected with convenience sampling, and 1250 questionnaires were distributed to 71 public healthcare institutions, out of which 929 questionnaires were received.

After collecting the data, questionnaires were thoroughly checked for missing values and outliers. In data cleaning process, 57 questionnaires with missing values and outliers were eliminated from the collected sample and in total 872 complete questionnaires yielding response rate of 69.76% were considered for further analysis. Of the 872 complete questionnaires of nursing staff, 79.93% (697) were females and 20.07% (175) were males. Majority of the respondents were between the age group of 36–45 years (43.11%) with an experience of 11–20 years (24.77%). In terms of educational qualification, 59.51% (519) had completed at least diploma in nursing.

4.6.2 Questionnaire Translation

The adopted questionnaires were originally in English language and all measures were administrated in native language, that is, Hindi and were checked for accuracy using back-translation procedure recommended by (Brislin, 1980).

The questionnaires were in English language, but the native language of respondents was Hindi, so the adopted questionnaires were translated in local language and then again in English by three language experts to assure the credibility of the questionnaire. Initially, the Hindi language expert prepared a translation from English to Hindi, which was subsequently back-translated into English by an English language expert. Minor differences that appeared during the translation process were resolved through discussion among both language experts and researcher to ensure that the meaning of all the items remained the same. Questionnaire is attached in Annexure - A.

4.6.3 Ethical Considerations

It is essential for researcher to follow the ethical norms while conducting research, and the norms have been followed persistently throughout the study. Permission to conduct the survey was taken from chief medical officer and concerned officers, and they raised their concern on confidentiality of the data. It was ensured by the researcher to maintain the confidentiality of the PHCI and of respondents. Kent (2000) proposed four ethical principles—autonomy, beneficence, justice, and nonmaleficence. The first principle, autonomy, was followed in the sense that each participant was given full right to agree or disagree, that is, self-determinism. Beneficence means obligation on the researcher to benefit the healthcare industry through her research. Justice means participants were fairly included in the study. Nonmaleficence principle was followed in the sense that none of the participants was affected mentally or physically.

To build the trust between researcher and participant, veracity, confidentiality, and fidelity was followed. Veracity was followed by providing the correct information about the study to the participants at all stages of research (Neuman & Kreuger, 2003). Confidentiality was guaranteed by the researcher through maintaining confidentiality about the identity and responses of the participants. Moreover, researcher held a meeting with the respondents to ensure confidentiality about the process of data collection, use of aggregate data, and revelation of the results to them. Anonymity of the participants was also maintained, as the researcher directly collected the questionnaires from the respondents. In addition, fidelity norm was executed by keeping the promise made to the nursing staffs about confidentiality and anonymity of their

responses. Coding of the questionnaire was known to both researcher and respondents and to avoid tempering of the data, complete questionnaires were sealed by the researcher.

4.6.4 Common Method Bias

Self-report data is common in psychological variables and in organizational behavior research; therefore, survey is the most effective method of ascertaining the experience of respondents under study. Standard procedure is followed in collecting data from the respondents related to their thoughts, feelings, believes, and attitudes about particular stimulus. This method is convenient, swift, and inexpensive in comparison to other methods of collecting information and data from respondents on specific subject.

In spite of all these advantages, self-report data has one concern that is common method bias because of 'consistency effect'. Common method bias exists in case data for both independent and dependent variables are obtained from the same respondents (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Respondents may maintain their response perceptions, attitude behavior owing to social desirability which could artificially inflate the relations between constructs under consideration.

To address this problem of common method bias in the study, the data were examined with most commonly used statistical procedure, that is, Harman's one-factor test (Podsakoff & Organ, 1986). This method specifies common method bias if primarily one single factor appears in factor analysis, and secondly, one single factor explains the major covariance in predictor and criterion variables (Krishnan, Martin, & Noorderhaven, 2006; Podsakoff & Organ, 1986). As per this technique, all the variables of related constructs under study were entered in the principal component factor analysis for determining whether majority of the variance is represented by one general factor.

4.7 Measures

Six standard scales were used in the study for measuring the constructs of interest. They included independent variables and dependent variables. The independent variables include measures of the work family conflict, patient incivility, bullying and workplace spirituality. The

dependent variables include measures of stress and quality of care. Measures were designed for gathering demographic information about the nursing staff, and these information included age, gender, education; experience, and marital status.

4.7.1 Independent Variables

4.7.1.1 Work-Family Conflict

Work-family conflict was measured with 7-point Likert scale developed by (Netemeyer, Boles, & McMurrian, 1996). The scale ranged from 1= Strongly Disagree to 7 = Strongly Agree. The scale measures the degree to which job demands and responsibilities interfere in the family responsibilities of the nursing staff. Some of the questions are "The demands of my home and family life" and "The amount of time my job takes up makes it difficult to fulfill family responsibilities". The value of reliability (Cronbach's alpha) for work family conflict is 0.89.

4.7.1.2 Patient Incivility

Patient incivility was measured using 10-items scale developed by Guidroz, Burnfield-Geimer, Clark, Schwetschenau, and Jex (2010),where the answers ranged from 1 = Strongly disagree to 7=Strongly agree. The items of this instrument were designed for measuring the frequency of insulting and rude behavior of patients and their relatives towards nursing staff. Some of the questions are, "Patients/visitors do not trust the information I give them and ask to speak with someone of higher authority" and "Patients/visitors make insulting comments to nurses". The reliability (Cronbach'salpha) of this scale is 0.93.

4.7.1.3 Bullying

Bullying was measured using multiple items scale developed by Quine (2001), where the answers ranged from 1= Strongly Disagree to 7 = Strongly Agree. Multiple items scale provides wider scope to respondents and allow more complete assessment of bullying at workplace (Spector, 1997). Bullying scale includes 20-item scale for measuring five specific categories of bullying; threat to professional status, threat to personal standing, isolation, overwork and destabilization. The reliability (Cronbach's alpha) of this scale is 0.96. Some of the questions are "Persistent attempts to belittle and undermine your work" and "Making inappropriate jokes about you"

4.7.1.4 Workplace Spirituality

Workplace spirituality was measured with scale developed by Rego and Pina e Cunha (2008). The scale consists of 17 items (two reverse coded) and 7-point Likert scale was used,where the answers ranged from 1 =Strongly disagree to 7=Strongly agree. Some of the sample questions are "I feel that the members of my team/group are linked by a common purpose" and "My work is connected with what I think is important in life." The reliability (Cronbach's alpha) of this scale is 0.97

4.7.2 Dependent Variables

4.7.2.1 Stress

Stress was measured using the nursing stress scale (NSS) that consisted of 29 items developed by Gray-Toft and Anderson (1981),where the possible answers ranged from 1= Strongly Disagree to 7= Strongly Agree. Pilot study was conducted in selected ten (10) PHCI to validate nursing stress scale (NSS) in Indian context. The results of the pilot study reported that loadings of one of the seven components of NSS, that is, uncertainty concerning treatment were below 0.4, so this component was not relevant for measuring stress of nursing staff working in PHCI in India. Eventually, 29 items were considered for the study from NSS to collect response on stress. Sample questions include "not enough time to provide emotional support to patients" and "not enough staff to adequately cover the unit". The reliability (Cronbach's alpha) of this scale is 0.97.

4.7.2.2 Quality of care

Quality of care was measured using 4-item scale developed by Aiken, Clarke, and Sloane (2002).The possible answers ranged from 1= Very Poor to 7= Excellent for first two (2) questions, 1 = completely disagree to 7 = completely agree for third (3rd) question and 1 = not at all confident to 7 = extremely confident for question number four (4) of scale used in study. The sample questions are "In general, how would you describe the quality of nursing care delivered to patients on your ward?" and "How confident are you that your patients are able to manage

their care when discharged from the hospital?" The reliability (Cronbach's alpha) of this scale was reported 0.89.

4.8 Controls

Past research has shown that demographic variables are controlled to prevent its probable influence on the relationship between independent and dependent variables (Sharma, Dhar, & Tyagi, 2015; Zeytinoglu et al., 2007). Demographic variables, namely, age, gender, experience, education and marital status are controlled in the study. As described in Table 4.3, the demographic variables being categorical in nature were coded; gender of respondents were coded as 1 for females and 2 for males; marital status of respondents, that is, unmarried, married and divorcee was coded 1, 2, and 3, simultaneously; and education, that is, diploma, graduation and post-graduation were coded as 1, 2, and 3, simultaneously. Age and experience were classified in continuous classes. For collecting information about experience, respondents were asked to indicate the number of years they had worked at their present organization and age was measured in years. All these demographic variables were controlled to prevent the influence of these variables on the relationships shared between independent and dependent variables.

Table 4.3: Coding of demographic variables done in SPSS

Age
1 = 25 to 35 years, 2 = 36 to 45 years, 3 = 45 year and above
Marital Status
1 = Married, 2 = Unmarried, 3 = Divorcee
Experience
1 = Below 1 year, 2 = 1 – 10 years, 3 = 11 - 20 years, 4 = 21 - 30 years, 5 = 31 years and above

4.9 Reliability and Validity

The quality and accuracy of measures can be drawn from the results of the study which depends on two significant requirements, that is, reliability and validity of the instruments used

for the study. Reliability means “dependability or consistency, that is, results are not erratic, inconsistent or unstable” (Neuman & Kreuger, 2003, p. 164). Validity proposes that, “results are truthful and there is match between ‘reality’ and the theories, concepts and descriptions researcher has used to analyze the world” (Neuman & Kreuger, 2003, p. 164). The reliability and validity of the research findings is a significant consideration for quantitative research.

4.9.1 Reliability

Reliability is an assessment of the observed variables to an extent, which shows the true “value” and measure the degree of consistency amongst the multiple measurements of variables (Hair, 2010). Reliability is the extent to which the set of variables consistently and accurately measure what they are intended to measure and give similar results under consistent conditions (Booth, Owen, Bauman, & Gore, 1996). Various methods are available to test the reliability of measures such as test–retest, internal consistency, inter rater and split half. However, the most common and consistent method to test the reliability of the measure is inter consistency (Hair, Tatham, Anderson, & Black, 2006). The rationale behind the significance of internal consistency is that all indicators of the scale measure the same construct and show high inter correlation.

4.9.1.1 Internal Consistency Reliability (ICR) Test

Internal consistency reliability (ICR) shows the consistency of results and correlations between different variables of the same construct. ICR was measured by calculating the Cronbach’s alpha value of the constructs under study. Initially, data was collected from 70 nursing staff to test the internal consistency of the scale. Minimum requirement of ICR test is 10 to 30 respondents, however, the sample size used for the study was 70, which fulfil the minimum requirement of ICR test. The result of collected data shows the applicability of scale in Uttarakhand, India because Cronbach’s alpha values of all scales are above 0.80 as described above in the measures section [4.7.4].

Internal consistency method was used for the study to analyze the reliabilities of the constructs under consideration with the help of inter item correlation, composite reliability and

Cronbach alpha, by describing the degree to which all the items of a particular construct are inter-related and measure the same concept (Cronbach, 1951).

Reliability shows the stability and consistency of the scale. However, there are other empirical bases that need to be fulfilled for proving the validity of the scale.

4.9.2 Validity

Validity is the degree (extent) to which the indicators accurately calculate what they are supposed to measure and conform the conceptual definition (Hair et al., 2006). "A scale is said to be valid if it measures what it claims to measure" (Kline, 1986, p. 640). After conformity of reliability with composite reliability and Cronbach's alpha, it is imperative to validate the scale. Moreover, reliability is not enough condition for validation of the scale because the conceptual and empirical criteria need to be fulfilled for validation of the instrument. Validity can be either face validity or the content validity. Empirically, construct related validity, that is, discriminant and convergent validity, are most commonly used method. These are measured by correlation between theoretically set of variables. Construct validity emphasizes on the degree to which the collected data reveal indication of discriminant validity and convergent validity.

4.9.2.1 Discriminant Validity

Discriminant validity shows that conceptually distinct measures should actually differ from each other (Burns Alvin & Bush Ronald, 1995). If two constructs are different then their respective indicators should share minimum correlation. Fornell and Larcker (1981) method is the most common technique for measuring discriminant validity. As per this technique, average variance extracted (AVE) of each construct should be greater than its squared correlation.

4.9.2.2 Convergent Validity

A convergent validity shows that all the constructs that are supposed to be theoretically related are in fact related to each other. All indicators of the construct should have high loadings on their respective factors. Bagozzi and Yi (1988) recommended three standard process to assess the convergent validity of the measurement model, that are, a) AVE of every construct should be greater than 0.5 (Fornell & Larcker, 1981); b) composite reliability should be greater than 0.7; c) factor loadings should be greater than 0.5 (Hair et al., 2006).

4.10 Data Analysis

The IBM® SPSS® Amos™ 21 (International Business Machines - Statistical Package for Social Science and Amos Graphics) data analytic tool was used for computing descriptive statistics like mean, standard deviation, correlations, internal consistency reliability. The technique used in this research work and their purpose are shown in Table 4.4.

Table 4.4: Technique used and their Purpose

Tool	Technique	Purpose
Amos (Version 21)	Structural Equation Modeling	Confirmatory Factor Analysis
SPSS (Version 21)	Hayes PROCESS	Direct, Mediation & moderation analysis

4.10.1 Technique Used

To analyze the data, two data analytic techniques were used, namely, Structural Equation Modeling (SEM) and Hayes PROCESS hierarchical regression.

4.10.1.1 Structural Equation Modeling (SEM)

SEM is a commonly used multivariate technique for quantitative researchers that can be executed to analyze the relationships amongst multiple independent and dependent variables simultaneously (Hoyle, 1995; Pedhazur, 1997). In comparison to other available multivariate techniques, SEM is more flexible and comprehensive in context to its relaxed statistical assumptions, because SEM is an expansion of General linear model (GLM), which is the combination of factor analysis, correlation, analysis of variance (ANOVA), and multiple regression analysis, and therefore, has strengths of and over these standard approaches. SEM is an extensive statistical method which estimates a sequence of separate but interdependent equations concurrently for testing the hypotheses about complex relations among observed and latent variables with multiple measures (Hoyle, 1995; Kaplan, 2008).

A model is a representation of theory, and SEM has two key models comprising of measurement model and structural model. The first step in SEM is to specify the measurement model which a) denotes the measurement relationship between items and constructs; b) identifies error terms for the items; and c) states correlation among the constructs. The measurement model is that element of the general model in which latent variables are specified as No and the analysis cannot be possible without affirming the model to be tested and the nature of relationship being hypothesized (Hoyle, 1995). The model indicates two parameters: fixed parameters which are fixed at zero, and free variables which are estimated from the gathered data and contain value greater than zero. Identification is the principle consideration while specifying the models in SEM because its main concern is obtaining a single exclusive value for each and every free parameter from the observed data (Hoyle, 1995). In other words, the ways in which the latent constructs are computed in terms of their respective indicators (Anderson & Gerbing, 1988). Each latent construct was examined in relation to its associated indicators. Confirmatory factor analysis (CFA) technique was applied to test the measurement model of the study before testing the mediation and moderation analysis.

4.10.1.1.1 Working with SEM

After specifying the model, the next task is to calculate the estimates for the observed variables (free parameters) and to check the fitness of the model with regard to the observed data (data collected for the free variables). In SEM, iterative methods such as maximum likelihood or generalized least square are preferred, and the estimation process of the parameters results in a single number known as *value of the fitting function* and this value ascertains the degree of association between the implied covariance matrix and observed covariance matrix. In simple terms, the degree to which the value of the observed covariance matrix is equivalent to the covariance matrix (values in the residual matrix are near to zero) determines the *fit* of the model in relation to the observed data. Fundamental step in SEM is testing the validity of measurement model (Hair, 2010), which can be assessed with goodness of fit indices. It indicates the suitability and validity of the measurement model through representation of the similarity of observed (reality) and estimated covariance matrix (theory). Basically, the fit of the model is compared to any other baseline model that describes the complete interdependence among the observed variables.

Indices are calculated by comparing the fit of the model with that of some other baseline model, which specifies the complete independence among observed variables. Absolute, parsimony and incremental fit indices are available for determining the fitness of the model. Some of the most common indices are goodness-of-fit index (GFI), Adjusted Goodness-of-fit-index (AGFI), Tucker–Lewis index (TLI), Incremental fit index (IFI), Comparative fit index (CFI), Normed fit index (NFI), root mean square error of approximation (RMSEA), chi square (Hoyle, 1995; Kaplan, 2008). Value of these indices should be between 0–1 (Hair et al., 2006), as 1 denotes the perfect fit of the model. The acceptable range of the indices is 0.8 and above (Anderson & Gerbing, 1988) and the value above 0.8 signifies that target model has a good fit relative to the baseline model.

Measurement model was used in this study to validate the measures (Work-family conflict, bullying, patient incivility, stress, workplace spirituality and quality of care) that were adopted for the study with CFA by depicting the values of goodness of model fit.

4.10.1.2 Hayes Mediation and Moderation Analysis

For mediation and moderation analysis, the Preacher and Hayes (2004) bootstrapping method was used because of its primacy to other available methods for various reasons. First, it is a better statistical test than Baron and Kenny (1986) mediation analysis that has more Type 1 error, and less statistical power, as well as this analysis does not address the significance of anticipated direction of direct or indirect effects between variables (Preacher & Hayes, 2004). Baron and Kenny (1986) model uses a three causal steps approach that consists of the significant and pair-wise relationship among the independent, dependent, and mediator variables. However, the bootstrapping method (Preacher & Leonardelli, 2001) is not limited to three constraints of Baron and Kenny's (1986) method, as this method can be applied even if there is no support for correlation between independent and dependent variables as well as among indirect effect variables. According to Hayes, the significant and interesting findings can be missed, if mediation is not tested in the absence of direct and indirect effects (Hayes, 2009). Moreover, bootstrapping does not rely on normality and large sample size, so Sobel test a function within the bootstrapping macro was used for analysis in this study (Preacher & Hayes, 2008). Preacher

and Hayes (2008) proposed 5000 bootstrapping samples to estimate the standard error of the variables for further analyses.

To test the hypotheses of the study, the multiple regression technique with script version of the Sobel macro for SPSS developed by Preacher and Hayes (2004) was followed (Hayes, 2013; Preacher, Rucker, & Hayes, 2007). The INDIRECT test (Preacher & Hayes, 2004) estimates the total, direct, and single-step indirect effects, which are percentile-based, bias-corrected, and accelerated bootstrap confidence intervals (CI) (Preacher & Hayes, 2008). Total indirect effect for mediation analysis was tested with 95% CI and the value more than zero validates the significant mediation. SPSS macro used ordinary least squares (OLS) regression to compute the estimates of each path.

The conceptual detail of mediation and moderation analysis is described below.

4.10.1.2.1 Mediation Analysis

Mediation analysis posits 'how' and by 'what means' exogenous variable 'X' transmits its influence on the endogenous variable 'Y' through potential intervening variable, mediator 'M'. Figures 4.1 and 4.2 represents the mediation model in which the influence of causal effect of 'X' is depicted, and the effect can be apportioned into its direct effect on 'Y', while controlling the mediator (path c') and its indirect effect on 'y' through 'm'. Path 'a' represents the effect of independent variable on the proposed mediator, path 'b' represents the direct effect of the proposed mediator on the dependent variable by partialling out the effect of 'X', path 'c' represents the total effect of the independent variable on the dependent variable, and path c' represents the direct effect of the independent variable on the dependent variable after controlling the proposed mediator. The indirect effect of independent variable 'X' on dependent variable 'Y' through mediator 'M' can be calculated as the product of *a* and *b* (i.e., *ab*). The total effect of independent variable 'X' on dependent variable 'Y' can be presented as the sum of direct and indirect effects (i.e., c = c' + ab). The difference between the total effect of independent variable 'X' and dependent variable 'Y' and the indirect effect of 'X' on 'Y' through mediator 'M' can be expressed as c' (c' = c - ab). Direct and mediation analysis was carried out with Model no. 4 as coded by AF Hayes.

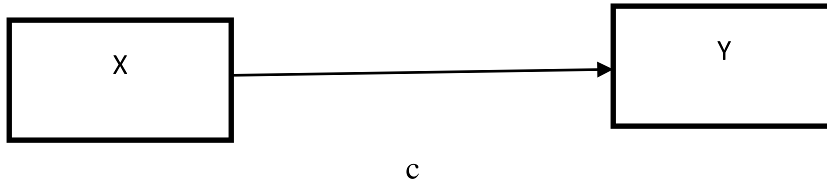

Figure 4.1: Direct effect X on Y

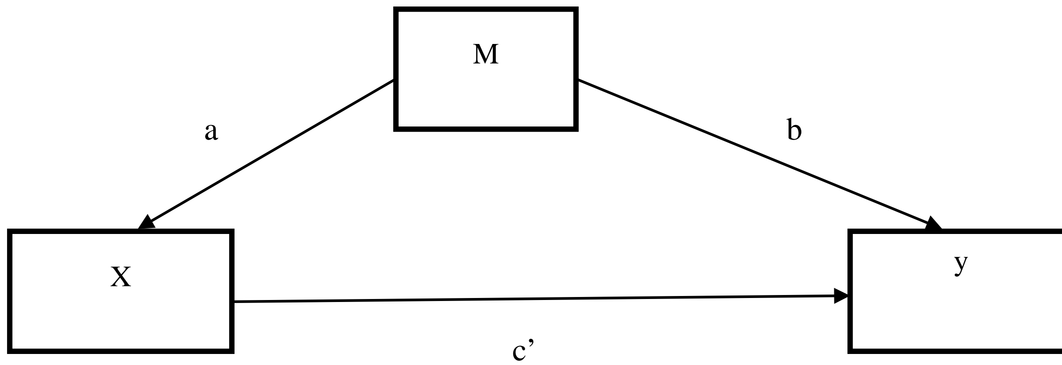

Figure 4.2: Mediation model showing effect of X is on Y through M

To test the mediation and indirect effect, the bootstrapping method was used, as it is one of the most promising techniques to analyze the mediation and moderation effect. Preacher and Hayes (2008) described the method as, “for now, the evidence supports our claim that the bootstrapping methods we describe here are preferred over methods that assume symmetry or normality of the sampling distribution of the indirect effect” (p. 884). Bootstrapping can be defined as, “an empirical sampling distribution” for the product of a and b, and “takes the researcher’s sample size of N and from it draws with replacement N values of (X, M, Y) to create a new sample” (Zhao, Lynch, & Chen, 2010). Bootstrapping method was used through SPSS macro advanced by Preacher and Hayes (2008).

Path a: Effect of the independent variable on the mediator $M = i_1 + aX + e_1$ (4.1)

Path b: Direct effect of the mediator on the dependent variable $Y = i_2 + c'X + e_2$ (4.2)

Path c': Direct effect of the independent variable on the $y = i_3 + cX + bM + e_3$ (4.3)

Dependent variable after controlling the mediator variable $c' = (a * b) + c$ (4.4)

4.10.1.2.2 Moderation Analysis

Moderation effect occurs when the relationship between two constructs depends on the third one. Regression weight of Y (dependent variable) on X (independent variable) varies with the function of moderator (M), as M interacts with X to predict Y (Figure 4.3). Using the SPSS macro provided by Preacher et al. (2007), the effect of workplace spirituality being moderator was estimated at varying levels by using a bootstrapping approach with 1,000 iterations. Stress was entered as the independent variable, quality of care as the outcome variable, and workplace spirituality as a moderator following Model 1 (Preacher et al., 2007). To know the magnitude of the moderating effect, the test was run three times; at the mean, at one standard deviation above the mean, and at one standard deviation below the mean, that is, mean ± 1 standard deviation.

$$Y = a_0 + a_1X + a_2M + a_3XM + r; \quad (4.5)$$

$$Y = (a_0 + a_2M) + (a_1 + a_3M)X + r; \quad (4.6)$$

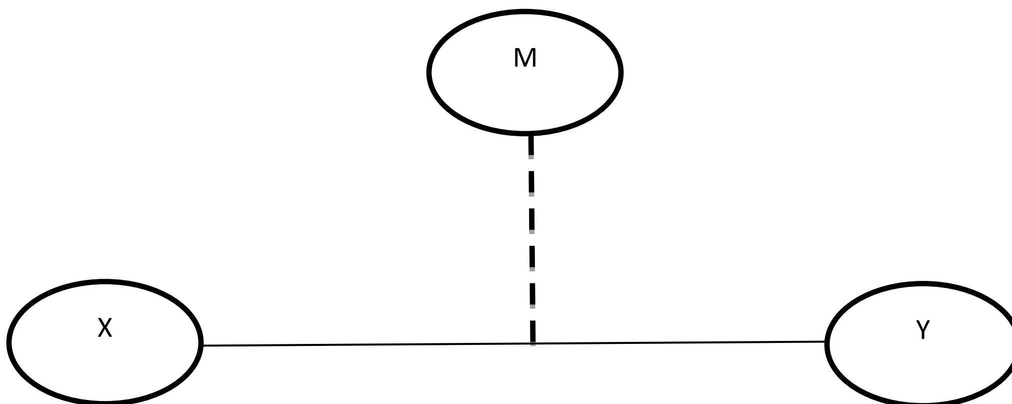

Figure 4.3 Moderation Model

4.11 Conclusion

The chapter has discussed about the methodology that has been adopted for the study, wherein the research design, scope of the study, and the process of data collection has been discussed in detail. Standard measures and self-reported questionnaires were adopted to collect the data by using survey method. All questions were responded by employees, that is, nursing staff. Nursing staff have provided their responses regarding work-family conflict, bullying, patient incivility, stress, workplace spirituality and quality of care. Questionnaire used for the study has been provided in Annexure - A. Detailed discussion with the advantages and rationale of two data analysis techniques (Structural Equation Modeling and Hayes PROCESS) over other statistical techniques have been highlighted in this chapter. In the following chapter, the results obtained from the data analysis techniques adopted for testing the study hypothesis has been presented in details.

CHAPTER 5

RESULTS

5.1 Overview

This chapter depicts the results of statistical analysis of the data that was collected through questionnaires. The results of the confirmatory factor analysis (CFA) and Hayes PROCESS for mediation and moderation analysis has been presented. It starts with the results of the pilot study, and further provided the description of demographic characteristics of respondents along with the results of the variance inflation factor and Harman's single factor test for data biasness. Measures used for reliability (Cronbach's Alpha) (Cronbach, 1951), convergent and discriminant validity and data biasness (Harman's single factor test) are reported, in addition to the results of measurement model obtained by using CFA. The validity of the scale was tested with statistical software like SPSS and AMOS. Hypotheses including direct, mediating, and moderating relationship are tested with SPSS software using Hayes PROCESS macro that included the features of SOBEL test also.

5.2 Results of the pilot study

The pilot study was conducted on seventy (70) nursing staff working in public health care institutions (PHCI) of Roorkee, Dehradun, Laksar, Mussorie, and Rishikesh, that is, in the Uttarakhand region. The preliminary statistical analysis was conducted on the data collected from the pilot study for testing the correlation among variables and reliability coefficient of the measures adopted for this study. The results of the pilot study are represented in the Tables 5.1, 5.2, and 5.3 for demographic details, inter-correlation, and reliability values of the scale, simultaneously.

The results demonstrated the significant correlation among the constructs with small sample size of seventy (70) respondents. WFC, bullying, and PI have a significant correlation with stress (0.39, 0.48, 0.40, simultaneously), and stress was adversely related with QC and WS (-0.94 and -0.80). Further, WS has a significant correlation with QC (0.76) as is shown in Table 5.2.

Table 5.1: Demographics of the pilot study

Employee details (n=70)	Frequency	Percentage (%)
Gender		
Male	26	37.14
Female	44	62.86
Age (in yrs)		
25 yrs - 35 yrs	12	17.14
36 yrs - 45 yrs	33	47.15
46 yrs and above	25	35.71
Education		
Nursing Diploma	47	67.14
Nursing Degree	23	32.86
Experience		
Less than 1 yr	7	10
1 yr - 10 yrs	19	27.14
11 yrs - 20 yrs	25	35.72
21 yrs - 30 yrs	10	14.28
31 yrs and above	9	12.86
Marital Status		
Married	42	60
Unmarried	22	31.42
Divorcee	6	8.58

Table 5.2: Inter-correlation of the variables (Pilot study)

	Gender	Age	Education	Experience	Marital Status	WFC	Bullying	Patient Incivility	Stress	WS	QC
Gender	1										
Age	.96**	1									
Education	.81**	.94**	1								
Experience	.96**	.95**	.94**	1							
Marital Status	.81**	.94**	.95**	.94**	1						
WFC	-.10	-.08	-.04	-.08	-.04	1					
Bullying	.02	.01	-.03	.01	-.03	.29*	1				
Patient Incivility	-.02	-.05	-.08	-.05	-.08	.43**	.29*	1			
Stress	-.01	-.03	-.06	-.03	-.06	.39**	.48**	.40**	1		
WS	-.02	-.01	.02	-.01	.02	-.31**	-.38**	-.30**	-.80**	1	
QC	.01	.04	.08	.04	.08	-.41**	-.50**	-.39**	-.94**	.76**	1

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

WFC = Work-Family Conflict, WS = Workplace Spirituality, QC = Quality of Care

Table 5.3: Reliability values of the scales (Pilot study)

Constructs	Reliability (Cronbach's Alpha)
Work Family Conflict	.95
Bullying	.98
Patient Incivility	.96
Stress	.98
Workplace Spirituality	.98
Quality of Care	.90

5.3 Sample Characteristics and Initial Analysis

The data was collected from nursing staff working in PHCI of Uttarakhand, India. The minimum recommended sample level for the estimation of SEM is five observations for each estimated parameter (Hair, Tatham, Anderson, & Black, 2006). A total of 1250 questionnaires were distributed and in total 929 filled questionnaires were returned by the respondents. 57 questionnaires were eliminated because of missing data; therefore, the sample size for testing the hypothesis was 872, so comprising a response rate of 69.76%. With regard to the demographic profile of the sample, respondents were primarily females (79.93%) and majority of the respondents were in the age group of 36–45 years. In terms of education, the primarily respondents (59.51%) were diploma holders, and the average experience of respondents was 11–20 years (24.77) and majority of the respondents (59.97%) were married. Table 5.4 presents the demographic profile of the respondents of main study.

5.4 Variance Inflation Factor (VIF)

The variables were checked for normality, skewness, kurtosis and non-multicollinearity with VIF. The results demonstrated that the normality of data is not a significant threat, as skewness and kurtosis were within one standard deviation of mean. VIF measures the inflation of variances of the estimated regression coefficients when the independent variables are linearly related (Neter, Kutner, Nachtsheim, & Wasserman, 1996). In this study, VIF values are in an acceptable range from 1.01 to 1.29, that is, the value below ten (10) is considered an indication of non-multicollinearity (O'brien, 2007).

Table 5.4 Demographic Details (Main Study)

Employee's details (n=872)	Frequency (s)	Percentage (%)
Gender		
Male	175	20.07
Female	697	79.93
Age (in yrs)		
25 yrs - 35 yrs	195	22.37
36 yrs - 45 yrs	376	43.11
46 yrs and above	301	34.52
Education		
Nursing Diploma	519	59.51
Nursing Degree	353	40.49
Experience		
Less than 1 yr	87	9.97
1 yr - 10 yrs	198	22.71
11 yrs - 20 yrs	216	24.77
21 yrs - 30 yrs	204	23.39
31 yrs and above	167	19.16
Marital Status		
Married	523	59.97
Unmarried	276	31.65
Divorcee	73	8.38

5.5 Descriptive Statistics

Descriptive statistics including standard deviation, mean and inter-correlation analysis for the variables considered in the study are examined and presented in this chapter. Reliability of each scale was tested for internal consistency by estimating Cronbach's alpha, inter-item correlation, and composite reliability.

5.5.1 Reliability of the Scale

Reliability of the scale depicts consistency, which demonstrates that it produces same results even if used at different times and in diverse contexts. Cronbach's alpha is the most extensively used method for measuring the reliability coefficient of entire scale. Reliability of the scale was analyzed with SPSS software, and the results reported that the values of Cronbach's alpha are above 0.7, that is, above the acceptable limits (Cho, Hong, & Hyun, 2009). The reliability values of individual constructs are work-family conflict = 0.89, bullying= 0.96, patient incivility = 0.93 Stress=0.97, workplace spirituality = 0.97 and quality of care = 0.89; which demonstrate the inter-consistency reliability of the scale. Further, composite reliability (CR) was tested and it varies from 0.89 to 0.97. The factor loadings of all measures are significant ($p < 0.001$) and within the acceptable limits.

Table 5.5 shows that the inter-item correlation reported value above 0.30 signaling that all measures are reliable. Table 5.5 depicts the descriptive analysis of the instruments used, comprising standard deviation, mean, and internal consistency reliability (Cronbach's alpha), and CR of each construct.

Table 5.5: Mean, Standard Deviation, Correlation and AVE values of the study

	Mean	SD	AVE	Square Root of AVE	Gender	Age	Education	Experience	Marital Status	WFC	Bullying	PI	Stress	WS	QC
Gender	1.79	.40			1										
Age	2.12	.74			.75**	1									
Education	1.40	.49			.41**	.81**	1								
Experience	3.19	1.26			.67**	.89**	.83**	1							
Marital Status	1.48	.64			.37**	.77**	.90**	.81**	1						
WFC	3.91	2.02	0.63	0.79	-.01	-.03	-.03	-.02	-.04	1					
Bullying	3.97	1.80	0.59	0.76	-.01	-.01	-.01	-.002	-.005	.14**	1				
PI	3.85	1.74	0.59	0.76	-.02	-.03	-.03	-.02	-.02	.10**	.47**	1			
Stress	3.99	1.82	0.56	0.74	-.03	-.05	-.04	-.04	-.03	.11**	.61**	.68**	1		
WS	3.36	1.98	0.68	0.82	.08*	.13**	.11**	.15**	.05	-.06*	-.43**	-.48**	-.59**	1	
QC	2.84	1.61	0.69	0.83	.16**	.20**	.15**	.20**	.09**	-.13**	-.36**	-.39**	-.46**	.74**	1

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

SD= Standard Deviation, AVE= Average Variance Extracted, WFC =Work Family Conflict, PI = Patient Incivility, WS = Workplace Spirituality, QC = Quality of Care

5.6 Validity of the Scale

Validity of the scale implies that the questions truly represent the theoretical concept and the instrument. Further, the variables should measure the same, as it claims to measure for the respective constructs. Construct validity of the scale was checked with convergent and discriminant validity

Discriminant and convergent validity was examined and reported for the constructs used in this study. Discriminant validity was depicted in Table 5.5, which presents the correlation matrix of all constructs. The square root of average variance extracted (AVE) for each construct is shown in diagonal elements. The results reported that the square roots of AVE values are greater than correlation coefficient of any two constructs. As per the method suggested by (Hair, 2010), Maximum Shared Squared Variance (MSV) and Average Shared Square Variance(ASV) values are below AVE values, thus, confirming the discriminant validity of the constructs under consideration. The results showed that the constructs of the study are indeed different from each other and provided evidence of the discriminant validity for the constructs used in the measurement model.

Convergent validity was depicted in Table 5.5 which shows that AVE ranges from 0.56 to 0.69 and composite reliability (CR) ranges from 0.89 to 0.97 for all the constructs, and all observable indicators loadings are high (> 0.7) and significant on their respective latent factors as tested using CFA [Table 5.6]. For work-family conflict the range is 0.74–0.86, for bullying it is 0.73–0.81, for patient incivility, it is 0.69–0.85, for stress, it is 0.61–0.80, for workplace spirituality, it is 0.61–0.88.and lastly, for quality of care, it is 0.83–0.84 [Table 5.6].

These results indicated convergent validity of the measurement model by meeting all three conditions as mentioned above. The results of CFA provide evidence of convergent validity for the constructs used in the study.

Table 5.6: Composite reliability, Cronbach's alpha reliability and Factor Loadings

Variables	Composite Reliability	Cronbach's Alpha	Mean	Standard Deviation	Loadings	t-value***
Work-Family Conflict (WFC)	.89	.89				
WFC1			3.82	1.93	.82	28.73
WFC2			3.86	2.25	.74	24.40
WFC3			3.89	1.98	.76	25.66
WFC4			3.93	2.01	.77	26.23
WFC5			4.07	1.94	.86	30.26
Bullying	.96	.96				
Bullying1			3.94	1.82	.77	27.24
Bullying2			4.01	1.91	.80	28.83
Bullying3			3.99	1.75	.73	25.28
Bullying4			3.95	1.82	.81	28.98
Bullying5			3.92	1.81	.75	25.82
Bullying6			3.92	1.77	.74	25.40
Bullying7			3.96	1.76	.76	26.33
Bullying8			3.90	1.74	.77	27.12
Bullying9			4.00	1.72	.77	27.03
Bullying10			3.94	1.76	.73	25.00
Bullying11			3.99	1.80	.79	27.83
Bullying12			3.96	1.77	.74	25.54
Bullying13			3.97	1.81	.79	28.02
Bullying14			4.00	1.85	.77	26.82
Bullying15			4.00	1.79	.76	26.76
Bullying16			3.95	1.78	.76	26.47
Bullying17			3.89	1.86	.76	26.67
Bullying18			4.01	1.79	.80	28.32
Bullying19			4.07	1.91	.77	26.88
Bullying20			4.08	1.83	.77	27.10

Patient Incivility (PI)	.93	.93				
PI1			3.97	1.71	.85	31.22
PI2			3.85	1.77	.77	26.71
PI3			3.85	1.72	.74	25.42
PI4			3.78	1.84	.71	24.09
PI5			3.80	1.73	.69	22.74
PI6			3.77	1.75	.75	26.01
PI7			3.89	1.73	.75	25.56
PI8			3.88	1.70	.78	27.17
PI9			3.86	1.69	.77	27.00
PI10			3.91	1.78	.80	28.48
Stress	.97	.97				
Stress1			3.97	1.78	.78	27.71
Stress2			4.08	1.74	.79	28.31
Stress3			3.95	1.78	.75	25.98
Stress4			3.96	1.77	.71	24.43
Stress5			4.02	2.97	.61	14.65
Stress6			3.94	1.82	.71	24.20
Stress7			3.93	1.77	.72	24.60
Stress8			3.94	1.72	.73	25.15
Stress9			4.11	1.69	.78	27.85
Stress10			3.93	1.81	.73	25.28
Stress11			4.03	1.75	.77	27.24
Stress12			3.92	1.76	.74	25.49
Stress13			4.02	1.86	.73	25.00
Stress14			4.00	1.83	.72	24.89
Stress15			4.02	1.70	.71	24.06
Stress16			4.00	1.82	.75	26.35
Stress17			3.96	1.77	.72	24.60

Stress18			3.87	1.74	.73	25.07
Stress19			3.99	1.79	.78	27.53
Stress20			4.02	1.76	.73	25.39
Stress21			4.11	1.76	.76	26.40
Stress22			3.92	1.79	.78	27.75
Stress23			4.06	1.80	.79	28.08
Stress24			3.92	1.83	.78	27.81
Stress25			4.01	1.80	.76	26.80
Stress26			4.04	1.82	.75	26.01
Stress27			4.04	1.87	.78	27.57
Stress28			4.08	1.81	.77	27.07
Stress29			4.09	1.84	.80	28.71
Workplace Spirituality (WS)	.97	.97				
WS1			3.31	1.92	.83	30.06
WS2			3.10	2.10	.85	31.69
WS3			3.24	3.09	.61	26.79
WS4			3.25	1.86	.86	32.00
WS5			3.40	1.83	.83	30.42
WS6			3.46	1.83	.80	28.94
WS7			3.43	1.89	.81	29.03
WS8			3.36	1.94	.77	27.09
WS9			3.34	1.96	.79	28.27
WS10			3.40	1.94	.85	31.43
WS11			3.35	1.92	.83	30.03
WS12			3.39	1.91	.88	33.14
WS13			3.41	1.88	.84	30.92
WS14			3.48	1.86	.86	32.10
WS15			3.38	1.86	.84	31.00

WS16			3.52	1.92	.84	30.84
WS17			3.38	2.00	.86	32.25
Quality of Care (QC)	.90	.89				
QC1			2.99	1.60	.83	29.02
QC2			2.82	1.61	.84	29.73
QC3			2.74	1.63	.83	29.05
QC4			2.81	1.64	.83	29.42
N = 872 *** denotes p < .001						

The data being collected using the same questionnaire and during the same time with cross-sectional research design, the probability of common method bias increases in the relationship between the proposed constructs. Self-reported questionnaires were used for the study, as independent variables and dependent variables were rated by same respondents, so probability of the common method bias increases in the data. To address the issue of common method biasness, generally accepted Harman's single factor test was conducted in this study. The first factor result of un-rotated factor analysis accounted for 39% which is less than 50% (Sharma & Dhar, 2016) of the variance, thus, did not describe the majority of the variance. So, it can be inferred that data of the present study did not suffer with the problem of common method bias.

5.7 Results of Confirmatory Factor Analysis (CFA)

To evaluate the validity of the scale and fitness of the hypothesized model based on the collected data, CFA was used and the evaluation was carried out in Amos. CFA is used to test the fitness of the data obtained from respondents and to assess whether the variables truly represents their respective constructs or not. It further helps in understanding the nature of constructs.

Table 5.5 depicts the means, standard deviation, inter-correlation and AVE of constructs under study. As exhibited in table, value of AVE is more than 0.5 of all constructs and square root of AVE is more than correlation of two constructs, so these results proves the discriminant

validity of the scale. Further, as per CFA results of alternative models [Table5.7] revealed better fit of proposed six factor model in comparison to alternative models. In this study, the correlation between the constructs (Work-Family Conflict, Bullying, Patient Incivility, Stress, Spirituality and Quality of Care) is found significant in the six factor model, as the factor loadings are greater than 0.6 and ranges from 0.61 to 0.88, thus, proving the convergent validity of the model. Further, the inter-factor correlations are not more than 1.00 with 95% confidence interval, which proves the discriminant validity of the model (Hair et al., 2006).

5.7.1 Assessment of the Measurement Model

The measurement model was tested using CFA and Table 5.7 exhibits those model-fit indices that indicate goodness of model fit.

Table 5.7: Results of Confirmatory Factor Analysis

	Values							
Model	Chi Square	DF	CMIN/DF	GFI	AGFI	IFI	TLI	RMSEA
6 factor model	5903.95	3403	1.73	0.87	0.86	0.95	0.95	0.02
5 factor model	9385.41	3475	2.7	0.74	0.73	0.9	0.89	0.04
4 factor model	13547.6	3479	3.89	0.63	0.61	0.83	0.82	0.05
3 factor model	18878.38	3482	5.42	0.42	0.4	0.74	0.73	0.07
2 factor model	19620.53	3484	5.63	0.42	0.39	0.73	0.72	0.07
1 factor model	29542.83	3485	8.47	0.27	0.23	0.56	0.55	0.09

DF= Degree of Freedom, CMIN= Minimum Discrepancy, GFI= Goodness of Fit Index, AGFI= Adjusted Goodness of Fit Index, IFI= Incremental Fit Index, TLI= Tucker-Lewis Index, RMSEA= Root Mean Square Error of Approximation

Chi square test was used for measuring the closeness of fit and the value≤ 3 shows good fit (Hayduk, 1987). The root mean square error of approximation is the square root of the difference between the sample covariance matrix and the model covariance matrix, and this square root

represents the fit of sample and population variance matrix. The values less than 0.05 indicate a good fit, and the values higher than 0.08 signifies a reasonable fit (Byrne, 1998). The fit between the observed covariance matrix and the hypothesized model can be explained by the goodness of fit indices. The GFI value explains good fit; the comparative fit Index (CFI) presents the complete covariation of data (Byrne, 1998). Tucker–Lewis index (TLI) is a comparison of normed chi-square values of specified and null model (Hair, 2010) and fit indices value ranges between 0.80 and0.90 which shows good model fit. The fit indices for model are χ^2 (Chi-square) = 5903.95 and df=3403, at p<0.01, CMIN/df= 1.73, GFI = 0.87, AGFI = 0.86, CFI =0.95, TLI =0.95, NFI = 0.90, IFI = 0.95 and RMSEA =0.02, and goodness of fit indices supported the overall measurement model.

5.8 Measurement Model

The measurement model describes the relationship between latent variables and their observed constructs. CFA is applied as the first step to estimate the adequacy of proposed measurement model for each construct. The fit of the model was determined by various fit indices such as Chi-square, RMSEA, GFI, and CFI. Primarily, model testing process is to ascertain the goodness of fit between the sample data and hypothesized model.

5.8.1 Hypotheses Testing

To test the proposed hypotheses, the Preacher and Hayes (2004) bootstrapping method was used. The proposed hypotheses were tested in two interlinked steps. In the first step, the direct relations between independent variables and mediator include hypotheses: H1 (WFC-stress), H2 (PI-stress), H3 (bullying-stress) and then mediator and dependent variable that is H4 (stress-QC). Further, simple mediation model that is H5 (a, b and c) which states that stress mediates the relation between independent variables and dependent variable was tested. In the second step, moderator (workplace spirituality) was introduced in the model and H6 was tested. The chances of multi-collinearity occur when two or more explanatory variables are correlated and to minimize this issue, all continuous variables were mean-centered (Aiken, West, & Reno, 1991).

Hypotheses were tested with (Preacher & Hayes, 2008) and the path coefficients were estimated through OLS regression by using SPSS macro named Process for direct and mediating

relation with bootstrapping process. This technique presents 95% bias-corrected and accelerated confidence intervals (BCa CIs). Indirect effects can be confirmed as significant, if the 95% (BCa CIs) does not contain zero.

5.8.1.1 Results of Hypotheses (H1, H2, H3 and H4)

The results of relationship between independent and dependent variables (H1, H2, H3 and H4) are presented in Table 5.8a, Table 5.8b and Table 5.8c.

Table 5.8a: Results of hypotheses H1, H4 and H5a

H1: Work-Family Conflict and Stress **H4: Stress and Quality of Care** **H5a: Stress mediates between WFC and Quality of Care**				
Variable	***B***	***SE***	***t***	***p***
Direct Effects				
Stress				
Constant	.10	.22	.45	.64
Work Family Conflict	.11	.03	3.25	.00
Gender	.05	.16	.31	.75
Age	-.08	.13	-.66	.50
Education	-.06	.19	-.34	.73
Experience	-.02	.07	-.39	.69
Marital Status	.11	.13	.87	.38
Quality of Care				
Constant	-.35	.13	-2.72	.00
Work Family Conflict	-.07	.02	-2.77	.00
Stress	-.43	.03	-13.55	.00
Gender	-.19	.11	-1.64	.09
Age	.23	.11	2.05	.04
Education	.24	.17	1.42	.15
Experience	.21	.06	3.55	.00
Marital Status	-.56	.10	-5.16	.00
Total effects				

Quality of Care				
Constant	-.40	.17	-2.27	.02
Work-Family Conflict	-.12	.03	-3.85	.00
Gender	-.21	.14	-1.50	.13
Age	.27	.12	2.13	.03
Education	.27	.20	1.37	.16
Experience	.22	.06	3.43	.00
Marital Status	-.61	.13	-4.42	.00
	Value	*SE*	*z*	*p*
Indirect effect and significance using normal distribution	-.04	.01	-3.15	.00
Sobel				
	M	*SE*	*LL 95% CI*	*UL 95% CI*
Bootstrap results for indirect effect				
Effect	-.04	.01	-.08	-.01
Note: N = 872. Bootstrap sample size = 1000, LL = lower limit, UL = upper limit, CI = confidence interval.				

Table 5.8b: Results of hypotheses H2, H4 and H5b

H2: Bullying and Stress **H4: Stress and Quality of Care** **H5b: Stress mediates between Bullying and Quality of Care**				
Variable	***B***	***SE***	***t***	***p***
Direct Effects				
Stress				
Constant	.11	.17	.66	.50
Bullying	.61	.03	17.48	.00
Gender	.04	12	.33	.73
Age	-.06	.07	-.86	.38
Education	-.09	.10	-.91	.36
Experience	-.03	.06	-.54	.58
Marital Status	.12	.08	1.47	.14

Quality of Care				
Constant	-.36	.13	-2.74	.00
Bullying	-.13	.04	-3.31	.00
Stress	-.36	.04	-8.62	.00
Gender	-.19	.11	-1.73	.08
Age	.23	.11	2.12	.03
Education	.25	17	1.48	.13
Experience	.21	.06	3.57	.00
Marital Status	-.56	.10	-5.39	.00
Total effects				
Quality of Care				
Constant	-.41	.16	-2.54	.01
Bullying	-.36	.03	-10.71	.00
Gender	-.21	.12	-1.72	.08
Age	.26	.11	2.29	.02
Education	.29	.17	1.63	.10
Experience	.23	.06	3.54	.00
Marital Status	-.61	.11	-5.52	.00
	Value	*SE*	*z*	*p*
Indirect effect and significance using normal distribution				
Sobel	-.22	.02	-7.72	.00
	M	*SE*	*LL 95% CI*	*UL 95% CI*
Bootstrap results for indirect effect				
Effect	-.22	.03	-.29	-.16

Note: N = 872. Bootstrap sample size = 1000, LL = lower limit, UL = upper limit, CI = confidence interval.

Table 5.8c: Results of hypotheses H3, H4 and H5c

H3: Patient Incivility and Stress **H4: Stress and Quality of Care** **H5c: Stress mediates between Patient Incivility and Quality of Care**				
Variable	***B***	***SE***	***t***	***p***
Direct Effects				
Stress				
Constant	.03	.16	.19	.84
Patient Incivility	.68	.03	21.33	.00
Gender	.02	.11	.24	.80
Age	-.02	.06	-.44	.65
Education	.05	.09	.53	.59
Experience	-.04	.05	-.76	.44
Marital Status	.03	.08	.35	.72
Quality of Care				
Constant	-.35	.13	-2.63	.00
Patient Incivility	-.14	.04	-3.55	.00
Stress	-.34	.04	-7.89	.00
Gender	-.19	.11	-1.71	.08
Age	.23	.11	2.08	.03
Education	.22	.17	1.30	.19
Experience	.22	.06	3.61	.00
Marital Status	-.54	.10	-5.07	.00
Total effects				
Quality of Care				
Constant	-.36	.15	-2.30	.02
Patient Incivility	-.38	.03	-11.75	00
Gender	-.20	.12	-1.68	.09
Age	.24	.11	2.17	.03
Education	.20	.17	1.17	.23
Experience	.23	.06	3.69	.00
Marital Status	-.55	.11	-4.80	.00
	Value	*SE*	*z*	*p*
Indirect effect and significance using normal distribution	-.23	.03	-7.39	.00
Sobel				
	M	*SE*	*LL 95% CI*	*UL 95% CI*
Bootstrap results for indirect effect				
Effect	-.23	.03	-.30	-.18
Note: N = 872. Bootstrap sample size = 1000, LL = lower limit, UL = upper limit, CI = confidence interval.				

As depicted in Figure 4.2, Path *a*, that is, the path from independent variables to mediator variable was investigated in the first step. H1 investigated the relationship between work-family conflict and stress. The results (0.11, p<0.001) reported that WFC has a direct and positive relationship with stress, thereby, proving the first hypothesis [Table 5.8a]. H2 examined the relationship between bullying and stress. The path coefficient (0.61, p<0.001) was significant which shows that bullying has positive relationship with stress, thereby, proving the second hypothesis [Table 5.8b]. Further, H3 examined the relationship between patient incivility (PI) and stress. The results (0.68, p<0.001) reported that PI is significantly and positively related to stress, and thus, validating the third hypothesis [Table 5.8c].

Similarly, Path *b* illustrated in Figure 4.2, that is, the direct effect of the mediator variable on the dependent variable is the second path in the analysis procedure. The relationship between stress and quality of care (QC) was examined in H4 while controlling the independent variables (work-family conflict, bullying, and patient incivility. The results revealed that when work-family conflict was controlled, stress and QC has a significant negative relationship (-0.43, p<0.001), when bullying was controlled, stress and QC has a significant negative relationship (−0.36, p<0.001), and when patient incivility was controlled, stress and QC has a significant negative relationship (-0.34, p<0.001). The results revealed the support for the fourth hypothesis [Table 5.8a, 5.8b, 5.8c].

5.8.1.2 Result of Mediation Analysis

The mediating effect of stress among WFC, bullying, PI, and QC was tested with hypothesis H5a, H5b, and H5c. Path *c'* as depicted in Figure 4.2, was followed to test the mediating effect of stress. Tables5.8a, 5.8b and 5.8c show that stress mediates the relationship between work-family conflict and quality of care according to H5a (WFC–stress: 0.11, p < 0.001 and stress–QC: -0.43, p<0.001); as per H5b, stress mediates the relationship between bullying and QC (Bullying–Stress: 0.61, p<0.001 and stress–QC: -0.36, p<0.001),and H5c states that stress mediates between patient incivility and QC (PI-Stress: 0.68, p<0.001 and stress-QC: -0.34, p<0.001).

The results revealed that stress has significant negative relationship with QC along with the indirect effect of independent variables and dependent variable at the significant level with two-tailed significance test, that is, WFC–QC (Sobel z) = −3.15, p<0.001, bullying–QC (Sobel z)

= −7.72, p<0.001, PI–QC (Sobel z) = −7.39, p<0.001(assuming a normal distribution), thereby, referring to the SOBEL by generating 1000 bootstrapped samples. Further, bootstrap results validated the results of SOBEL test (Table 8a, 8b, 8c), with 95% CI, which did not contain zero, WFC-QC (-0.08, -0.01), bullying-QC (-0.29, -0.16) and PI–QC (-0.30, -0.18) thus, indicating the significance of mediating path.

As per results, WFC influenced quality of care indirectly through the effects of stress. The indirect effect was found to be negative (-0.04, p<0.001) as hypothesized in H5a. Bullying influenced quality of care indirectly through the effects of stress. The indirect effect was found to be negative (-0.22, p<0.001) as hypothesized in H5b. Patient incivility influenced quality of care indirectly through the effects of stress. The indirect effect was found to be negative (-0.23, p<0.001) as hypothesized in H5c. Hence, the fifth hypothesis (5a, 5b and 5c) was supported. The detailed results are presented in the Figure 5.1 and Tables 5.8a, 5.8b, 5.8c.

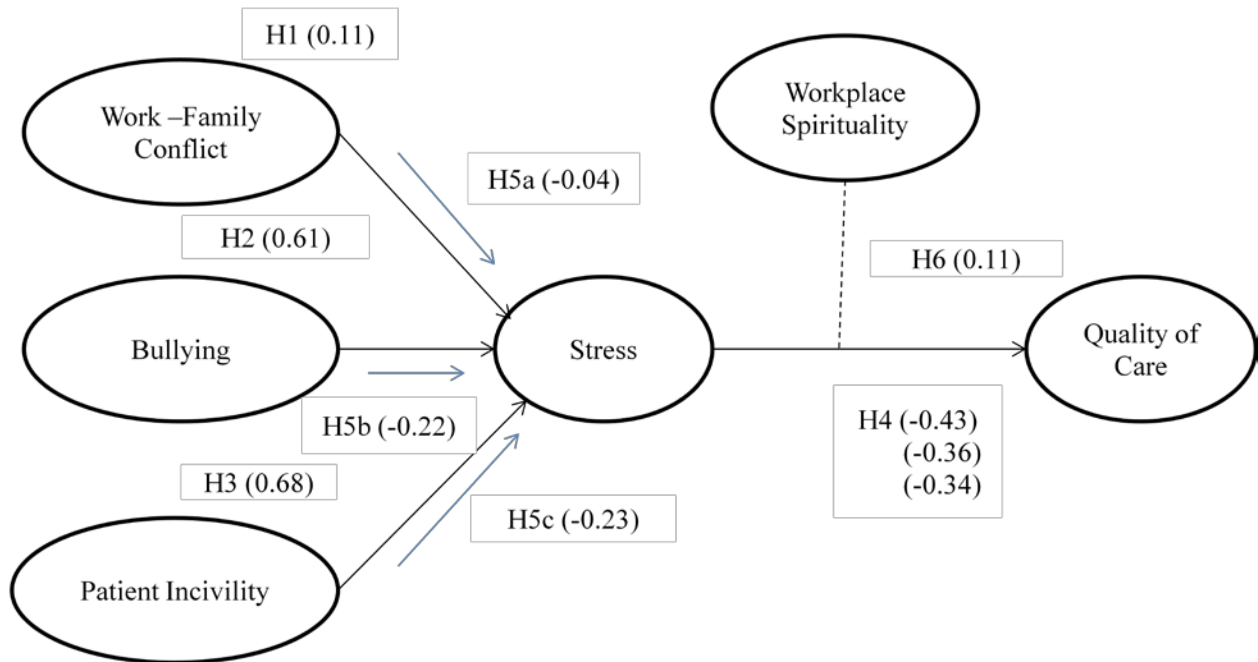

Figure 5.1: Hypotheses Results

5.8.1.3 Result of Moderation Analysis

The moderating effect of workplace spirituality was examined using a bootstrapping approach with 1000 iterations in H6. Stress was entered as independent variable, QC as an outcome variable, and WS as a moderator in Model 1, as per (Preacher & Hayes, 2008) which was followed for data analysis.

Table 5.9 shows the results of the moderation analysis, that is, workplace spirituality moderated the relationship between stress and quality of care in such a manner that it reduces the negative effect of stress on QC, and the moderation effect was found significant ($\beta = .11$, $t = 2.71$, $p < 0.001$). Figure 5.2 depicts the graphical presentation of the interaction effect by using Aiken and West method (Aiken et al., 1991). Separate equations using one above and below the average of the moderating variable was used to assess the moderation effect. As per H6, the slope of interaction effect shows that negative relationship exists between stress and quality of care, and this relationship becomes weaker with high levels of workplace spirituality (simple slope = 0.05, $t = 1.03$, $p< 0.05$) than low levels of workplace spirituality (simple slope = -0.17, $t = -3.42$, $p< 0.01$).

Table 5.9: Regression results for the conditional indirect effect (moderation)

Predictor	***B***	***SE***	***t***	***P***
<u>Quality of Care</u>				
Constant	-.29	.14	-2.02	.04
Stress	-.05	.03	-1.95	.05
Workplace Spirituality	.73	.03	22.06	.00
Stress *Workplace Spirituality	.11	.04	2.71	.00
Gender	.18	.11	1.55	.11
Age	.02	.11	.19	.84
Education	.01	.15	.05	.95
Experience	-.01	.05	-.16	.86
Marital Status	.003	.10	.03	.97

Workplace Spirituality	Boot indirect effect	Boot *SE, T-value*	Boot *LL 95% CI*	Boot *UL 95% CI*
Conditional indirect effect at **Workplace Spirituality = M ± 1 SD**				
- 1 SD	-.17	.05, -3.42	-.27	-.07
M	-.05	.03, -1.95	-.11	.0003
+ **1 SD**	.05	.05, 1.03	-.04	.15
Note: N = 872, Bootstrap sample size = 1000 M = Mean, SD = Standard deviation, LL = Lower Limit, UL = Upper Limit, CI = Confidence Interval				

In this study, the results of response obtained have shown that level of WS is low (Mean = 3.36), so the high level of stress has an adverse impact on QC (Mean = 2.84) provided by nursing staff.

Figure 5.2 shows that when level of stress is low and WS is low the quality of care is moderate but as the level of stress increases and workplace spirituality (WS) level is still low, the quality of care (QC) decreases. Whereas, when the level of WS is high and the level of stress is low the quality of care is better, and as the stress increases when WS is high, the quality of care is least affected, it deteriorates but not as much as it did in the case of low WS, the quality of care remains in a moderate state due to high workplace spirituality.

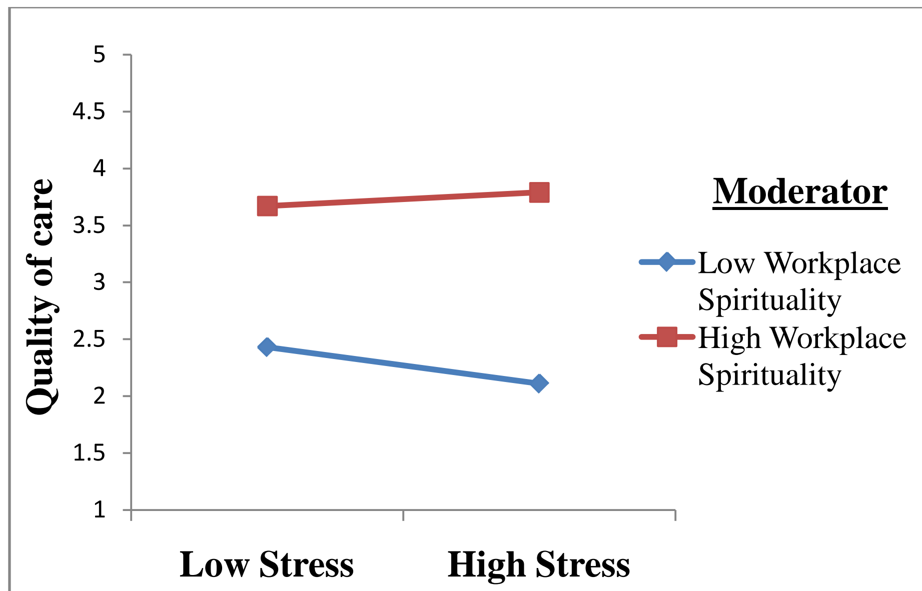

Figure 5.2: Moderating effect of Workplace Spirituality on the relationship between stress and quality of care

Thus, the result revealed that the WS moderates the relationship between stress and quality of care, as low level of workplace spirituality strengthens the negative relationship between stress and quality of care and high level of workplace spirituality weakens the negative relationship between stress and quality of care. High level of workplace spirituality weakens the inverse relationship between stress and quality of care as shown in Table 5.10 below.

Table 5.10: Moderation Results

Variables	**Values**
Independent variable (Stress)	- .05
Moderator (Workplace Spirituality)	0.73
Interaction (Stress * Workplace Spirituality)	0.11

5.9 Conclusion

This chapter presented and described the results of the statistical analysis of the hypotheses in detail. CFA was conducted to assess the fitness of measurement model for each construct. Correlation, reliability, and validity were examined based on the hypothesized model.

Statistical process named Hayes PROCESS was used to analyze the relationship between predictor, criterion, and moderator variables. The results have shown that independent variables work-family conflict, bullying and patient incivility have positive relationship with stress, and stress further have adverse effect on quality of care. The findings have shown the mediating influence of stress between independent variables (WFC, bullying and PI) and dependent variable that is quality of care. Furthermore, the relationship between stress and quality of care is moderated by workplace spirituality. The results are presented in tabular form, and the moderating relationship is graphically represented for clarity and profound understanding of the concept and the relationship between constructs under study. All six hypotheses are supported in this study. In the following chapter, the detailed discussion and implications of the results are explained.

CHAPTER 6
DISCUSSION

6.1 Overview

This chapter begins by recapitulating the key research questions and elaborating the findings of the study. The purpose of this research was to study the antecedents and consequences of stress along with its mediating role between independent variables and dependent variable. Further, the moderating role of workplace spirituality between stress and quality of care was examined. This chapter focuses on the detailed explanation and interpretation of the research findings for the six hypotheses under study. The findings were supported with past literature and contribution of the present research in public healthcare institutions was specified with theoretical and practical implications. Furthermore, the future research directions and possibilities of the study have been discussed along with the limitations of the study.

6.2 Summary of Findings

In general, all the research hypotheses of the proposed model were supported by the findings of the study. First, work-family conflict (WFC) has positive relationship with stress, that is, higher the level of WFC, higher is the level of stress amongst nursing staff. Second, bullying has positive relationship with stress level, which indicates that higher level of bullying inflates the stress of employees. Third, patient incivility is also positively related to stress because higher the level of incivility, higher is the level of stress amongst employees. Fourth, stress acts as an effective mediator among work-family conflict, bullying, patient incivility, and quality of care, thus, indicating that stress works as an underlying factor in the relationship between independent variables and dependent variable quality of care. Further, workplace spirituality considerably moderated the inverse relationship between stress and quality of care.

6.3 Hypotheses Discussion

6.3.1 **Hypothesis 1:** Work-family conflict has a positive relationship with stress

On the basis of the first hypothesis, work-family conflict has a positive relationship with job stress, thereby, indicating that higher the WFC, higher is the level of job stress amongst employees. The results have shown that higher interference of work role in family role, particularly, in the long run causes physical and psychological strain amongst employees (Kalliath, Kalliath, Chan, & Thachil, 2013).The results of this study support previous studies because the spillover effect of WFC affects both the spheres of life, that is, work and family life (Rao & Indla, 2010) and causes job stress to employees. Nurses need to fulfil both the roles by balancing time between family and work (Parasuraman & Greenhaus, 2002). Along with their job, one of their main priorities is to provide care to elderly and dependents, specifically in the collectivist culture countries like India (Valk & Srinivasan, 2011). Past literature has defined it as WFC, as demands at workplace interfere with their demands in their family, and this conflicting situation depletes the energy of an individual. As per the study, nurses of PHCI experience high level of WFC (Mean = 3.91), and they face difficulty in devoting their time and energy to fulfil family demands. Nursing is a demanding job because nurses have to work around the clock with continuous change in shifts, which puts them in jeopardy related to maintaining balance of their time between work and family affairs (Bruck & Allen, 2003). Moreover, nurses are required to express positive emotions at workplace even while handling emergency and difficult situations (Roussel, Swansburg, & Swansburg, 2006). Nurses are supposed to deal with injury, emergency situations, serious ailments, and death. Along with all these emotionally demanding situations, deficient workforce and infrastructure is a common issue that is faced by every nursing staff. Nurses need to devote their extra energy and time to handle all these situations, and as a result, they are not able to give enough time to their families. Such working environment produces strain amongst nursing staff, which in turn makes it difficult for them to fulfil their family responsibilities.

All the above issues are specifically salient in public healthcare institutions of India owing to paucity of manpower and required resources. With the implementation of various health awareness schemes by the government of India, patient load has increased, whereas the infrastructure, resources and manpower are not equipped to handle this increasing workload.

According to the respondents, longer duty hours and increased workload are common among PHCI nursing staff because they need to handle the demanding healthcare services. Owing to all these functions of nurses, they face time and strain based on WFC, which is one of the significant contributors in elevating their stress level (Greenglass, Burke, & Fiksenbaum, 2001). Nurses play a significant role in saving lives of patients and rejuvenating the health of people. Moreover, nurse to patient ratio in India is 1:15 (Garari, 2014), which is above the standard ratio provided by WHO. With increasing workload, the role of work domain competes with family role because of limited time and energy resources (Mauno, Kinnunen, & Ruokolainen, 2006). For this reason, nurses are supposed to do multiple and diversified roles like patient admission, room preparation, routine inspection of equipments and machinery of ward, medication of the patients, routine checkup, and taking care of patients hygiene.

Considering the demographic composition of public healthcare institutions, the percentage of females is high in comparison to males. Moreover, India has collectivistic culture, where it promotes the interdependence of parents and children, which further elevate parental overload. In India, females have higher responsibilities towards taking care of children and parents. Nurses have disclosed that their roles at workplace are emotionally, psychologically, and physically demanding, and the role stressors reduce their available energy and time in fulfiling their parenting and other family responsibilities, thereby, causing high imbalance between work and parental overload; and family distress elevates the level of WFC. Furthermore, past literature has identified that the role-related time commitment has a significant impact on elevating WFC. Time being limited, devoting more time to fulfil the demands of one role results in less time to accomplish the responsibilities of another role. Same is true in nursing profession because nurses have 24/7 job that gives rise to a situation where most of their time is dedicated towards their work and they hardly get time to fulfil their family responsibilities. Continuous experience of such conflicting situation disrupts the family life which causes stress amongst nurses. Another significant predictor of work-family conflict is role related stress. The role of nurses demands physical and emotional labor, which causes strain among them, thereby, resulting in undermining their ability to meet the obligations of family role. The role overload has been signified as the time based antecedent because carrying out large number of responsibilities in limited time results in increased commitment towards one role in comparison to the other. By doing too much

work within limited time, nurses are likely to experience stress at workplace. Thus, it is clear that employees, who face WFC for a long time, are more susceptible to stress in their life.

It is evident in the past studies that employees working in highly demanding jobs like nursing, policing experience high WFC and eventually stress (Adib-Hajbaghery, Khamechian, & Alavi, 2012). Work is just one of various dimensions of life, and other spheres also require time and attention of an individual. It is imperative to balance the various spheres of life and neglecting one dimension of life for another hampers the smooth functioning of life. Such discrepancy between work and family life causes physical, mental, or emotional strain because an individual confronts a situation where his or her job and family demands exceed the social and psychological resources. Continuous confrontation of strain and tension causes stress among nurses. Nurses need to be free from any sort of emotional or psychological stress to handle their stressful job of providing comprehensive care to all kinds of patients through assistance in living by nursing and providing rehabilitative care. Moreover, they also need to take care of their dying patients. Work and family are two indispensable dimensions of life, and imbalance of one dimension has adverse impact on the other dimension. The feeling of not fulfiling the family responsibilities create strain, and in the long run it has a negative impact on their career. So, for better care of patients, the work-family conflict issue of the comprehensive care givers, that is, nursing staff of public healthcare institutions needs to be addressed.

6.3.2 **Hypothesis 2:** Bullying has a positive relationship with stress

On testing the second hypothesis, it was found that bulling positively affects stress among nursing staff, thereby, indicating that higher the bullying, higher will be their stress level. The results of study harmonize with the past literature where it has been proved that bullying is one of the key factors responsible for causing stress amongst the nursing staff (Murray, 2009). Several studies have recognized the problem of bullying in various professions such as police constables, teachers, IT professionals, prison officers, and nursing staff (Hansen, Hogh, & Persson, 2011). Workplace bullying has been extensively studied and recognized in the nursing profession (Somani, Karmaliani, Farlane, Asad, & Hirani, 2015). The past literature bears evidence of the fact that nurses face bullying at workplace because they are humiliated, ignored, and criticized persistently. They even experience power abuse which undermines their self-confidence (Pai & Lee, 2011). One of the prime factors of distress amongst nurses is bullying

which also include the poor relationships amongst staff members (Farrell & Shafiei, 2012). Moreover, recent studies have recognized that conflict between colleagues in nursing is on the rise (Bakker, 2012; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013). The problems of bullying in nursing was identified long back in 1980's, and even in the 21st century this problem exists, specifically among Indian nurses (Makkar & Sanjeev, 2013). The results of the study have supported high occurrence of bullying incidents as depicted by the mean score (M= 3.97).

Nurses revealed the need to work in a collegial manner (Hippeli, 2009) because any time they could be called for help. Caring the ill is a team work, and they need help of each other to provide effective care to patients. However, the results of this study demonstrate that the interpersonal conflicts and weak relationship exist amongst nursing staff, and this has been put forth in the past studies (Cox, 2001). Weak interpersonal relations are more significant in jobs entailing high workloads, low job autonomy and adverse working conditions (Sharma et al., 2014). Various factors such as shortage of nursing staff, role conflict, and low opportunity of skill development, poor working conditions with inappropriate equipments, and other infrastructural facilities in public health care institutions (PHCI) are the underlying factors that increase the probability of bulling amongst nursing staff (Mael & Jex, 2015). The conflict amongst nurses stimulates aggressive behavior at workplace like assigning extra work, criticizing publically, and taking undue advantage of power. Nurses usually face role ambiguity (Specht, 2013) because they are supposed to fulfil various roles such as medication and routine check-up of patients, housekeeper, administrator of beddings, and medical equipment of the ward and preparing rooms for the patients. Each nurse is supposed to do all these tasks, and they experience lack of role clarity in their profession because role ambiguity inflict politics in team which have undulating effect that will ultimately lead to escalation of the workplace bullying (Vickers, 2014). All these factors cause workplace bullying and eventually elevate the psychological and physical stress amongst nurses. Bullying represents the unresolved and intensified conflict among team members. Conflicts that are not listened and resolved either due to poor management or lack of leadership vision augment the interpersonal aggression and eventually trigger the culture of bullying in workplace.

Employees who experience bullying behavior at workplace show higher stress symptoms such as anxiety, lack of concentration, sleeping problems in comparison to their non-bullied

coworkers (Idsoe, Dyregrov, & Idsoe, 2012). Past studies have shown that employees who are bullied develop symptoms like restlessness, chronic fatigue, decreased energy, worthlessness, and hopelessness (Mawritz, Folger, & Latham, 2014; Razzaghian & Shah, 2011). It was found that the persistent exposure of nurses to long lasting aggressive behavior, be it verbal or non-verbal abuse, has adverse impact on their physical and psychological strength and this causes stress. Bullying is a systematic activity repeated at frequent intervals to harass and offend the target. Nurses face both horizontal and downward bullying owing to power imbalance. In PHCI, there is no clear cut demarcation of power and position, and this discrepancy provides an opportunity to bully the fellow nurses. Nurses face horizontal bullying related to intergroup and interpersonal conflict with fellow nurses. They face horizontal bullying either due to difference in experience or expertise or may be because bullying is attached with influential group or person.

In this study, nurses face abuse like threatening, undermining gossiping, undue interference and fault finding and these make it difficult for the target to seek even assistance within job setting. Such situations are also faced by the new entrants, less experienced and contractual nurses. Nursing care is a team job, and they seek guidance and support from their seniors and colleagues. However, the organizational structure of nursing department and unsupportive behavior of seniors and team members lead to lack of trust and faith in the system that ultimately results in frustration amongst nursing staff. Unsupportive colleagues and seniors are one of the significant factors of bullying among nurses. Interestingly, juniors don’t get enough organizational support to deal with this issue, as their seniors are themselves involved in bullying behavior. Seniors generally withhold necessary information and unreasonably refuse the leave application and even don’t nominate them for trainings and promotions. Permanent and experienced nurses have more tendencies to target the freshly recruited or the nurses on the contract to bully. The stealthy reasons of aggressive behavior are shortage of manpower, culture of the organization, lack of effective leadership, and personality differences. Nurses are considered as ‘oppressed group’ in healthcare institutes, and females are majority in number in the nursing profession. According to the oppression theory, lack of power and control over job procedures in working environment lead to low self-esteem, insomnia, apathy, social phobia, and depression, which contributes to the development of strain and stress amongst the target.

Bullying is considered as more distressing and crippling problem for nurses than any other work related stress because of its lasting effect not only on the target but also on bystander.

Vertical bullying is the most common type of bullying, that is, misuse of power gained through organizational position (Namie, 2007). Seniors with aggressive personality show aggressive behavior, where as lazy managers with passive or reactive personality type (Ambrien Ahmed, Hasnain, & Venkatesan, 2012) put the burden on junior staff to achieve the target. In nursing context, seniors used to forward their workload on junior nurses as practice of forwarding the work responsibilities to them. Another reason is the shortage of manpower because seniors need to do the multi–tasking such as performing nursing job along with various administrative tasks within limited time and owing to time constraints they forward some of their duties and responsibilities on the junior nurses. Nurses face instability at workplace because their area of responsibility is shifted without their consultation, and they even feel demoralized for continuous undervaluation of their services. Nurses face bullying not only from senior nurses, but also from the doctors by abusing them in front of patients, putting undue workload, and laying all blame on them if anything wrong happened to patient. All these reasons along with emotional pressure of the nursing job arouse extra demand of energy at workplace, thereby, resulting in imbalance between available demand and energy. As per the JD-R model; job characteristics, extensive workload, and poor psychosocial environment trigger the interpersonal conflicts as well as long term conflicts that leads to workplace bullying. Bullying behavior depletes the energy resource of nurses and leads to psychosomatic symptoms like depression, insomnia, and anxiety. Moreover, nurses experience stress in their lives owing to disproportion of job demands and job resources.

Bullying represents the negative culture and environment of an organization. Bullying is such psychological behavior that nurses learns from each other. So it's essential for management to understand the extremity of the situation for restraining its psychosocial impact on nurses in terms of increased stress level. Various practices should be initiated to curb the mushrooming of bullying culture before it becomes epidemic and spoils the whole system of PHCI.

6.3.3 **Hypothesis 3:** Patient incivility has a positive relationship with stress.

On the basis of the findings, patient incivility has a positive relationship with nurses stress, indicating that higher the nurses experience patient incivility, higher would be their stress

level. The findings of this study can be substantiated with the results of past studies, which provide evidence of the fact that violent behavior of patients and their relatives causes stress for nurses.

Workplace violence has a significant occupational health issue in public healthcare institutions (Arnetz, Aranyos, Ager, & Upfal, 2011; Beech & Leather, 2006). The results highlight the everyday reality of nurses, who face episodes of patients' aggression and violence while working in public healthcare institutions (Chapman & Styles, 2006). As per Hahn et al. (2008), the risk of violence and aggression is intrinsic to the characteristics of nursing job such as interacting with impulsive patients and their families who are in physical and emotional pain, enforced medical procedures, touching of intimate areas, disparity in treatment between staff and patient (Arnetz et al., 2015). Nurses have reported about aggressive behavior of patients and their relatives, and they are supposed to deal with each kind of patients be it drug addict, psychiatry, emergency and intensive care unit (ICU) patients and their relatives. Nurses face various safety issues while taking care of patients owing to a) scarcity of staff b) working without any safety personnel's specifically during night shifts c) working with addicted and emotionally disturbed patients (Trinkoff et al., 2008). Nursing staff compared to the other staffs are more exposed to violent behavior of patients and their families because they closely monitor the health issues of the patients as per the demand of their job.

Public healthcare institutions are facing shortage of nursing staff which is one of the significant reasons for the patient's incivility. Because of the shortage, the ratio of patient to nurse is quite high, and it ranges between15 to 30 patients for one nurse against the standard ratio of 6 : 1 (Sharma & Dhar, 2016; Tubbs-Cooley, Cimiotti, Silber, Sloane, & Aiken, 2013) and this result in high workload of nursing staff because one nurse is supposed to do the work of five nurses. Moreover, along with providing care to patients, nurses are supposed to do various administrative tasks like maintaining patient files and preparing bills of patients, in addition to performing duties of pharmacist and class IV (four) employees as well as taking care of equipment's of their ward (Aiken et al., 2001). Within limited time and energy, they have to do various tasks and in this process sometimes patients and their relatives feel that they are being neglected, and therefore, express abusive and aggressive behavior towards nurses.

Nurses work in shift, that is, they work both during day and night. Nursing is female dominated profession specially in India (Sharma et al., 2014), and the probability of abusive and aggressive behavior of patients and their relatives is more towards females (Yadav, 2007). A primary concern of nurses is the inadequate safety measures provided by public healthcare institutions (Sharma et al., 2014). In absence of the safety measures, people from outside can easily enter any hospitals even with unwanted things like drugs and weapons. The burden of surveillance duty has been placed on nurses and they need to keep an eye on access of any unwanted things in PHCI in absence of adequate security guards. Nurses take care of patients, their families and relatives and do surveillance, but in process they get no time to protect themselves (Kane, 2009). Majority of nurses don't feel safe while working and even feel vulnerable at the time of violent incidents because of inappropriate security arrangements in PHCI (Strasser, Hutton, & Gates, 2008). In addition, past studies have found that patients are the prime perpetrators of physical and verbal abuse to nurses (Farrell, Bobrowski, & Bobrowski, 2006; Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010). Hostile behavior such as verbal aggression and mistreatment by patients and their families is noteworthy predictor of stress among nurses. Such intimidating situation depletes the energy of and eventually decreases nurses' ability to regulate their behavior and emotions (Srivastava, 2005) to deal with hostile patients and their relatives (Felblinger, 2008).

The results of the study found that nurses working in public healthcare institutions face higher level of patient incivility (Mean = 3.85). On the one hand, nurses use their physical, emotional, and psychological energy to provide the best care to patients, and on the other hand, patients and their families mistreat them, yell at them and even physically abuse the nurses. Patients for whom nurses provide optimum care do not respect them. Respondents have revealed that they face undue behavior and demand of patients like kicking, spitting, pinching, scratching or verbal threat as well as aggressive behavior in their day-to-day activities which show the disrespect they have for nurses.

Nurses primarily deal with patients and their relatives; they are the face of the hospital and mediators between patients and doctors. Nurse's presence in tensed situations like handling OPD, accidents, deaths and transferring patient to another hospital expose them to more aggressive and abusive behavior of patients and their families than any other staff members of PHCI (Ahmed, 2012). The factors associated with organizations and patients precipitate violent

and aggressive behavior towards nursing staff. Factors like use of alcohol and drugs, overcrowding, long waiting period, social or cultural behavior, (Chapman & Styles, 2006) mental illness, physical and emotional issues have frequently been cited as causes of patient's violence. As per the results, it was found that in Indian PHCI nurses face high incivility because patient's pain and unidentified fear regarding patient's health escalate tension and anxiety among patients and their family members. For all these factors, patients and their families take out their frustration on nurses by making insulting comments and treating nurses as inferior and obtuse. The study found that organizational factors also contribute to patient's violent behavior such as process to check the identity, doctor's unavailability, long discharge procedure, annoyance about the procedures and paper formalities of public hospitals of India (Ayranci, Yenilmez, Balci, & Kaptanoglu, 2006; Barlow & Rizzo, 1997; Hahn et al., 2008). As reported by the respondents, the interaction between patient and nursing staff contributes to patient's aggression like physical contact, enforced treatment, painful procedures, and dissatisfaction from doctor's treatment (Hahn et al., 2008). Moreover, lack of facilities and not maintaining timely treatment in PHCI increase vulnerability and arouse resentment in patients and their family members, and they manifest their resentment in the form of verbal and physical aggression and abuse towards nursing staff. Further, high risk is intrinsic in the nature of public healthcare occupation because nurses are supposed to interact with patients who are in pain, anger, frustration and even those who got admitted against their wish (Chapman & Styles, 2006).

Nurses being victims of aggressive and abusive behavior not only face the physical abuse, but also encounter consequent emotional and psychological effects like anxiety, sadness, helplessness, and depersonalization (Chapman & Styles, 2006). Violent acts and behavior of patients have become a routine in public healthcare institutions because nurses even deny reporting issues of abusive behavior. They have started feeling such violent behavior of patients is normal and have accepted this as a part of nursing profession (Chapman & Styles, 2006).

Exposure of nurses to patient's abusive behavior while performing their duties disturb their concentration and contributes to anxiety, physical, psychological, and emotional disturbances for nurses. Violent behavior towards nurses by patients and their companions have long term psychological impact on nursing staff like sleep disorders, anxiety, low self-esteem, headache, procrastinating behavior, loneliness and depression. These symptoms verify the presence of stress among nurses (Gray-Toft & Anderson, 1981). Long term experience of

patient's violent behavior even causes post-traumatic stress disorders that adversely influence job dissatisfaction, loss of concentration, productivity and even increased the feelings of withdrawing from the profession. Holden (2013) explained such experiences as 'cognitive dissonance', that is, the discomfort and stress experienced by employees who perform their duties in situations that are contradictory to his or her beliefs, values, and ideas.

The course of events like patient incivility has long term psychological impact on nurses because such behavior of patients put these noble professionals in question, and they develop self-doubt about their capability to take care of patients, and therefore, feel guilty about choosing the profession of nursing (Arnetz & Arnetz, 2001). Moreover, patient incivility has considerable tangible and intangible cost in terms of economic and social costs. Economic costs like loss of wages owing to absenteeism and attrition of nurses, early retirement, sickness absence, replacement costs, and compensation claims are substantial in PHCI (Beech & Leather, 2006), as physical assault often results into physical injury and even death. Patient's violence has profound influence on the psychological wellbeing of nursing staff. Intangible cost of PI gives a negative image of nursing job, and therefore, arouses difficulties in recruitment and retention of nursing staff and results in loss of self-confidence and motivation for future generation to choose nursing profession. The cost of patient incivility has three dimensions—nurses, patients and organization, and society at large. Environment of incivility is damaging the individual and organizational health. With the understanding of violent indicators, nurses can prepare themselves to handle the situation or can make efforts to prevent violent episodes from taking place. Management needs to restrain the PI by various checks, such as providing adequate security and adequate training (Dhar, 2015b; Srivastava & Dhar, 2015) to nurses so that they can handle such situations for preventing the damage on nursing profession and professionals.

6.3.4 **Hypothesis 4:** Stress has a negative relationship with quality of care

The findings of the study revealed that stress has a negative relationship with quality of care which means that higher the level of stress among nurses, lower will be the quality of care provided to patients.

Stress has been ranked the first among top ten factors affecting quality care of nurses (AbuAlRub, 2004). The study has found high level of stress (Mean = 3.99) amongst nursing staff working in public healthcare institutions. Nursing professionals are the bloodline of healthcare

systems and are an integral part of healthcare services. They become stressed only when the job demands exceed their physical, economic, social, spiritual, psychological, and organizational resources (Yau et al., 2012). Stress has been a contributing factor for absenteeism, turnover and decrease in number of employees as well as decline of organizational performance in PHCI (Sharma, Dhar, & Tyagi, 2015). Public dealing jobs have more probability of experiencing stress among employees working in professions like policing, nursing and other healthcare professionals. Nursing profession has diverse dimensions such as caregiver, administrative, counselor and supervisor to patient. Nurses have higher responsibility than other healthcare professionals towards treatment, recovery, safety and health maintenance of patients (Currie & Hughes, 2008), who are chronically ill or struggling with life threatening diseases. Along with taking care of the patients, they are supposed to deal with the patient's relatives. The multiple roles at workplace contribute to occupational stress among nursing staff. Working environment such as inadequate infrastructure, equipments, and manpower put extra burden on nursing staff along with their responsibility of providing care to patients as well as intensifying stress of nurses (Tapas & Dangre, 2014). Nursing staff considers stress as a serious work related issue that impacts their job performance (Kordi, Mohamadirizi, Shakeri, Modares Gharavi, & Salehi Fadardi, 2014). Past studies have identified various sources that cause stress among nurses like working against the clock, inadequate staffing level, work environment, management style, and erratic nature of their work (Hipwell, Tyler, & Wilson, 1989; Nabirye, Brown, Pryor, & Maples, 2011).

According to the study, nurses are facing intense problems like work overload, lack of facilities, and performing multiple jobs with minimum resources. Even after decades, things have not changed much for nursing staff because they are occupying the lowest position in the workplace hierarchy, having unrealistic workload, lack of manpower, and basic facilities. In the 21st century, there is no positive change for nurses working in PHCI because they still have to work in extreme stressful working conditions. Nurses are supposed to work for more than 12 hours, and have to do frequent night shifts, so they experience lack of sleep, improper diet, deficiency of rest, chaos and even unresponsive management and bureaucracy (Kane, 2009). Along with all these issues, they have to deal with the anger and frustration of the doctors, patients, and their families. In short, nursing staff in PHCI have to work more owing to lack of nurses because they are sufficiently astute to manage the manpower and other resources for

providing the best care to patients. Quality of care is still an unmet challenge (Mean = 2.84) in PHCI of India, despite various technical improvements and efforts by policy makers and other patrons (Bajpai, 2014).

With energy and vision, nurses try to overcome the impediments coming in the process of providing care to patients. However, to overcome the obstacles, they use their energy much more than they get in return in the form of respect, appreciation, position, power or salary. In spite of their efforts to cure patients, the percentage of crime faced by nurses is the highest (72%) in comparison to other healthcare professionals (Nambiar-Greenwood, 2012). Present study found that nurses working in PHCI are exposed to varied injuries such as needle stick injury, pernicious infectious ailments, back injury and adverse effect of prolonged exposure to chemical substances. In the long run, all these issues in totality create withdrawal symptoms such as anxiety, depression, job dissatisfaction, higher absenteeism, and feeling of helplessness. In the course of juggling from daily care for patients, handling OPD, assisting doctor in Operation Theater, as well as carrying out administrative tasks, nurses leave the hospitals with tired body and weary soul. Even after all these events, nurses neither get appreciation from management or doctors and nor from patients for whom they give the best of their efforts to provide them the best care.

Nursing staff feel discontented and discouraged owing to profuse work responsibilities, less development opportunities, detachment from personal and social life and moral distress along with despairing feelings about working environment and its impact on the QC they provide to their patients (Åhlin, Ericson-Lidman, Norberg, & Strandberg, 2015). Daily nurses have to shake off their feelings of moral distress and awful realization that in such working conditions they could not give appropriate care to the patients

Past literature has shown that the adverse relationship exists between employee's performance and their perception of negative workplace environment (Oswald, 2012). As negative working environment has adverse influence on the employees' psychology, emotion, and behavior (O Donovan, Doody, & Lyons, 2013), it prevents them from achieving the goal by endangering their mental peace and threatening their psychological wellbeing. The prolonged period of stressful environment causes distress, which in turn incapacitates the ability of a nurse in handling the situation, thereby reducing their concentration and work output. The relationship

between the stress and quality is self-evident because staff with stress symptoms is less likely to provide quality care, as stress increases the medical errors and decreases the nurses' ability to provide the best care (Montgomery, 2014).

This study has revealed that nursing is a high risk profession concerning the stress related diseases. The consequences of stress has an adverse impact on the functional capacity of nurses like low quality of care (M = 2.84). Nurses work with focus on healing, but they often have to deal with bereavement. Nurses experience patient's suffering and bereavement throughout their career and such emotionally intense situations are one of the workplace stressors that influence stress (Karimi, Leggat, Donohue, Farrell, & Couper, 2014). Nurses are the right hand of a physician, however, in this study nurses revealed that in spite of getting appreciation for their work, doctors used to criticize them in public. Nurses revealed that if something wrong happened to patients, usually they are blamed in spite of the fact that they have just followed the prescription of the doctors. Response provided through questionnaires show that because of lack of adequate staff in public healthcare institutions, nurses have to do various clerical tasks like documentation and other administrative tasks, and they don't get enough time to complete their nursing task as well as to provide the adequate psychological and emotional support to patients.

The findings revealed that they feel abandoned from complicated daily activities which results in anger, dejection, and anxiety. According to Roy Adaptation Model (RAM), the interaction between environment and individual has reciprocal effects on each other (Roy, 2011). Stress results from the interaction between nurses and working environment which is not only taxing but also has high job related demands that exceed his or her resources (Chan & Wan, 2012). Nursing staffs of the study uncover their stressful conditions such as various emotional, physical, and psychological demands of job related tasks that create stress among nurses who feel incapable of completing the required nursing tasks effectively and efficiently with resources at hand (Chan & Wan, 2012). Stress has its impact not only on the professional life but also on their personal life, as they not only distance themselves from work or become unfocussed, they also experience sleep disturbances, disturbed personal relations, rumination about work and various health problems (Lim, Hepworth, & Bogossian, 2011).

This study has revealed that the suffering and death of patients with whom nurses feel connected creates stress amongst them. It is observed that nurses in public healthcare institutions

face conflict and criticism from doctors because they are extremely discouraged about their work which affects their performance at workplace. Moreover, physicians don't even provide the adequate information about the patient's health, and as a result they are not able to provide the exact information to the patient's families. Nursing staff also revealed that they don't get opportunity to share their experiences and feelings with other unit members which creates stress, and so they are not able to concentrate on the nursing tasks.

Nursing staff revealed that job stressors are detrimental to their performance. Nurses divert their energy and efforts to cope up with stress and its immediate reactions like depression and anxiety which in turn reduce their ability to perform their tasks efficiently (Cooper, 2013). Nurses try to deal with stress by regulating their emotions, behavior, thoughts and actions, and their coping up efforts consume the limited pool of resources and energy of nurses. With depleted energy, nurses feel helpless to complete the impending tasks for providing the best QC to patients. Nurses always have too much work to do along with handling emotionally taxing situation as well as coping with the fast pace of diverse and demanding changes, and in addition to these, they are directly exposed to injury and chronic illness to such an extent that they confront insomnia, back pain dizziness, depression, and apathy (Sharma et al., 2015).

It has been evinced statistically and theoretically that when care givers (i.e., nurses) themselves are under stress and going through the problems of anxiety, depression, sleeplessness, nausea, and headache, they are not able to give their best to provide quality care to patients (Garg & Dhar, 2014). Nurses working in PHCI deal with stressful working environment, unsupportive management, conflict with fellow workers and doctors, and inadequate infrastructure and basic facilities which lead to exhaustion of their energy while managing all these issues. Nurses working within environmental and time constraints are unable to provide consistent care to patients (Koy, Yunibhand, Angsuroch, & Fisher, 2015), and in order to cope up with time constraint, they adopt selective focusing in day to day nursing activities. Lower level of energy and resources has an adverse impact on efforts that they give for providing QC to patients which ultimately affects them along with the patients and organizations. Time pressure forces nurses to make unfeasible choice between task completion and patient care. Nursing profession is ethical in nature and moral distress is rooted in the professional integrity of nurses.

Moral distress among nurses occurs when they can't act as per their professional values and confronts external challenges because of organizational and system constraints which eventually manifest psychological and emotional disequilibrium (Maluwa, Andre, Ndebele, & Chilemba, 2012). Nurses feel frustration and dissatisfaction with their work, and therefore, experience moral distress when they become aware about their failure to deliver quality care because of work pressure and time constraint. Nurses are the most vital resource of PHCI, therefore, support and stress free working environment can lead to betterment of quality of care.

6.3.5 Hypothesis 5 (5a, 5b, 5c): Stress mediates the relationship between independent variables (work-family conflict, bullying and patient incivility) and dependent variable (quality of care).

The fifth hypothesis specified that the relationship among WFC, bullying, PI, and QC is mediated through stress experienced by nursing staff. Conceptually, it means that WFC, bullying, and PI affects the QC due to the underlying stress that evolves because of these factors. The results of the study suggest that the above said organizational and individual factors have a significant influence on stress experienced by nurses and eventually on the quality of patient care. WFC, bullying, and PI are some of the sources that cause stress amongst the nursing staff. Past researchers have found the mediating role of stress between stressors and job performance.

The literature review has suggested that the relationship among the above said factors and quality of care is largely affected by variables like workload, fatality, conflict with physician and colleagues, and lack of support all of which represents the various dimensions of stress amongst the nurses. Nursing is a highly demanding profession dominated by females, who are challenged by multiple responsibilities at work and home. It is difficult for nurses to neglect their family responsibilities, specifically because of the gender–role ideology of collectivist culture in India (Desai, Majumdar, Chakraborty, & Ghosh, 2011). work-family conflict is becoming an issue for all employees, but it disturbs the women employees most, specifically in India (Mäkelä & Suutari, 2015; Reddy, Vranda, Ahmed, Nirmala, & Siddaramu, 2010). Women work in two shifts; one at workplace and the other at home, and they have to bear the pressure of multiple roles and responsibilities simultaneously rather than in transitional sequence (Desai et al., 2011). Nursing job being emotionally, physically, and psychologically demanding exploit their whole energy, so nurses are unable to expand their energy in family responsibilities which ultimately results in imbalance between work and family life.

As discussed, nursing is high risk and emotionally strenuous profession because nurses handle the lives of patients, which in itself built pressure and stress on them for handling each process carefully. Moreover, persistent encountering of abusive, threatened, offensive behavior and misuse of power by seniors make the situation difficult for nurses to work professionally. Besides, aggressive, violent, and impolite behavior of patients towards nurses makes the situation more vulnerable for them to work with because the nurses put their whole energy and efforts to save their lives. Constant problems of systems along with the pressures of above mentioned sources make it difficult for nurses to abide by the situation with full vigor and energy. Furthermore, internal environment pressures such as lack of facilities, supplies, equipment, support system, rest breaks, leaves, and unmanageable shifts augment the severity of situation. Similarly, external pressures such as hostile and harassing behavior of patients and their relatives and lack of recognition contribute to the upsurge of frustration among nurses. It is observed that maximum number of nurses working in public healthcare institutions faces these problems every day, and they have considered all these issues as part of their jobs, which shows the severity of the problem. The inability to match the resources and demands of diverse roles has rippling effect on nurse's professional and personal life. The feeling of not being able to fulfil the duties of generous profession results in chronic reactive moral distress among nurses which in the long run contribute to nurses stress and manifest similar symptoms like anxiety, depression, lack of concentration, helplessness (Pardeshi, 2014). Therefore, they adopt selective focusing for patient care and are not able to work with dedication for long hours and have spillover effect on their QC provided to patients.

Conditions resulting in stress amongst the nurses detract their ability to concentrate as well as make sound decisions in delivering quality care. work-family conflict, bullying, and patient incivility has a significant impact on nurses' stress and ultimately on the QC delivered by nurses. The findings of this study highlight the influence of job stressors on nurses as well as on patient care. So, it is high time for management and policy makers to create a beneficial environment in order to lessen stress among nurses, so that they can deliver quality services to the patients.

6.3.6 Hypothesis 6: Workplace Spirituality moderates the relationship between stress and quality of care such that it reduces the effect of stress on quality of care

The sixth hypothesis specified the role of workplace spirituality as a moderator between the relationship shared by stress and quality of care of nursing staff. Conceptually, it can be explained as higher the workplace spirituality, lesser will be the adverse effect of stress on quality of care and vice versa. Spirit is the essence of life and the most profound core of existence which brings awareness and gives the direction to connect with inner-self (Sharma, Rastogi, & Garg, 2013). It is the process of self-enlightenment, that is, to connect a person with inner conscious and with others which is an important resource of an individual to handle even the worst situation by managing himself or herself. Spirituality is the foundation of one's daily life, and in variety of ways, it enriches the sense of connectedness which helps in balancing the varied role of one's life.

The results of this study revealed that the low level of workplace spirituality makes the impact of nurse's stress more intense on quality of care. The absence of domains of spirituality that are practice, belief, and experience is one of the causes of low WS among nursing staff (Richards, Oman, Hedberg, Thoresen, & Bowden, 2006). Moreover, the challenging and hectic task of nursing staff as well as overcoming stressors like bullying, work-family conflict, and patient incivility contributes to low spiritual well-being of nursing staff. Balancing family demands simultaneously with unsupportive seniors, patients and working environment demands, claims huge energy of nursing staff even beyond their capacity. As per the job demand resource (JD-R) model, the imbalance of the job demands and available resources causes stress among employees. The conservation of resources model states that physical, emotional, psychological, and spiritual resources are limited and depletes with time, and if not regained, it leads to stress among nursing staff (Halbesleben, Wakefield, Wakefield, & Cooper, 2008). Nursing care is in itself a spiritual experience and is quite enjoyable as nurses embody the values and virtues of patience, benevolence, selflessness, and compassion. However, in the present scenario, nurses are experiencing chaos, ambiguity, and paradox in the working environment, and on the name of noble duties for mankind, PHCI are exploiting the available healthcare manpower. These institutes even lack the adequate structure and systems where nurses can raise their life energies to handle all odds of working environment, eventually causing psychological disorders like anger, depression, anxiety, moral distress, and severe physical ailments.

Workplace spirituality is a dynamic, personalized, and multifaceted phenomenon which aligns the body, mind, emotions and energy of an individual. Such unique dimensions and features of spirituality make it more practical for diverse organizational settings, specifically, in healthcare institutions because both the systems are dedicated for the betterment of mankind. In this study, spirituality was tested to ascertain the magnitude of moderating impact on relationship between stress and quality of care. The results revealed that spiritual level of nursing staff is on lower side (M=3.36), which shows that their coping mechanism to handle stress is weak and this adversely affects their performance in terms of quality of care.

Spirituality is like the breath of life as well as an essential part of one's life which could be understood by being conscious to one's inner self. The results of this study have shown lack of sense of community with team members. They feel that in spite of the common purpose, that is, patient care, team members don't provide enough support and care to each other in public healthcare institutions.WS means employees recognizing work as an opportunity to be conscious about himself or herself and about society in a meaningful way (Giacalone & Jurkiewicz, 2010). As reported by the respondents, they sense that leaders lack in providing values within an organization for the betterment of the society. Nurses revealed that culture and environment of PHCI do not respect and value the spiritual values of individual employees at workplace, and this is reflected by the lower level of mean value. It is a spiritual path following which nurses can learn to be more caring, helpful, thoughtful, and compassionate with superiors, colleagues, and patients (Finney, 2008). They expect that the management and leaders would provide spiritual support to them, so that they could be more spiritual in their work which will prevent the negative influence of stress on their personal and professional life and eventually on their performance. The study revealed that spirituality has a unique capacity, propensity, and awareness of force, which is innate to each individual. Workplace spirituality is nothing but a discipline, which focuses on bringing the harmony between body and mind by considering the external and internal environment of an individual (Richards & Bergin, 2005; Richards, Sanders, Lea, McBride, & Allen, 2015). As per the results, workplace spirituality among nursing staff is on the lower side, as they are not provided adequate culture and support to experience and enhance their spiritual values. Past research has shown that with spiritual support at workplace, employees can progress towards knowledge (Liu, Rao, Tuggle, & Chauvel, 2015), connectedness, love, hope, values, creativity, and happiness (Hill & Dik, 2012).

Nursing staff face the challenges of life and death of others, who have come with a hope of healthy life. The results have shown that nurses face the challenge of workplace environment, that is, scarcity of resources, uncooperative colleagues, and patients as well as internal locus of control, that is, disturbed emotions, social, behavioral and cultural factors. The interface of workplace milieu and internal locus of control creates imbalance of emotions, energy and behavior which leads to various physical, psychological, and emotional problems. They feel difficulty in managing the imbalance of workplace challenges and inner self owing to lack of spiritual environment at workplace (Garcia-Zamor, 2003).Workplace spirituality is a positive force for nursing staff that moderates the adverse influence of stress on their patient care and gives direction to their mind and actions to proceed in betterment of mankind.

Nursing unlike other professions is not a job but a mission of providing services for healthy world. Nurses face job stress due to challenges of handling life and death of people, so they need stress coping mechanism like of highest level in need hierarchy (Lim, Bogossian, & Ahern, 2010). However, nurses are not considered as a holistic human being because personal, professional, social, psychological, and spiritual aspects of their life are neglected at workplace (Ozbasaran, Ergul, Temel, Gurol Aslan, & Coban, 2011). Thus, workplace spirituality can play a vital role in overcoming the effect of various stressors such as family conflicts and aggressive behavior of colleagues, seniors and patients by infusing positivity concerning oneself, others, and towards environment challenges.

As per the existential view of workplace spirituality, employees can find meaning, happiness, and connection with work and people at workplace (Gupta, Kumar, & Singh, 2014). Nursing care represents the essence of spirituality, which is to provide selfless services for the better health of the society (Siegrist, 1996). To take the right decision (Tasic & Andreassi, 2008) at the right time in case of emergencies and unique heath problem of each patient, nurses need the right combination of intelligence quotient (IQ), emotional quotient (EQ), and spiritual quotient (SQ). Cognitive knowledge can be managed with the first level of intelligence, that is, IQ; and EQ is the next level of logical reasoning, that is, managing emotions of self and of others. Nurses handle the basic job tasks with IQ and manage the emotions of self, patients, and their relatives with EQ. However, nurses require the next level of intelligence, that is, SQ to manage themselves. Nurses need to contemplate primarily on SQ, that is, state of conclusive awareness for developing the sense of self-identity, so that they can distinguish themselves from

the situation to make the work more meaningful. Same has been described in Bhagvad Gita in the context of karma yoga, in which it is stated that one should focus own energy to perform his or her duties consciously by being objective about the events and situations.

As per the respondents the spiritual intelligence, nourishment of inner self with meaningful work can act as a resource to buffer the adverse impact of job stress on their quality of care. Past research has also shown that the encouragement of spirituality at workplace has multifold benefits towards healthcare institutes, healthcare employees, and patients such as enhanced motivation and commitment of employees (Sekhar, Patwardhan, & Singh, 2013), job satisfaction and dedication which enhance the performance of healthcare employees. The results have shown the low level of spiritual quotient owing to lack of spiritual environment at workplace. Public healthcare institutes by encouraging spiritual enrichment can give an opportunity to nurses to bring their whole self at work and provide them means for higher job satisfaction, commitment and personal fulfilment (Tischler, Biberman, & McKeage, 2002). So, spirituality at workplace can emerge as a resource from within which can help in maintaining a balance between the imbalance of job demands and job resources of nursing staff, thereby, reducing the stress levels.

Spirituality has always been a foundational part of nursing care, and the orientation of nursing care has always been altruistic and spiritual. Workplace spirituality can enhance their quality of nursing services by expanding their frontiers of consciousness towards benefits of the mankind. Spiritual encouragement can guide the nurses to have better insight and broader vision to solve the problems and challenges at workplace. Workplace spirituality may fulfil the highest need (Liu & Robertson, 2010), that is, sense of achievement among nurses at workplace which boosts their morale to fulfil their duties with honesty and integrity by surpassing all odds of personal and professional life. The results displayed that working in physically and psychologically taxing environment along with lack of spirituality at workplace encourages the nurses to experience dullness in their job. They don’t feel enjoyment in doing tedious and repetitive job tasks and so feel psychologically drained and are not able to provide satisfactory patient care.

Nursing staff faces the stressors like interpersonal conflicts, workload, work-family conflict, patient incivility, and management pressures. Stress from guilt of not being able to give

appropriate time to patents' needs in over taxed and pressurized environment is increasing as the value of caring is submerged and endangered because of various above mentioned stressors. Day to day activities can bring short term positive changes in nursing staff, but spirituality at workplace can help them to sustain their positivity, commitment, motivation, and morale. Public healthcare institutions needs to create organizational culture that support and encourage nursing staff to cultivate spiritual awareness at workplace and to move them towards transpersonal cognizance for transforming the consciousness of care among them.

6.4 Theoretical Implications

The study extended the line of research by highlighting the paramount role of workplace spirituality in moderating the relationship between stress and quality of care services. Past studies have done research considering varied perspective of spirituality, but scant research is available considering the significance of workplace spirituality on job outcomes of employees working in the service sector. Moreover, the findings impart empirical support for the applicability of job demand resource (JD-R) model in developing and eastern countries. Constructs under study were analyzed in light of the JD-R model which provides strong foundation for the research by considering the holistic prospect of stressors and resources. Considering WS as a significant resource to overcome stress in the overarching JD-R model of stress is a novel effort in behavioral science. Although variables under study are observed individually in the western countries, the applicability of theories and variables developed in the western culture needs to be tested in diverse cultures of the eastern society (Demerouti & Bakker, 2011). The comprehensive model comprising diverse dimensions of stressors and quality of care is the first to be studied in the context of Indian nurses working in public healthcare institutions. The empirical findings support the mediating role of stress between stressors and quality of care, thereby, contributing to the mediating literature on stress from the nursing perspective. Further, self-identity model was applied in the study to explain the workplace spirituality. The explanation of self-identity model in the context of eastern country and to explain the buffering effect of workplace spirituality with this model is a unique effort in the study.

Although significant research has been conducted on stress in the western countries, there is paucity of research considering the cultural and demographic diversity of developing countries

like India. The study contributes to the existing literature on nursing by developing a comprehensive model that represented three perspectives—organizational, individual and patients—based on the working conditions of Indian nurses. Healthcare services revolve around patients, and their perspectives have been addressed in this study which is missing in the nursing literature. Not only behavior of service provider, but also the behavior of patients has a crucial impact on healthcare services. Disruptive behavior of patients has profound repercussions for both patients and nurses because stressed environment results in the increased medical errors. Past studies have stressed on organizational and individual aspects of job stress, however, the patient's behavior is also a significant stressor for nurses and has critical impact on nursing care. Consistent with empirical and theoretical literature, WFC and bullying are some of the prime causes to increase the level of stress among nursing staff. This study has given attention to routine stressors that nurses encounter on day to day basis and which act as silent killers for nursing staff (Adams, 2014). The findings highlighted the turmoil of nurses and the irony of healthcare sector where the angels of health are unable to protect their own well-being because of integrated and environmental stressors related to job. Stress has been considered innate to nursing profession which percolated in their attitude, behavior and actions and eventually reflected in the quality of nursing care. The findings highlight the problems faced by nurses while working in Uttarakhand region. Nurses working in public healthcare institutions of hilly region perform their job duties with minimal resources and the prevailing working environment leads towards the extremity of the current situation. The JD-R model advocates that nurses exploit their available resources while managing organizational challenges and work family balance as well as imbalance of job demands and resources that create stress amongst them. Nurses can prepare themselves to manage the challenges by awakening their spiritual consciousness with finding meaningfulness of their work, serve others, as well as perceive control over the environmental challenges as explained by the self-identity model of workplace spirituality.

Healthcare sector in India is going through transition stage, and it can grow only with quality services of committed, motivated, and healthy nursing staff. Less attention has been paid to the spiritual resources and its relationship with positive job outcomes and healthcare impairment causes in context to Indian nurses. This study unexplored the aspects of spiritual

resources with the JD-R model, and the new facets of stress–workplace spirituality–quality of care has been touched which explored panorama for further research in nursing.

6.5 Suggestions / Practical Implications

The study puts forward some important suggestions for the organization and policy makers for healthcare institutions. Increased workload, workplace aggression, work family imbalance, lack of support, weak interpersonal relations at workplace and dwindling quality of care are crucial issues for nurses and public healthcare institutions.

First, to keep a check on the bullying, collegial support and teamwork (Bhagat, 1997; Ojha, 2014) could play an important role in preventing the harassment at the workplace (Fox & Stallworth, 2009). Moreover, it is the responsibility of the organization, especially, the immediate supervisor to ensure a safe work culture for the subordinates. Regular monthly meetings to understand the issues faced by the subordinates could be organized and measure to prevent bullying shall be discussed. For instance, subordinates working under a particular supervisor must be shifted under some other supervisor after a certain time period (Bhagat, 2002). In case of a senior or colleague bullying a subordinate, team rotation will help in escaping the harassment and resolve the matter amicably (Rocker, 2008).

Lack of infrastructural facility, cleanliness and low manpower creates a sense of frustration amongst the patients and their family members which bursts out in the form of incivility. To prevent this, cleanliness and proper medical facilities shall be provided for the patients and to bridge the gap of nurse and patient ratio, increased trained manpower is required. Staffing level should be reviewed to manage the patients' loads in triage zone. Further, violence management teams including councilor, nurse, and safety personnel need to be formed to manage the patients and relatives in a better way and to ensure the safety to nursing staff (Van Fleet & Van Fleet, 2010). In addition, knowledge management (Venkatesan & Ahmed, 2012) and open communication shall be promoted so that the nurse staff feels comfortable in communicating to their supervisors about the incivility that they face. The study has provided more insights into the problem of PI and has provided few recommendations to enhance the feeling of safety among nurses. Comprehensive program on de-escalation and management of aggression should be included in the professional education of nurses (Crilly, Chaboyer, & Creedy, 2004).

To prevent the work–family conflict amongst the nurses, management should ensure facilities like crèche for the children of the female nurses and flexible shift timings for the nurses as it will help them in taking a break from their stressful job and for better quality of life (Rao, Arora, & Vashisht, 2013). Moreover, job rotation will help in preventing adverse effect of stress developed from the work. Breaks during the shift timings will also help in relieving the stress, furthermore, collegial support will also help in overcoming the stress. Stress relieving exercise must be organized once a month to help develop a warm relation amongst the colleagues as well as extend their stress handling skills. Management can frame supportive policies like family responsive workplace policies (Hackman & Oldham, 1980), employee assistance programs and flexible time scheduling for nurses to balance work and family life, and to eventually reduce their stress level (Tang, 2005). Majority of nurses are females and are considered prime care takers of home as per Indian culture. So, leaders and senior management of female nurses should frame flexible human resource practices (Dhar, 2015a) for supporting nurses in carrying out family responsibilities, which may reduce the work-family conflict as well as upsurge their job satisfaction and performance (Carlson, Kacmar, Zivnuska, Ferguson, & Whitten, 2011). Senior management should pay attention on concerns like changing societal and demographic culture such as nuclear families, dual working couples, and single parents while framing benefit programs (Bahadur & Dhawan, 2008). Effective governance of policies can help management in optimum utilization of resources (Vashisht, Mehta, & Arora, 2006).

Exposure to emotional and psychological situations like chronic illness and death of patients can't be changed because these are integral to nursing profession (Moos, 2012). However, nurses can shield themselves from the adverse impact of their profession by being conscious of themselves and their actions as it will enable them in handling the challenges objectively (Thomas, 2004). Yoga and meditation is the answer to overcome the stressful environment of the hospitals. Balancing the emotions will help in dealing with the practical problems at workplace. Breathing techniques like pranayama, music therapy etc. will help in managing emotions and better performance at workplace. Nursing literature has shown the holistic perspective of nursing care in the same way as nurses should be considered a holistic person who comes with body, mind, emotions and spirit at workplace. Spiritual intelligence can work as a catalyst to control the impact of stress in nurses. Spiritual quotient (SQ) creates awareness among individuals to use their intelligence quotient (IQ) and emotional quotient (EQ)

consciously. Spiritually intelligent people better manage their and other's emotions, as they become conscious about their actions and don't indulge themselves with the outcome of actions. WS has multifarious impact on nurses as well as on healthcare institutes. Organization culture and leaders can infuse the comprehensive component, that is, spirituality at workplace by connecting values associated with both the organization and employees (Vaill, 1998). Environment of trust, creativity (Andreassi, 2003), respect within workplace and connectedness between units, satisfies the spiritual needs of nurses and builds transcendence and teamwork within workplace. With intrinsic and existential view of WS, employees connect and fulfil their spirit through work. The spirituality makes nurses feel connected and they even find meaning to their work and so they enjoy their work for the betterment of patients and society. With such perspective, they can safeguard themselves from adverse impact of stressors as it not always challenges and circumstances that infuse stress, but the level of stress also depends on the perception of the perceiver.

Motivation and morale of nurses can be improved by turning the psychosomatic toxic environment into healthy and helpful workplace (Bhagat, 2003) which in due course will improve the patient care. Routine challenges of nursing profession disrupt the daily life of nurses and the past studies have identified that daily stressors have stronger influence on emotional and psychological wellbeing of nurses. Leisure can act as a buffer for the adverse impact of routine stressors, and the leisure activities like relaxation, adequate rest breaks, short training sessions and recreational activities can act as coping strategies for stress.

6.6 Conclusion

The chapter has explained the insights of the results found in this study. The purpose of this study was to test the conceptual model which indicates the mediating role of stress in linking the relationship among work-family conflict, bullying, patient incivility, and quality of care as well as the moderating role of workplace spirituality in stress and quality of care. The results of all six hypotheses have been justified with the past literature. The immediate concerns of improving the present state of nursing staff for better care of patients have been suggested. Further, the theoretical contributions of the research to the current literature have been provided. Lastly, the limitations and future scope accompanied by the overall conclusion of the study has been discussed.

CHAPTER 7

CONCLUSION AND FUTURE SCOPE OF WORK

7.1 Conclusion

The present study was an effort to explore the environment of public healthcare institutes and to assess the importance of nursing staff in providing quality of care to the patients. The study also focused on identifying the factors that operate in the work environment of the public health care institutions and affect the nursing staff adversely eventually affecting the quality of care for the patients. Also, it is an effort to explore the domain of spirituality and use it to overcome the stress caused by the environmental factors operating in the public healthcare institutions.

This study identified the factors such as work-family conflict, bullying and patient incivility as significant stressors that lead to creation of stress amongst the nursing staff and have a negative impact on the quality of services provided to the patients by the nurses.

The study also strived to provide the solution to the problem by incorporating the spiritual dimension which is the third level of intelligence i.e. spiritual intelligence and it was found that workplace spirituality acted as a moderator in between stress and quality of care provided to the patients.

The study was supported well by the literature and the theoretical framework gave a strong foundation for the study. Descriptive research methodology was adopted for this quantitative study and survey was the mode of data collection following the convenience sampling technique. The data was collected from the public healthcare institutes of Uttarakhand region, India. Data was analyzed using regression analysis technique and were supported by the relevant literature with detailed justification for the findings of all the hypotheses in the discussion section. Lastly, the present chapter discuses the theoretical as well as managerial implications based on the findings of the study, followed by the limitations and future scope of the study.

7.2 Limitations of the Study

Though the study has made significant contributions, still there is always a scope for something better which could be termed as limitations of the study. First, the data was collected from one of the branches of healthcare institutions, that are, public healthcare institutions. The elements of stress and its impact could be diverse in private healthcare institutions, so it limits the generalizability of the study at macro level. Second, the majority of sample for this study are females working in the public healthcare institutions only. Male nurses working in healthcare service sector were under-represented, so it limits the applicability of findings on male nurses. Third, the cross– sectional research design was adopted and data was collected at a single point of time, so it is difficult to assess the direction of the causality of variables. Longitudinal design can better depict the proof of causality between constructs with continuity of the respondents encountering stressful challenges and observation of changes that occur over time. Fourth, the instruments used for this study were developed originally in English. Although, measures were translated in Hindi and back translated in English by linguistic experts, there is a scope of misinterpretation of the questions by Hindi speaking respondents. Fifth, the instruments used in this study are self-reported measures which are open for self-reporting biasness. As self-report measures may underestimate or overestimate the results, the statistical results proved nonexistence of common method biasness. Sample for the study was confined to nursing staff only, because considering employees working on diverse job profiles in healthcare institutions can provide better insight of the problems prevailing in working environment. This study was limited to Uttarakhand region only; other states could have different culture and working environment which could be considered for future studies.

7.3 Future Scope

Although the study has few limitations, it has opened new avenues for future research. The study has considered work-family conflict, bullying, and patient incivility as potential stressors for nursing staff. In future, more organizational and individual level stressors could be considered to understand the causes of stress among nursing staff from broader perspective. Various demographic factors like number of dependents at home and personality factors need to be considered for understanding the impact of stressors as per their perceived value. The elements of stressors can be replicated in varied healthcare institutions including private sector

and this can improve the generalizability of the results. Further, comparative research on diverse departments and units of healthcare institutions can provide an in-depth understanding and impact of workload and patient's chronic illness on the stress level of nursing staff. On the basis of the characteristics of the variables, these can be replicated in other settings like policing, security services etc. Other industries and sectors may differ in work settings and characteristics and application of the study in diverse sectors will increase the probability of getting a more generalized results. Nursing is female dominating profession, and the results may vary with application of the model in male dominating professions like policing and this can present the broader and generalized application of the conceptual model. Although, present research has used convenience sampling technique and in the near future, usage of other available sampling techniques can help in profound results. A detailed comparative study based on the result outcomes of different sampling techniques can also be conducted in future.

Empirical and qualitative research has its own strengths and limitations, but combination of both qualitative and quantitative research design can provide thorough and comprehensive results. Further, longitudinal research design can be implemented to test and establish the causal factors of stress as well as to establish the causality of relationship between variables. Longitudinal study can provide a clear picture about the evolution and consecutive phases of stress so this design is critical in understanding the prevalence and impact of stress among nursing staff. Longitudinal study helps in investigating the continuity of the responses and changes that occur over the period of time (Zikmund & Babin, 1997). Further, culture can play a significant role on the working environment and structure of an organization. In future, comparative study can be conducted by considering the collectivist culture as in Asian countries and individualistic culture as in Western countries. The results from comparative studies can depict the nature and impact of varied stressors on employees and the direction of relationship between variables from varied perspectives.

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ANNEXURE- A

QUESTIONNAIRE

S. No.	Particulars
A.	**Work Family Conflict Scale adapted from Netemeyer, McMurrian and Boles, 1996 (7 point Likert Scale)**
1.	The demands of my work interfere with my home and family life.
2.	The amount of time my job takes up makes it difficult to fulfil family responsibilities.
3.	Things I want to do at home do not get done because of the demands my job puts on me.
4.	My job produces strain that makes it difficult to fulfill family duties.
5.	Due to work-related duties, I have to make changes to my plans for family activities.
B.	**Bullying Scale given by Quine, 2001 (7 point Likert Scale)**
a)	**Threat to professional status**
1.	Persistent attempts to belittle and undermine your work
2.	Persistent unjustified criticism and monitoring of your work
3.	Persistent attempts to humiliate you in front of colleagues
4.	Intimidatory use of discipline/competence procedures
b)	**Threat to personal standing**
5.	Undermining your personal integrity
6.	Destructive innuendo and sarcasm
7.	Verbal and non-verbal threats
8.	Making inappropriate jokes about you
9.	Persistent teasing
10.	Physical violence
11.	Violence to property
c)	**Isolation**
12.	Withholding necessary information from you
13.	Freezing out/ignoring/excluding
14.	Unreasonable refusal of applications for leave, training or promotion
d)	**Overwork**
15.	Undue pressure to produce work

16.	Setting of impossible deadlines
e)	**Destabilization**
17.	Shifting goalposts without telling you
18.	Constant undervaluing of your efforts
19.	Persistent attempts to demoralize you
20.	Removal of areas of responsibility without consultation
C)	**Patient Incivility scale given by Guidroz et al., 2010 (7 point Likert Scale)**
1.	Patients and their family do not trust the information I give them and ask to speak with someone of higher authority.
2.	Patients and their family are condescending to me.
3.	Patients and their family make comments that question the competence of nurses.
4.	Patients and their family criticize my job performance.
5.	Patients and their family make personal verbal attacks against me.
6.	Patients and their family pose unreasonable demands.
7.	Patients and their family have taken out their frustrations on nurses.
8.	Patients and their family make insulting comments to nurses.
9.	Patients and their family treat nurses as if they were inferior or stupid.
10.	Patients and their family show that they are irritated or impatient.
D)	**Stress scale adapted from Gray–Toft and Anderson, 1981 (7 point Likert Scale)**
a)	**Death and Dying**
1.	Performing procedures that patients experience as painful
2.	Feeling helpless in the case of a patient who fails to improve
3.	Listening or talking to a patient about his/her approaching death
4.	The death of a patient
5.	The death of a patient with whom you developed a close relationship
6.	Physician not being present when a patient dies
7.	Watching a patient suffer
b)	**Conflict with physicians**
8.	Criticism by a physician
9.	Conflict with a physician
10.	Fear of making a mistake in treating a patient
11.	Disagreement concerning the treatment of a patient
12.	Making a decision concerning a patient when the physician is unavailable

c)	**Inadequate preparation**
13.	Feeling inadequately prepared to help with the emotional needs of a patient's family
14.	Being asked a question by a patient for which I do not have a satisfactory answer
15.	Feeling inadequately prepared to help with the emotional needs of a patient
d)	**Lack of support**
16.	Lack of an opportunity to talk openly with other unit personnel about problems on the unit
17.	Lack of an opportunity to share experiences and feelings with other personnel on the unit
18.	Lack of an opportunity to express to other personnel on the unit my negative feelings toward patients
e)	**Conflict with other nurses**
19.	Conflict with a supervisor
20.	Floating to other units that are short-staffed
21.	Difficulty in working with a particular nurse (or nurses) outside the unit
22.	Criticism by a supervisor
23.	Difficulty in working with a particular nurse (or nurses) on the unit
f)	**Work load**
24.	Breakdown of computer
25.	Unpredictable staffing and scheduling
26.	Too many non-nursing tasks required, such as clerical work
27.	Not enough time to provide emotional support to a patient
28.	Not enough time to complete all of my nursing tasks
29.	Not enough staff to adequately cover the unit
E)	**Workplace Spirituality adapted from Rego and Cunha, 2008 (7 point Likert Scale)**
a)	**Team's sense of community**
1.	People in my team/group feel as if they were part of a family
2.	My team/group promotes the creation of a spirit of community
3.	I feel that the members of my team/group support each other
4.	I feel that the members of my team/group care about each other
5.	I feel that the members of my team/group are linked by a common purpose
b)	**Alignment between organizational and individual values**
6.	I feel positive about the values prevailing in my organization
7.	People feel good about their future with the organization

8.	My organization respects my "inner life"
9.	My organization helps me to live in peace/harmony with myself
10.	The leaders of my organization try to be helpful to the larger social good of the community
c)	**Sense of contribution to the community**
11.	My work is connected with what I think is important in life
12.	I see a connection between my work and the larger social good of my community
13.	When working, I feel helpful for the whole society
d)	**Sense of enjoyment at work**
14.	I experience joy in my work
15.	Most days, I feel joy when coming to work
e)	**Opportunities for the inner life**
16.	My spiritual values are not valued in my workplace (Reverse Coded)
17.	In my workplace, there is no room for my spirituality (Reverse Coded)
F)	**Quality of Care scale given by Aiken et al., 2002 (7 point Likert Scale)**
1.	In general, how would you describe the quality of nursing care delivered to patients on your unit?
2.	How would you describe the quality of nursing care delivered to patients on your last shift?
3.	Overall, over the past year would you say the quality of patient care
4.	How confident are you that your patients are able to manage their care when discharged from the hospital?