

When good HR gets bad results: exploring the challenge of HR implementation in the case of workplace bullying

Chris Woodrow, NIHR King's Patient Safety & Service Quality Research Centre, King's College London

David E. Guest, Department of Management, King's College London
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Research on the relationship between HRM and organisational performance has highlighted a gap between intended and implemented HR practices. However, this gap has rarely been explored systematically, and the consequences of the effectiveness of the implementation process for relevant outcomes remain poorly understood. This article addresses this issue by examining the process and quality of HR implementation. Drawing on a model of HR implementation, it presents a detailed case study of the implementation of HR practices relating to workplace bullying. Findings reveal that while the policy reflected best practice, implementation was uneven, resulting in persisting high levels of bullying which negatively affected staff well-being and performance. The results indicate that it is misleading to look just at HR practices, and that even 'best HR practices' are unsuccessful unless implemented effectively. It is argued that a greater focus on HR implementation will improve our understanding of the HRM – performance relationship.

Contact: Prof David E. Guest, Department of Management, King's College London, London, UK. Email: david.guest@kcl.ac.uk

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INTRODUCTION

The association between HRM and organisational performance has been well established (Boselie *et al.*, 2005; Combs *et al.*, 2006). However, the process whereby this link operates remains unclear, leading to calls to open up the 'black box'. Researchers have responded by focusing on the mediating processes whereby HR practices can affect employee attitudes and behaviour, typically based either on the ability, motivation, opportunity model or a human capital model (Subramony, 2009; Jiang *et al.*, 2012). However, these models continue to link the presence of specific HR practices to employee attitudes and behaviour without explicitly considering the quality of these practices and of their implementation. Recognising this, Wright and Nishii (2013) have called for a greater focus on implementation, and Khilji and Wang (2006), among others, have reported a gap between intended and implemented HR practices. Furthermore, Becker and Huselid (2006) have argued that the ability to implement HR strategy and HR practices is an important source of competitive advantage.

Despite some recognition of the importance of the implementation rather than simply the presence of HR practices, there has been limited attention to effective implementation processes and how employees respond to them. The aim of this article is therefore to address the process of HRM implementation and its relationship with employee responses. This is achieved

through a detailed case study analysis of one particular practice, concerning the management of workplace bullying and harassment. The research draws on a conceptual model developed by Guest and Bos-Nehles (2013). By focussing on the influence of HR implementation on employee attitudes and behaviour, it makes a distinctive contribution by helping to explain the role of employee responses in the link between HRM and outcomes. By adopting a case study approach within a specific analytic framework, it extends previous research by providing a fuller understanding of how and why implementation of HR practices can succeed or fail, as well as considering some of the consequences.

HR PRACTICES AND THEIR IMPLEMENTATION

Following previous studies indicating a gap between intended and implemented HR practices, Guest and Bos-Nehles (2013) have proposed a novel framework setting out four stages in the implementation process. This framework forms the basis for the research reported here. They suggest that HR implementation begins with the decision to adopt a particular HR practice, for example, the decision to use psychometric testing in selection or an attitude survey to seek employees' views. Most research studies report considerable variation in the number of practices in place across organisations, reflecting variations in the decision to adopt specific practices. The second stage concerns decisions about the quality of the HR practice. For example, a decision to use psychometric testing may be followed by the adoption of more or less valid tests. The third stage involves a decision about whether to make use of the practice. Regular appraisals may be required but line managers have to decide whether or not to undertake them. The fourth and final stage concerns the quality of implementation. For example, line managers may agree to appraise their staff but, perhaps because of time pressures or because they view appraisals as unhelpful, they conduct poor quality appraisals. According to Guest and Bos-Nehles (2013), a full analysis of implementation needs to consider each of these stages because a line manager's decision about whether to undertake serious appraisals depends on prior decisions about the presence of the appraisal system and its quality.

The Guest and Bos-Nehles model additionally highlights the need to consider who is responsible for implementation and who is likely to evaluate its effectiveness. Turning first to responsibility for implementation, they suggest that HR managers are likely to have an important role in the first two stages of the implementation process, often with the support of the top management team, but thereafter line managers increasingly take centre stage (Brewster and Larsen, 2003). With respect to evaluation of the quality of implementation, a range of stakeholders can be identified including senior managers, line managers, HR managers and, perhaps crucially, employees (Tsui, 1987).

Huselid *et al.* (1997) found that line managers' perceptions of the quality and effectiveness of HR practices are associated with firm performance. Moreover, Guest and Conway (2011) have shown that the assessments of HR effectiveness by both senior HR managers and chief executive officers are associated with performance and that HR effectiveness has a stronger association than the more conventional measure of the presence of HR practices. Nevertheless, employees who are on the receiving end of the HR practices may be best placed to judge the extent and effectiveness of their implementation. There is evidence that employees are less likely than HR managers to report the presence of HR practices (Liao *et al.*, 2009; Guest *et al.*, 2010), reflecting the gap between intended and implemented practices. However, like Nishii *et al.* (2008) have indicated, it is not only the presence of a practice but the attributions concerning its purpose that can affect how employees respond. The major distinction drawn by Nishii *et al.* concerned employees' perception about whether a practice takes sufficient account

of their interests and is likely to benefit them or benefit only the organisation, potentially at their expense. We extend this analysis to argue that a related factor will be employees' perceptions of the good faith of both senior and local line management to take seriously the implementation of HR practices, particularly those that focus on workers' well-being.

While most HR practices are directed towards seeking (high) employee performance, others are intended to promote or protect employee well-being. Among these are the provision of a safe working environment, a concern for work-life balance, fair treatment and avoidance of bullying and harassment. Support for these practices is signalled through legislation in most advanced industrial democracies. While they may not appear to directly affect performance, they can have an indirect impact by influencing employee well-being, which in turn can have an impact on performance. It is therefore essential that their implementation is taken seriously in organisations rather than treated like a marginal activity. It is one of these HR practices – activities to minimise bullying and harassment – that provides the focus of this study and serves to highlight the important role of HR implementation. In the next section, we briefly describe current approaches to understanding and managing bullying and harassment at work.

BULLYING AND HARASSMENT AT WORK

Workplace bullying refers to the process of 'harassing, offending, socially excluding someone or negatively affecting someone's work tasks' which occurs 'repeatedly and regularly (*e.g.* weekly) and over a period of time (*e.g.* about 6 months)' (Einarsen *et al.*, 2003: 15). Workplace harassment has been defined as 'interpersonal behaviour aimed at intentionally harming another employee in the workplace' (Bowling and Beehr, 2006). We use 'bullying' like an overarching term for these two behaviours. Studies of workplace bullying typically examine its antecedents and consequences. The dominant approach to studying the antecedents of workplace bullying has taken a work environment perspective (see Einarsen, 2000), which states that environmental stressors produce aggressive behaviour which, if left unchecked, can lead to bullying. Bullying is therefore most prevalent in organisations with weak management control and inadequate HR policy where aggressors are undeterred from acting (Salin, 2003). Likewise, bullying is reported more readily by individuals who also report negative features of the work environment such as lack of role clarity and poor social climate (*e.g.* Skogstad *et al.*, 2011). The second major strand of research has examined the consequences of bullying, typically treating it like a serious workplace stressor which results in negative outcomes for victims including anxiety, depression, sickness absence and turnover (for an extensive review, see Høgh *et al.*, 2010).

A central feature of a typical organisational approach to the management of bullying is a bullying policy, the responsibility for which lies with the HR function (Einarsen and Hoel, 2008). An explicit policy is important because it ties together the separate components, forming the primary source of information for anyone involved in bullying and acting like a mechanism of communication with the workforce. Rayner and Lewis (2010) have outlined three essential features of an effective bullying policy. The first is a general introduction with a clear statement of the organisations' opposition to bullying, a definition of bullying and references to other useful policies such as the disciplinary and whistle-blowing policies. The second is a description of the informal routes through which conflicts might be prevented or resolved, with particular emphasis on the role of local line managers. The third is a description of the formal process through which bullying might be managed, which should stress the importance of early resolution. They additionally note that a bullying policy must be accompanied by promotion through staff training and induction, by providing managers with the skills to implement the

policy. A bullying policy document should also outline relevant HR practices for the management of bullying. Vartia and Leka (2010) have described these practices using the commonly cited stage intervention framework. Primary stage interventions aim to prevent bullying from occurring and are typically conducted at the organisational and workplace levels. They include training for managers and staff, changes to the work environment and the adoption of a 'zero tolerance' approach to bullying. Secondary stage interventions aim to combat the process of bullying once it has begun and range from physical relocation of staff to informal third party intervention (Fisher and Keashly, 1990). Finally, tertiary stage interventions involve curative practices focused at the individual level, including counselling, training and return to work initiatives.

While an extensive body of literature has accumulated outlining recommended HR policies and practices for the management of bullying, less attention has been paid to their adoption and implementation. In terms of the model of HR implementation outlined earlier, we know little about whether the recommended HR practices have been adopted in organisations or whether their adoption leads to effective implementation by line managers, as judged by employees whose well-being and performance they might affect. There are several reasons why it is important to investigate the implementation of HRM in the specific case of bullying. First, like the literature has indicated (Høgh *et al.*, 2010), bullying is a highly prevalent workplace stressor with the potential to damage staff well-being. Second, the broader costs of bullying at work are high; the total annual cost of workplace bullying in the UK alone, for example, has been estimated to be £13.75 billion (Giga *et al.*, 2008). Third, research suggests that the implementation of relevant HR policy and practice would reduce bullying behaviour. For example, at a local level, supervisory support is negatively related to bullying behaviour (Zapf *et al.*, 1996), while *laissez-faire* management styles are associated with increased bullying (Hoel *et al.*, 2010) because the presence of local managers who appear unwilling to implement policy can lead to the perception that the costs of bullying are low (Salin, 2003). Furthermore, the role of senior management in visibly highlighting the importance of bullying policy has been identified as a crucial element in the successful management of bullying (Rayner and McIlvor, 2008). Taken together, these findings indicate that the presence of good quality HR policy and practice and its implementation by senior and local management can minimise levels of bullying. In turn, levels of bullying can lead to better employee outcomes, such as increased commitment and decreased sickness absence and turnover, which are expected to increase organisational performance.

THE CURRENT STUDY

This study has three broad aims. First, it aims to make a theoretical contribution because it is the first study to apply and test the Guest and Bos-Nehles systematic four-stage framework of HRM implementation. Second, the research aims to make a methodological contribution to the study of HRM implementation. Previous studies examining HRM implementation have typically used survey methods and presented results at an organisational level (see, *e.g.*, Huselid *et al.*, 1997; Guest and Conway, 2011). By contrast, we take a case study approach in one large organisation, utilising multiple sources of data. Third, the study aims to make a specific contribution to the workplace bullying literature. Although this literature indicates that workplace bullying is both common and damaging, and offers a set of prescriptions for good policy and practice, there is almost no research examining how far organisations adopt recommended HR policies and practices and, if so, whether they are effectively implemented.

An anticipated contribution of the research, therefore, is the provision of practical guidelines about how bullying policy may be more effectively implemented.

METHODS

Data collection took place during 2008 and 2009 in a large National Health Service (NHS) acute hospital in London. Because the aim of the research was to examine, in some depth, the implementation of specific HR policy and practices relating to workplace bullying, we adopted a case study methodology utilising multiple sources of data. The hospital was selected on the basis that reported levels of bullying, both in it and in some comparable London hospitals, were higher than the national average. This meant that we were able to examine whether these high rates of bullying were related to the way in which the bullying policy was designed or implemented.

Data were collected and analysed using the Guest and Bos-Nehles implementation framework, stage one of which concerns the presence of relevant policy and practice. All UK NHS Hospital Trusts are expected to have a policy on bullying and harassment. Therefore, with respect to stage one, the decision to have a policy was determined externally. Data collection and analysis therefore focused on stages two, three and four of the framework.

To assess stage two of the implementation process, relating to the type and quality of organisational policies, a series of steps were taken. First, a core set of 'best HR practices' for the management of bullying was compiled by reviewing existing literature. Second, we established the policies and practices in place at the organisation through detailed searches of the staff intranet and examination of a number of organisational grievance files relating to incidents of bullying. Third, interviews were conducted with HR managers to confirm policy and practice, understand its evolution and address any queries. Finally, the hospital's approach was compared with the best HR practices to determine the quality of the policy.

Stages three and four of the implementation process, addressing the extent and quality of local implementation of bullying policy and practice, were explored using two methods. The first was an analysis of data from the National Survey of NHS Staff, an annual staff attitudes survey conducted in every UK NHS organisation by the Healthcare Commission (now the Care Quality Commission, <http://www.cqc.org.uk>). Respondents are a random sample of the entire workforce in each organisation. The purpose of this analysis was to establish the levels of bullying behaviour within the host organisation, and to examine the relationship between implementation, bullying and employee outcomes. The questionnaire contains a number of validated measures of employee attitudes, based on Michie and West's (2004) framework. The core question asked staff to respond yes or no to whether they had 'personally experienced harassment, bullying or abuse at work' during the previous 12 months from a manager, team leader or their colleagues.

To assess the relationship between implementation, levels of bullying and employee outcomes, we performed mediated regression analyses on the data from the staff surveys conducted in 2006 and 2007. Specifically, we hypothesised that policy implementation would be associated with better employee outcomes, and that these associations would be mediated by reduced levels of bullying. The independent variables in the analyses were two factors that might indicate how far policy was implemented within the organisation, namely perceived supervisory support and perceptions of effective organisational action in cases of bullying. The dependent variables in the analyses were three variables which have previously been identified as outcomes of bullying, namely serious stress, intention to leave and job satisfaction. The variables used in the analysis and their means, standard deviations, internal consistency scores

and intercorrelations are shown in online Appendix S1. The 2006 sample contained 491 respondents, and the 2007 survey contained 404. Regression analyses were undertaken using the three-step procedure described by Baron and Kenny (1986), with Sobel tests undertaken to ascertain the strength of the indirect effects.

The second method of data collection to explore stages three and four of the implementation model consisted of qualitative interviews with a sample of individuals from the organisation and aimed to investigate the extent and quality of implementation of the bullying policy. The sample was recruited via invitation letters attached to payslips in 2009. Invitations asked for individuals who had any experience of workplace bullying, and hence some experience with the process of policy implementation, to contact the research team. The final sample reported here consisted of 12 individuals who represented a mix of occupational groups and types of experience with the policy: four administrative staff, six nurses, one divisional manager and one medical consultant. Eight of these individuals reported that they were victims of bullying, two had been involved in managing cases of bullying, one had witnessed bullying and one had been accused of bullying.

The interviews were semistructured (see online Appendix S2 for the interview schedule) and based on critical incident technique (Flanagan, 1954) methodology. Each interview began with a general request to the participant to outline the nature of their involvement in bullying. Participants then described, in depth, a specific and salient incident of bullying. The researcher sought to assess each individual's views on the causes of this incident, its consequences and any action taken to alleviate the situation or prevent its reoccurrence. Interviews lasted approximately 40 minutes and were audio-recorded and then transcribed. The interview data were analysed for emergent themes using an approach based upon the method described by Miles and Huberman (1994). Analysis began with a set of five broad predefined codes, and additional codes were added as they emerged, resulting in the identification of 39 distinct codes which were treated as lower-order themes. These were then grouped under nine higher-order themes, relating to the following participant perceptions: causes of bullying; content of bullying; definition of bullying; effects of bullying; implementation of bullying policy; line manager behaviour; organisational action on bullying; process of reporting bullying; suggestions for improvements to bullying management.

RESULTS

The quality of bullying policy

To judge the quality of the organisation's bullying policy (*i.e.* stage two of the model), we compared the hospital's policy and practices with those that emerged from the literature review of recommended 'best practices' for the management of bullying. These are shown in online Appendix S3.¹ The detailed review revealed that the organisation's bullying policy and practice was broadly in line with recommended best practice. The organisation's policy outlines a zero tolerance approach to bullying, with managers encouraged to create an environment where bullying is not tolerated and staff are confident about discussing their concerns informally. In the first instance, staff are advised to confront alleged perpetrators or to raise concerns with their managers. Managers are advised to use informal routes to deal with these complaints if possible. Additionally, various avenues of support and informal routes for resolution are available for staff who feel that they are victims of bullying. These include a counselling service, occupational health services, a bullying helpline and teams of trained mediators. Victims can make formal complaints and use the grievance procedure.

In terms of dissemination, the policy is available to staff through a local intranet and promoted to newcomers during induction. Regular training schemes are run to raise awareness of bullying and acceptable workplace behaviour, training in how to handle bullying is mandatory for new management staff, and local managers are required to provide periodic briefings on bullying during team meetings. Workforce data are routinely examined by HR staff to identify problems and monitor levels of bullying. The bullying policy was revised and reinforced in 2006, a process which was accompanied by an awareness campaign intended to promote the policy and the organisation's commitment to the effective management of bullying. This campaign was visibly backed by senior figures including the HR director who, given the data about high levels of bullying, had been keen to ensure that the hospital could demonstrate that it had the best available policies and practices in place.

In sum, the policy and practice at the organisation was in line with recommendations regarding best practice in the management of bullying with evidence for the existence of all the aspects of a best practice approach detailed in Table 2. With regard to stage two of the Guest and Bos-Nehles framework, therefore, we found that the organisation has high-quality HR policies and practices to address workplace bullying.

The implementation of bullying policy and the quality of this implementation

We would expect high-quality policy and practice to result in low levels of reported bullying. However, the staff survey results, presented in Figure 1, show a rising trend from about 21 per cent in 2005, falling slightly in 2006 when the policies were reinforced but rising thereafter to about 26 per cent in 2007 and 28 per cent in 2008. Figure 1 sets this against the national average for acute hospitals in England and reveals that levels of workplace bullying reported at this hospital have consistently remained above the national average. It is particularly noteworthy that levels of bullying have risen following the intervention to address the issue, which occurred in 2006.

Figure 1 *Reported levels of bullying 2005–2008*

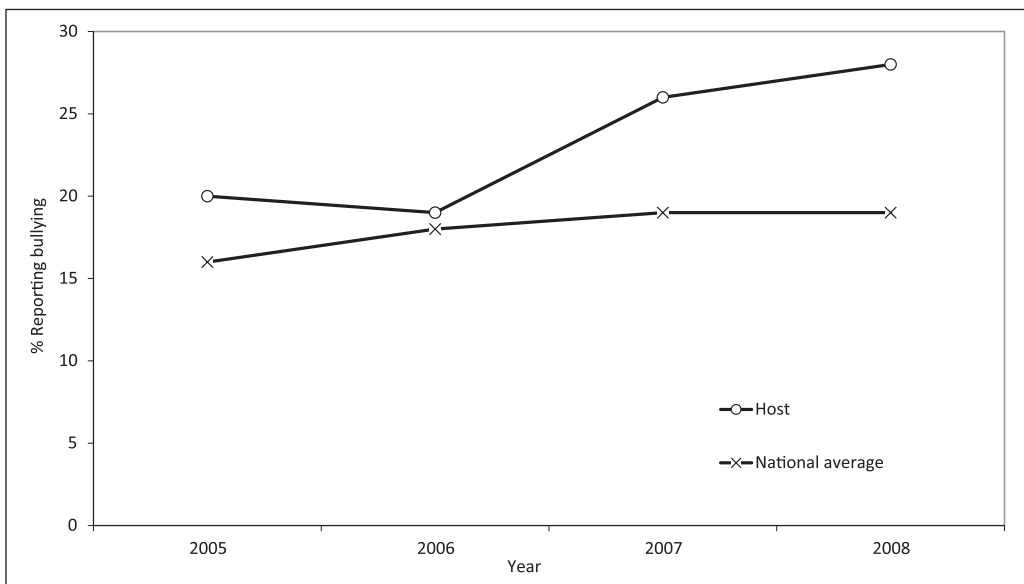
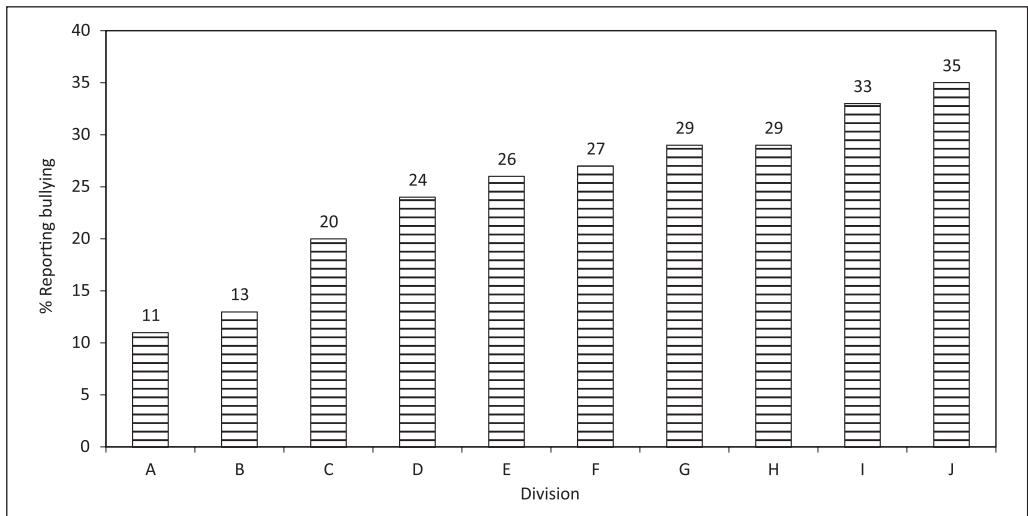


Figure 2 *Reported levels of bullying by organisational division in 2007*

The data in Figure 2 reveal large variations in reported bullying between different organisational divisions in the 2007 survey² and indicate wide variations that cannot be explained by the kind of work undertaken by staff. This suggests that divisional management and related subcultures may play a role in implementing bullying policy. There are also variations by type of staff with highest levels reported by nurses and allied health professionals (both 31 per cent), followed by administrative and clerical staff (28 per cent), medical and dental staff (25 per cent), scientific and technical staff (23 per cent) and those working in central functions (15 per cent). The source of bullying is fairly evenly divided between those at more senior levels and other staff at broadly similar levels. The targets of bullying are predominantly lower grade staff but include some managers and clinical staff.

Tables 1 and 2 show the results of the mediation analyses. In step one, each outcome in both data sets was significantly predicted by supportive supervision and bullying policy implementation. The results of step two and three of the analysis indicate that bullying mediated the relationship between the two implementation variables and both stress and intention to leave in 2006. In 2007, bullying mediated the relationship between the two implementation variables and both job satisfaction and stress. In each case, the Sobel test revealed that the indirect effect was significantly different to zero. The mediation effect was not in evidence for job satisfaction in 2007 and intention to leave in 2006. Hence, the findings reveal partial support for the hypothesis that perceptions of supportive supervision and bullying policy implementation are associated with lower bullying which, in turn, is associated with more positive outcomes.

Survey results additionally revealed that a high proportion of respondents (80 per cent in 2006 and 81 per cent in 2007) indicated that they knew how to report incidents of violence, bullying or abuse. A far lower proportion (46 per cent in 2006 and 30 per cent in 2007) indicated that they had reported the last such incident they had witnessed.³

The second method used to assess the implementation of bullying policy and the quality of this implementation was the analysis of staff interviews data. The interviews revealed a range of perceptions with regard to these issues. First, several examples were provided of good

TABLE 1 Mediated regression analyses showing the relationship between local work environment, bullying and employee outcomes in 2006

Independent variables	Dependent variables (c pathways)		Mediator (a pathways)		Dependent variables (b and c' pathways)		
	ITL ^a	Job satisfaction ^a	Stress ^b	Bullying ^b	ITL ^a	Job satisfaction ^a	Stress ^b
Effective action on B&H	-0.19***	0.19***	0.63***	0.48***	-0.18***	0.16***	0.72**
Support from supervisor	-0.42***	0.61***	0.65***	0.63**	-0.41***	0.59***	0.71***
Mediating variable							
Bullying					0.05	-0.11***	3.89***
Sobel tests							
Effective action on B&H					-1.23	2.76***	-3.55***
Support from supervisor					-1.17	2.29*	-2.69***
Model statistics							
N	476	478	470	474	473	474	468
Adjusted R ²	0.28	0.50			0.28	0.51	
F	91.75***	241.69***			61.65***	167.83***	
Independents ΔR ²	0.28***	0.50***					
Mediator ΔR ²				0.00	0.00	0.01***	
Chi square			59.94***	59.56***			71.19***
Hosmer and Lemeshow			5.46	7.10			7.48
Nagelkerke R ²			0.13	0.19			0.20

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$.

^a Entries are standardised beta coefficients.

^b Entries are odds ratios.

B&H, Bullying and harassment; ITL, Intention to leave.

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$.^a Entries are standardised beta coefficients.^b Entries are odds ratios.

B&H, Bullying and harassment; ITL, Intention to leave.

TABLE 2 Mediated regression analyses showing the relationship between local work environment, bullying and employee outcomes in 2007

Independent variables	Dependent variables (c pathways)		Mediator (a pathways)		Dependent variables (b and c' pathways)		
	ITL ^a	Job satisfaction ^a	Stress ^b	Bullying ^b	ITL ^a	Job satisfaction ^a	Stress ^b
Effective action on B&H	-0.13**	0.16***	0.73*	0.56***	-0.10*	0.19***	0.77
Support from supervisor	-0.39***	0.52***	0.60***	0.52***	-0.35***	0.58***	0.64**
Mediating variable							
Bullying					0.12*	-0.07	1.88*
Sobel tests							
Effective action on B&H					-2.14*	1.63	-2.09*
Support from supervisor					-2.16*	1.65	-2.10*
Model statistics							
N	387	391	389	392	385	389	387
Adjusted R ²	0.20	0.49			0.21	0.49	
F	48.36***	187.58			34.79***	126.81***	
Independents ΔR ²	0.20***	0.49					
Mediator ΔR ²							
Chi square			31.79***	56.62***	0.01*	0.00	38.41***
Hosmer and Lemeshow			7.75	4.84			4.65
Nagielka R ²			0.11	0.20			0.13

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$.

^a Entries are standardised beta coefficients.

^b Entries are odds ratios.

B&H, Bullying and harassment; ITL, Intention to leave.

* $p < 0.05$ ** $p < 0.01$ *** $p < 0.001$.^a Entries are standardised beta coefficients.^b Entries are odds ratios.

B&H, Bullying and harassment; ITL, Intention to leave.

TABLE 3 *Positive reports of bullying policy implementation*

Interviewee	Quote
P11, manager	<i>I had consultant-to-consultant communication from that trainee's consultant about the incident, about the issues. They were very open to it. We spoke about the goods and the bads of the situation and possibly some mitigating factors. They were going to take it further and let me know.</i>
P7, target	<i>The manager stood by me, and she said, 'if I were you, I'd go to the bullying team and report what [the perpetrator] has done, because it's not really nice . . . I wrote a complaint to the manager and I'm quite happy the way the manager sorted it out.</i>

practice in the implementation of bullying policy. A central feature of these accounts were line managers who had proactively intervened in a conflict, resolving issues in an informal manner before a formal complaint of bullying or harassment was made, as per the advice in the policy document. Table 3 shows excerpts from interviews with individuals who expressed this view. In the first example in Table 3, a medical consultant describes a situation where one of her trainees had been involved in an altercation with an individual who was training with another consultant. In this instance, the manager noticed that her trainee appeared to be upset and discussed the issue with him. Despite describing some difficulties involved in approaching another senior member of staff regarding an issue such as bullying, the manager did this, resulting in the resolution of the situation. In the second example, a target of bullying describes approaching his manager when he felt bullied by another member of staff. His manager first tried to resolve the situation informally and, when this proved ineffective, encouraged the target to pursue a more formal means of resolution through the HR function, as per the advice provided by the policy. In terms of the Guest and Bos-Nehles framework, these examples provide evidence that in some cases of bullying within the organisation, managers chose to implement policy (stage three) in a high-quality fashion with the best interests of the member of staff at heart (stage four).

Conversely, however, a greater number of accounts of bullying featured managers who had failed to become involved in resolving the conflict, as illustrated by the examples in Table 4. In the first example, a junior member of staff describes a situation where she reported to her manager that she felt bullied, but was told by the manager that he was not responsible for issues relating to conflict with other staff. In the second example, a junior member of staff describes a situation where she reported being bullied by a colleague to her manager. However, the manager appeared worried that she would be implicated in the complaint and, as a result, attempted to dissuade the complainant from taking further action. Both of these situations are clear examples of a failure at stage three of the Guest and Bos-Nehles implementation framework. That is, managers simply chose not to implement the bullying policy. The third example, by contrast, shows a failure at stage four of the framework. Here, a nurse felt bullied by a colleague and approached her manager. When the manager failed to intervene informally in an effective fashion, the target decided to make a formal complaint. However, it appeared that the manager lacked the skills and motivation to be involved in the investigation and, as a result, there were several delays in the hearings, the target felt unsupported and the situation worsened. This example provides evidence of a failure at stage four of the implementation process; while the manager made some attempt to implement the policy, a lack of skills and motivation resulted in low-quality implementation.

TABLE 4 *Lack of implementation of bullying policy*

Interviewee	Quote
P6, target	<i>My manager agrees with me, but on two occasions he said 'sorry, I'm not your manager when it comes down to any problems with other colleagues. I'm only your manager when it comes down to the job.'</i>
P4, target	<i>I told her it was unacceptable how my immediate colleague was also treating me, and I told her that it can't go on . . . but she tried to dissuade me from making a complaint . . . she asked me if I'd made a complaint against her . . . then she warned me: if I had made a complaint I'd better answer her questions as it would come out.</i>
P9, target	<i>I put in a formal complaint about [the bully's] behaviour, and [my manager] said 'we're going to have a hearing,' and then she'd spoken to HR and she'd come back and said, 'we're not having a hearing, you need to do this and you need to do that.' [I said] 'look, I've just put in a complaint. Can you not just deal with it?'</i>

TABLE 5 *Attributions for lack of implementation of bullying policy*

Interviewee	Quote
P10, manager	<i>It's almost as though there are two sets of rules: there is the policy, and then there is different people's interpretation of that policy . . . senior people would be telling me: 'you can do this, but don't do that. Do the next bit, and maybe just let that go for a little while.' Then you start to think: 'if I let it go, am I protected? Do my senior managers think that I'm doing a bad job because I'm sticking to policy?</i>
P2, target	<i>For drug errors you get disciplined, and obviously you have two disciplinaries and you're out. I think it needs to be a bit stronger in that if [bullying] does happen and you get a warning, then that's it: we're not tolerating it . . . zero tolerance.</i>
P11, manager	<i>You can also waste a lot of time . . . this took a huge amount of time, and at one point I did think, God, here I, you know, I'm going to fall out with X, I'm going to fall out with Y, and I'm standing up for something that I believe in, is this the right thing to do? I thought it took a lot of courage.</i>
P1, target	<i>I feel that a lot of the supervisors in our place, especially the administrators . . . I'm sure they might have gone for training, but they don't really practise what they've learnt. They put personal friends before professional standards.</i>
P12, target	<i>My colleagues told me they made so many complaints about her to her manager, but she's just not willing to do anything because for her it's a hassle.</i>

Poor quality or non-existent policy implementation was attributed to a number of factors by interviewees, examples of which are shown in Table 5. These attributions fell into two broad categories. The first concerned difficulties which managers faced when attempting to implement policy, particularly where they lacked either the confidence or the time to do so. The issue of lack of management confidence as a barrier to implementation is illustrated by the first quote in Table 5, where a manager describes her attempts to follow the policy after an accusation of bullying from an individual in her team. The manager describes a situation where she was encouraged by senior managers not to follow the policy rigidly and, in particular, not to escalate the process as rapidly as the policy suggested. As a result, the manager lost

confidence in her ability to implement the policy. The second quotation in Table 5 provides further insight into why managers feel unsupported in implementing bullying policy. Here, an individual who perceived herself to be a victim of bullying notes that poor job performance in the hospital is tolerated far less than issues of staff conflict, suggesting that a zero tolerance approach should be taken to the management of bullying. In fact, the bullying policy document in the organisation does explicitly refer to a policy of zero tolerance, although this individual and others clearly believed that this was not actively enforced by managers. As a result, several interviewees raised the point that the organisation effectively tolerated a culture in which bullying behaviour was permitted as long as there was a focus on patient care, particularly because the policy did not appear to be followed by senior management, making policy implementation at a local level more difficult. A further important factor that prevented managers from implementing policy concerned time restraints, as illustrated by the third quotation in Table 5. Here, a senior consultant notes that implementation of the policy was so time consuming that she had considered not intervening when she witnessed one of her junior staff being bullied.

The second broad set of factors to which interviewees attributed poor management of bullying concerned management competency. Several participants, including those with management responsibility, felt that a lack of training in either conflict resolution or general leadership skills led to failures in policy implementation. One consequence of the lack of training reported by some participants was that managers failed to distinguish between managing their teams and forming personal relationships with team members, as illustrated by the fourth quotation in Table 5. Here, an individual who felt that she was being bullied by a colleague raised the issue with her manager, who failed to take action, either formally or informally. The target attributed this to the fact that her colleague and her manager were friends outside work, and the manager therefore felt unable to discipline the alleged perpetrator. Management competency was also described as a cause of poor policy implementation where managers were perceived to lack the motivation to manage cases of bullying. This point is illustrated by the final quote in Table 5, where a target of bullying describes a situation where several complaints of bullying were made to the manager of an individual who had exhibited a consistent pattern of hostile workplace behaviour. In the view of the target, however, the manager failed to act on the complaints because this would have been too much of 'a hassle'.

A number of perceived consequences of poor policy implementation emerged from the interviews, examples of which are shown in Table 6. First, several participants felt that a lack of management intervention had directly contributed to the development of bullying behaviour because perpetrators came to believe that the costs of their behaviour were low. Hence, the lack of policy implementation on the part of managers served to increase bullying, as illustrated by the first quotation in Table 6. A second perceived consequence of a lack of policy implementation was that the effects on targets were prolonged because they were left with few avenues of support when their immediate line manager was deemed to be tolerating the behaviour and, in some cases, was even the cause of it. This issue is highlighted by the second quotation in Table 6, where a new member of staff describes the isolation and stress she felt when her manager refused to act upon a reported incident of bullying from a colleague. Finally, interviews revealed that the experience of being bullied impacted upon the quality of care provided to hospital patients. Specifically, some staff reported that where a case of bullying was left unresolved, they felt less enthusiastic and motivated in their interactions with patients, as illustrated by the third quotation in Table 6. This implies that in this context, bullying has consequences for patients beyond its impact on the staff directly affected.

TABLE 6 *Consequences of lack of implementation of bullying policy*

Interviewee	Quote
P12, target	<i>Because she's not monitored, she gets away with things . . . and the more she gets away with things, the more she's going to do, and this is just a circle.</i>
P4, target	<i>I felt like I couldn't approach my line manager to talk to her, because I tried to do that . . . and she basically put a stop to me straightaway . . . I became withdrawn, I kept quiet, and I thought that I couldn't speak up because she'd knock me down. I thought 'grin and bear it until you learn the job and then you'll be able to cope better.' I felt demoralized, I felt humiliated . . . towards the end of the year I was very stressed out . . . I'd be in tears.</i>
P6, target	<i>If you are not relaxed and if you are not happy, your relationship with the patients is completely different . . . when you are with the patients you don't manifest that you are happy. You just perform, but your relationship is different.</i>

DISCUSSION

The research reported here has sought to understand how HRM affects outcomes. One stream of previous research has placed employee responses at the heart of the analysis and has shown that HR policy and practice can affect employee attitudes and behaviour, which in turn affects organisational performance (Nishii *et al.*, 2008; Messersmith *et al.*, 2011; Jiang *et al.*, 2012). The second approach to understanding the process whereby HRM affects outcomes addresses the implementation of HRM on the grounds that any impact is likely to be limited if good HR policy and practice is poorly implemented. A body of literature has acknowledged and emphasised this focus (Khilji and Wang, 2006; Wright and Nishii, 2013), but mainly as a general issue meriting further research. Some empirical work at a macro cross-organisational level has explored the effectiveness of HR implementation and shown that it has a greater impact on outcomes than the presence and content of practices (Guest and Conway, 2011). Guest and Bos-Nehles (2013) have taken this a step further by presenting a four-stage framework within which to analyse the HRM implementation process more systematically than in the past. The research presented here advances our understanding of the processes involved in HR implementation by utilising the framework to explore the implementation of a specific practice. It also utilises a case study approach to provide a more detailed analysis that informs us about the relative importance of the four stages of implementation and additionally sheds light on how and why each stage makes a difference. It therefore provides a fuller explanatory analysis and offers more detailed insights and guidelines for practice.

For this study, we chose to examine the specific topic of bullying and harassment in a health-care setting. This is an important and somewhat sensitive issue. It is also a topic on which there has been extensive research designed to identify good practice. The findings within the Guest and Bos-Nehles framework reveal that with regard to the first stage, the presence of a policy, there was a national expectation that each hospital would have a bullying policy. Turning to stage two of the implementation framework, local hospital management determined the quality of the policy, and the findings confirmed that bullying policy and practices at this hospital were in line with published recommendations regarding best practice. On this basis, it can be argued that the aspect of the implementation process for which the HR function has the primary responsibility has been effectively addressed; on the evidence of the existing literature, there is good policy and practice in place. However, the research revealed that at the third and fourth stages of implementation, there was a lack of consistency and quality of

application. This was reflected in the uneven levels of reported bullying across divisions and in the accounts of staff who had been bullied and of those with some responsibility for the management of bullying. While bullying policy and practice could be successfully implemented at a local level, there was more evidence of poor implementation. The major finding of this research, therefore, is that high-quality HR practices count for little if they are poorly implemented. In this specific case, there were rising reported levels of bullying even after a major review and organisation-wide reinforcement of the policy. The research revealed that those individuals who reported poor local support and a lack of faith in policy implementation reported higher levels of bullying, which in turn were related to poorer outcomes. This finding highlights the consequences of poor quality implementation.

One aspect of our results that warrants further discussion is the significant increase in reported rates of bullying between the 2006 and 2007 survey rounds. This may have been partly a consequence of the awareness campaign, which was implemented at the time. Awareness campaigns can result in more staff recognising unacceptable bullying behaviour, and may therefore be followed by increases in reported rates of bullying in surveys. Subsequently, these rates would be expected to decrease as the culture of reporting becomes more open, more complaints are dealt with informally and norms regarding acceptable behaviour become embedded in practice (Rayner and McIvor, 2008). The significant increase in reported levels of bullying between the 2006 and 2007 surveys could support this interpretation, although it should be noted that rates of bullying were already above average levels prior to the awareness campaign. However, the 2008 survey revealed further increases in bullying rates, and it is difficult to use the awareness campaign to explain this. A more likely explanation is incomplete implementation in several divisions.

The findings of this research raise several implications for practice in the implementation of bullying policy. If, as appears to be the case, the presence of 'best practice' HR for the management of workplace bullying is not leading to the intended results, then a different approach is required; this has implications for HR policy and practice more generally. The study suggests that while the presence of high-quality HR policies and practices is an essential antecedent to effective implementation, we need to pay more attention to the contextual factors that facilitate or inhibit implementation. Individuals perceived that managers lacked the skills, motivation or time to implement policy effectively. Importantly, some managers appeared to be receiving mixed messages regarding policy implementation, with a discrepancy between the advice in the policy document and the advice provided by senior divisional management, reducing their confidence to implement policy. The evidence also reveals divisional subcultures where issues such as bullying are treated with varying degrees of priority. In large highly complex professional bureaucracies such as acute hospitals, with a number of strong and potentially competing value systems as well as divisional and other subcultures, combined with highly pressured work and an understandable desire to focus on treatment of patients, careful staff management will not always receive high priority. However, our findings suggest that there are avenues through which organisations might tackle these issues. First, the findings suggest that firm organisational leadership and supporting policies will be required to create an environment where HRM is implemented fully and effectively. Local managers are more able to implement policy where they are supported in doing so from above. Hence, a policy must be supported from the top of the organisation if it is to be successful. Second, the research also highlights the role of line management in this respect. As Hope Hailey *et al.* (2005) have noted, they may be neither willing nor able to manage challenging staff issues and especially to deal with difficult, often barely visible forms of conflict such as bullying. Here, the support of local HR managers, perhaps in the guise of business partners, becomes important. As

Harrington *et al.* (2012) point out, trust between managers, HR professionals and employees is an essential component of a successful bullying policy. We also need to consider the wider range of HR policies and practices that might support effective implementation of bullying policy and the more general management of bullying. These include training and development but could be more fully reflected in appraisal, reward and promotion systems.

The research presented here highlights a range of issues and an extensive research agenda for the study of HR implementation. First, and importantly, it suggests that the four-stage analytic framework adopted to study the implementation of HR policy and practice has utility in highlighting the range of factors that must be taken into account. Moreover, our findings suggest that organisations wishing to audit the efficacy of HR policies should examine their implementation, and that the framework of Guest and Bos-Nehles (2013) provides an effective way of doing this. Second, our research suggests that case study methods are a useful way of examining issues around implementation of HRM because they are able to elucidate the causes and consequences of poor implementation, as well as the context in which it occurs. Finally, and with respect to the specific issue of bullying, it is important to note that there is still a marked absence of research on the effect of interventions. It can be difficult for HR professionals to recommend policy and practice with confidence in the absence of a strong evidence base for their efficacy (Rousseau and Barends, 2011), and more research is required in this area.

Future research on HR implementation might explore two issues in particular. The first would be to extend this type of detailed case study, with the distinctive insights it provides in comparison to the more conventional survey data, to other HR practices. These might include, for example, appraisal systems and performance-related pay, both of which have been the focus of extensive research but not within the kind of HR implementation framework utilised here. The second kind of research could build on the finding that there are marked variations in reported levels of bullying across the clinical divisions. This confirms that it was possible to implement the policies more effectively and maintain low levels of bullying. We were not able to explore the reasons for this but based on other research in the same setting, we would speculate that the top management in the division had a key role to play in shaping divisional culture and priorities. Some seem to have accorded a higher priority than others to the way in which the workforce was managed. This could be investigated more fully in future research, possibly utilising the concept of a 'strong' HR system outlined by Bowen and Ostroff (2004). They argue that a strong HR system is one which is highly distinctive, consistent and achieves consensus among relevant stakeholders, and they outline these characteristics in some detail. There is some preliminary evidence supporting the relevance of this perspective in health care (Stanton *et al.*, 2010).

There were a number of limitations to this research. The first is that the interview study sample was weighted towards individuals who perceived themselves to be victims of bullying, which may present issues for interpretation of the findings. For example, while the survey data indicates that bullying is higher in areas where policy was perceived as ineffective, it is possible in some cases that staff were simply critical of policy as a result of their experiences with bullying. The inclusion of a survey item to isolate witnesses of bullying could have negated this issue to some extent, as could the inclusion of more managers and witnesses in the interview phase. Unfortunately, however, the researchers had no control over the content of the survey, while recruitment to the interview phase was problematic because of the sensitive nature of the topic. A second limitation is that the surveys were cross-sectional, precluding claims for causality. Finally, the research was conducted in a single organisation. Caution must therefore be taken in generalising the study findings. Future research in this area might usefully examine whether similar findings emerge from different contexts such as private sector organisations.

CONCLUSIONS

This study demonstrates how good HR policies and practices can still get bad results. In doing so, it has highlighted the importance of HR implementation, and of using a systematic framework to analyse it. Our results further reveal the complex nature of the relationship between HR policy and practice and outcomes and reflect a need to adopt broader approaches to researching the way in which HR policy and practice influence both proximal and distal indicators of performance. This case has shown how this applies to the management of bullying, and it is likely to generalise to other areas of HR policy and practice.

If this research had been part of a typical study of the relationship between HRM and performance, with the standard focus on the presence of HR practices and organisational performance, then it would have revealed a strong positive association because the case study organisation is one of a number of world-class hospitals with excellent results when judged on standard clinical criteria. It is increasingly accepted that HRM has its impact on performance through the way in which it affects employee attitudes and behaviour (Jiang *et al.*, 2012). In this case, on a potentially important indicator of staff well-being, the results look less encouraging, as reflected in levels of bullying and in associated evidence of higher intention to quit, higher stress and lower satisfaction. By implication, the hospital could be performing even better. In conclusion, therefore, we argue that we need to include staff well-being as an outcome, and we need to pay particular attention to processes of implementation in seeking to improve our understanding of the relationship between HRM, well-being and performance. Indeed, the findings raise, once again, the question of how far HR practices can result in positive outcomes for both staff well-being and organisational performance.

Notes

1. Source: Beswick, Gore, & Palferman, 2006; British Medical Association, 2006; Lohro & Hilp, 2001; Rayner and McIvor, 2008; Rayner, Hoel & Cooper, 2001; <http://www.rcn.org.uk>; NHS Employers, 2006; Vartia and Leka, 2010, Rayner and Lewis, 2010.
2. Data are presented for 2007 only because of coding changes between survey rounds.
3. The available data for later years shows similar levels, although the focus here was limited to the years around the review and updating of policy and practice.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1 Variables used in the analysis.

Appendix S2 Interview schedule.

Appendix S3 Recommended inclusions for a best practice approach to the management of workplace bullying.

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