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Student Nurse Perceptions of Horizontal Violence During Clinical HOspital Rotations

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Phoebe Marie Burda

has been found to be complete and satisfactory in all respects,
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Walden University
2020

Abstract

Student Nurse Perceptions of Horizontal Violence During Clinical Hospital Rotations

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MSN, University of Central Florida, 2013

BSN, Western Carolina University, 1983

AA, University of Florida, 1980

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The nursing profession is facing its largest professional nurse deficit in history. With nursing schools unable to produce enough new nurses to replace the number of nurses retiring, it becomes increasingly important to retain as many nurses as possible within the profession. Nursing research literature has reported that up to 60% of newly registered nurses will leave their first job within their first year of practice citing *horizontal violence* as a contributing factor. The literature does not address if or how early student nurses might perceive exposure to *horizontal violence*. The purpose of this qualitative, interpretive, phenomenological study was to obtain student nurse perspectives of their lived experiences with *horizontal violence* during their clinical hospital rotations. The theory of cognitive adaptation supported the study by looking at students' ability to gain mastery, assign meaning, and restore self-esteem over events. This study used voluntary student nurse participation in an online survey. A total of 72 student nurses logged onto the survey, with 23 responding to the survey questions. The data analysis consisted of coding and thematic analysis. The research results show that student nurses are victims of *horizontal violence* from nursing staff and nursing leadership as early as their first clinical hospital rotation. Coping abilities of student nurses range from avoidance of the event to leaving the profession. Recommendations for change in professional nursing include changes in academic preparation and to clinical enculturation of student nurses. These positive cultural changes within academic and clinical nursing will help protect our student nurses from early attrition. Saving our students will decrease nurse turnover and improve patient outcomes resulting in positive social change for the nursing profession.

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Dedication

This dissertation is dedicated to my family and friends who have heard for years, "I can't because I have schoolwork." My father, Conrad, who looks down upon me with pride as he loved learning and education. My mother, Patricia, who continually encourages me to push through, hold my head high and obtain the education she has always dreamed of for both of us. My husband, Kurt, who has put up with years of isolation, tears, frustrations, and without whom I do not believe I would have ever completed this journey and accomplished this dream. Kurt, you always said, "if it was easy, everyone would have a PhD"! And, last but certainly not least, to my daughter, Patricia, who has always loved me unconditionally…. may this inspire you to never give up on your dreams! I love you all and thank you for your support.

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And finally, to Dr. Sandra Swearingen, my dear friend and mentor. You saw this possibility in me a long time ago (long before I did) and never stopped encouraging me to go further. Where shall we go next?

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Chapter 1: Introduction to the Study

Introduction

The American Association of Colleges of Nursing (AACN) (2014) projected a deficit of 1.05 million nurses by the year 2020. This deficit projection is due to a projected 19% growth in the workforce and not enough new nurses coming into the profession to replace the Baby Boomer generation retirements. Another factor contributing to this deficit was new nurses leaving the profession due to needless acts of *horizontal violence* (Goodare, 2015; Keeling & Templeman, 2013; Lee, Bernstein, Lee, & Nokes, 2014; Thompson & George, 2016; Weaver, 2013). Up to 60% of new nurses will leave their first position in nursing within the first year due to some form of *horizontal violence*; many of them will leave the profession entirely within the first year of employment (Bartholomew, 2014; Colduvell, 2017; Flateau-Lux & Gravel, 2014; Frederick, 2014; Goodare, 2015; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2015; Tee, Ozcetin, & Russell-Westhead, 2016; Walrafen, Brewer, & Mulvenon, 2012; Weaver, 2013). Although there are concerns for the attrition of new nurses from the profession due to *horizontal violence*, there was a deficit in the literature about perceptions of student nurses regarding their experiences with *horizontal violence* during hospital rotations.

According to the most recent Gallup (2018) poll, nursing ranked number one for ethical and honest standards in an occupation for the 17th year in a row. Bound by laws, the profession of nursing was one of the most trusted professions (Bowllan, 2015; Nixon, 2014). However, nurses were four times more likely to experience workplace violence

than professionals in other industries (Gallup, 2018). The Joint Commission (TJC) (2016) reported that this workplace violence had reached epidemic levels. The saying that *nurses eat their young* was still true in nursing as nurses continued to communicate feelings of being members of an oppressed workgroup (Birks et al., 2017; Coluvell, 2017; Courtney-Pratt, Pich, Levett-Jones, & Moxey, 2018; Dent 2017; Frederick, 2014; Granstra, 2015; Maryniak, 2015; Matheson & Bombay, 2007; Schneider, 2016; Weaver, 2013). In addition to the violence in the profession, there were large numbers of baby boomer generation nurses retiring, which was leaving the profession of nursing vulnerable to an increasing number of vacancies (AACN, 2014).

In Chapter 1, I focus on the background of *horizontal violence* in the profession of nursing, why its continued existence is a problem, the purpose of this research study, the research questions, theoretical support, and boundaries for this research inquiry. I conclude Chapter 1 by explaining the significance of this research study on the phenomenon of *horizontal violence* as it relates to the vulnerable population of student nurses.

Background

The term *horizontal violence* was familiar to most nurses although they may refer to it as *workplace violence, lateral violence, incivility, bullying,* or other negative terminology (Birks et al., 2017; Birks, Budden, Biederman, Park, & Chapman, 2018; Budden, Birks, Cant, Bagley, & Park, 2017; Christie & Jones, 2013; Courtney-Prat et al., 2018; Echevarria, 2013; Eilers, 2017; Flateau-Lux & Gravel, 2014; Lee et al., 2014; Maryniak, 2015; Park, Cho, & Hong, 2015; Pheko, 2018; Purpora, Cooper, & Sharifi,

2015; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Smith, Gillespie, Brown, & Grubb, 2016; Taylor, 2016; TJC, 2016; Weaver, 2013; Webster, Bowron, Matthew-Maich, & Patterson, 2016). The phenomenon of *horizontal violence* is overt (openly visible) or covert (secretly hidden) negative behavior in the workplace and regardless of the name, it was having a detrimental impact on the profession of nursing (Bartholomew, 2014; Christie & Jones, 2013; Courtney-Pratt et al., 2018; Eilers, 2017; Flateau-Lux & Gravel, 2014; Goodare, 2015: Koh, 2016; Maryniak, 2015; Rittenmeyer, Huffman, Hopp, & Block, 2013; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Weaver, 2013). Peers perpetrated *horizontal violence* upon peers, specifically preying on those considered vulnerable (Bartholomew, 2014; Chang & Cho, 2016; Christie & Jones, 2013; Rittenmeyer et al., 2013; Sanner-Stiehr & Ward-Smith, 2015; Taylor, 2016; Tee et al., 2016; Weaver, 2013; Webster et al., 2016). This phenomenon negatively impacted the individual nurse, organization, and profession (Bartholomew, 2014; Christie & Jones, 2013; Goodare, 2015; Koh, 2016; Lee et al., 2014; Matheson & Bombay, 2007; Roberts, 2015; Tee et al., 2016; Walrafen et al., 2012; Weaver, 2013).

Horizontal violence is known as a negative, problematic phenomenon within the profession of nursing (Bartholomew, 2014; Birks et al., 2018; Christie & Jones, 2013; Eilers, 2017; Flateau-Lux & Gravel, 2014; Goodare, 2015; Koh, 2016; Matheson & Bombay, 2007; Rittenmeyer et al., 2013; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2015; Smith et al., 2016; Taylor, 2016; Tee et al., 2016; TJC, 2016; Walrafen et al., 2012; Weaver, 2013). It is not only a problem in the United States but occurred throughout the

international nursing profession (Birks et al., 2017; Budden et al., 2017; Flateau-Lux & Gravel, 2014; Goodare, 2015; Koh, 2016; Park et al., 2015; Taylor, 2016; Tee et al., 2016). The most common behaviors identified as *horizontal violence* were verbal abuse, innuendos, humiliation, excessive criticism, infighting, sarcasm, intimidation, bullying, undermining, withholding information, scapegoating, broken confidences, gossip, incivility, and sabotage (Bowllan, 2015; Courtney-Pratt et al., 2018; Ebrahimi, Hassankhani, Negarandeh, Jeffrey, & Azizi, 2017; Echevarria, 2013; Eilers, 2017; Flateau-Lux & Gravel, 2014; Koh, 2016; Lee et al., 2014; Nixon, 2014; Pheko, 2018; Rittenmeyer et al., 2013; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Schneider, 2016; Weaver, 2013). TJC (2016) named five categories to recognize these behaviors, which were "threat to professional status, a threat to personal standing, isolation, overwork, and destabilization." Although many hospitals have implemented zero-tolerance workplace violence policies, new nurse orientation programs, and teamwork initiatives for existing staff, the culture of *horizontal violence* in nursing has seen little positive change (Courtney-Pratt et al., 2018; Potera, 2016; Sanner-Stiehr & Ward-Smith, 2015; Webster et al., 2016). The American Nurses Association (ANA, 2015) issued a position statement requiring all nurses to create an ethical culture where dignity, respect, and fairness are present for all persons. Unfortunately, there was still an unusually high number of new nurses who leave their jobs and the profession within the first year of practice, specifically as it related to acts of *horizontal violence*

(ANA, 2015; Bartholomew, 2014; Goodare, 2015; Karatas et al., 2017; Tee et al., 2016; Walfaren et al., 2012; Weaver, 2013).

There were two negative behaviors within the phenomenon of *horizontal violence* that received a lot of attention, incivility, and bullying. Incivility in nursing was found mostly in literature as it relates to nursing academia and stemmed from faculty to student, student to student, faculty to faculty, and student to faculty (Bowllan 2015; Cassum, 2018; Clark, Nguyen, & Barbosa-Leiker, 2014; Koharchik, 2018; Sauer, Hannon, & Beyer, 2017). The international issue of incivility in academia was increasing, in part due to generational changes on the part of the student and instructor belief that as a rite of passage students should be able to handle adversity to become a good nurse (Cassum, 2018; Natarajan & Muliira, J.K., 2018). Incivility was in clinical nursing but to a lesser extent (Bosllan, 2015; Smith et al., 2016). Bullying has received much attention in the media, especially as it related to students and school; however, the phenomenon was not only found in school but continued into the home and workplace (El Rahman, 2017; Granstra, 2015; Karatas, Ozturk, & Bektas, 2017). Bullying involved inequality of power between the bully and the victim and usually occurred two or more times per week over an extended period (Echevarria, 2013; Frederick, 2014; Lee et al., 2014; Purpora et al., 2015; Rittenmeyer et al., 2013; Roberts, 2015; Schneider, 2016; Wilson, 2016). Bullying was a behavior that repeatedly occurs (El Rahman, 2017; Smith et al., 2016). It is an abusive, aggressive form of behavior whose adverse effects have become increasingly severe (Bowllan, 2015; Karatas et al., 2017). Bullies sought out individuals with the

intent to cause harm (Granstra, 2015). Victims of bullying described the behavior as hostile and degrading (Courtney-Pratt et al., 2018; El Rahman, 2017; Smith et al., 2016).

Incivility differed from bullying in intent, intensity, and frequency (Smith et al., 2016). Incivility was at the lesser end of the *horizontal violence* spectrum, whereas bullying was said to be at the higher end (Purpora et al., 2015; Roberts, 2015; Schneider, 2016). Clark et al. (2014) suggested that incivility and bullying require further independent consideration. TJC (2016) included bullying as a form of disruptive behavior that led to increased medical errors and was detrimental to patient safety. Both incivility and bullying were complex phenomena with definitions and behaviors similar to *horizontal violence*; however, in the context of this study, they are both a symptom of the broader phenomenon of *horizontal violence* (Cassum, 2018; Frederick, 2014; Nixon, 2014; Roberts, 2015; Sauer et al., 2017).

The impact of *horizontal violence* on the profession of nursing is acknowledged, but what was not known is how student nurses perceive acts of *horizontal violence*, specifically through their lived experiences. A qualitative, phenomenological approach was the best method for researching the lived experiences of student nurses regarding *horizontal violence* experiences during their clinical rotations (Bradbury-Jones, Sambrook, & Irvine, 2011; Taylor, 2016; Wilson, 2014). The importance of researching student nurses was that results would contribute to the understanding of the high number of new nurses leaving within the first year of practice. The use of semistructured interviews, resulting in categorizing, coding, and theming was a suggested method of data collection by Chapman, Styles, Perry, and Combs (2010); Keeling and Templeman

(2013); and Taylor (2016). Their research looked at student nurse's adaptation, perceptions of professionalism, and attempting to understand the complexities of *horizontal violence*.

This study is important to the profession of nursing because having a better understanding of how student nurses perceived lived experiences of *horizontal violence* during their clinical hospital rotations provides insight into the early increasing attrition rate from the profession. Decreasing *horizontal violence* behaviors in nursing may decrease the attrition rate from the profession, thus improving patient outcomes and strengthening hospital organizations (Furst, 2018; Sanner-Stiehr & Ward-Smith, 2015; Walrafen et al., 2012; Weaver, 2013). Along with decreasing these negative behaviors within the profession of nursing, an opportunity to positively change the culture in nursing arises. Walden University (2018) defined *social change* as "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and societies." The results obtained from this study may lead to a positive social change by an increased body of knowledge of student nurse perception on exposure to *horizontal violence* during clinical rotations and the potential impact it may play in a student nurses continuing in the profession.

Problem Statement

The profession of nursing was facing a critical shortage of registered nurses due to the expansion of needed nursing services, boomer generation retirements, a low number of new nurses graduating from nursing schools, and by acts of *horizontal*

violence perpetrated upon new nurses (Bartholomew, 2014; Colduvell, 2017; Dunn, 2012; Frederick, 2014; Goodare, 2015; Tee et al., 2016; Thompson & George, 2016; Walrafen et al., 2012; Weaver, 2013). Student nurses were a needed commodity for becoming registered nurses and filling in some of the personnel shortages (Sanner-Stiehr & Ward-Smith, 2015). Student nurses who had a positive experience during their clinical rotations were more likely to seek employment in that unit where they felt accepted and nurtured (Bartholomew, 2014). Student nurse exposure to *horizontal violence* behaviors during their clinical rotations may affect their future in nursing (Tee et al., 2016). Budden et al. (2017) reported that up to 72% of Australian nurses had experienced *horizontal violence* in some form. If they decide to leave the profession, there will be a shortage of younger nurses in the clinical setting. In this study I explored what student nurses perceived about their clinical hospital rotations regarding experiences with *horizontal violence*. I examined whether they perceived the behavior as negative, or as a normal part of the culture of nursing. Positive culture change may result from this study by providing support for future research studies focusing on the creation of a more positive work environment for student nurses and improving the culture in the profession of nursing to reduce turnover.

Purpose of the Study

The purpose of this qualitative, interpretive phenomenological study was to explore student nurses' perceptions about their lived experiences with *horizontal violence* during their clinical hospital rotations. Student nurses voluntarily participated in an online survey regarding their perceptions of lived experiences with *horizontal violence*.

Research Question(s)

What are student nurse perceptions of *horizontal violence* experiences during their clinical hospital rotations?

Conceptual Framework of the Study

The conceptual framework for this study was Taylor's (1983) theory of cognitive adaptation. Taylor's theory had evolved since its start, but the originality of the 1983 model gives a robust framework on which to build this research study. The basis of this theory was to assign meaning to the experience, gain mastery over the event, and restore self-esteem (Taylor, 1983). Determining the meaning and essence of the lived experience of a phenomenon for a specific individual or group was the core question for a phenomenological study (Jack & Wibberley, 2014; Patton, 2015; Sloan & Bowe, 2014; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). The three tenants of this theory resonated with this research study aligning with the student nurse trying to understand the *horizontal violence* event, overcoming the experience, and maintaining the ability to continue in the profession. Without the impression that the event was significant, the student would not have the desire to gain mastery over the event. Some students could overcome the events more quickly than others and did not perceive the event as a threat (Taylor, 1983). Future research studies can use probing interview questions to reveal how student nurses perceived any influence the event had on their self-esteem. The results from this study contribute to current literature about new nurses leaving the profession early by adding insight on early negative experiences as a student nurse and the ability or nonability of the student to overcome the event.

Nature of Study

Qualitative Study

Qualitative research seeks to answer a deeper understanding of the relationship between a phenomenon and the person(s) of interest (Cypress, 2015; Padilla-Diaz, 2015). Analysis of human experiences, culture, and social phenomenon is based in the social sciences and used when a researcher wants to seek a deeper understanding of meanings or experiences of lived events by looking at the what, why, who, and how (Cypress, 2015; Patton, 2015). Hermeneutic phenomenology is an interpretive study approach that allowed researchers to understand how people engage with things around them, making it the best design approach for this study (Jack & Wibberley, 2014). Guided by one primary research question, I proposed probing with semistructured interview questions to gather data. Data collection in the form of an interview is a suggested method for a phenomenological approach to a qualitative study (Lockwood, Munn, & Porritt, 2015). I proposed recording the interviews, transcribed verbatim, and a review with research participants for accuracy. The participant review of their interview was member checking and helps to decrease researcher bias and increase the credibility of a qualitative research study (Ravitch & Carl, 2016). Analysis of collected interview data would result in themes. In this study I aimed to focus on the perceptions of nursing students' experiences with *horizontal violence* as relayed to me through an interview process. The face-to-face interview was the proposed method of data collection, but due to the COVID-19 pandemic, I conducted interviews using a survey format.

Data collection in the form of a survey was also a suggested method for a phenomenological approach to a qualitative study (Cypress, 2015; Ponto, 2015). I recorded the survey answers verbatim and reviewed them for accuracy. Analysis of collected survey data resulted in categories and themes. This study aimed to focus on the perceptions of nursing students' experiences with *horizontal violence* as relayed to me through an online survey process.

Definitions

The following definitions will add clarity to this study for the reader.

Bracketing: Putting aside researcher assumptions and life experiences that could bias the research study findings (Peat, Rodriquez, & Smith, 2019).

Clinical rotation: A core component of nursing education where students participate in supervised learning and have the opportunity to use information and skills learned in the classroom (University of Pittsburg, 2018).

Horizontal violence Any form of negative overt or covert behaviors perpetrated by peers upon peers, preying on those considered vulnerable (Bartholomew, 2014; Chang & Cho, 2016; Taylor, 2016; Tee et al., 2016).

Illusions: Looking at the known facts in a particular way to produce a positive result over mental and physical outcomes (Taylor, 1983).

Lived experience: How human beings interpret and process experiences. How they "perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (Patton, 2015).

Member checks*:* Method of validity for qualitative research where the researcher reconnects with the research participant to verify data and interpretation, therefore establishing credibility and trustworthiness (Ravitch & Carl, 2016; Yuksel & Yildirim, 2015).

Nursing deficit: The critical international challenge of a shortage of nurses caused by an increase in health care needs and a decrease in the number of nurses available to meet those needs (Sigma Theta Tau, n.d.).

Phenomenology*:* Discipline founded in philosophy, is a form of qualitative research that seeks to answer the meaning, structure, and essence of lived experiences of a phenomenon by a person or group of people (Patton, 2015).

Student nurse: Student in an educational program that leads to licensure as a registered nurse (RN) after practicing what they learned in the classroom by participating in clinical rotations that are supervised by a nursing instructor (Nursing Careers, 2016).

Assumptions

Assumptions are the beliefs that the researcher brings to their research before the beginning of their study (Creswell, 2012). The assumptions regarding student nurse experiences with *horizontal violence* leading to this research project were:

1. All subjects participated voluntarily and were willing to share personal information.
2. All subjects were comfortable with the survey questions.
3. All subjects told their stories honestly.

4. All subjects had heard the term *horizontal violence* and had some form of perceived experience to share.
5. All subjects report being exposed to *horizontal violence* during their clinical hospital rotations.

Scope and Delimitations

In this research study, I focused on obtaining a deeper understanding of what it means to experience *horizontal violence* as a student nurse during clinical rotations. I chose this research based on a gap in the literature, focusing on how student nurses feel about experiencing this phenomenon. Participants must have (a) completed at least one clinical rotation in the hospital, (b) been at least 18 years old, and (c) had some type of experience that they define as *horizontal violence*. I used a qualitative phenomenological approach to this study because I wanted to glean information about the student nurses' lived experiences. Participants were required to speak, write, and understand English as I am unable to interpret other languages. Student participation was voluntary. I had no affiliation with student grades or employment. Using the theory of cognitive adaptation allowed me to glean information about how the student processed and overcame the event that they describe as *horizontal violence*. Issues of curriculum and discipline in the academic setting of student education were not part of this study. The specific focus of this study allowed for reflection on *horizontal violence* among student nurses as a potential precursor to the early departure from the profession. Results from this study may apply to other professions where *horizontal violence* occurs and are using student internships before employment.

Limitations

The first expected limitation of this study was the ability to obtain enough student nurses to participate who understand *horizontal violence* and could identify what they perceived as *horizontal violence*. Students may believe that what they have experienced is part of the culture of nursing and believe that they need to conform to these behaviors to be a nurse, therefore not participating. To address this limitation, I was going to provide flyers, speak to hospital personnel who coordinate student rotations to identify the best time to connect with students and speak to faculty to elicit support for participation. Essential to the successful recruitment of participants would be the wording contained on the recruitment flyer. Changing from in-person interviews to survey interviews, I provided multiple emails and social media postings to encourage student nurses or those who knew student nurses to elicit support for participation. Essential to the successful recruitment of participants was the wording contained in my recruitment email. I believe that stating that I was a student nurse helped other students to participate.

The second limitation of this study would be reconnecting with participants for member checking for validation of information. Ravitch and Carl (2016) stated that member checks allow the researcher to explore their interpretation of the data adding more depth to researcher understanding. I would have addressed this limitation during the interview process by obtaining permission to contact them via email to confirm the accuracy of my interpretation of their shared information. I would allow 2 weeks for them to email me with any corrections before continuing with the data analysis.

A final limitation of this study was my lack of experience as a researcher. Being a novice researcher required that I examine any bias or preconceived ideas that I may have. Rubin and Rubin (2012) and Kelly-Quon (2018) suggested formulating interview questions to offset any biases the researcher may have. The mistakes that many novice interviewers make is to create barriers to communication between themselves and the participants (Gesch-Karamanlidis, 2015). There is an expectation on the part of the participant that the researcher can be trusted with the information shared and has enough knowledge to guide the interview process (Rubin and Rubin, 2012). Establishing trust through unbiased and answerable questions required intuition that many novice researchers do not possess (Kelly-Quon, 2018). Acknowledging my limitations will propel me to be a more responsible researcher. Early and repeated practice of my interview techniques will allow me to overcome some of the limitations that I may encounter as a novice researcher.

Significance

Earlier studies have explored *horizontal violence* in the profession of nursing. However, few studies have focused on the phenomenon in student nurses, especially concerning the student nurse perception and understanding of the phenomenon. This study had the potential to advance current knowledge of student nurse understanding of *horizontal violence*. It may have enabled changes to be made in the educational preparation of students as they prepare for transitioning from academia to clinical nursing. Additionally, reports of *horizontal violence* within the hospital from student nurses may allow for directed re-education of current staff nurses.

As the boomer generation, nursing workforce retires, focus on retention efforts of new nurses into the profession was critical for sustaining the profession. With the profession of nursing acknowledging the detrimental existence of the phenomenon of *horizontal violence* within the profession, the knowledge gained from this study will enable nursing professionals to enact change for a more positive, engaged clinical experience for student nurses. The goal of identifying *horizontal violence* in clinical rotations and improving nursing student clinical experiences allowed nursing professionals an opportunity to focus on creating a safe, conflict-free transition from academia to practice. A welcoming clinical environment came with hopes of decreasing the attrition of new nurses from the profession, thus creating a positive social change for the profession of nursing.

Summary

In Chapter 1 I included an introduction to the background, problem, and purpose of conducting a research study of the perceived experiences of *horizontal violence* by student nurses during their clinical hospital rotations, and the significance of this research to the profession of nursing. I also provided the research questions, definitions, limitations, scope, delimitations, and a theoretical foundation to guide the study. In Chapter 2, I will discuss a review of the existing literature on *horizontal violence* and the concepts supporting this study.

Chapter 2: Literature Review

Introduction

Governed by a code of ethics and recognized as a caring and compassionate profession, nursing suffered from the existence of negative behaviors, labeled as *horizontal violence*, which was driving nurses away from the profession (Koh, 2016; Nixon, 2014; Schneider, 2016; Weaver, 2013). Nurses were facing the most substantial nursing shortage in the history of the profession (AACN, 2014). With four generations in the workforce creating different work ethics, many new nurses were leaving the profession due to being victims of *horizontal violence* (Chachula, Myrick, & Yonge, 2015; Egues & Leinung, 2013; Goodare, 2015; Thompson & George, 2016; Weaver, 2013). Successful transition of student nurses into the profession was vital to the future of professional nursing (ANA, 2015; Bartholomew, 2014; Flateau-Lux & Gravel, 2014; Gardiner & Sheen, 2016; Goodare, 2015; Nixon, 2014; Sanner-Stiehr & Ward-Smith, 2015; Tee et al., 2016; Walfaren et al., 2012; Weaver, 2013). Positive student experiences may lead to successful clinical placement of the students into an environment where they felt cared for (Bartholomew, 2014; Weaver, 2013). Exposure to a culture of *horizontal violence* during clinical rotations may affect the student nurse's ability to cope and make a successful transition into the profession of nursing (Nixon, 2014; Tee et al., 2016; Weaver, 2013). The purpose of this qualitative, interpretive phenomenological study was to discover a deeper understanding of what student nurses perceive as their experiences with *horizontal violence* during their clinical hospital rotations.

Horizontal violence is a phenomenon documented as a negative influence within the profession of nursing (Bartholomew, 2014; Birks et al., 2018; Christie & Jones, 2015; Egues & Leinung, 2013; Goodare, 2015; Koh, 2016; Matheson & Bombay, 2007; Rittenmeyer et al., 2013; Tee et al., 2016; TJC, 2016; Walrafen et al., 2012; Weaver, 2013). *Horizontal violence* is negative behavior perpetrated by peers upon peers, especially peers who are vulnerable (Bartholomew, 2014; Chang & Cho, 2016; Christie & Jones, 2013; Koh, 2016; Rittenmeyer et al., 2013; Tee et al., 2016; Weaver, 2013; Webster et al., 2016). New nurses were a vulnerable population and the literature showed that up to 60% of new nurses leave their first job within the first year of employment with many of them leaving the profession entirely (Bartholomew, 2014; Colduvell, 2017; Flateau-Lux & Gravel, 2014; Frederick, 2014; Goodare, 2015; Maryniak, 2015; Tee et al., 2016; Walrafen et al., 2012). Weaver (2013) reported that a third of new nurses leave within the first year of employment. The excitement felt by new nurses entering the profession turned to dread and anxiety when they met the overwhelming responsibilities of the profession (Gardiner & Sheen, 2016; Goodare, 2015; Nixon, 2014). There was a lack of research surrounding how early exposure to acts of *horizontal violence* may occur with student nurses and if early exposure to *horizontal violence* may lead to the early departure from the profession (Sanner-Stiehr & Ward-Smith, 2015). The purpose of this study was to discover the common or shared experiences of student nurses' perceptions of *horizontal violence* from students who have participated in at least one hospital clinical rotation. Findings in this study regarding student nurse exposure to *horizontal violence*

will result in positive changes in the identification of how early the profession of nursing needs to focus on cultural improvements.

In Chapter 2, I show the results of literature search strategies, how the identification of crucial concepts supports this study, and the lack of information on student nurse perceptions of experiences with *horizontal violence* during their clinical hospital rotation. In this chapter, I review current research studies using the theory of cognitive adaptation to support the cognitive abilities of individuals to cope with and process events in their lives that have negatively impacted them.

Literature Search Strategies

Utilizing the Walden University Library, an extensive search produced a substantial amount of literature. Search criteria included peer-reviewed journals, English text, dissertations, and a 5-year search span of 2013 through 2018. Databases searched were CINAHL plus with full text, Medline with full text, ProQuest Nursing and Allied Source, Cochrane Database of Systemic Reviews, and Joanna Briggs Institute EBP database. Other searches conducted outside of Walden University library included Google, Google Scholar, books, and websites, including, but not limited to the ANA, American Association of Colleges of Nurses (AACN), Gallup, and TJC.

Search terms used were *horizontal violence, lateral violence, workplace violence, incivility, bullying, oppression, feminist and feminist theory, nurse as wounded healer, social change, student, student nurse, new nurse, and nurses eat their young.* I used search terms in multiple combinations to find a maximum number of qualifying articles noting and not duplicating the use of the same articles that may appear in different

searches. I searched the terms *theory of cognitive adaptation* and *Shelley Taylor* using all the aforementioned criteria minus a time frame for better utilization of how this theory originated and how it supports other research studies. Once screened for inclusion in this research project, I read and re-read articles for pertinent information and accuracy of the information and then used as a reference.

Conceptual Framework

The theory of cognitive adaptation (Taylor, 1983) guided, informed, and supported this research study. This theory basis is on the premise that perceived social support is more important than actual support and that social support is vital to the maintenance of health (Taylor, 2019; Taylor et al., 2004). Taylor's (1983) early experiences with her mother's death from cancer in 1974 influenced the development of this theory. The theory was developed by assessing the cancer patient's ability to sustain and modify current threats and perceived future threats to wellness (Taylor, 1983). Taylor (1983) stated that most people do not seek professional help but instead rely on social networking and individual relationships to overcome personal problems, thus supporting an individual's ability to produce illusions of current and future health. The theory proposed that adjustment to events centers around three tenets, which are searching for the meaning of the event, gaining mastery over the event, and restoration to self-esteem through positive self-enhancement or positive illusions (Taylor, 1983). Taylor (1983) proposed that the ability to overcome these three tenets rested on an individual's ability to form and maintain illusions.

The search for meaning after a traumatic event allowed someone to seek to understand the event and the impact it may have had in their lives (Taylor, 1983). The main focus of searching for meaning was to determine the significance that the event may have had on an individual's life (Taylor, 1983). Mastery of the event centers around gaining control to prevent a similar event from occurring again. Many persons believe that with mastery manifested in a mental realm, and by having a positive attitude, they can control what will happen in the future (Taylor, 1983). Mastery may involve making changes to their behavior by taking active steps to avoid the situation from happening again (Smith et al., 2016; Taylor, 1983). After assigning meaning and obtaining mastery, bolstering self-esteem through self-enhancement is the final step in overcoming negative events. People who have experienced a victimization event often present with decreased self-esteem. Self-enhancement is the process of acceptance and adjustment through comparison to others who have experienced a similar or worse event resulting in improved self-esteem (Taylor, 1983). If there are no real comparisons to draw from other people, the victim creates mental illusions to justify self-promotion (Taylor, 1983). A social comparison is relevant because it brings psychological processes together with clinical outcomes (Taylor, 1983). When illusions shatter because of a lack of control over situations, individuals become adaptable, self-protective, and functional (Taylor, 1983).

When people are unable to self promote, they often self-blamed and exhibit poor coping abilities (Taylor, 1983). By using social comparisons, a cognitive effort allows someone to pull themselves up into a position of positive reinforcement (Taylor, 1983). The crux of this theory is that people are adaptable and self-protective in the face of

adversity (Taylor, 1983). By creating positive mental illusions, people use cognitive, adaptive efforts of assigning meaning, gaining mastery, and self-promotion to overcome the event and continue moving forward with their lives (Taylor, 1983). Although Taylor's theory of cognitive adaptation originated in association with the ability of people to deal with clinical illnesses such as diabetes, cancer, and HIV, I proposed that the cognitive ability to overcome perceived or real events aligned with my study.

The first qualitative study to use cognitive adaptation theory about workplace violence in nursing was by Chapman et al. (2010). This study found that perceived meaning and mastery over an adverse event allowed individuals to make cognitive efforts to improve self-esteem. Results showed that assigning meaning to the event occurred in a sequential, logical matter of fact manner when explaining why the event occurred. Gaining mastery over the event was carried out through counseling, reporting the event, and not allowing themselves to be placed in the same situation again (Chapman et al., 2010). To boost self-esteem, nurses assigned positive evaluations to themselves, others, and the organization. Self-reflection showed that nurses felt that they could have handled the situation better (Chapman et al., 2010). By minimizing the adverse event, a person assigned a protective, positive value to their life through assigning positive illusions (Chapman et al., 2010). Pheko (2018) also found that mastery over the event occurred in an organized and sequential manner in his autoethnographic research. According to Pheko (2018), when an individual cannot make sense of the event, they experienced feelings of confusion and shame. Next, they approach the event, such as returning to work, with dread and apprehension.

The theory of cognitive adaptation (Taylor, 1983) and the findings in Chapman et al. (2010) directly relate to this research study. If students, as newcomers into a unit, perceive or experience a negative event of *horizontal violence*, but the social support in the unit is strongly positive, they may not have perceived the event as significant (Taylor, 2008). Social support was the belief that one is cared about and valued in a social network (Taylor, 2008). Emotional support and informational support were both forms of social support, which both show an ability to reduce stress and enhance well-being (Taylor et al., 2004). During the survey process, nursing students reported how they could have handled a situation better and how they will not place themselves in that situation again. These behaviors showed the tenets of cognitive adaptation through assigning meaning to the event, mastering the event, and overcoming the event through positive self-reflection.

Literature Review Related to Key Variables and Concepts

Horizontal violence is a negative part of the culture within the profession of nursing and has international recognition (Birks et al., 2017; Birks et al., 2018; Chachula et al., 2015; Goodare, 2015; Koh, 2016; Rittenmeyer et al., 2013; Taylor, 2016; Tee et al., 2016). *Horizontal violence* consists of negative behaviors that were overt or covert and occurred in the workplace (Bartholomew, 2014; Christie & Jones, 2013; Goodare, 2015; Koh, 2016; Rittenmeyer et al., 2013; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Taylor, 2016). *Horizontal violence* is one of several reasons that nurses, especially new nurses, leave the profession (Bartholomew, 2014; Colduvell, 2017; Frederick, 2014; Goodare, 2015; Tee et al., 2016; Walrafen et al., 2012;

Weaver, 2013). Although organizations and institutions have issued statements of zero tolerance, these behaviors continue to exist (ANA, 2015; Budden et al., 2017; Koh, 2016; Potera, 2016; Rittenmeyer et al., 2013; TJC, 2016; Weaver, 2013; Webster et al., 2016). This research study describes a deeper understanding of what it means to experience the phenomenon of *horizontal violence* as perceived by student nurses during their clinical hospital rotations. Significant to their stories is their ability to positively or negatively cognitively process what they have experienced.

The literature search yielded five specific themes regarding *horizontal violence* in the nursing profession. The first theme examines violence in nursing, both physical and psychological, with explanations of why violence is prevalent. The second theme explores the historical prevalence of *horizontal violence* in nursing and why the profession is susceptible to these behaviors. The third theme describes the impact of *horizontal violence* on the individual, organizational, and professional levels of nursing. The fourth theme involves vulnerable populations described as those groups of people who were most susceptible to the acts of *horizontal violence*. The final theme coveres student nurses and *horizontal violence*. The results of these themes revealed in the literature, allowed this researcher to recognize the lack of information available surrounding the student nurse's perception of *horizontal violence* experiences during their clinical hospital rotations.

Violence in Nursing

The media portrays violence in all aspects of daily lives with global increases in workplaces, impacting all cultures, races, and ages (Hopkins, Fetherston, & Morrison,

2014). Workplace violence is any form of intentional violence directed at someone while they are working (Koh, 2016; Papa & Vanella, 2013; Sanner-Stiehr & Ward-Smith, 2015). Workplace violence had the potential to exist in any workplace resulting in many injuries and death (Hopkins et al., 2018; Lee et al., 2014). Healthcare settings have reported three times greater rate of workplace violence than private industries, and it is a global issue (Christie & Jones, 2013; Hopkins et al., 2018; Papa & Vanella, 2013; Potera, 2016; Samadzadeh & Aghamohammadi, 2018). Industries, especially those in healthcare are at higher risk of violent behaviors because of extended contact with the public (Hopkins et al., 2018; Koh, 2016; Lee et al., 2014; Johann & Martinez, 2017; Papa & Vanella, 2013; Samadzadeh & Aghamohammadi, 2018). In the United States, 45% of all workplace violence occurs in the healthcare setting (Hopkins et al., 2014). Eighty percent of reported violent acts in a healthcare setting occurr in the emergency department with reporting from other high-stress areas such as labor and delivery, pediatric units, and mental-health areas (Hopkins et al., 2018; Papa & Vanella, 2013; Park et al., 2015; Samadzadeh & Aghamohammadi, 2018). Hostile work environments are toxic emotionally, spiritually, and psychologically (Sanner-Stiehr & Ward-Smith, 2013).

Nursing is a demanding profession where nurses make up the largest population of healthcare providers making them the most susceptible to acts of violence (Birks et al., 2018; Christie & Jones, 2013; Dunn, 2012; Gardiner & Sheen, 2016; Hopkins et al., 2014; Hopkins et al., 2018; Wilson 2016). Up to 50% of nurses and students reported physical or verbal abuse by patients and or their family members (Hopkins et al., 2018; Maryniak, 2015; Papa & Vanella, 2013; Park et al., 2015; Potera, 2016; TJC, 2016).

Hopkins et al. (2018) reported that 100% of nurses would be a victim to some form of violence at least once in their career. These violent behaviors stem from an individual's lack of control over their situation and reliance upon healthcare workers (Birks et al., 2018; Christie & Jones, 2013). Contributing to the propensity for violence is increased patient acuity with heavy workloads and low staffing levels (Birks et al., 2018; Chachula et al., 2015; Christie & Jones, 2013; Goodare, 2015; Park et al., 2015). Acuity and staffing levels are coupled with the increased cost to provide healthcare and a focus on reducing healthcare expenditure (Birks et al., 2018; Budden et al., 2017; Koh, 2016; Papa & Venella, 2013). These characteristics lead to an increase in poor communication and strained interpersonal relationships, resulting in acts of violence (Birks et al., 2018; Christie & Jones, 2013). Students are exposed to some form of violence during their clinical rotations due to the increased violence reported from within the profession of nursing (Hopkins et al., 2014). Acknowledging that the profession of nursing was susceptible to an alarming amount of physical violence, the purpose of this study was to focus on non-physical violence.

When the violence comes from peers and other staff members, it is usually non - physical violence with the percentage of reported abuse increasing to as much as 75% (Birks et al., 2018; Koh, 2016; Maryniak, 2015; Papa & Vanella, 2013; Park et al., 2015). Eilers (2017) stated that 80% of nurses had experienced some form of *horizontal violence,* with an even higher percentage having witnessed these acts. These acts of violence were termed *horizontal violence*, *lateral violence*, *bullying*, *workplace violence,* and *incivility,* and are referred to as *nurses eat their young* (Birks et al., 2018; Christie &

Jones, 2013; Koh, 2016; Kumaran & Carney, 2014; Lee et al., 2014; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Schneider, 2016; Taylor, 2016; Weaver, 2013). The overall organizational culture drives leadership styles creating a breakdown in workflow and communication amongst staff (Birks et al., 2018; Christie & Jones, 2013; Koh, 2016; Lee et al., 2014; Maryniak, 2015; Weaver, 2013). The hierarchical structure of nursing creates an environment of seasoned nurses who believe that they had the power over younger nurses who must experience their rite of passage into the profession of nursing (Birks et al., 2018; Eilers, 2017; Furst, 2018; Koh, 2016; Kumaran & Carney, 2014; Rush, Adamack, Gordon, & Janke, 2014; Nixon, 2014; Schneider, 2016; Smith et al., 2016; Weaver, 2013; Wilson, 2016). Perpetrators possess age and experience, whereas the victim demonstrates a personality of depression and anxiety, making them most susceptible to acts of *horizontal violence* (Koh, 2016; Maryniak, 2015; Weaver, 2013). The culture of the organization and leadership supports the acts of *horizontal violence*, protecting the perpetrator, and teaching the new staff that they will become perpetrators if they want to fit in (Koh, 2016; Sanner-Stiehr & Ward-Smith, 2015; Schneider, 2016; Weaver, 2013; Wilson, 2016). Rush et al., 2014), Goodare, (2015), and Echevarria, (2013) reported that nurses who have reliable support systems at work would have decreased absenteeism and higher job satisfaction when *horizontal violence* was present than nurses who do not have support. It is vital to support and mentor our new staff to be successful or the nursing profession will lose them (Chachula et al., 2015).

Historical Prevalence

Traditionally, nursing is a hierarchical profession reflecting a profession of order and obedience (Birks et al., 2017). When restraints and limitations define a profession through obedience, it is oppression (Rooddehghan, Yekta. & Nasrabadi, 2015). Nursing is a profession existing internationally in oppression (Rooddehghan et al., 2015). Paulo Freire (1970) introduced a theory of oppression where he outlined oppression as one individual or group having overwhelming control over another individual or group. He described this imbalance of power as a historical reality in work settings where the more experienced person must pour knowledge into others who are new to the learning, but in the process, they try to control thinking and actions (Freire, 1970). This oppression leads to a reduction of critical thinking and problem-solving abilities of the new workforce (Freire, 1970). *Horizontal violence* fuels the historically embedded oppressed group behavior in nursing (Budden et al., 2017; Courtney-Pratt, 2018).

Roberts (1983) is the first person to introduce the theory of oppression to the field of nursing as an explanation of how nurses assimilate into the profession. Historically, being a physician was a male dominate role while being a nurse was a female subordinate role creating a long-standing culture of the power imbalance between physicians and nurses where nurses did not have autonomy of practice (Balanon-Bocato, 2018; Lee et al., 2014; Matheson & Bombay, 2007; Rittenmeyer et al., 2013; Roberts, 1983; Weaver, 2013). It was not until the 1980s that nursing education moved to the universities out of physician-dominated education hospitals (Gardiner & Sheen, 2016). Rittenmeyer et al. (2013) stated that the basis of oppression in nursing are apparent in the political,

historical, and cultural structure of an organization. This oppression creates a culture where these behaviors are considered part of the reality of nursing and not questioned (Balanon-Bocato, 2018; Courtney-Pratt et al., 2018; Maryniak, 2015; Rooddehghan et al., 2015; Weaver, 2013). Weaver (2013), Lee et al. (2014), and Rooddehghan et al. (2015) reported that nurses continue to have both real and perceived oppression, mainly from existing in a profession governed by physicians and administrators. The continued oppression in nursing has the power to erode the nurse as a professional (Chachula et al., 2015; Rooddehghan et al., 2015). According to Roberts (2015) and Balanon-Bocato (2018), when senior nursing staff holds and acts upon informal power, they prevent the group from becoming organized and from developing unity, thus perpetuating the oppression.

Feminism has also equated the oppression of women with being victims of suppression and violence. Feminism is about activism to achieve equality between the sexes and is a form of political positioning (Green, 2012). Feminist theory is an extension of feminism into a theoretical, philosophical theory focused on looking at gender equality (Crossman, 2019; Green, 2012). The hierarchical imbalance of power of physician over nurse allows the suppression of women and the continued existence of aggressive acts (Chachula et al., 2015; Courtney-Pratt, 2018; Granstra, 2015). El Rahman (2017) reported that it is common to see men being more aggressive with men and women with women. The significance of the feminist theory in nursing is that women outnumbered men by an average of 10:1 in nursing (Becker's Hospital Review, 2015). Questions of an imbalance of power within the profession of nursing impacts the stability of the

organization (Green, 2012). Feminism supports the movement from power over others to an environment of power with others (Green, 2012).

Dating back to days of Greek mythology, the theory of caregivers as wounded healers appears in the professions of psychiatry, psychotherapy, and religion (Christie & Jones, 2013; Conti-O'Hare, 2002). The belief is that all humans have experienced some trauma in their lives that drives their behavior (Christie & Jones, 2013). The drive to heal oneself is one of the most basic human qualities (Conti-O'Hare, 2002). Describing the nurse as walking wounded, Conti-O'Hare (2002) introduced the theory of nurses as a wounded healer as a way for the profession of nursing to heal itself. The steps of this theory consisted of recognition, transformation, transcendence, walking wounded, and wounded healers (Conti-O'Hare, 2002). The term walking wounded describes nurses who have an ineffective coping ability and work with unresolved personal trauma (Conti-O'Hare, 2002; Sanner-Stiehr & Ward-Smith, 2015). This trauma may project onto patients and other staff (Conti-O'Hare, 2002). When nurses suffer due to overwhelming pain, there is a compromise in their well-being (Dunn, 2012). The ability of the nurse to transcend over their sufferings allows them to build therapeutic relationships with others (Christie & Jones, 2013; Sanner-Stiehr & Ward-Smith, 2015). Relating to *horizontal violence*, the process of healing in this theory is either one-on-one or as a group (Christie & Jones, 2013). Because *horizontal violence* is subjective, reflective practice occurs at each step allowing for gaining insight into the traumatic event and to themselves (Sanner-Stiehr & Ward-Smith, 2013).

The theory of cognitive adaptation aligns with theories of nurses overcoming oppression, feminism, and wounded healers in nursing practice. Freire (1970) stated that it is when the oppressed become involved in their struggle for equality, that they will begin to believe in themselves. According to Taylor (2008), the perception that the work environment is nurturing decreases turnover and supports coming to work. Working in a supportive culture allows people to interpret potentially stressful encounters as a challenging event or a chance to learn (Taylor, 2008). Taylor (2008) stated that positive social support is most important to newcomers within the organization.

Impact of *Horizontal Violence*

Horizontal violence has a lasting impact on the individual, the organization, and the community when left unresolved (Lee et al., 2014; Maryniak, 2015; Sanner-Stiehr & Ward-Smith, 2015; TJC, 2016; Weaver, 2013). These negative behaviors are a topic of import for over two decades in the profession of nursing (El Rahman, 2017; Roberts, 2015; Rush et al., 2014). The degradation of others through verbal confrontations and cruel acts results in a wide array of adverse outcomes (Christie & Jones, 2013; Koh, 2016; Rittenmeyer et al., 2013; Sanner-Stiehr & Ward-Smith, 2015; Weaver, 2013). Chachula et al. (2015) reported that 15-20% of nurses have a sensitive nature making them more susceptible to becoming overwhelmed more quickly and easily susceptible to acts of *horizontal violence*. Constant change, authority structures, and financial cutbacks are all contributing factors to the continued acts of *horizontal violence* in nursing (Courtney-Pratt et al., 2018).

Individual impact. The impact on individuals experiencing *horizontal violence* are psychological and physical, with some victims experiencing a wide array of both. Psychological adverse outcomes reported by individuals are lack of self-confidence, job insecurity, difficulty forming relationships with peers, and manifestations of physical illnesses (Chachula et al., 2015; Christie & Jones, 2013; Echevarria, 2013; Goodare, 2015; Koh, 2016; Lee et al., 2014; Maryniak, 2015; Papa & Vanella, 2013; Purpora et al., 2015; Sanner-Stiehr & Ward-Smith, 2013; Weaver, 2013; Wilson, 2016). Victims of *horizontal violence* reported feeling isolated, powerless, and not valued (Christie & Jones, 2013; Egues & Leinung, 2013; Lee et al., 2014; Maryniak, 2015; Nixon, 2014; Sanner-Stiehr & Ward-Smith, 2013; Weaver, 2013; Wilson, 2016). Some of the most common physical complaints of victims are headaches, stress, worry, sleep deprivation, exhaustion, depression, and inability to concentrate with many of these symptoms occurring simultaneously (Bowllan, 2015; Christie & Jones, 2013; Courtney-Pratt et al., 2018; Egues & Leinung, 2013; Granstra, 2015; Goodare, 2015; Karatas et al., 2017; Koh, 2016; Levette-Jones, Pitt, Courtney-Pratt, Harbrow, & Rossiter, 2015; Roberts, 2015; Weaver, 2013; Wilson, 2016). New nurses report experiencing stress through burnout, bullying, and feeling unprepared for a significant amount of responsibility placed upon them (Echevarria, 2013; Gardiner & Sheen, 2016; Karatas et al., 2017). The persistence of these negative behaviors lead to damaging and irrevocable effects on nurses (Hopkins et al., 2018; Lee et al., 2014; Rooddehghan et al., 2015). The continued existence of chronic psychological or physical ailments potentially results in increased depression, post-traumatic stress disorder and attempted suicide (Bowllan, 2015; Courtney-Pratt et

al., 2018; Egues & Leinung, 2013; Koh, 2016; Lee et al., 2014; Levette-Jones et al., 2015; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2015; Weaver, 2013; Wilson, 2016). Weaver (2013) stated that when nurses leave the profession due to *horizontal violence*, it is unfortunate, but when they take their lives, it is a tragedy.

Chachula et al. (2015) reported that in Canada, a review of the literature shows the reasons nurses are leaving the profession are job satisfaction, exhaustion and burnout, and environmental quality. In Iran, Rooddehghan et al. (2015) reported similar findings with the inclusion of severe nursing shortages as a reason for leaving the profession. Taylor (2016) reported five themes in her qualitative study regarding nurse's perception of *horizontal violence* in practice environments as being: negative behaviors minimized and not recognized, nurses afraid to report, skills of isolation and avoidance, nurses have a lack of respect and support, and organizational chaos exist making reporting irrelevant to the more significant issues within the hospital. These findings are consistent with other studies by Birks et al. (2018) and Rittenmeyer et al. (2013). It is reasonable to assume that if nurses have these themed issues, that they, approach newcomers with decreased self-confidence and impaired professional identity (Furst, 2018).

Organizational impact. The collective individual costs of health and turnover result in organizational issues of decreased patient satisfaction, increased employee health cost, and increased spending for recruiting (Dunn, 2012; Lee et al., 2014). The results of physical and psychological impairments to the victims of *horizontal violence* on the organization are an increase in absenteeism, low staff morale, and increased turnover (Chachula et al., 2015; Christie & Jones, 2013; Eilers, 2017; Egues & Leinung, 2013;

Granstra, 2015; Karatas et al., 2017; Koh, 2016; Papa & Vennela, 2013; Potera, 2016; Roberts, 2015; Taylor, 2016; TJC, 2016). Comorbidities and increasing acuity levels of patients leave staff feeling physically and mentally exhausted (Gardiner & Sheen, 2016). Reduced levels of commitment and motivation result in increased workplace errors (Flateau-Lux & Gravel, 2014; Wilson, 2016). Safety and quality of patient care are at risk as *horizontal violence* behaviors increase and peer communication decrease (Courtney-Pratt et al., 2018; Dunn, 2012; Echevarria, 2013; Eilers, 2017; Flateau-Lux & Gravel, 2014; Gardiner & Sheen, 2016; Koh, 2016; Lee et al., 2014; Matheson & Bombay, 2007; Purpora, Blegen, & Stotts, 2015; Roberts, 2015; Rooddehghan et al., 2015; Rush et al., 2014; Sanner-Stiehr & Ward-Smith, 2013; Schneider, 2016; Taylor, 2016; TJC, 2016; Webster et al., 2016). A lack of workforce, job ambiguity, stressful work environments, and poor leadership are common themes in organizations that have a high incidence of *horizontal violence* (Koh, 2016; Maryniak, 2015; Sanner-Stiehr & Ward-Smith, 2013). Organizational chaos is a term used to describe the environment in many hospitals as communication breaks down (Echevarria, 2013; Eilers, 2017). In an organization with chaos, there is an increase in workplace errors which may go unreported due to fear and embarrassment (Birks et al., 2018; Eilers, 2017; Flateau-Lux & Gravel, 2014; Koh, 2016; Tee et al., 2016; Weaver, 2013; Wilson, 2016). Chaotic work environments give legitimate power to acts of *horizontal violence* (Pheko, 2018).

Increased incidences of *horizontal violence* results in lack of reporting and an increase in patient errors due to fear of reprisal, the belief that nothing will ever change, and that the perpetrators will remain protected (Christie & Jones, 2013; Echevarria, 2013;

Eilers, 2017; Koh 2016; Sanner-Stiehr & Ward-Smith, 2015; Weaver, 2013). The psychological stress experienced by the victims of *horizontal violence* not only leads to high turnover rates but to an increased premature exodus from the profession (Christie & Jones, 2013; Echevarria, 2013; Egues & Leinung, 2013; Potera, 2016; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2013; Sanner-Stiehr & Ward-Smith, 2015; Schneider, 2016; Wilson, 2016). Increased recruitment and retention efforts are necessary for the organization when *horizontal violence* behaviors are high (Egues & Leinung, 2013; El Rahman, 2017; Furst, 2018; Koh, 2016; Papa & Venella, 2013; Potera, 2016; Sanner-Stiehr & Ward-Smith, 2015; Taylor, 2016).

Community impact. The impact of *horizontal violence* leads to a negative organizational reputation within the community (TJC, 2016). Increased lawsuits, staff disability claims, and loss of profits are all a result of the erosion of the relationships between organization and community (TJC, 2016). Estimates are that every litigated case cost $3.1 million per person per incident, and this does not include the indirect costs such as lost time from work, medical leaves, and time and attendance (Papa & Venella, 2013). Negative publicity was another variable that is hard to quantify, but it can have long term effects on an organization (Papa & Venella, 2013). Actions of nurses can cost the organization both reputation and financial stability (Echevarria, 2013; Sanner-Stiehr & Ward-Smith, 2015; Weaver, 2013). The estimated cost of replacing one nurse can be as much as $110,000.00. As turnover increased, many hospitals find themselves faced with financial burdens too substantial to overcome, and this leads to the possibility of closing their doors (TJC, 2016). It is difficult to put a dollar amount on the cost, but when

hospitals suffer financially, the cost to the community is far-reaching (Echevarria, 2013; Koh, 2016; Papa & Venella, 2013).

Vulnerable Populations

The term *nurses eat their young* is an example of the vulnerable nature of new nurses into the profession of nursing (Kumaran & Carney, 2014). Nurses with less experience are at a higher risk of experiencing *horizontal violence* from peers (Birks et al., 2018; Budden et al., 2017; Flateau-Lux & Gravel, 2014; Johann & Martinez, 2017; Park et al., 2015; Sanner-Stiehr & Ward-Smith, 2015; Taylor, 2016; Weaver, 2013). Reports of nurse bullying upon vulnerable populations exists internationally with issues reported in Egypt, Australia, Italy, and the United Kingdom (Birks et al., 2018; Roberts, 2015). The United Kingdom and New Zealand have the most research about new nurses and *horizontal violence* (Flateau-Lux & Gravel, 2014). In studies conducted in Australia and United Kingdom, by Birks et al. (2017) and in the United States by Furst (2018), age, gender, and sex of the student do not make a difference in experiences of bullying, but ethnicity does impact experiences. Furst (2018) found that age, gender, ethnicity, and degree are all correlating factors with intent to leave the profession.

Many senior staff nurses believe that it is their right to have authority over new staff, even when they do not have management authority, and this becomes harmful to those with less experience (Koh, 2016; Granstra, 2015; Weaver, 2013). New graduate nurses report having learning opportunities blocked and given too much responsibility with no support (Budden et al., 2017; Nixon, 2014; Rittenmeyer, 2015; Roberts, 2015). When new nurses are assimilating into practice, they experience high levels of stress.

When met with *horizontal violence* from staff, new nurses are at risk of skill and competency development and delayed the advancement of critical thinking skills (Lee et al., 2014; Nixon, 2014; Rush et al., 2014). New graduate nurses report insensitivity, coupled with a lack of respect from existing staff members (Nixon, 2014; Rush et al., 2014). The path from novice to competent nurse suffers, which delays improvement in patient care and outcomes (Gardiner & Sheen, 2016). The sacrifice of professional competence and the reputation of a new nurse disrupts growth into professional identity (Lee et al., 2014).

Student nurses are also a vulnerable population who are susceptible to acts of *horizontal violence* (El Rahman, 2017; Keeling & Templeman, 2013; Smith et al., 2016; Taylor, 2017; Webster et al., 2016). Clinical placements are part of the core training for student nurses where they learn to apply their classroom and simulation learning to the real world of nursing (Birks et al., 2018; Gardiner & Sheen, 2016; Nixon, 2014). Students report a mix of feelings when entering the clinical environment ranging from joy and pride to stress and anxiety (Birks et al., 2017; Birks et al., 2018; Budden et al., 2015; Goodare, 2015; Nixon, 2014; Levette-Jones et al., 2015). Characterized by low confidence and poor communication skills, students look to experienced staff for proper guidance (El Rahman, 2017; Gardiner & Sheen, 2016; Webster et al., 2016). When nursing students lack a connection with a mentor, they made more mistakes and have difficulty in distinguishing behaviors that are appropriate or inappropriate in the workplace (Budden et al., 2017; Schneider, 2016). Additionally, student nurses report feelings of low self-esteem by being ignored or feeling unwelcomed by staff nurses

(Levette-Jones et al., 2015; Smith et al., 2016; Webster et al., 2016). Many student nurses say that many of these behaviors start in nursing school with nursing faculty (Birks et al., 2017; Rittenmeyer, 2013; Schneider, 2016). This confusion leads to a lack of confidence and behaviors that mimic the professional behaviors seen (Keeling & Templeman, 2013; Schneider, 2016). Students report not speaking up due to fear of retaliation or receiving poor grades (Balanon-Bocato, 2018; Birks et al., 2018; Courtney-Pratt et al., 2018; El Rahman, 2017; Levette-Jones et al., 2015).

Ritttenmeyer et al. (2015) and Koh (2016) reported that although *horizontal violence* is widespread throughout the profession of nursing, those most likely to report these incidences are those most vulnerable, specifically student nurses, new nurses, and older nurses. Females are more likely than males to report acts of *horizontal violence* because men are more concerned with guilt and embarrassment than the violent act (El Rahman, 2017). Australian students reported behaviors such as eye-rolling, name-calling, and exclusion during their clinical placements (Birks et al., 2018; Taylor, 2017). Some student nurses report that when they do speak up, they heard that no one cares and that they may not be able to get a job if they cause problems (Birks et al., 2018; Budden et al., 2017; Courtney-Pratt et al., 2018; El Rahman, 2017; Nixon, 2014; Taylor, 2016). The most common response to *horizontal violence* for vulnerable nurses instead of reporting is to do nothing or take part in the negative behaviors themselves (Balanon-Bocato, 2018; Birks et al., 2017; Bowllan, 2015; Karatas et al., 2017; Rittenmeyer 2013; Webster et al., 2016). New nurses take part in the behavior because *horizontal violence* is a learned behavior (Sanner-Stiehr & Ward-Smith, 2013). There is a logical assumption that if

student nurses rotate through adverse practice environments with a staff who have low self-esteem and decreased job satisfaction, the result would be increased new nurse dissatisfaction with the profession of nursing as a career choice and increased possibility of early attrition from the profession (Furst, 2018). No literature has confirmed this connection (Furst, 2018).

Student Nurse and *Horizontal Violence*

The profession of nursing has a high incidence of violence, but there is not much information on the exposure student nurses incur during their clinical experiences (Budden et al., 2017; Samadzadeh & Aghamohammadi, 2018). The confusion over a clear definition of what constitutes *horizontal violence* prevents the profession from assessing the scope of the problem in nursing students (Hopkins et al., 2018; Smith et al., 2016). Furthermore, student nurses require more supervision, but most organizations do not have clear boundaries regarding nursing student responsibilities during clinical rotations making them more susceptible to acts of violence (Kumaran & Carney, 2014; Samadzadeh & Aghamohammadi, 2018). Ten percent of Australian nursing students reported that they do not know if they experienced *horizontal violence* (Budden et al., 2017). Although students are not able to articulate being victims of *horizontal violence*, they do report their enthusiasm for the profession has diminished (Keeling & Templeman, 2013). This diminished enthusiasm results when the responsibility of the real world replaces their ideal world of what they thought about nursing (Jack & Wibberley, 2014; Kumaran & Carney, 2014; Levette-Jones et al., 2015).

During clinical rotations, students are guests with specific learning directives and limited time frames (Wilson, 2014). Clinical placements are a time for nursing students to seek the meaning of being a nurse, develop into a safe, competent nurse, and become enculturated into the profession (Goodare, 2015; Levette-Jones et al., 2015; Webster et al., 2016; Wilson, 2014). Competence and a sense of potential create unique vulnerabilities for student nurses (Bowllan, 2015). Ninety-five percent of nursing students in Australia reported that they are unhappy and depressed by the end of their three-year educational journey into nursing (Goodare, 2015). Webster et al. (2016) reported in a Canadian study that the clinical staff nurse could create a positive or a negative impression on the student nurse, which stays with the student long after they have left that clinical area. Smith et al. (2016) reported that 89% of Canadian nursing students and 53% of British nursing students report experiencing negative behaviors from a staff nurse. These students reported feeling disrespected and powerless (Smith et al., 2016). New Zealand reported that 90% of student nurses will experience some form of *horizontal violence* during their clinical placement. In Turkey, 100% of student nurses reported that yelling is the most common form of abuse (El Rahman, 2017). In the United States, 95.6% of fourth-year nursing students state that they had experienced some form of cursing or rude, demeaning behavior with clinical instructors being the main perpetrator (El Rahman, 2017).

Fear of making mistakes and a lack of real-world experience hinder student nurses from learning, and many do not assert themselves into learning opportunities (Kumaran & Carney, 2014; Levette-Jones et al., 2015). Student nurses do not want to appear as if

they are stupid, nor do they want to cause harm to a patient (Levette-Jones et al., 2015). As students shy away from learning opportunities, they become more vulnerable to acts of *horizontal violence* (Courtney-Pratt et al., 2018; Kumaran & Carney, 2014; Smith et al., 2016). An Iranian study found that student nurses report that most violence comes from the family of patients, patients, and faculty, in that order (Samadzadeh & Aghamohammadi, 2018). Fear keeps student nurses from reporting incidences mainly because they think that these behaviors are part of the profession, that they caused the incident, or that they are making much ado over nothing (Budden et al., 2017; Courtney-Pratt et al., 2018; Nixon, 2014). It is conceivable that students who have early exposure to violence will have a propensity for early attrition from the profession (Hopkins et al., 2018). The literature does not show adequate exploration regarding exposure to *horizontal violence* in student nurses (Hopkins et al., 2014; Karatas et al., 2017; Levette-Jones et al., 2015). Further research is needed to explore perceptions of prevalence and impact on student nurses in the clinical setting (Bowllan, 2015; Webster et al., 2016).

Summary

With an increasing demand for nurses, there is an urgent need to focus on the cultivation of student nurses into the profession (Smith et al., 2016). Ethical, compassionate, and caring are all words that people use to describe nurses. When violence enters the profession, it became less than those descriptive words and requires attention and resources allocated on an individual, organizational, and community level (Birks et al., 2017). Educational and clinical institutions have a responsibility to protect student nurses from injury and harm as they enter the profession (Budden et al., 2017).

The vulnerability of student nurses to *horizontal violence* increase the risk for physical and psychological distress or attrition from the profession as they attempted to assimilate into practice (Furst, 2018; Hopkins et al., 2018; Webster et al., 2016). There is a limited amount of time students spend in clinical hospital rotations, so the exposure to *horizontal violence* may have a long-term detrimental effect on the profession (Budden et al., 2017; Webster et al., 2016). The positive reception of student nurses into the profession may lead to clinical success as these students are our future colleagues (El Rahman, 2017; Levette-Jones et al., 2015).

Many of the research studies found in the literature search are from other countries such as Canada, Australia, Turkey, and Iran. Due to various types of clinical settings and experiences, there are varying reports about the exposure a nursing student may have to *horizontal violence* during their clinical hospital rotations. There is a gap in the literature on nursing student's perception of their clinical experiences, especially as it relates to *horizontal violence*. Through an online survey, this study provides a deeper understanding of student nurse experiences with *horizontal violence* in clinical hospital settings by exploring their perceptions of lived experiences.

Chapter 3: Research Method

Introduction

Nursing is a complex and trusted profession noted for its compassion; however, the literature reported that within the profession of nursing, there are various forms of violence, making nursing a dangerous profession (Bowllan, 2015; Gallup, 2018; Nixon, 2014). Seasoned nurses navigate the violence with coping skills developed over time. New nurses and student nurses are susceptible to physical and psychological issues as they experienced the violence, many of them for the first time in their lives (Bartholomew, 2014; Chang & Cho, 2016; Christie & Jones, 2013; Koh, 2016; Rittenmeyer et al., 2013; Tee et al., 2016; Weaver, 2013; Webster et al., 2016). The result of this violence is an increased early exodus from the profession with as many as 60% of new nurses leaving their first position within the first year of practice and many of these new nurses leaving the profession entirely (Bartholomew, 2014; Colduvell, 2017; Flateau-Lux & Gravel, 2014; Frederick, 2014; Goodare, 2015; Roberts, 2015; Sanner-Stiehr & Ward-Smith, 2015; Tee et al., 2016; Walrafen et al., 2012; Weaver, 2013).

Horizontal violence in the profession of nursing exists, and when student nurses are present during their clinical rotations, they witness the violence (Bradbury-Jones et al., 2011). The literature review confirmed the historical and current existence of the phenomenon and the impact it is having on the profession. With a growing number of vacancies in the profession, there was an immediate need to gain a deeper understanding from student nurses as to what it means to experience *horizontal violence* in the clinical setting. The purpose of this qualitative, interpretive phenomenological study was to

explore student nurses' perceptions about their experiences with *horizontal violence* during their clinical hospital rotations.

In Chapter 3, I will focus on the research design, rationale for the design, and the role that I utilized as the researcher in this qualitative study. In the methodology section of Chapter 3, I will discuss participant selection, instrumentation, and data analysis. In Chapter 3, I also explore issues of trust and ethical considerations of this study.

Research Design and Rationale

Qualitative research begins with an interest, problem or question and seeks to explore, uncover, describe, and develop a deeper understanding of what it means to experience a specific phenomenon (Cypress, 2015; Lockwood et al., 2015; Padilla-Diaz, 2015; Ravitch & Carl, 2016; Sloan & Bowe, 2014). It is personal, with flexible guidelines, and is essential when there was a need to discover unknown significances of what it meant to experience a specific phenomenon (Cypress, 2015; Patton, 2015). It focuses on the subjective experiences of human beings and their in-depth description of the experience (Lockwood et al., 2015; Sloan & Bowe, 2014). If the research question in qualitative research is strong enough, there is no need for additional research questions (Lockwood et al., 2015). This description of qualitative research made it the correct approach for this study, and one research question was strong enough to guide the study. The research question for this study was, "What are student nurses' perceptions of *horizontal violence* experiences during their clinical hospital rotations?"

The relevance of qualitative research in any healthcare study is to improve the quality of healthcare practice through the stories of those who have experienced the

phenomenon (Lockwood et al., 2015). Qualitative research in nursing offers insight into lived experiences from different nursing aspects (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). Qualitative research describes the methodology, or the way research was done on the topic, whereas phenomenology is the method or specific technique used for the research (Lockwood et al., 2015; Sloan, 2014). The phenomenological approach to qualitative research seeks to uncover and describe a deeper understanding of everyday experiences (Patton, 2015; Sloan & Bowe, 2014). Phenomenology is a method and a philosophy whose purpose is to identify a situation and seek to understand how it is perceived by those who experience it (Cypress, 2018; Ravitch & Carl, 2016; Sloan & Bowe, 2014). Phenomenological research reports experiences as lived by the participants who had a meaningful and significant relationship to the phenomenon (Yuksel & Yildirim, 2015).

Edmund Husserl, considered the father of phenomenology, was the first to apply this method of research to social sciences. He said that we only know what we experience through our perceptions and the meanings that we apply to our worldview (Patton, 2015). He believed that a researcher could bracket their bias and transcend to a global view of the phenomenon (Sloan & Bowe, 2014). There are several approaches to phenomenological research, but there are two most commonly used approaches (Sloan & Bowe, 2014). The first approach is Husserl's phenomenology, also referred to as descriptive or transcendental phenomenology. The second approach is Heidegger's phenomenology, also referred to as interpretive, hermeneutic, or existential phenomenology (Sloan & Bowe, 2014; Willis et al., 2016). Martin Heidegger was a lab

assistant to Husserl, who believed that the researcher could not remove themselves (bracket) from a phenomenon because human beings had their life views and experiences that were part of their worldview (Dunn, 2012; Sloan & Bowe, 2014). He believed that phenomenology required a personal investment from both the participant and the researcher. This investment gave a voice to the experience making Hermeneutic phenomenology more complex (Cypress, 2015; Sloan & Bowe, 2014; Wilson, 2014).

Hermeneutic phenomenology is an interpretive study approach that allows researchers to understand how people engage with things around them, making it the best design approach for this study (Cypress, 2018; Jack & Wibberley, 2014; Sloan & Bowe, 2014). Hermeneutic phenomenology looks at lived experiences rather than theorized experiences (Bradbury-Jones et al., 2011; Cypress, 2015; Sloan & Bowe, 2014). It refers to the study of personal experiences and requires the involvement of the researcher to interpret the meanings as described by the participants (Padilla-Diaz, 2015; Sloan & Bowe, 2014; Willis et al., 2016). Hermeneutics is the study of the interpretation of how people described the meaning of their experience with the phenomenon (Willis et al., 2016). It does not look for truth but looked for the participant's perception of the truth (Sloan & Bowe, 2014). As researchers, as human beings, human existence is part of who we are, and thus researchers cannot disengage from the world by claiming indifference to the research topic (Sloan & Bowe, 2014; Wilson, 2014). Hermeneutic phenomenology is a human science of studying people. This makes it the best method of research for education, health, and nursing sciences (Cypress, 2015; Sloan & Bowe, 2014). Dunn (2012) used hermeneutic interpretive phenomenology when he researched what keeps

nurses in nursing. His study looked at the relational experiences of nurses in the context of a nursing situation.

Role of the Researcher

The primary role of the researcher in phenomenological research is to bring individual experiences to words and attempt to understand them by assigning categories and themes to the data (Cypress, 2015; Sanjari et al., 2014). Researcher interpretation remains robust throughout the entire process as there is more to the lived experience than a singular description of one lived event (Sloan & Bowe, 2014; Wilson, 2014). In hermeneutic phenomenology, the researcher compares statements made by research participants to create themes (Cypress, 2015; Sloan & Bowie, 2014). The process involves analysis and interpretation of the data and development of themes until data saturation or no new themes appear (Cypress, 2015).

Reflexivity is the process of researcher ability to reflect on how the questions, method, and subject of their research may influence the data collection and analysis of results (Peat et al., 2019; Sloan & Bowe, 2014). This reflection was retrospective of events or experiences lived through in the past by the researcher (Reid et al., 2018; Sloan & Bowe, 2014). Reflectivity allowed the researcher to use empathy and prior experience in data analysis for interpretation of the spoken word for thematic development (Sloan & Bowe, 2014).

Researchers must be competent in interviewing skills such as clarifying, paraphrasing, reflection, and listening (Padilla-Diaz, 2015). The researcher should be prepared for the interview to decrease any discomfort from the participant (Cypress,

2018). The framework of the study guided the development of the interview and probing questions, and the researcher may alter questions based on responses from participants (Cypress, 2018; Willis et al., 2016). There is a responsibility for the researcher to be transparent and disclose supportive or nonsupportive results of data to the framework of the study and to suggest possible future research (Reid, Brown, Smith, Cope, & Jamieson, 2018; Willis et al., 2016). At the end of the interview, it is proper for the interviewer to thank the participant (Cypress, 2018).

In this research study, I would participate in the interview process by actively asking questions, guiding the interview, and listening to the participant. I would also observe the participant for nonverbal expressions during the interview process and documenting those observations. I had no supervisory control over any students who voluntarily participated in my research study. Although the study was to occur at the hospital where I work, there was no mention of my role or affiliation with the hospital. My anonymity was accomplished through the removal of the employee name tag and by performing interviews in a neutral space to eliminate anyone speaking to me who may know my affiliation with the hospital. There were no incentives associated with participation in this study, and there was no conflict of interest as I do not interact with students within the clinical setting of the hospital.

Additionally, there was no disclosure of who takes part in the study to any hospital or academic personnel. I will keep all hard data in a locked file cabinet in a locked office, and electronic data stored on a secured drive and research folder protected by the hospital firewall. Participant names would change when using specific quotes in

the final results of the study with the only identification to name association located with me in a separate locked file cabinet in a locked office. Identification of participants is Student Nurse 1 (SN1), Student Nurse 2 (SN2), and so on, with the only identifier being the number in association with the order in which the interview took place.

In this research study, I was unable to conduct interviews due to the COVID-19 pandemic, so I created an online survey. I utilized my prepared interview questions and tweaked them slightly to fit the online survey format. Participant names were not part of the survey allowing for complete anonymity for participants.

Methodology

Participant Selection

Qualitative research recommends the selection of participants for research studies using purposeful sampling, which means that the participants will meet specific criteria of study guidelines (Padilla-Diaz, 2015; Peat et al., 2019; Smith & Osborn, 2008; Yuksel & Yildirim, 2015). Participants should have some experience with an understanding of the phenomenon (Peat et al., 2019; Yuksel & Yildirim, 2015). There is no specific number of participants for qualitative research, but when conducting interviews, three to six is the recommended number for novice researchers (Smith & Osborn, 2008). Sloan and Bowe (2014) and Peat et al. (2019) stated that the participant pool should remain small (approximately ten or less) with a focus on the indepth description of the experiences of the phenomenon. These recommended small numbers of participants allow the researcher to provide a detailed examination of similarities and differences

(Smith & Osborn, 2008). A larger sample of participants can result in the researcher losing depth of information for the breadth of participation (Smith & Osborn, 2008).

This research study used a purposeful sampling of participants by requesting voluntary participation from students who have had some perceived encounter with *horizontal violence* during their clinical rotation. For this study, I recommend a small number of participants, six to seven, with a maximum number of 20 participants or until data saturation reached. Participant selection was through voluntary response to advertising for student nurse participation at one hospital. Participants must be obtaining their first nursing degree, which eliminates persons who have been a nursing assistant, licensed practical nurse, or some other form of nursing personnel before obtaining their registered nurse degree. Student nurses can be from any school, so the level of registered nurse education will not be a part of participant elimination, allowing associate and baccalaureate nursing students an equal opportunity to participate. Students can be at a junior or senior level of nursing school, but they must have completed at least one clinical rotation and be at least 18 years old. The student will voluntarily contact me through the information provided on the flyer. Through this initial contact, I will ensure that students verbally acknowledge that they meet the participation criteria.

As the research method for this study changed to an online survey, participation was sought until a significant number of responses were received, looking for a minimum of 20 responses or until the achievement of data saturation. Participation was through voluntary responses to advertising for student nurse participation via several hospitals, social media, Walden connections, and deans of local nursing schools. Participants were

obtaining their first registered nurse degree. Student nurses were from any school or part of the United States. The student was provided with my contact information if they had questions. No students reached out to contact me through this survey process. The first question on the survey was an acknowledgment that participants met the research criteria.

Instrumentation

In qualitative research, the researcher is the research instrument as the process must remain flexible for alteration (Cypress, 2018; Sanjari et al., 2014). The most common data collection techniques used in phenomenological research is the interview (Cypress, 2018; Padilla-Diaz, 2015; Sloan & Bowe, 2014; Willis et al., 2016; Yuksel & Yildirim, 2015). The interview questions are open or semi-structured allowing space for study participants to expand upon their descriptions of the phenomenon (Cypress, 2018; Padilla-Diaz, 2015; Sloan & Bowe, 2014; Smith & Osborn, 2008). The semi-structured interview allows the researcher and participant to enter a dialogue, and the interview structure remains flexible (Smith & Osborn, 2008). The flexibility of the semi-structured interview allows for the development of trust between the researcher and the participant and allows the interviewer to follow and explore the participant's area of interest (Cypress, 2018; Smith & Osborn, 2008). The advantage of using a semi-structured interview is the facilitation of rapport, greater flexibility of coverage, and the production of richer data (Smith & Osborn, 2008). The disadvantage of using the semi-structured interview is the decreased ability of the researcher to prepare for all possible points of interest the participant may want to discuss, and the amount of time required for transcription and analysis (Smith & Osborn, 2008).

Additionally, the researcher will be making notes regarding nonverbal communication from the participant as well as environmental factors. The notes of the researcher are incorporated into the final thematic results. Interviews continue until six or seven student nurses have participated, allowing me to gain a deeper understanding of what it means for a student nurse to experience *horizontal violence* during their clinical hospital rotation. Interviews will continue for up to 20 student nurses or until data saturation is reached.

Researcher Developed Instrumentation

Although the interview is semi-structured, the researcher needs to prepare an interview guide (see Appendix A) to prepare for delicate or sensitive questions (Smith & Osborn, 2008). When developing the interview guide, the researcher should determine the most logical order for the questions and place sensitive questions toward the end, thus allowing the participant to relax and develop a rapport with the researcher (Smith & Osborn, 2008). Questions should remain open-ended, and the researcher should prepare prompts or probing questions for the interview to decrease, leading a participant to a specific answer (Smith & Osborne, 2008). The flexibility of the semi-structured schedule allows the researcher to take questions in a different order or to take the interview in a different direction as needed to obtain content validity (Peat et al., 2019; Smith & Osborn, 2008). The more preparation the researcher does before the actual interview, the more the researcher can concentrate on the information received from the participant during the interview making the research results more robust (Cypress, 2018; Smith & Osborn, 2008). The development of trust between myself and the participant will

establish the validity of the interview questions. If necessary, an alteration of questions may happen at any time before or during the interview process.

Procedures for Recruitment, Participation, and Data Collection

Recruitment will take place at the hospital where I am employed. The term used at the hospital for researcher personnel is without compensation (WOC), ensuring that there is no financial conflict for this research study done at this hospital by this researcher. Five local nursing schools participate in clinical rotations at this hospital, which should provide a robust student nursing pool. I expected to obtain the necessary number of participants for this study without having to recruit outside of the hospital. If necessary, for additional student nurse recruitment, I would contact the deans of local nursing schools.

Recruitment flyers are put up in nursing break rooms throughout the hospital, asking for voluntary participation. The flyer would make clear that the *horizontal violence* is not about this specific hospital as many of the students participate in clinical rotations at neighboring hospitals. Additionally, the flyer includes criteria for participation and my contact information. There is no incentive for student participation in this study. Interviews are done outside of my work hours and outside of the student clinical hours.

Data collection consists of interviews, observations, and interviewer notes (Cypress, 2018). Data collection is face-to-face, audio-recorded interviews allowing me as the researcher to pay attention to the non-verbal communication and to probe for more content. The interview is a conversation with a purpose and will last 30-60 minutes

(Cypress, 2018). The aim of qualitative interviewing is to elicit information pertinent to the research question (Cypress, 2018). Transcription of each interview would be verbatim and usually takes five to eight hours, depending on the length of the interview and the researchers' typing abilities (Smith & Osborn, 2008). I will obtain consent to contact participants for possible clarification interviewing to clarify researcher interpretation during the data analysis. After completion of the transcription, participants will have an opportunity to review transcripts for accuracy, also known as member checking (Amankwaa, 2016; Connelly, 2016). The opportunity for member checking is optional for participants.

Data Analysis Plan

Qualitative data analysis allows the researcher to examine qualitative data to derive an explanation for the research phenomenon through deductive or inductive processes (Cypress, 2018; Onuoha, n.d.). The most common data analysis plan for qualitative research is thematic analysis, where the researcher names common themes, textual analysis (expressed words), and structural analysis (interpreted words) (Padilla-Diaz, 2015; Smith & Firth, 2011; Willis et al., 2016). One concern with thematic analysis is the possible fragmentation of data through misinterpretation from the researcher (Smith & Firth, 2011).

Data analysis in Hermeneutic phenomenology consists of three steps, which are holistic theming, extraction of statements or phrases, and researcher interpretation (Peat et al., 2019; Sloan & Bowe, 2014). The researcher reads each transcript multiple times so that the researcher became very familiar with the content and gains new insights each

time (Cypress, 2018; Peat et al., 2019; Smith & Osborn, 2008). Interpretive phenomenological analysis (IPA) is the process that allows the researcher to navigate between layers of interpretative data (Peat et al., 2019; Smith & Osborn, 2008). IPA is a dynamic research process allowing the researcher to have an active role (Peat et al., 2019; Smith & Osborn, 2008). Connecting IPA to hermeneutics is a two-stage interpretation process (double hermeneutics) where the participants are trying to make sense of their world, and the researcher is trying to make sense of the participants making sense of the phenomenon (Peat et al., 2019; Smith & Osborn, 2008).

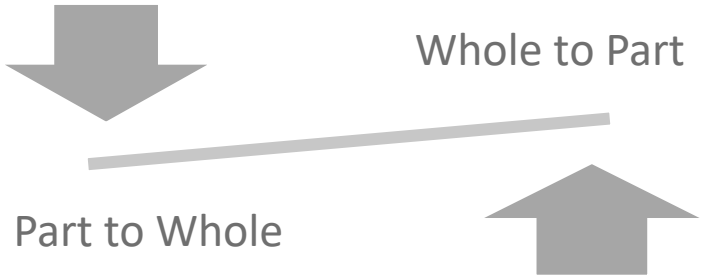

Figure 1. Double hermeneutic process of data interpretation.

This extraction and interpretation process aligned with holistic theming constitutes an action called the Hermeneutic circle (Harris, 2015; Leung, 2015; Peat et al., 2019; Sloan & Bowe, 2014). Within the Hermeneutic circle, the researcher moves from whole to part and part to whole units of meaning to interpret a deeper meaning of the phenomenon (see Figure 1) (Leung, 2015; Peat et al., 2019; Willis et al., 2016). This hermeneutic circle was what allows people to understand the whole of something through the parts and understand the parts through their relationship with the whole (Harris, 2015). A change of understanding of any part of the data forces us into an interpretive

hermeneutic circle of understanding, making the circle one of growth and adaptation (Harris, 2015). This continual process of analysis allows the researcher to modify their interpretative meaning as they gain a deeper understanding of what they believe the participant meant (see Figure 2) (Padilla-Diaz, 2015; Smith & Osborn, 2008; Willis et al., 2016). Active engagement with the hermeneutic circle ensures transparency between data and interpretation (Peat et al., 2019).

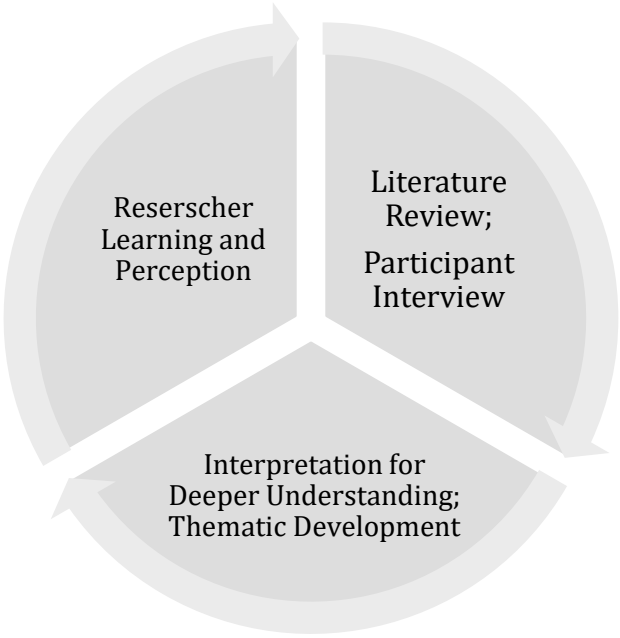

Figure 2. Hermeneutic circle of researcher continual analysis and interpretation.

Data is read multiple times to assign proper descriptive codes. Coding involves categorizing data into concepts, categories, themes, or patterns (Onuoha, n.d; Willis et al., 2016). The recommendation is to have no more than 25 to 30 categories (Cypress, 2018). For better organization, data goes in a matrix table, including researcher thoughts or interpretations (see Table 1) (Onuoha, n.d; Willis et al., 2016). The matrix table allows the researcher to compare rows and columns for similarities and differences. The final

data analysis plan includes observational data from the researcher field notes including nonverbal observations of the participant and any environmental factors present during the interview (Cypress, 2018; Onuoha, n.d.; Willis et al., 2016).

Table 1

Suggested Initial Matrix Table of Interview Data

Annotations of interesting or significant statements	Verbatim transcription	Emerging categories (25-30)	Non-verbal observations or communications
Examples: Summarizing, paraphrasing, associations, connections, preliminary interpretations	Chronological sequence	Examples: Concise phrases, psychological terminology,	Researcher input

Table 2

Suggested T*hematic Matrix of Data Interpretation*

Page number for reference of exact verbiage	Categories	Themes (5-6)	Comments
Reference page number as the researcher moves away from what the participant said.	Extracted from the matrix table	Consist of combining categories	Note any dropped categories or themes

The next step of data analysis is to begin to look for connections between the emerging categories taking them out of chronological sequencing and applying analytical or theoretical emphasis to them (Peat et al., 2019; Smith & Osborn, 2008). This process is interpretive and involves the researcher interpreting what the participant said against

what is precisely said by the participant (Cypress, 2018; Smith & Osborn, 2008). Categories are clustered into themes requiring the researcher to create another table containing identifying words and page numbers corresponding to the superordinate themes (see Table 2) (Peat et al., 2019; Smith & Osborn, 2008). The recommendation for data reduction of categories is to have 5 or 6 themes (Cypress, 2018). Throughout this process, some themes may drop as they do not fit into the emerging thematic structure (Cypress, 2018; Smith & Osborn, 2008). The exact process is conducted on all participant transcripts separately and then comparing individual transcript to one another looking for similar and different themes, and acknowledging repeating and new patterns (Peat et al., 2019; Smith & Osborn, 2008). The final step is the analysis of each transcript to create a table of superordinate themes prioritizing and reducing themes in conjecture with the research question (Peat et al., 2019; Smith & Osborn, 2008).

Issues of Trustworthiness

The trustworthiness of data interpretation in qualitative research is the validity or rigor of the research (Connelly, 2016; Yuksel & Yildirim, 2015). Validity means that the research question is appropriate for the outcome, the methodology is appropriate for the research question, the design is appropriate for the methodology, the participant selection and data analysis was appropriate, and the results are appropriate for the original intent of the research (Leung, 2015). Validity in phenomenological research includes collaboration between the researcher and the participant to verify that the researcher has captured what the participant wanted to express (Padilla-Diaz, 2015). Heidegger believed that interpretation was only valid when the researcher's background

combines with the participant statements (Dunn, 2012). Rigor from qualitative research comes from engagement with participants, transcribing the interview verbatim, member checking, and incorporating field notes into the data analysis process (Dunn, 2012). Rigor creates a trust for the participant and the ability to claim the methodological soundness of the study by the researcher (Dunn, 2012). Four criteria support trustworthiness in qualitative research, which are credibility, dependability, confirmability, and transferability (Amankwaa, 2016; Connelly, 2016). A qualitative research study does not need to include all four criteria (Connelly, 2016).

Credibility is the most important criteria because it establishes the truth of the study (Connelly, 2016). Extended engagement with the participants, observation, peer-debriefing member checking, and reflective journaling are all ways that the researcher achieves credibility (Amankwaa, 2016; Connelly, 2016; Yuksel & Yildirim, 2015). The sensitivity of context, the rigor of analysis, transparency of the narrative produced, and the impact and importance of the research results are all components of established credibility (Onuoha, n.d.; Peat et al., 2019). Dependability is the stability of the study over time, and the conditions of the study carried out through peer debriefing and a reliable audit trail (Amankwaa, 2016; Connelly, 2016). Confirmability refers to the neutrality of the study or the degree to which replications of findings in a study are possible (Amankwaa, 2016; Connelly, 2016). Methods of establishing confirmability are the maintenance of audit trails to include raw data, data reduction strategy, detailed notes, review by a colleague, peer debriefing, and member checking (Amankwaa, 2016; Connelly, 2016). The exact replicability of a study proves reliability (Leung, 2015). The

transferability of a qualitative study refers to the extent that the findings are useful in other settings (Connelly, 2016). Researchers achieve transferability through detailed descriptions of participants, locations, and components of the study, and by being transparent about analysis and results (Amankwaa, 2016; Connelly, 2016). Transferability includes reactions and observations not caught on the audio recording, relationship established between participant and researcher, and personal feelings of the researcher (Amankwaa, 2016; Leung, 2015).

Interview techniques such as using minimal probes or not interrupting allow participants adequate time to answer questions. The development of trust between researcher and participant is achieved through not rushing the interview process, asking one question at a time, and watching for nonverbal cues from the participant (Smith & Osborn, 2008).

Ethical Procedures

In all research, specifically qualitative studies, following formal ethical procedures is vital because topics may be personal and sensitive to the participants (Reid et al., 2018). Internal review boards protect the researcher and the participant from harm (Reid et al., 2018). After obtaining formal approval, the next ethical issue the researcher faces is securing the research setting (Reid et al., 2018). From the beginning to the end of the research process, the principles of beneficence, non-maleficence, justice, and equity require the researcher to remain truly reflexive (Reid et al., 2018).

The double hermeneutic relationship between the researcher and participant strengthens the ethical quality of the research (Peat et al., 2019). This relationship raises

concerns about privacy, honest and open interactions, and avoiding misinterpretations (Sanjari et al., 2014). Ethical issues in qualitative research include approval from the research site, protection of participants, correct sampling, recording, storing, and dissemination of information (Cypress, 2018; Reid, 2018). The ethical concerns in qualitative research are anonymity, confidentiality, and informed consent (Lin, 2009; Sanjari et al., 2014). Anonymity involves removing all identifying components (person, place, organization) from the data. Maintaining all collected data in a locked cabinet protects the confidentiality of the data, with only the principal researcher having key access (Sanjari et al., 2014). The importance of informed consent is for the researcher to inform the participant of all aspects of the research project, including how the collected data will be used (Sanjari et al., 2014). The informed consent in a qualitative study is an ongoing negotiation as the participant has the right to stop or rescind consent at any time (Sanjari et al., 2014). Consent should be obtained both in writing and orally at the beginning of the audio recording of the interview (Sanjari et al., 2014).

When dealing with sensitive topics, researchers should have a plan in place if a participant is experiencing moral distress (Lin, 2009; Sanjari et al., 2014). When researching ethically sensitive issues, there may be ethical issues that arise unexpectedly during the interview, which required a significant degree of reflexivity on the part of the researcher (Reid et al., 2018). Researchers must minimize too much self-disclosure and remain objective with displays of emotion (Sanjari et al., 2014). Gaining truthful knowledge and staying objective during observations are other characteristics that support ethical behavior during a qualitative interview (Sanjari et al., 2014). The usual

length of time for data retention is three to ten years, which is determined by the agency overseeing the research (Lin, 2009).

Specifically, for this study, I will obtain informed consent from each participant, provide member checking for accuracy of data, and maintain all audio and written data in a locked office and locked file cabinet. Any specific quotations used in reporting of information will have names changed to SN1, SN2, and so on, allowing for the anonymity of participants. I will remind participants at the beginning of the study that they may withdraw at any time or not answer a specific question if they feel uncomfortable with sharing personal information. Results remain in a secured, locked cabinet for the length of time required by Walden University and the hospital where the research occurred. Hard and electronic data will be accessible only to myself and the primary investigator overseeing the research study at the hospital. There are no concerns at this time regarding the ability of this research data to be stored securely.

Summary

Qualitative research is complicated and time-consuming, especially for novice researchers. Interviewing in qualitative research began with the assumption that the participant has meaningful information to share regarding a specific phenomenon. The relationship between researcher and participant is a partnership of equality, where the past comes to the present. The steps to efficiently analyze data in qualitative research are transcribing data, organizing data, coding data, confirming data, and reaching a conclusion by stating the outcomes of the data.

In Chapter 4, I will review the purpose and research question for the study and describe the setting, demographics, and characteristics of the study. Chapter 4 will provide detailed interview profiles, including date, time frame, variables, and any unusual circumstances encountered. In the data analysis section of Chapter 4, I will show the initial categorization and subsequent theming of the interview transcriptions. I will also establish the trustworthiness of the research study by showing relativity to credibility, transferability, dependability, and confirmability. Chapter 4 will conclude when I show the research results related to the research question to support or negate the framework of the study using quotes from transcripts.

Chapter 4: Results

Introduction

The purpose of this qualitative, phenomenological study was to explore student nurses' perceptions regarding their lived experiences with *horizontal violence* during their clinical hospital rotations. Student nurses voluntarily took part in this research study regarding their perceptions of lived experiences with clinical rotations and *horizontal violence*. The one research question that guided this study was, "What are student nurse perceptions of *horizontal violence* experiences during their clinical hospital rotation?"

In Chapter 4, I will focus on components of the research study, including the setting, demographics, data collection, and data analysis. I will also show how I established trustworthiness by implementing credibility, transferability, dependability, and conformability in the research study. The chapter will conclude with the results of this research study.

Setting

The setting of this research study was via an online survey conducted through the services of SurveyMonkey. The questions were open-ended, allowing for individual responses. The survey was completely anonymous, with no identifying questions asked. Participation was entirely voluntary, with participants selecting "agree" to the first question, which screened for participant acknowledgment of being at least 18 years of age, having read the research study information, and acknowledging that they were participating voluntarily. Answering "agree" to the first question served as the participant's informed consent for this study (Appendix B).

Email and Facebook were the primary sources of recruitment for participants. I sent emails to several nursing school deans at local universities requesting their assistance in sending out the information to their students. Additional emails went out from the hospital where I work by the registered nurse educator overseeing student placement. Utilizing these two methods for email, I was able to ensure anonymity for participants as I had no information on who received the survey information. On Facebook, I began by posting the information and SurveyMonkey link on my page. Several of my friends shared my post on their pages. To reach more potential participants, I contacted several nursing groups on Facebook, including Walden nursing pages. Some nursing groups required permission from an administrator before posting, so I sent my information to those administrators, and they granted permission to recruit via their group. After sending out the first survey request and information through as many Facebook groups as I could find, the responses were not as robust as I had hoped, so I resent the survey a second time, 45 days later, to all Facebook groups. This second sending allowed me to receive additional responses, and several nurses responded that they had meant to take it and would do so now. After the second round of social media responses, I found that I had received enough responses and was receiving similar answers indicating data saturation. The survey does remain open, but to date, there have no further responses, leaving the number of responses at 72.

Specific to the timing of this research study was the outbreak of the coronavirus pandemic. I mention this because a few of the participants explicitly stated that their clinical experience was cut short due to the restrictions placed on students. They stated,

"Preceptorship/senior capstone in CCU. But cutoff due to COVID19," and "Due to the pandemic, I did not get to be a charge nurse as I was supposed to be."

The unprecedented organizational restrictions caused by coronavirus had an unknown impact on responses to this survey as students had limited clinical exposure or were exposed to the clinical side of nursing at a very stressful time in nursing history. Schools of nursing had moved to all online formats for teaching, and hospitals were not allowing students into their facilities to protect patients, staff, and the students. Recruitment for this survey was difficult because of these barriers. It becomes increasingly challenging to recruit students when there are no students available. Using a social media platform was unexpected but allowed me a forum in which I could receive enough responses to the survey.

Demographics

An outline for student nurse participation appeared in the introduction to the survey. The criteria for participation were:

1. The participant must be a nursing student.
2. Will receive no compensation for participation.
3. That all information remains confidential.
4. That they do not have to answer all of the questions.
5. That they may quit taking the survey at any time they wish.

I then provided contact information for myself, the research department of the hospital where I work, and IRB overseeing this research study should they have any questions or concerns. This information was all included as an introduction to the survey and served

as the informed consent for participation. No research participant reached out to me, the research department, or the IRB at any time during this research process.

The first question stated that the participant had read the consent, was at least 18 years of age, and was participating voluntarily. Their options were to select, agree, or disagree. If they selected disagree, they could not proceed any further in the survey. Selecting agree sent the participant into the survey. There were no participants who selected disagree. There were no questions on this survey regarding ethnicity, gender, age, educational level, locality of the participant, the identity of an educational institution, or identity of medical facility relating to the participant story. Questions 2 through 4 requested specific information regarding year participant completed their first clinical rotation (n = 19) (see Table 3), did the participant have previous exposure to clinical hospital settings (n = 23) (see Table 4), and if so, in what capacity (n = 8) (see Table 5). The remainder of the questions were open-ended to allow for expanded responses from the participant. There was a total of 26 questions (n = 26) (see Appendix C).

Table 3

Completed First Clinical Rotation

	2017	2018	2019	2020
Number	1	6	6	6
Percentage	4%	32%	32%	32%

Table 4

Worked in Hospital Prior to Clinical Rotation

	Yes	No
Number	10	13
Percent	43%	57%

Table 5

Position Previously Worked in Hospital

	Volunteer	CNA	LPN	Clerical
Number	1	4	2	1
Percentage	12.5%	50%	25%	12.5%

Data Collection

In Chapter 3, the plan for data collection was to perform face-to-face interviews using semi-structured open-ended questions. Due to the COVID-19 pandemic, I used an alternate method of data collection. According to Ponto (2015), surveys can examine human behavior, and survey research has become an acceptable method for qualitative research studies. Although survey research takes time for participation, the time is notably less than other research methods, including interviews. It has become more practical when looking for insight into the intangible aspects of clinical life (Kelley-Quon, 2018).

Additionally, survey research can reach a broader representation of the population under study, which can yield more accurate data and allow the researcher to infer something about the population as a whole (Kelley, Clark, Brown, and Sitzia, 2003; Ponto, 2015). As stated before, I did reach out to many nurses and used social media to

reach different areas of the country, yielding a diverse sampling of responses. This random sampling would not have occurred using face-to-face interviews.

To create the survey, I used my proposed interview questions and interview guide to transfer the questions into a survey using mostly open-ended written questions. Because the interview format was changed, the interview questions changed from semi-structured, where the researcher can change or omit questions based on the answers from participants, to structured questions with no variability. Member checking was not an option as the written interview format allowed for complete anonymity and no way for the researcher to follow up with the participants. To allow the participants to feel more comfortable with the survey, I asked three short, fact-based questions at the beginning. The survey questions followed a clear, concise pattern flowing from one question to another, allowing the participants to see and respond appropriately to the questions.

A total of 72 (N = 72) interested persons logged onto the survey and selected "agree" for the first question. There was not a way for me to determine how many of these persons may have answered "disagree" initially and discovered that they could not see the remainder of the survey, so they changed their answers to "agree." The maximum number of responses to any of the questions was 23 resulting in a 32% response rate. The number of participant responses to questions ranged from 8 to 23 (see Table 6). The variance in the number of responses to the questions gives me confidence that the respondents read each question and took time to answer only those questions that they felt comfortable answering. The average time participants spent on taking the survey was 17 minutes.

Data collection began by downloading each response. Maintenance and storage of the electronic data was in two separate computers, and both computers have firewalls for protection. There is not a need for a hard copy of the data. Responses were transcribed verbatim onto an excel spreadsheet with all 72 participant responses and the corresponding questions. This matrix format allowed me to look at all individual responses to a specific question comparing for similarities and differences of responses. I created new tabs on the excel spreadsheet for each question. All responses to questions were transcribed verbatim onto the corresponding tab. This method allowed me to view all participant answers to individual questions at the same time. Comparing and contrasting all answers to each question allowed me to begin the coding process.

Data Analysis

Once transcription for all responses was on the excel spreadsheet, I was able to review all responses collectively from each participant and then collectively review all responses to a single question. Data was read multiple times to look for differences and similarities in responses. Multiple readings of the responses allowed me to analyze what the participant said continually and to modify my interpretations. With each reading of responses, I gained a more in-depth insight into what I thought the participant was saying. While interpreting what I thought the participant was saying against what was said, categories began to develop. A new excel matrix was developed to record categories, codes, and themes of the data.

Table 6

Number of Responses per Question

Question Number	Number of Responses
1	*n* = 72
2	*n* = 19
3	*n* = 23
4	*n* = 8
5	*n* = 23
6	*n* = 22
7	*n* = 23
8	*n* = 22
9	*n* = 18
10	*n* = 20
11	*n* = 20
12	*n* = 18
13	*n* = 22
14	*n* = 18
15	*n* = 17
16	*n* = 19
17	*n* = 14
18	*n* = 14
19	*n* = 14
20	*n* = 13
21	*n* = 22
22	*n* = 19
23	*n* = 16
24	*n* = 13
25	*n* = 16
26	*n* = 9

I developed the first categories by assigning a category word or phrase to every response to each question. Performing this step multiple times, I ensured that I was categorizing each response without bias to what I was reading. As reported previously, each question received 8 to 23 responses, so there were many categories recorded. I then analyzed the categories and grouped items into codes, which gave me a manageable cluster of thoughts and ideas for which I could group in themes. Once the thematic

analysis was completed, themes were reviewed for their correlation to the research question regarding student nurse perceptions of *horizontal violence* during their clinical hospital rotations. Initial themes were recorded with responding question numbers for comment referencing, as seen in Table 7. Many participant responses were similar which allowed themes to emerge readily. Student nurses feel strongly about how they should be treated and were forthcoming regarding positive and negative clinical experiences. Less frequently occurring themes were also noted and will be addressed later in this summation (see Table 7).

Table 7

Thematic Analysis

Question number for reference of exact verbiage	Themes	Comments: Dropped themes
9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 23, 24, 25	Student nurse perceptions of staff and their future	Additional barriers to learning
5, 6, 7, 8, 10, 11, 15, 16, 17, 26	Learning and clinical application	Comments about the survey
14, 20, 21 and 22 (all responses), 26	Knowledge/Experiences of *horizontal violence*	Clinical faculty issues
5, 6, 7, 8, 13, 15, 17, 25	Good clinical experience	
5, 6, 7, 8, 11, 20, 23, 24,26	*n*egative experience/questioning profession	

Evidence of Trustworthiness

Qualitative research must provide elements of being trustworthy. According to Amankwaa (2016) and Connelly (2016), four components support trustworthiness, which are credibility, dependability, confirmability, and transferability. Every qualitative research study does not have to possess all four. Descriptions of these components found in Chapter 3 specific to this study have changed due to the change of research technique. Specific to face-to-face interviews, and not achievable for an online survey, are the actions of extended engagement with the participant, member checking, and detail descriptions or observations of the research environment. Additionally, there is not an ability to probe for further details of events. By clearly defining the population of interest, providing easy access, and using random sampling, survey research provides trustworthiness as a qualitative research method (Ponto, 2015).

Credibility

Credibility established the truth of a study through sensitive research, rigorous analysis, and the importance of the results (Connelly, 2016; Onuoha, n.d.; Peat et al., 2019). Ravitch and Carl (2016), stated that scrutinization of coding allows the researcher not to force data to conform to researcher bias and accept the responses that do not fit into a particular category, but rather focus on how that data may challenge what the researcher thought before the research starting. Credibility, in this study, was obtained by asking appropriate open-ended questions and focusing questions on the participant experiences. Collecting responses until data saturation was achieved, reading all responses multiple times, using credible interpretation without bias, and allowing those

outlying responses to trigger additional thought and consideration are all additional steps for building credibility.

Transferability

Transferability is the applicability of one research study to a different setting and researcher through detailed descriptions of context and data results (Amankwaa, 2016; Connelly, 2016; Ravitch & Carl, 2016). It is up to others to assess if this component has been achieved and is transferable to their setting (Korstjens & Moser, 2018; Ravitch & Carl, 2016). I have provided detailed descriptions of the survey process, data collection, and data analysis for the reader to make their own judgment on transferability.

Dependability

Part of the research study audit trail is the dependability or consistency of a study over time, based on a solid research plan and resembles reliability in quantitative research (Korstjens & Moser, 2018; Ravitch & Carl, 2016). Proposed data collection should answer the research question, research methods should answer the core research concepts, and interpretation of the data demonstrates rigorous research analysis (Korstjens & Moser, 2018; Ravitch & Carl, 2016). As the data collection method changed from my initial proposal, so did my dissertation chair change. I shared all new research plans, research survey questions, and survey results with my new Walden chair and my VA PhD mentor and discussed any preconceived bias I had regarding this research. Because I was hand coding the survey responses, it was important to get a second research opinion to ensure that my viewpoints did not intermingle with the participant responses. I accomplished this by sharing my audit trail of collected and analyzed data.

Confirmability

The final component of trustworthiness in qualitative research is the confirmability or neutrality of the study. Confirmability is the second component that provides an audit trail of a research study (Korstjens & Moser, 2018). According to Ravitch and Carl (2016) qualitative researchers are not objective, but they provide data that can be confirmed. Data interpretation by the researcher is based on their preconceived notions of what the results will be (Ravitch & Carl, 2016). By keeping a clear audit trail, having my results reviewed by peer colleagues, and reviewing the data multiple times, I have provided a confirmable study.

Results

After conducting the survey and gathering all of the responses, manual coding was done until themes emerged that directly related to the research question of student nurse perception of their experiences with *horizontal violence* in their clinical hospital rotations. The final themes for this research study are defining the clinical experience, nurse realities, understanding of *horizontal violence*, and student perceptions of nursing staff. There were two discrepant themes, additional barriers to learning and comments on the survey.

Theme 1: Defining the Clinical Experience

Some research questions revolved around recalling positive and negative experiences with nursing staff and nursing management during students' clinical hospital rotations. There were 42 responses throughout the survey that I coded as positive and 34 responses that I coded as negative. By asking for both positive and negative experiences,

I engaged the respondents to think back on all they had experienced. I wanted to immerse their thoughts in the clinical aspects of their learning. Using this technique allowed me to read the responses of each respondent to get a bigger picture of their overall experiences.

When reading some of the positive statements regarding clinical experiences with nursing staff, I could hear the excitement through their descriptions. Some of those positive statements follow.

> "The nurses were helpful and willing to work with us. My most memorable experience was a nurse offering us to shadow her when we were turned away by our patient."
>
> "My nurse took me around to do everything with her, draw labs, give meds, various techniques to care for specific cardiac patients."
>
> "My best experience was with a young, extremely thorough nurse who offered a safe, respectful place for me to learn and try out new skills. She was so knowledgeable and also had a beautiful humility to her that left me eager to learn."

Some students were pleasantly surprised by their clinical experience as expressed by Respondent 44, who stated, "I can say that I really learned a lot from them, especially when I was rotated at NICU. It feels grateful to work with those clinical nursing staff in providing care to newborns. You are not just to learn knowledgeably but skillfully. And the best experience that I ever had in that clinical rotation is that when I was the one who performed the newborn bath. Because I didn't expect that as a man, who will be able to handle babies with care." And then, Respondent 48 who stated, An RN I was not

assigned to pulled me to see her do an admission on a patient with a lobectomy, and later my assigned R*n* allowed me to do blood transfusion with her supervision. In fact, the charge nurse pulled me to also show me how he would be able to insert an IV on a "hard stick". I felt the staff that day were the most student friendly of any clinical day I have ever had."

Although most of the students reported that they had limited interactions with nursing leadership or management, comments from Respondent 37 and Respondent 68 respectively were, "During a rotation during my rotation on the cardiac floor, the charge nurse came around to me and the rest of my classmates and commented on how well we have been performing and that it had been a while since he found a group of student nurses that were very competent with their job task," and "At one hospital I worked at, the nurse manager frequently hung out around the nurses station and always asked if she could help one way or another to all her nurses. She acted as a "resource nurse" and always wanted to help if she had the time. She was a great example of servant leadership (something I value highly)."

When it came to relaying information about negative experiences with nursing staff, many of the responses had similar responses to their experiences.

> "The RN I was assigned to was always gone, and I had no idea where she was in this huge hospital, I had to continually look everywhere for all 8 hours of clinical. When I finally had moments with her, she was rude and condescending when I had questions."
>
> "Stuck with a preceptor who did not want to teach or do anything with a patient."

“Most troubling experiences are when you get placed with the nurse who "doesn't want a student." I've only ever had this happen to me once, and that day was a struggle. The nurse was always casually "running off" without telling me where she was going or what she was doing. She wouldn't let me practice any skills because she kept doing them when I barely had my back turned. I was only allowed to do vital signs, not even assess my patients.”

“I had one preceptor who made me nervous in terms of her Hand hygiene. Whenever I had questions that were more disease process oriented, she would reply, oh honey, that’s beyond our pay scale. I felt admonished for being bright eyed and excited to learn.”

“Some nurses would disappear, and I wouldn’t know what to do.”

“The nurse ignored myself and my group.”

“Nursing staff wouldn't assist you and stayed on their phone the majority of the time.”

*“*Negative experiences with nursing leadership or management were minimal due to students stating that they did not have much exposure to them.”

“Management of the clinical location were very rude.”

“Cold/harsh NURSE manager did not care if students were on the unit.”

Respondent 68 did share, “At a recent clinical experience, the nurse manager was extremely rude to me. I walked past her office (first day on the unit) and simply asked how to get to a specific area. She asked me "why do you need to know?" I told her "I'm helping my nurse and going to take the vital signs of a patient and got lost on the way."

She never told me how to get to where I was going, but instead was very rude and said, "you need to be with your nurse at all times. You shouldn't be taking vital signs on your own. Put the thermometer back and find your nurse." This was my SENIOR YEAR of nursing school and frustrated me extremely."

Theme 2: Nurse Realities

This theme includes the many responses received about the learning opportunities that were or were not present for each student. I coded 86 responses for this theme. For nursing students, this is where classroom meets clinical, and comments about fear and anxiety were mixed with descriptions of learning experiences.

> "Being fresh from fundamentals course, I was a bit nervous of applying my skills, but the staff helped greatly with any doubts I had."
>
> "That feeling scared is normal, but that energy can be transformed into curiosity and willingness to be active in my experiences."
>
> "It will increase my knowledge from listening to the nurse and receiving guidance. It will also help me acquire the skills needed to perform well on staff. It will also force me to critically think, especially under pressure."
>
> "It will influence me to make sure I am looking at the whole patients *n*onverbal and verbal."
>
> "ICU Care such as oral care, mouth care, suction, wound care, repositioning, NG tube, medications."
>
> "I learned confidence in addition to completing some skills hands on for the first time that day."

"I remember getting pulled to the orthopedic floor from the diabetic unit. I had no experience in ortho, and none of the nurses or other CNAs would help me. "

"The patient had a deep festering wound that smell really bad."

"There were many things I've learned. not just by brain, but also with skills."

"I will take the experience as a learning experience in the sense that I know what to do for my next clinical rotation."

"Asking for help is beneficial; not everyone will be helpful or understanding."

"Always spend time learning about every patient especially those that can't speak for themselves."

"People are always watching you no matter what you are doing so be on your best behavior because it can land you a job."

"Knowledge is not enough to learn something; you really have to balance it between skills."

Respondent 17 said it best when they stated, "I may not feel the smartest and the best when I'm in class, but the clinical experience is worth all the pain experiences."

Theme 3: Understanding of *Horizontal violence*

There were two questions on the survey that directly related to the topic of *horizontal violence*. Question 21 asked the student nurse to describe what they know about *horizontal violence* and nursing practice. Twenty-two student nurses responded to this question, and 19 (86%) of these responses did describe some element or form of *horizontal violence*.

"Nurses can be jerks to one another. When they withhold information that could help the other nurse, are condescending and passive aggressive."

"*Horizontal violence* typically deals with a form of bullying, hostility, aggression, or just rude behaviors from one group of nurses to another. This is typically seen in nurses to nursing students with the "old eat their young" mentalities."

"That's where the stress of the job is transmitted subtly unto coworkers."

"Hostile violence in nursing can be described as hostile, intimidation, and bullying. I've seen the majority of this come from nurses hung up on the letters behind their names."

"*Horizontal violence* is a threat to nursing practice, it is allowed to thrive by leadership and management and must be dealt with by providing clear job expectations, training on workplace interpersonal communication skills and emphasis on respectful workplace environment and consequences for those who threaten the wellbeing of others through *horizontal violence*."

"Sometimes there is resentment and hostility among coworkers. It affects job satisfaction, happiness, and performance."

"This has to do with bullying or other forms of physical or nonphysical (i.e psychological, denying leave, etc) harm from other staff members or leadership at the workplace."

The three responses that indicated student nurses were not familiar with the term *horizontal violence* stated, Respondent 17, "I am unfamiliar with the term. I can assume it means violence between nursing staff," Respondent 47, "I know very little regarding

horizontal violence concerning nursing practice," and Respondent 51, "Make friends with people you can."

Question 22 asks the student nurse to describe a time when they were a victim of *horizontal violence* or when they witnessed *horizontal violence*. Responses should correlate to their response in question 21 because if they know what *horizontal violence* is, they should be able to give a suitable example. There were 20 respondents to this question and ten (50%) said that they had witnessed or been a victim of *horizontal violence*. Interesting to note is that when reading responses from the seven who indicated that they had neither seen nor been a victim of *horizontal violence,* four (57%) had described *horizontal violence* events in their answers to previous questions on this survey.

> Respondent 11 stated "n/a" to question 22 but answered a previous question with, "the nurse ignored myself and my group."
>
> Respondent 17 who was unfamiliar with the term stated, "During clinical I collected vital signs late due to a run in with other nursing staff also checking vital signs. Once I collected the patient vital signs, I told the nurse, who told me I needed to put them in the computer system. I explained I was told I did not have access and was not allowed to enter information into the file. She then complained I gave her vital signs too late, and I needed to learn how to put it in the system."
>
> Respondent 47 who knows very little about *horizontal violence* stated, "The RN I was assigned to was always gone and I had no idea where she was in this huge hospital, I had to continually look everywhere for all 8 hours of clinical. When I

finally had moments with her, she was rude and condescending when I had questions."

Respondent 51 stated, "to make friends" and previously stated, "Saw nurses talk bad about each other. Not work together."

Three responses were not descriptive of *horizontal violence*.

"I have experienced that as an RA with my boss. He made various sexual advances, numerous times of him talking down on the staff to invoke more productivity, this individual was very rude and wasted time by making stay help him with personal issues outside of our job scope."

"The other tech was upset that I was sitting 1:1 and she was doing the EKG and finger stick."

"Patient visitor got violent with nurse."

Theme 4: Student Perceptions of *n*ursing Staff

One surprising theme from this study was the strong feelings that student nurses shared regarding how they were treated by nursing staff and how they will treat student nurses in their future. I counted 141 responses of varying degrees to support this theme. Most of the responses dealt with being nice to student nurses as seen in the following statements from the survey.

"It will remind me to always be kind to the younger generations of nurses."

"The nurse didn't want a student, and there wasn't enough nurses scheduled to pass me off to another nurse on the unit."

"Not everyone will help you along the way."

“I will feel humble enough to never do that to a nursing student whenever I get assigned one in the future. Or I will not volunteer myself if I know I am having a bad day.”

“I learned how to never treat a student nurse or anyone for that matter.

not all nurses are likeable.”

“As a student nurse, I don’t think I had any recourse. I was part of a distance program so I didn’t have the rapport necessary to be very frank with my school professor about my observations. I would have feared losing the right/ ability to get placed again the following semester.”

“I will ensure to never "eat my young" as a seasoned nurse, and I will always be willing to help my colleagues.”

“I will make sure to treat students and new nurses the way I’d want to be treated.

*n*urses should NOT eat their young.”

“The people who are resentful are also not the caliber of nurse that choose to be preceptors or are asked to be a preceptor. *n*ot everyone cares about growing the profession.”

“I will never make my student feel like a burden - it's a terrible feeling that I've experienced and puts a damper on their education.”

“If I ever become a preceptor or have a student shadowing me, I will take the time to involve the student in the care and teach them to the best of my ability.”

“I will strive to encourage others wherever they are in their journey to think critically, be courteous, and always desire learning and growth.”

“That management may not always have your best interest in mind.”

“Welcome my students.”

“Teach our students as they are the future nurses/us.”

“I will always make sure to be available to teach new nurses things.”

“I would never treat someone this way. It’s no room for this is nursing.”

“If you have nothing nice to say, say nothing at all. We are a team.”

Some responses were disappointing to read as listed in the following statements.

“Not sure I want to be a staff nurse.”

“Limit how much help I can do. Be helpful, but not to helpful.”

“I learned that the nurses are being reminded of the same basics that we were being taught in school.”

“It makes me hope I don't end up being a mean nurse.”

“Please make sure staff nurses are receptive to learners. They were in our position once. We just want to learn and learn from the right people.”

“It did not impact my decision to become a nurse, but did influence my thoughts about locations I would apply for in the future.”

“It has made me rethink job locations.”

“Again, I have learned what not to do as a nurse.”

“I was entirely disappointed in the clinical experience. I felt that the nurses would prefer not to have students, and they always ran behind.”

“It has taught me to get help and never let my guard down while also being attentive to my surrounding which is why I can't get comfortable.”

"I will never make my student feel like a burden - it's a terrible feeling that I've experienced and puts a damper on their education."

"Professionally, it has made me more aware that it does occur, and it is something I should look out for to ensure it does not occur to me in my upcoming career."

Discrepant Theme 1: Additional Barriers to Learning

Several of the student nurse responses involved other disciplines or factors, outside of nursing, that added to their anxiety and created barriers to their learning.

"All files are signed online, which meant a lot of time accessing it before signatures could be added."

"Due to the pandemic, I didn't get to be a charged nurse as I was supposed to be."

"The respiratory therapists always looked at all nursing students like we were stupid."

"My instructor showed favoritism, and it showed. I don't think she should've been a clinical instructor at all."

"The biggest thing I had trouble with was my instructor asking me to do things most nurses wouldn't ask or even focused on during clinical such as stopping what I am doing to go take out some trash from random patients' room especially when discharged."

Discrepant Theme 2: Comments on the Survey

There were a few comments made about the survey. Allowing some students to share their experiences was a good thing. Commenting on the survey experience was good for the respondents as well as the researcher.

“Thank you so much for the opportunity to share my experience with you.”

“Some of these questions are confusing.”

“This was interesting to complete. Good luck in your endeavors!”

Summary

The experiences of the student nurses who responded to this survey were split almost equally, with 42 coded comments leaning toward positive and 34 coded comments leaning toward negative. Entering the clinical environment for the first time can be daunting, and the first impression is lasting. The interactions with staff nurses may indeed set the tone for the student nurse moving forward into their career. There is a wariness in some of the answers that reflect the fear of doing something wrong and corresponding responses on how student nurses will treat student nurses in the future when they are a staff nurse. Student nurses had minimal interaction with management or leadership. They were, however, keenly aware that the leadership sets the tone of the unit and the quality of care that the patients receive.

There was mixed knowledge regarding *horizontal violence*. Some nurses described the phenomenon very well but could not articulate that what they had experienced was indeed *horizontal violence*. This result would indicate that nursing students view many of the behaviors seen and experienced as part of the culture of nursing. Being afraid to confront the behavior is expected, as student nurses feel it is not their place to speak up. When asked what they would like staff nurses to know, student nurses were very articulate about what they would say and how they will behave in the future.

Nursing is a tough profession physically, mentally, spiritually, and will challenge even the fiercest personality. One student nurse summed up the experience nicely when they stated, “I know it's really hard to become a nurse as what others say, "*n*ursing is the most difficult course." But I think it depends on you; if really have the passion to fulfill your dreams, nothing is impossible. Great things happen. So, that's how my experiences influence me to become a nurse in the future.”

In chapter 5, I will discuss the interpretation of study findings, limitations to the study, and recommendations for future research. Additionally, I will discuss implications for social change and recommendations for practice.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Although there is a vast amount of literature on the topic of *horizontal violence* and nursing, little is known about the impact of *horizontal violence* on student nurses as they enter the clinical realm for the first time. The profession of nursing facing the most significant deficit of nurses in the history of the profession, understanding what student nurses experience critical to the actual survival of the profession. The purpose of this qualitative, phenomenological research study was to obtain current student nurse's perceptions about their lived experiences with *horizontal violence* during their clinical hospital rotations. Welcoming student nurses into a positive work culture increases the chances of their success, and thus the success of the profession while experiencing *horizontal violence* may have a detrimental impact on the profession and the student nurse.

This research study was guided by one research question, which asked how student nurses perceived their experiences with *horizontal violence* during their clinical hospital rotation. Invitations were sent to student nurses and invited to participate voluntarily in an online survey interview, which circulated through emails and social media. To obtain the robust number of participants needed for the survey, I circulated the invite twice through social media postings until I was satisfied that a suitable number of responses were expressing the same sentiments indicating data saturation.

Key Findings

Seventy-two student nurses logged in to the survey answering “agree” to Question 1, which served as the informed consent for this study. The number of student nurses who responded in answering at least some of the additional questions was 23 (32%). Eighteen student nurses had their first clinical rotation within the past 2 years, and 10 student nurses had previous experience in a hospital in roles such as nursing assistant, volunteer, clerical, or licensed practical nurse.

When describing their positive experiences with staff nurses, 20 (87%) of 23 respondents were able to describe a good experience they had during their clinical time. These nurses went on to describe what they learned and how the experience left them feeling encouraged and excited for their future. The other three student nurses expressed anxiety and disappointment about not having a good experience, but they did learn “what not to do.” In describing difficulties with staff nurses, three (14%) of 22 responses stated that they did not have any negative experiences to share. There were several responses where student nurses shared their surprise at the lack of knowledge some of the staff nurses had. When asked what they learned from these experiences, most were able to articulate how to treat a student nurse or the patient better.

Interactions with nursing leadership or management reported being minimal from the perspective of student nurses. Most of the statements about management were positive, with an expressed understanding that the management sets the tone for the unit. nineteen students responded to the question of a negative experience, and four (21%)

stated that they had been treated rudely by a manager. In contrast, two (11%) stated that they had issues with their instructors.

Questions that specifically addressed *horizontal violence* showed that in 19 (86%) of 22 responses, student nurses were able to describe acts of *horizontal violence*. Ten (50%) of 20 student nurses were able to describe a *horizontal violence* event that they had seen or witnessed. Seven (35%) stated that they had neither seen nor witness an act of *horizontal violence*; however, four of those seven respondents had described some type of *horizontal violence* in their previous responses to questions on this survey. When describing how *horizontal violence* has impacted them personally and professionally, 14 (88%) of 16 responses stated how they felt personally, whereas 12 (100%) responses stated how they felt professionally. Student nurses' express desires to be a better nurse than what they saw, to speak up to protect themselves and others, or to change jobs where they can be happy.

The survey concluded with a question asking the student nurse to reflect on all they have experienced and what they would tell current nursing staff and management. Overwhelmingly, 17 (100%) of the responses stated that current nursing needs to be kinder to student nurses. Remember what it was like to be a student nurse, and student nurses want to learn from you were the two most common responses.

Interpretation of the Findings

In Chapter 2, I began by defining *horizontal violence*, as found in the literature. As stated by Hopkins et al. (2018) and Smith et al. (2016), there is confusion over the definition of *horizontal violence*, and several student nurses taking this survey stated that

they do not know what the term means. The literature reported specific to student nurses and *horizontal violence* there is confusion over a clear definition of *horizontal violence* preventing researchers from understanding the full scope of this problem (Hopkins et al., 2018; Smith et al., 2016). Without supplying definitions and allowing students to answer in their words, the survey yielded accurate descriptions of *horizontal violence* from student nurses using descriptive words or phrases found in the literature. Student nurses who participated in this survey reported they have experienced or witnessed bullying, rudeness, threats, innuendoes, intimidation, ignoring, and gossiping. They used phrases such as *nurses eat their young*, not being team players, and students not welcomed.

> "I know that the phrase "nurses eat their young" came about for a reason."
>
> "Nurse abuse is prevalent in the practice and usually comes from other nurses."
>
> "Sometimes there is resentment and hostility among coworkers."
>
> "Hostile, intimidation, bullying- I've seen the majority of this come from nurses hung up on the letters behind their names."
>
> "Nurses can be jerks to one another. When they withhold information that could help the other nurse, are condescending and passive aggressive."

Without understanding the definition of *horizontal violence* or understanding that they had been a victim of these acts, students described a situation involving *horizontal violence* in their statements. These same students stated that they had not been a victim of *horizontal violence*. This finding confirms results reported by Keeling and Templeman (2013) when they stated that many students are not able to describe how they were victims of *horizontal violence*, but their experiences have left them with decreased

enthusiasm about nursing. Respondent 6 stated, “nursing staff wouldn't assist you and stayed on their phone the majority of the time. We were in the conference room and they unprofessionally told us to get out.” Then respondent 6 stated, “I have not experienced *horizontal violence*. I've seen nurses treat colleagues very poorly however.” Respondent 56 stated, “some nurses would disappear, and I wouldn’t know what to do. I needed help with a patient’s meds and she just kinda kept leaving me on my own.” Respondent 56 further stated, “I have never seen or been a part of *horizontal violence*.”

Conceptual Framework Analysis

The theory of cognitive adaptation was the supporting framework for this research study. The theory’s three tenets of searching for meaning, gaining mastery, and restoration to self (Taylor, 1983) are all present in the responses received from the student nurses. Evidenced by student comments in this research study, some student nurses have strong coping abilities and can overcome negative events showing a positive outcome while other student nurses feel confused and disappointed with their clinical experiences.

> “It has made me more aware that it does occur, and it is something I should look out for to insure it does not occur to me in my upcoming career.”
>
> “It grows a slight anger inside of me. Everyone starts out as a student, so why try to make their lives a living hell and think you're "so much better" than them. It makes me never want to work at that workplace and never be that nurse. I was entirely disappointed in the clinical experience.”
>
> “At the end of the day kind words and teamwork makes the burn out bearable.”

Searching for Meaning

When searching for meaning, one must understand why the event occurred and see the impact it has left on their lives (Taylor, 1983). The expressive passages and phrases used by student nurses when describing the impact their experiences had on them personally and professionally align with defining a meaning to the events. Responses in the survey vary from shock, anger, and disappointment over staff not being welcoming to the students into the clinical realm of nursing. Many students mentioned that they thought the staff nurse was too busy, too sick, or just having a bad day. They are assigning meaning as to why things occurred. Personal and professional impact on students was described when they said they would not treat student nurses the way they were treated. Many expressed a need to protect themselves from staff, being afraid to speak up, and how they should not be too helpful because they think their presence threatened the staff.

"I will keep my experiences in mind to shape how I interact with new students."

"Be mindful about what you say to students."

"It has influenced me to never be that kind of nurse."

"If you have nothing nice to say, say nothing at all. We are a team."

"Students are just trying to learn and help."

"I am sometimes afraid to speak up."

"I felt that the nurses would prefer not to have students."

"I would never treat someone this way. It's no room for this is nursing."

"Preceptor was busy and felt I took too much of her time."

"Limit how much help I can do. Be helpful, but not to helpful."

Gaining Mastery

When gaining mastery over an event, one must try to control elements of their future experiences to prevent the event from happening again (Taylor, 1983). The student nurses were very clear about how to control elements of the clinical environment. From rethinking jobs and not working in specific units, to never letting their guard down at work and reporting incidents to HR, students are already calculating how to control what happens to them in the future. Students state that they will be more prepared for their next clinical placement. Student nurses are learning early in their clinical rotations whom they want to emulate and whom they do not want to become.

> "I will not work in an environment that I am unhappy."
>
> "We need lessons on how to protect ourselves out in the field."
>
> "Be mindful about what you say to students. We may have thick skin, but rudeness and hostility still bother us."
>
> "Remember that once upon a time you were a student as well and at the end of the day none of us are God!"
>
> "I may not feel the smartest and the best when I'm in class, but the clinical experience is worth all the pain experienced."

Self-Restoration

Negative events often result in decreased self-esteem for the victim (Taylor, 1983). For better self-esteem, people compare their experiences to other people who have had similar or worse experiences. This projection allows the victim to become adaptable (Taylor, 1983). If the person is not able to overcome the victimization, they exhibit poor

coping skills while avoiding the situation altogether (Taylor, 1983). For some student nurses, the responses to *horizontal violence* events were described by what happened to others, but not to them. However, when asked to describe a negative experience, they were able to define an event that had happened to them. Some students had negative experiences, but very clearly stated that they were able to create positive outcomes. Other student nurses make blanket statements that all floor nurses are rude and only nurses in specialty areas are nice. These nurses have a plan on how to avoid their perceived problem units or have stated that they will reconsider their career choice. They would rather avoid the issue than learn to gain control over the issue and will be surprised to find out that these problems occur even in the specialty areas.

> "My thoughts about clinicals before I started was that students would be helpful and appreciated. After I realized that we weren't as welcomed as I had anticipated my priority was more about getting the information that I needed to complete my care plan, nursing threads."
>
> "Floor staff was never as pleasant as other areas, such as mental health, cath lab, and clinics."
>
> "Always strive for high standards towards my work ethics."
>
> "Just do your best and never attempt to discourage yourself."

Nursing is a difficult profession without adding the extra layers of negative interpersonal relationships. I believe that using the theory of cognitive adaptation for this research allowed me to understand the thoughts behind the responses received from students. Without performing face-to-face interviews, it is difficult to interpret the written

word without researcher bias. Aligning the student nurse responses with the three tenants of assigning meaning, gaining mastery, and self-restoration allowed me to see the struggle that many were experiencing. In Chapter 1, I suggested that results from this study would contribute to current literature about new nurses leaving the profession early by adding insight on early negative experiences as a student nurse and the ability or nonability of the student to overcome the event. none of the respondents in this research wrote down any thoughts of leaving the profession, only thoughts of reconsidering where they want to work.

"I will never work as a floor nurse. I don't feel the teamwork with other RN."

"It has made me rethink job locations."

Literature Review Comparison

The results of this research survey confirm that *horizontal violence* is still a problem in the profession of nursing. Student nurses' descriptions match what the literature showed was prevalent in the profession of nursing, proving that student nurses are a vulnerable population and that they were exposed and victimized by acts of *horizontal violence* during their clinical hospital rotations.

We know that student nurses require additional resources, such as increased supervision with clear boundaries. Without clear protocols within hospital organizations on how to precept student nurses, students felt confused and disillusioned with the real world of nursing confirming findings reported by Jack and Wibberley (2014), Kumaran and Carney (2014), Levette-Jones et al. (2015), and Samadzadeh and Aghamohammadi (2018). Nurse managers represent the organizational leadership structure to students, thus

impacting student experiences in a positive or negative manner. The survey results support the literature of leadership setting the tone of the unit.

> "Cold/harsh nurse manager did not care if students were on the unit."
>
> "Management of the clinical location were very rude."
>
> "Did not impact my decision to become a nurse but did influence my thoughts about locations I would apply for in the future."
>
> "Please make sure staff nurses are receptive to learners. They were in our position once. We just want to learn and learn from the right people."
>
> "I was new to the floor, wasn't sure where everything was, took a wrong turn and asked for help (which is what we're told to do!) and still got in "trouble" for it. Not all managers are nice."
>
> "The nurse manager working alongside her nurses during a shortage of nurses on the floor."
>
> "Nurse manager frequently hung out around the nurses' station and always asked if she could help one way or another to all her nurses. She acted as a "resource nurse" and always wanted to help if she had the time. She was a great example of servant leadership."

Literature showed that nurses experience physical and psychological symptoms when they were victims of *horizontal violence* (Bowllan, 2015; Chachula et al., 2015; Christie & Jones, 2013; Courtney-Pratt et al., 2018; Echevarria, 2013; Egues & Leinung, 2013; Goodare, 2015; Granstra, 2015; Karatas et al., 2017; Koh, 2016; Lee et al., 2014; Maryniak, 2015; Papa & Vanella, 2013; Purpora et al., 2015; Roberts, 2015; Sanner-

Stiehr & Ward-Smith, 2013; Weaver, 2013; Wilson, 2016). The personal impact on students psychologically resulted in student survey responses of fear and anxiety; however, none of the students relayed any physical ill effects. Confirming findings reported by Levette-Jones et al. (2015), Smith et al. (2016), and Webster et al. (2016) were student nurse reports of feeling isolated and not valued by staff.

> "It affects job satisfaction, happiness, and performance."
>
> "Threaten the well-being of others through *horizontal violence*."
>
> "I don't feel students were really welcomed. I feel like we were an added liability and responsibility that was pushed on the nurse."
>
> "As a student nurse, I don't think I had any recourse. I would have feared losing the right/ability to get placed again the following semester."

Student nurses who reported having had a good experience during their clinical rotation are excited about continuing to learn, and some expressed surprise at areas of nursing where they excelled. Students who have a positive experience are more likely to develop into a safe, competent nurse (Goodare, 2015; Levette-Jones et al., 2015; Webster et al., 2016; Wilson, 2014).

> "When you find the right nurse they LOVE to teach."
>
> "Said she couldn't have gotten through the busy day without my help."
>
> "Experience really gives me the courage to move forward to become a staff nurse in the future."
>
> "People are always watching you no matter what you are doing so be on your best behavior because it can land you a job. My last clinical rotation landed me a job

on the labor and delivery floor."

Although students in this survey expressed that they would report acts of *horizontal violence* in the future, none stated that they had reported the acts of *horizontal violence* that they experienced. Fear can prevent students from reporting *horizontal violence* as they try to fit into the culture of a unit (Budden et al., 2017; Courtney-Pratt et al., 2018; Nixon, 2014).

"I would have spoken up sooner."

"I would acknowledge their unprofessional behavior."

"I am sometimes afraid to speak up."

This survey focused on one point in time of the student nurse journey. The themes found in Chapter 2 of historical prevalence, organizational impact, and community impact are neither confirmed nor disconfirmed by the results of this study. There is a strong correlation between what new nurses have reported and what the student nurses in this survey report. The psychological impact experienced by students during their first experience with clinical nursing can only compound as they move forward in the profession. These findings support and extend the body of knowledge in the profession of nursing regarding student nurses experiencing *horizontal violence* during their clinical hospital rotations. What the results of this research study do not show is if student nurses believe that what they experienced is part of the culture of the profession of nursing or if what they experienced is a result of a nurse having a bad day.

Limitations to the Study

The components of validity and rigor must be apparent in the interpretive findings of qualitative research. According to Leung (2015) the validity in qualitative research is achieved when there is alignment of research question to the outcome, methodology to the research question, and design to the methodology. All of these components were described and aligned in the proposal for this research study. There are however several limitations to maintaining the proposed alignment in this study, thus creating limitations to trustworthiness. Due to the outbreak of COVID-19 and the ensuing pandemic there were significant changes to data collection techniques and an inability to achieve proposed quality validity and rigor.

One of the first actions taken when the COVID-19 pandemic began was to remove students from their universities, which in turn removed them from the hospitals. Then classes ended, and accessibility to students became even more difficult. The original data collection method was to use face-to-face interviews, which is a suitable methodologic choice for a qualitative phenomenological study. The interview method with open-ended questions and the ability of the researcher to use probing questions to obtain more in-depth information could have yielded different results than I did obtain in this study using an online survey format. The supporting actions to achieve trustworthiness through extended participant engagement, reflective journaling, observation, and debriefing using member checking were all eliminated. I was able to maintain trustworthiness through maintenance of audit trail, rigor of analysis, and transparency of analysis and results. There was a level of trust from student nurse

participants to researcher as they shared their stories and personal details but the depth of responses was limited to what the student was willing to write versus what might have stated during a conversational interview process.

Projected limitations outlined in Chapter 1, was getting enough responses, reconnecting with participants to validate their responses, and being a novice researcher. The limitation of being able to obtain enough student nurses to participate in the research was a challenge as I changed to an online survey format. After multiple postings and extensive outreach, I was able to obtain the needed responses to reach data saturation. Being a novice researcher was evident in the writing of the survey questions. I used the original interview guide that I had developed for the interview and transferred the questions to open-ended survey questions. I believe that the appearance of multiple open-ended questions did make it challenging for students to participate, as evidenced by 72 students logging on to the survey, and only 23 students taking time to respond.

There were a limiting number of demographic questions regarding hospital experience on the survey, but no questions regarding gender, age, ethnicity, education level, and location of respondents. Adding these demographic questions could have yielded another layer of rich statistical data adding to the results of this study. Adding other demographic data would have supported the transferability of the study to other disciplines.

Another limitation of qualitative research is the bias of the researcher. Hermeneutic phenomenology research suggested that there is a level of researcher involvement in the research process and the interpretation of findings (Willis et al.,

2016). Data interpretation for this research study was completed by hand and by me alone, thus allowing for any bias that I may have toward the subject of student nurses experiencing *horizontal violence* to creep into the final data analysis. Having a dissertation committee and peer mentors to review my findings helped to prevent me from presenting results in a non-logical, biased manner.

Recommendations

Whether or not student nurses can identify acts of *horizontal violence*, the results of this research study support that they are indeed experiencing *horizontal violence* during their first clinical rotations. These survey results answer the research question, which was to discover what student nurse perceptions are of *horizontal violence* experiences during their clinical rotations. Student nurses who participated in this research were clear about their feelings of how they experienced their clinical rotations. Many were left confused, some even questioning their decision to continue in this profession. The results of this research resonate with and add to existing literature regarding *horizontal violence* in the profession of nursing. Resulting themes found in this research study correlate to current literature on new nurses in the profession, signifying that student nurses and new nurses are both vulnerable populations to acts of *horizontal violence*, and both experienced similar physiological outcomes. Gaining mastery over these *horizontal violence* events may be determined by the individual's ability to self motivate into overcoming and persevering.

The global issue of workplace violence in nursing is considered a professional hazard (Christie & Jones, 2013; Hopkins et al., 2018; Papa & Vanella, 2013; Potera,

2016; Samadzadeh & Aghamohammadi, 2018). The problem of *horizontal violence* is also international in the profession of nursing but is an element that stems from within the profession itself (Birks et al., 2017; Budden et al., 2017; Flateau-Lux & Gravel, 2014; Goodare, 2015; Koh, 2016; Park et al., 2015; Taylor, 2016; Tee et al., 2016). To eliminate *horizontal violence* from the profession would be the ultimate goal, but this recommendation may be too lofty. More reasonable recommendations for future research start with a more in-depth and narrower look at *horizontal violence* at a specific hospital or a specific nursing education institution.

Correcting the problem of *horizontal violence* within a hospital would involve a pre-survey, education, leadership training, and follow up survey. This follow-up would involve more than the hospital stating in a policy that they do not tolerate violence of any kind but would involve a culture change. A study of this proportion would have easy to control variables and visible outcomes with future research studies resulting from those outcomes. The additional recommendation would involve educating nursing students in nursing school about the true definition of *horizontal violence*, how to identify these acts of *horizontal violence*, how to appropriately respond to these acts of *horizontal violence*, and how to overcome and preserve in the face of *horizontal violence*. These two study recommendations would result in opportunities to do longitudinal studies to determine if the lack of *horizontal violence* in a specific hospital or a specific group of nurses would help to decrease attrition from the profession.

I would be remiss if I did not mention the recommendation of face-to-face interviews with student nurses regarding their perceptions of *horizontal violence* during

their clinical hospital rotations. This study did provide results showing that student nurses are experiencing *horizontal violence* as early as their first clinical rotation. The ability to probe with interview questions, to obtain in-depth personal data, would allow me the opportunity to examine the phenomena of *horizontal violence* in student nurses more closely. Results from in-person interviews would allow me to look at specific demographics such as age, gender, first or second career, and ethnicity. A locality study such as this would provide useful data to local nursing schools as well as local hospitals.

Implications

This study contributes to the current body of knowledge regarding student nurse experiences with *horizontal violence*. *Horizontal violence* in the form of bullying, incivility, and many other negative behaviors is prevalent in society and not limited to the profession of nursing. The idea that we could eradicate these behaviors entirely from life is unrealistic. The initiative for change must start within each individual person, educational institution, and hospital organization. With the degree of mounting social issues in our world today and the fact that nursing is the most trusted profession, it is imperative that nurses lead the way to a more positive and inclusive society. Beginning within our own profession, there has never been a more appropriate time for positive social change.

Positive Social Change

Social change per Walden University (2018) is "a deliberate process of creating and applying ideas, strategies, and actions to promote the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, and

societies." This study is about understanding student nurse perceptions in an effort to promote the worth and development of these individuals. Results from this study support positive social change across the profession of nursing by providing a foundation for nursing education and hospital organizational reform. For the positive change to occur, we must all be involved in the change. Seasoned nurses everywhere need to listen to student nurses to help soften our approach to them and each other. Student nurses were very clear in their responses to remind nurses that they were once students and that the students were there to learn. Many of the student responses indicated that they would remember what it was like to be a student nurse. Remembering their experiences is how the change begins. By promoting the positive experiences of students, these students become our positive future leaders in nursing education and hospital institutions. These students are the hope for our positive cultural shift in nursing. A positive shift in the culture of nursing will improve patient outcomes, decrease financial burdens on hospitals, and decrease registered nurse attrition.

Methodological, Theoretical and Empirical

Although Taylor's theory of cognitive adaptation originated in association with the ability of people to deal with clinical illnesses such as diabetes, cancer, and HIV, it is my proposal that cognitive ability to overcome perceived or real events aligned with this research. According to Taylor (2008), the perception that one is cared about in the work environment decreased turnover and supported coming to work. Working in a supportive culture allows people to interpret potentially stressful encounters as challenging events or a chance to learn (Taylor, 2008). Taylor (2008) stated that positive social support is most

important to newcomers into the organization. This theory resonated with this research study because if students as newcomers into a unit perceived a negative event of *horizontal violence*, but the social support in the unit is strongly positive, they may not perceive the event as significant enough to be considered *horizontal violence* and thus will not report it as such. Using the theory of cognitive adaptation, student nurses, our future generation of nurses, will learn how to overcome *horizontal violence* and create a new positive nursing workforce.

Qualitative phenomenological research was the appropriate methodology for any study involving lived experiences (Cypress, 2018; Patton, 2015; Ravich & Carl, 2016; Sloan & Bowe, 2014). The Covid-19 pandemic did change the manner in which I recruited participants, but the study did yield to the results that I sought to obtain. The results from this study do support that student nurses are exposed to and are victims of acts of *horizontal violence* as early as their first clinical rotation. Moving forward, I would recommend a mixed method research study to achieve more in-depth results which would increase the validity and rigor of this study (Ravich & Carl, 2016). A mixed method study would give the profession of nursing results for more direct intervention by defining characteristics such as gender, age, ethnicity, and locality. Further probing of student nurses would help the profession of nursing to understand if student nurses felt that their experience was normal for the nursing environment. If student nurses feel *horizontal violence* was part of the nursing culture, it may be difficult for student nurses to identify the behaviors making it difficult to measure (Taylor 2016). Without accurate measurement, it is difficult to apply effective interventions (Taylor, 2016).

Clinical, Educational and Leadership

As positive change occurs within nursing and fewer nurses leave the profession due to acts of *horizontal violence*, the possibilities for improving nursing practices are endless. Generational nursing will learn how to work together, accentuating each generation's strengths, and nursing will gain a respected seat at the executive table. Many positive social outcomes can result from everyone taking steps toward improving student nurse experiences in clinical rotations.

Nursing schools must incorporate education on the phenomenon of *horizontal violence* and the negative impact it has had on the individual, organization, and the profession of nursing. nursing faculty must change in their approach to placing student nurses in clinical rotations based on feedback from previous students or by open dialogue with nursing leadership of the clinical facility. Nursing faculty should take a collaborative approach to what experiences their students are having in their clinical rotations.

Hospitals must look at nursing units collectively and individually to educate staff on *horizontal violence*. A no-tolerance approach to *horizontal violence* on all levels of the hospital organization is a minimum requirement. The positive change in the treatment of student nurses will enhance relationships among current nursing staff, decrease nursing turnover, and improve patient outcomes. When patient outcomes improve, the hospital improves its financial bottom line, and the community is well served (Furst, 2018; Sanner-Stiehr & Ward-Smith, 2015; Walrafen et al., 2012; Weaver, 2013). The movement toward excellence in nursing establishes a decrease in tolerance for these negative behaviors. Hospital administrators need to be made aware that the acts of

horizontal violence are detrimental to the organization and that they are responsible for setting the positive tone within the organization.

Conclusion

This qualitative phenomenological research study sought to and provided insight into what our current student nurses perceive of *horizontal violence* experiences during their clinical hospital rotations. Conclusively, the results of this study show that student nurses are experiencing *horizontal violence* as early as their first clinical rotation. The literature showed that *horizontal violence* is part of the culture of nursing and is many times used as indoctrination for new nurses. The literature also shows the detrimental impact that *horizontal violence* has on the individual physically and psychologically, leading up to death in some cases.

The predictions of the profession of nursing experiencing its most significant deficit of staff nurses by 2020 are upon us. Compounded unexpectedly by a pandemic of unknown boundaries, nursing retirements are increasing, resignations are increasing, and nursing staff is struggling to take care of patients while risking their own lives in doing so. The exodus from the profession in increasing in ways that we were not expecting. We need our student nurses, more than ever, to be encouraged by their choice of nursing as a career. We need to welcome all student nurses into the profession and help them to assimilate successfully into practice. We need to eliminate *horizontal violence* in the profession of nursing!

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Appendix A: Interview Guide

Introductory Statement

Thank you for agreeing to participate in my research study. I am conducting this research study as part of my PhD studies. Everything that we discuss here is confidential, and your name will not appear in any of my work. There is no form of compensation for your participation in this study, and your participation is voluntary. If there is ever a time during the interview process that you would like to quit, please let me know, and we will stop.

I will be using quotes from your story in the reporting of my results; however, I will create an alias so there will be no way for others to identify you. You should be able to identify yourself in the research paper. Today, we will be discussing your perception of *horizontal violence* during your clinical rotations. I will ask you to sign a consent form or participation, and I will audiotape our interview so that I may pay more attention to what you are saying.

At the end of the interview, you may add any further information that you think we did not cover or that you think is pertinent to the topic we are discussing. I will ask for your contact information at the end of the interview in case I need further clarification on something that you said in your interview. Also, you will be provided the opportunity to

read the transcription of the audio recording, if you choose too, to verify what you said is what you intended to say.

Do you have any questions before we begin?

I will turn on the audiotape at this time.

Turn on Recorder

My name is Phoebe Burda, and I am a student at Walden University, conducting a research study as part of my dissertation. Before the interview questions begin with you, I need to verify consent. Please answer yes or no to the following two questions.

Are you participating in the research study voluntarily?

Do I have your permission to audio record this interview?

Interview Questions

- When did you complete your first clinical rotation?
    - Tell me about any other clinical exposure to nursing staff you may have already experienced (Prompting details: where, when, how long, in what capacity).
- The next few questions will reflect on your interactions with the nursing staff.
    - Tell me about the best experience you had in your clinical rotation.
        - What did you learn from this experience?
        - How will this experience influence or not influence you as you move forward to becoming a nurse?
    - Tell me about a troubling or difficult experience you encountered during your clinical rotation.

        - Tell me more. What were the circumstances surrounding the event?
        - What did you learn from this experience?
        - Reflecting on this experience, what, if anything, would you do differently?
        - How will this experience influence or not influence you as you move forward to becoming a nurse?

- The next few questions will reflect on your interactions with leadership or management.
    - Tell me about the best experience you had with leadership or management.
        - What did you learn from this experience?
        - How will this experience influence or not influence you as you move forward to becoming a nurse?
    - Tell me about a troubling or difficult experience you encountered with leadership or management during your clinical rotation.
        - Tell me more. What were the circumstances surrounding the event?
        - What did you learn from this experience?
        - Reflecting on this experience, what, if anything, would you do differently?
        - How will this experience influence or not influence you as you move forward to becoming a nurse?

- Tell me what you know about *horizontal violence* concerning nursing practice.
    - In your own words, define *horizontal violence*. (Prompting words: bullying, incivility, workplace violence).
    - Tell me about a time you were a victim of *horizontal violence*.
    - (Optional question) Describe a situation where you observed *horizontal violence*.
    - Please describe for me how your experience with *horizontal violence* has influenced you personally (follow up with how it has influenced your decision to become a nurse).
- Reflecting on everything you have said here today, if you had the opportunity, what would you like to tell staff nurses or nursing leadership about your first experience with clinical hospital nursing? (Prompting words: communications, interactions, hospitality).
- What other information would you like to share with me regarding your first clinical experience in the hospital?

Is there anything else you would like to share with me at this time?

Closing Statement

Thank you so much for participating in my research study.

As a reminder, I will be following up with you after I transcribe the interview or if I have any questions that need clarification.

Could you please give me an email or phone number, whichever is the best way to reach you?

I will be back in touch with you within five days so that all of the information you shared is still fresh in your mind.

I will now turn off the audiotape.

Appendix B: Informed Consent (Question 1)

Student *n*urse Perceptions of *Horizontal violence* During Their Clinical Hospital Rotations

Survey is for student nurses and is being conducted as part of a student nurse doctoral study.

Dear Student *n*urse,

You are being invited to participate in a survey research project looking for Student *n*urse Perceptions of *Horizontal violence* During Their Clinical Hospital Rotations. You are being contacted because you are currently a student nurse. This survey is being conducted as part of a nursing student doctoral study. The survey asks questions about your perceptions of events observed or experienced during your hospital rotations as a student nurse. It should take you about ten to fifteen minutes to complete.

The results of this project will be used for the completion of a nursing student doctoral research project. Through your participation, I hope to understand how student nurses describe their experiences as they are training to become a nurse. My hope is that the results of the survey will be useful in making improvements in clinical experiences for student nurses. I will share my results by completing my dissertation and eventually publishing them in a scientific journal.

There is no funding for this research project. There is no direct benefit to you for participating in this study. There are no known risks to you if you decide to participate in this survey, however, should any unexpected injury occur as a participant in this study, treatment will be provided in accordance with applicable federal regulations (38 CFR 17.85). This requirement does not apply to injuries obtained due to noncompliance with study procedures or research conducted for VA under a contract with an individual or a non-VA institution [HT1]. The alternative of participating in the survey would be not participating in the study. I will not share any of your responses with anyone outside my research group which consists of me and my mentor who is a PhD R*n* overseeing my research project.

I will do my best to keep your information confidential. All data is stored in a password protected electronic format. To help protect your confidentiality, the surveys will not contain information that will personally identify you. The results of this study will be

used for scholarly purposes only and may be shared with Augusta University, Walden University, or Charlie *n*orwood Research representatives.

I hope you will take the time to complete this questionnaire; however, if you agree to participate in the survey you are not required to answer all the questions. Your participation is voluntary and there is no penalty if you do not participate. If you have any questions or concerns about completing the questionnaire, about being in this study, or to receive a summary of my findings you may contact me at 407-399-2550.
If you have any questions or concerns about the "rights of research subjects", you may contact the Augusta University IRB Office at (706) 721-1483, Charlie *n*orwood Research Department at (706) 733-0188 x 2510, or the VA Privacy Officer is 706-733-0188 extension 7603.

Sincerely,

Phoebe Burda, PhD(c), R*n*
Phoebe.burda@waldenu.edu

1. By clicking on agree, you are indicating that you have read the above information, that you are at least 18 years of age, and you are participating voluntarily. If you do not wish to participate in this study, please click on disagree and exit the survey. Thank you.

- o Agree
- o Disagree

Appendix C: Survey Interview Questions

2. When did you complete your first clinical rotation?

3. Prior to your first nursing clinical rotation, have you worked in a hospital before?

4. If you answered yes to question 2, what was your position and how long ago was this?

5. Describe the best experience you had in your clinical rotation with nursing staff.

6. What did you learn from the experience you described in question 4?

7. How will the experience you described influence or not influence you as you move forward to becoming a staff nurse?

8. Describe a troubling or difficult experience you encountered during your clinical rotation with nursing staff.

9. What were the circumstances surrounding the event you described in question 7?

10. What did you learn from this experience you described in question 8?

11. Reflecting on this experience, what, if anything, would you do differently?

12. How will the experience you described in question 8 influence or not influence you as you move forward to becoming a nurse?

13. Describe the best experience you had with leadership or management during your clinical hospital rotation.

14. What did you learn from the experience you described in question 12?

15. How will the experience you described in question 12 influence or not influence you

as you move forward to becoming a staff nurse?

16. Describe a troubling or difficult experience you encountered with leadership or management during your clinical hospital rotation.
17. What were the circumstances surrounding the event described in question 15?
18. What did you learn from the experience you described in question 15?
19. Reflecting on the experience described in question 15, what, if anything, would you do differently?
20. How will the experience you described in question 15 influence or not influence you as you move forward to becoming a nurse?
21. In your own words, describe what you know about *horizontal violence* concerning nursing practice.
22. Describe a time that you were a victim of *horizontal violence*. If you have not been a victim, please describe a situation where you observed *horizontal violence*.
23. Please describe how your experience with *horizontal violence* has influenced you personally.
24. Please describe how your experience with *horizontal violence* has influenced you professionally.
25. Reflecting on everything you have experienced, if you had then opportunity, what would you like to tell staff nurses or nursing leadership about your first experience with clinical hospital nursing?
26. If there is anything else you would like to share at this time, please do so below.