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Reducing Lateral Violence Among Nurses Through Staff Education

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This is to certify that the doctoral study by

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

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MSN, Western Governor's University, 2013

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Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Most nurses experience lateral violence (LV) during their careers. LV can be detrimental to nurses' livelihoods and careers, to facilities due to nurse replacement costs, to the nursing profession due to attrition, and to patient safety. The purpose of this staff education project was to educate registered nurses on the issue of LV and to equip nurses to respond to their aggressors. The project question addressed whether education would increase awareness of LV and empower nurses to stand up to their aggressors. The theory of the nurse as the wounded healer, social learning theory, and the theory of reciprocal determinism guided this project. Pretest, posttest, and evaluation data were collected from 155 nurse participants who completed an online education module. Data were analyzed by calculating the change scores between pretests and posttests and by assessing the evaluation data based on the number of nurses who answered at the highest positive levels on a Likert-style scale. Results showed a 24.64% increase in awareness from the pretest to posttest. Evaluation data indicated that nurses felt they had a better understanding of LV, felt better equipped to confront their aggressors, were concerned about the incidence of LV in the workplace, and wanted further education. Findings may be used to support positive change through routine education on LV to enable nurses to identify LV behaviors and use strategies including cognitive rehearsal, conflict resolution, and emotional intelligence to combat LV and change the culture of the nursing profession.

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Dedication

I dedicate this project to all of my fellow nurses; to those who suffer *and* perpetrate lateral violence, we are all in this together. I write this for you and for me as no one is infallible and we are all subject to episodes of undesirable moods and behavior. However, I still believe us to be altruistic and purpose driven. We can often feel as if our profession is highly regarded, yet thankless. Through this project and research, I thank you. I wish to see us thrive through self-realization and a willingness to behaviorally change. From one nurse to another, let us reflect the compassion and care we shine onto our patients and families onto each other.

Acknowledgments

First, Tavey and Edward, I miss you every day. I would like to give thanks to my family for their love and support over the last 3 years. They never thought I would make it to college, let alone be the first to obtain a doctoral degree. I also am grateful for my friends and significant other for listening to my incessant complaining about having to repeatedly revise and submit elements of this paper. You have been so gracious, and I appreciate it very much.

I cannot thank my preceptor, Twilla Harrington, RN, enough for seeing me through all of my practicum hours and the implementation of this project. She was with me every step of the way and; without her, this project would not have been possible.

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As for my other committee members, Dr. Cole and Dr. Vitale, I appreciate all of your time and feedback on my project. I appreciate all of your help.

Last, but surely not least, I give a heartfelt thank you to Janie Griffin, RN, my boss. She has been supportive from the beginning and has remained flexible with my schedule as I worked my way through Walden's program. It truly would not have been possible without you.

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Section 1: Nature of the Project

Lateral violence (LV) has plagued the nursing profession for decades and has been on the increase (Bartholomew, 2006; Christie & Jones, 2013; Chu & Evans, 2018). LV, which is workplace violence among organizational peers, is noted to be a worldwide epidemic (American Nurses Association [ANA], 2011; Johnson, 2009; Vessey, DeMarco, & DiFazio, 2011). Almost 50% of nurses have reported incidents of strong verbal abuse and threatening body language, and over 50% of nursing students have reported being belittled by a staff nurse (ANA, 2011). Christie and Jones (2013) reported that 85% of nurses experience some form of lateral violence during their career, and over 90% of nurses have witnessed LV happening to their coworkers. LV is a global problem affecting most nurses at some point during their careers (Vessey et al., 2011). Curtis, Bowen, and Reid (2013) noted that roughly 20% of newly graduated nurses in Australia leave the profession within a year after graduation because of incidences of LV. Vogelpohl, Rice, Edwards, and Bork (2013) revealed that over 30% of new nursing graduates change jobs frequently, and almost 30% will leave the profession.

The solution to reducing LV in nursing is unknown, but some researchers have found that the nursing profession is regarded as oppressed due to a hierarchical organizational system that lends itself to perpetuating LV (Becher & Visovsky, 2012; Christie & Jones, 2013; Curtis et al., 2007). Coursey, Rodriguez, Dieckmann, and Austin (2013) noted a few successful LV policy implementations in some facilities, but discovered that most LV policies are not implemented properly, are not enforced, and are in place merely to satisfy compliance mandates. There is a lack of evidence to direct best

practice regarding implementations for LV (Coursey et al., 2013). Much of the literature indicated a need for improved studies and further research to have successful implementation (Coursey et al., 2013; Jiao et al., 2015; Vessey et al., 2011).

Several researchers have illustrated the problem of LV and made recommendations, yet few have proposed viable solutions or implementations to curb the incidence of LV (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Griffin, 2004; Koch, 2012; Stanley, Martin, Michel, Welton, & Nemeth, 2007). The purpose of the current project was to address the issue of LV and implement an educational module to increase awareness of LV to empower nurses to stand up to those who are committing acts of LV. If no solution is implemented and if nurses do not come together to create a better work environment, the number of nurses will continue to decrease, costs to facilities will continue to increase, and the number of positive patient outcomes will decline (American Association of Critical Care Nurses [AACN], 2004; ANA, 2016; Curtis et al., 2007; Hayden, 2016). Findings from this project may contribute to a new culture of nursing in which nurses care for one another as well as for patients.

Problem Statement

Lateral violence is defined as disruptive behavior that is deliberately imposed on one employee by another (Christie & Jones, 2013; Woelfle & McCaffrey, 2007). There are many contributing factors to the increasing nursing shortage. However, there is one inconspicuous cause of the decreasing number of nurses: lateral violence (Curtis et al., 2007). In cases of LV, the individual responsible for the bad behavior is typically lacking some sense of control and seeks to remedy that by verbally abusing, belittling,

humiliating, or intimidating a targeted other (Embree & White, 2010; Murray, 2009). These types of behaviors may leave the person experiencing LV feeling vulnerable, defenseless, angry, depressed, and hopeless. Once these emotions are set in place, it can be difficult to recover a sense of normalcy, which can affect work relationships, home life, and patient outcomes, and may also result in the nurse leaving the profession.

Local Relevance of Problem

LV is currently present in the Pacific Northwest. Etienne (2014) conducted a study in the Pacific Northwest by administering the Negative Acts Questionnaire-Revised (NAQ-R). Findings showed that 48% of nurses experienced LV behaviors (being ignored, having opinions ignored, and excluded) within the previous 6 months (Etienne, 2014). There were no substantial data on the incidence of LV at the DNP project site, and the organization does not release turnover rates. However, a local travel agency provided information on the need for relief workers as well as the unfilled nursing shifts on any given day, which average around 50 (Local health care agency owner, personal communication, August 31, 2018). At the time of the study, these were the only available data in the area. A nurse at the local facility disclosed that over half of unit nurses left their jobs due to lateral violence and that she was considering leaving the profession to pursue entrepreneurial endeavors because going to work was too stressful (personal communication, date). This is one example of many stories I heard while researching this problem in nursing units across the area.

Significance for the Field of Nursing

The impact of LV can have a ripple effect. The nurse feels the initial insult, but repeated attacks of LV may result in feelings of vulnerability, anger, depression, hopelessness, and anxiety (Dehue, Bolman, Vollink, & Pouwelse, 2012; Vessey et al., 2011). Victims of LV in nursing also tend to have an earlier onset of cardiovascular disease as well as other physical ailments (Christie & Jones, 2013). The ripple effect can occur when a nurse begins having trouble with home life and interpersonal relationships outside of work, and leaving the job or profession can have a lasting psychological impact (Griffin, 2004; Vessey et al., 2011).

LV directly contributes to the nursing shortage in that 30%-50% of new nurses leave their first job within the first year after employment because of LV by senior nurses, and one in three nurses will leave after 2 years (Coursey et al., 2013; Curtis et al., 2013; Robert Wood Johnson Foundation, 2014; Sauer, 2013; Winfield, Melo, & Myrick, 2009). Although many factors contribute to the nursing shortage, such as an aging nursing population, an increasingly elderly population, health care reform, lack of nursing educators, and decreased nursing school enrollments due to lack of faculty and clinical site availability (ANA, 2016; McMenamin, 2014), one of the major factors in the nursing shortage is LV (Curtis et al., 2007; Vogelpohl et al., 2013). Conversely, the nursing shortage contributes to increased incidence of LV. The nursing shortage causes decreased job satisfaction, fatigue from overtime and long shifts, and injury (ANA, 2016). These factors increase the incidence of LV and decrease the number of nurses in the workforce, making LV a cause and effect of the nursing shortage.

Nurse attrition and other effects of LV, such as lower job satisfaction, anxiety, depression, and lack of trust for the organization, decrease the delivery of quality patient care, diminish safety, and can result in preventable patient deaths (AACN, 2014; Christie & Jones, 2013). Some examples of the negative effects of LV on patient care are errors made due to nurses not asking questions out of fear of belittlement, decreased tolerance and patience for patients, less energy to put forth at work, and short staffing due to increased absences (Griffin, 2004; Johnson, 2009). Another issue associated with LV is the financial burden. Absenteeism, overtime, utilization of travelers and/or agency staffing, and onboarding new staff are costly to a health care organization, and costs range from $30,000 to $100,000 per individual per year (Becher & Visovsky, 2012). Estimates of costs of onboarding new staff are $64,000 to $145,000 per nurse (Hayden, 2016). The financial burden does not rest solely on the shoulders of an organization. Other financial burdens occur from costs related to the LV victim's need for mental health care and disability, facility costs due to adverse patient outcomes, and costs to patients who are unable to obtain health care due to decreasing numbers of primary care providers (ANA, 2015; Bennett & Swatzky, 2013; Hayden, 2016; Vessey et al., 2013).

LV has been studied since the 1970s (Bartholomew, 2006). Researchers have examined the phenomenon every few years as if it were a new topic. The literature indicated that the problem of LV is staggering, but researchers have not offered concrete solutions to address the problem. LV has existed so long within the nursing profession that it appears to be ingrained in the culture. Therefore, it may be difficult to effect change quickly.

Purpose

There is a significant gap in practice due to the lack of a policy and procedure to reduce LV. There is no current, formal process to deal with LV. There are only position statements and recommendations, which leave the profession without accountability to the nursing workforce (AACN, 2004; ANA, 2015; Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2008). There is no federal regulation or policy regarding LV at this time, and there is no policy at the state level, either. An interview with an Oregon health legislator revealed that he did not know of LV or its consequences (personal communication, March 21, 2016). This lack of knowledge makes it difficult to put the issue of LV on a legislative agenda. There are currently no mandates by the state board of nursing regarding LV. The search for mandates or policies on the board's website only referred to other organizations' position statements and listed other websites that made materials on LV that were available for purchase. There are policies and mandates for physical violence toward nurses, but none on LV, bullying, or incivility. The Board of Nursing website also redirected inquiries of bullying to the state Nursing Association that listed only recommended actions regarding LV. The Joint Commission standard LD.03.01.01 states that leaders are to "create and maintain a culture of safety and quality" (ANA, 2015, p. 2), but it is up to nurse leaders to enforce this standard and all employees to follow suit. What is observed in practice is nurses behaving badly toward each other.

The project question for the DNP staff education project of lateral violence in nursing was the following: Will education increase awareness of LV and empower nurses

who are victims of LV to confront their aggressors? The gap in practice is wide and could close at the project site organization through the implementation of this DNP project. Specifically, the gap can be closed through repeated education as many other practice problems are addressed. The purpose of this doctoral project was to inform and equip nurses with communication tools through education so that a behavior change could occur in nursing units, facilities, organizations, and communities.

Nature of the Doctoral Project

Literature on lateral violence in nursing was searched using CINAHL Plus with Full Text, Medscape, Pub Med, Cochrane Reviews, and the Joanna Briggs Institute. Journal articles and education-based materials published between 2010 and 2017 were included. Search terms that were used included *nursing*, *lateral violence*, *violence*, *horizontal violence*, *incivility*, *harassment*, *workplace violence*, and *vertical violence*.

Meeting the goals of this lateral violence in nursing staff education project, raising awareness and offering active solutions to lateral violence in nursing, was achieved by a variety of methods. Licensed nursing staff in a regional organization completed an education module on LV. Pretests and posttests were administered and evaluated for learning (i.e., increased awareness). Additionally, there was a course evaluation to address whether the nurse felt more equipped to handle incidents of LV. Because there was no formal method for dealing with the problem of LV, this project raised awareness of LV and provided nurses with proactive, meaningful ways to address instigators.

Findings would indicate an increase in knowledge as evidenced by the difference in pretest and posttest scores. Additionally, it was anticipated that the nurses would feel more equipped to deal with LV and would desire further education. These findings would begin to close the gap in practice by decreasing the incidence of LV by encouraging nurses to stand up to their aggressors. Additionally, the findings may also be used to promote routine education on LV as well as a standard of practice or policy.

Significance

The significance of this DNP staff education project was how it would affect the stakeholders. One group of stakeholders in this project was the licensed nursing staff within a Pacific Northwest regional medical center's Home Care Services division. Nurses are at the frontlines of LV and therefore may be greatly affected by the outcomes of this project. Other stakeholders included management, the organization, and the community. Management had a stake in how nurses are performing and the number of nurses who can be obtained and retained to care for patients. The organization's stake was in retention of nurses and how retention rates can affect patient outcomes, nursing turnover costs, and overall impact to the organizational budget (Hayden, 2016; Jones & Gates, 2007). The community had a stake because patients expect to receive safe care, not poor outcomes as a result of LV (ANA, 2015; JCAHO, 2008; Oregon Nurses Association [ONA], 2009). Other stakeholders include the Home Care Services Clinical Council and the facility's Workplace Violence Committee so that they can develop continuing quality improvement (CQI) plans.

The potential contributions of this project to the nursing practice are nurses who treat each other as they are taught to treat their patients, which will create an environment that is nurturing to individual strengths and that transforms negative behaviors into moments of consideration and learning. This positivity and growth may curb organizational spending, decrease nursing turnover, improve patient outcomes, and increase solidarity among nurses to propel the profession forward. Additionally, national standards and/or policy regarding LV could become a reality.

This project has a high potential for transferability as LV is not confined to the nursing community within health care organizations, but also affects nurses in academia, student nurses, and other health care professionals (Curtis et al., 2006). Nurses are social change agents (AACN, 2006). In this case, nurses will make a change for themselves as well as the profession. Based on conversations with many nurses in this care arena, I concluded that this project would have a positive impact. Although change may not occur rapidly, change will occur, which is what is desired and needed by the nursing community. This project was viewed in a favorable light by project site staff and could be the impetus for organizational change throughout this region and across other regions where this organization is present. Project findings may also effect change in other areas of the medical community. Bandura (1969) noted that behavior is learned by imitation. If nurses can change their behaviors by learning from each other, others may do the same.

Summary

LV is a significant problem in the nursing profession. The purpose of this project was to change a dysfunctional caring culture to one that values respect and cohesiveness

among nurses. Nurses are at the forefront of patient care and play an integral role in the health care system. The statistics on LV that were reported by the ANA (2011) are staggering, and LV shows no sign of abating unless there is action to stop it. The relevance of LV has been documented for decades from all areas of the world. Positive social change can result in decreased LV for individuals, professions, organizations, and the community. The question addressed in this staff education project on lateral violence was whether education would increase awareness and empower nurses to confront their aggressors. In the next section, I examine the theories behind this project, provide definitions of terms, address the history and scope of the problem, and offer potential solutions. Additionally, I describe my role as the DNP student.

Section 2: Background and Context

LV is defined as the overt or covert commission of verbal or nonverbal acts of aggression (ANA, 2011; Griffin, 2004) between nurses within an organization (Christie & Jones; 2013; Granstra, 2015). For this DNP staff education project, LV was used to describe untoward behavior, even though LV encompasses other terminology that is used interchangeably in other literature. These terms include, but are not limited to, horizontal violence, incivility, harassment, and bullying. Other definitions will be discussed later in this section.

LV affects over 85% of nurses at some point in their career (Christie & Jones, 2013). The purpose of this nursing staff education project was to increase awareness of lateral violence and empower nursing staff to confront their aggressors. The practice-focused question was the following: Will education increase awareness of LV and empower nurses who are victims of LV to confront their aggressors? In this section, I describe various concepts, models, and theories for LV. Specifically, I address social learning theory (Bandura, 1969), the theory of reciprocal determinism (Bandura, 1986), and the theory of the wounded healer (Conti-O'Hare, 2002). The local background and context of this practice problem, terminology definitions, the scope of the LV problem, and the role of the doctoral student are also addressed in this section.

Concepts, Models, and Theories

There are numerous theories and conceptual frameworks associated with LV mentioned throughout the literature. In this section, I examine the theories that were used in this project: social learning theory (Bandura, 1969), the theory of reciprocal

determinism (Bandura, 1986), and the theory of the nurse as the wounded healer (Conti-O'Hare, 2002). Several other models were considered and rejected, including oppression theory, the health belief model, and the theory of conservation of resources.

The oppressed group theory, or oppression theory, was introduced by Freire (1970) and proposed that there is an acceptance and allowance of oppression because of an imbalance of power and that there is a relationship between the oppressed and the oppressor. Roberts (1983) described nurses as an oppressed group in that nurses often feel powerless and therefore seek power by airing their grievances and tearing down their peers. An imbalance of power (perceived or actual) exists between staff nurses, staff nurses with titles, management, and nurse executives (Becher & Visovsky, 2012; Coursey et al., 2013; Curtis et al., 2007; Stanley et al., 2007; Rodwell & Demir, 2012; Weaver, 2013). Curtis et al. (2007) described a pecking order that nurses establish among themselves. Freire (1970) noted that the oppressed put themselves in this category by accepting oppression, are oppressed by force (and remain in that state out of fear), or fight for liberation (which carries with it the risk of becoming a perceived or actual oppressor). The purpose of this project was to raise awareness and offer solutions to LV among nurses. Changing perceptions of oppression was not the main focus of this project; therefore, oppression theory was not used. Changing perceptions may occur after awareness is increased and learned strategies to combat LV are employed.

The health belief model (HBM; Hochbaum, Rosenstock, & Kegels, 1952) includes six constructs: perceived severity, perceived susceptibility, perceived benefits, perceived barriers, self-efficacy, and cue to action. The model assumes that patients

change health behaviors based on those constructs (Jones et al., 2015). Stanley et al. (2007) applied the HBM to create the Lateral Violence in Nursing Survey which is used to identify the perceived seriousness of LV, perceptions of the oppressors, and perceptions of the mediators. Although the HBM is generally applied to patient health behaviors and illness, it can also be applied to nursing behaviors. Although this theory addresses behavioral change, it was not used because the nurses at the project site organization already desired change and did not need to be convinced that changing the culture was a good idea.

Allen, Holland, and Reynolds (2014) studied the association between bullying and burnout using the theoretical framework of conservation of resources (COR). Allen et al. applied COR to evaluate the efficacy of psychological detachment as a mediating response between bullying and burnout. The theory suggests that when stress is actual or perceived from internal or external sources, individuals attempt to adapt to the stress (Hofböll, 1989). When bullying in the workplace occurs, it has a profoundly negative impact on nurses and increases stress levels that are not mediated well, which increases the risk for burnout (Allen et al., 2014). LV has been associated with burnout and compassion fatigue (Stamm, 2010), which is a point where there is an ineffective adaptation to stress. Due to LV being past the point of adaptation, this theory was not used for this project.

This project on lateral violence in nursing was guided by the theory of the nurse as the wounded healer (Conti-O'Hare, 2002), social learning theory (Bandura, 1969), and the theory of reciprocal determinism (Bandura, 1986). The theory of the nurse as the

wounded healer describes those who find healing by helping others through similar experiences. Well over half of nurses experience LV in their career (Christie & Jones, 2013). Nurses who have suffered LV attacks may be able to help others cope and heal from LV while healing themselves. Christie and Jones (2013) discussed the theory of the nurse as the wounded healer and how to use this theory to cope with incidences of LV.

The wounded healer refers back to Greek mythology and the immortal centaur, Chiron, who was mortally wounded but was unable to die (Hamilton, 1969). To get past the pain and suffering of the wound, Chiron went to Hades to transform his pain into healing power for others who were suffering (Hamilton, 1969). The theory, as it relates to nursing, suggests that ineffective coping after trauma will render the nurse "walking wounded" (Christie & Jones, 2013, para 7). If the nurse can effectively deal with the trauma, the pain may be used to help others heal similar traumas and thereby heal their own pain (Christie & Jones, 2013). Sanner-Stiehr and Ward-Smith (2015) used this theory to improve nurse retention by creating a staff development program for those who have suffered LV. The overall statistics of LV and the local nurses sharing their stories illustrate that there are already walking wounded. This theory was chosen to guide this project in hopes that the walking wounded can transform into wounded healers.

Social learning theory, which is also called social cognitive theory, suggests that individuals' behaviors are learned by observing and imitating others (McLeod, 2016). Bandura (1977) stated that human behavior is learned by watching others and once the individual creates a concept of the behavior, it will then guide the individual as to how they act. Negative behaviors, like positive behaviors, can be imitated and learned. If

negative behaviors can be addressed and replaced with positive behaviors, it is conceivable that others will imitate these positive behaviors. Bandura (1986) went a step further to acknowledge the relationships between personal factors, the environment, and behavior in the theory of reciprocal determinism. All three are interdependent: Behavior can change the overall environment, and the environment can change the behavior depending on the personal factors involved. If the environment can change (by altering personal factors), it may change attitudes and expectations, according to social learning theory. Walrafen, Brewer, and Mulvenon (2012) used social learning theory and the theory of reciprocal determinism to identify the type and frequency of several behaviors associated with LV to create interventions for those specific behaviors. Walrafen et al. observed that negative behaviors might be duplicated by others so that they may feel more included in the workplace. Sanner-Stiehr and Ward-Smith (2015) applied social learning theory to their study that addressed nursing students' responses to LV using cognitive rehearsal. Because behaviors can be learned and imitated and because behaviors can influence the overall work environment, social learning theory and the theory of reciprocal determinism were used to guide this project.

Relevance to Nursing Practice

Lateral violence (LV) in nursing has a decades-long history. Freire (1970) coined the term *lateral violence*. Later, Meissner (1986) described nurses as cannibalistic, genocidal caregivers by introducing the term and the idea of "nurses eating their young" (p. 1). LV is a phenomenon that has been noted time and time again, yet it is dismissed as something that is routine in the profession, which perpetuates its presence. LV has been

used interchangeably with other terms such as incivility (Lachman, 2014), bullying (Johnson, 2009; Murray, 2009; Pontus & Scherrer, 2011; Sauer, 2012), horizontal violence (Becher & Visovsky, 2012; Curtis et al., 2006; Granstra, 2015), vertical violence (Cantey, 2013), harassment (Murray, 2009), workplace aggression (Farrell et al., 2006), and nurse-to-nurse violence (Embree & White, 2010). Although harassment and bullying may be identified individually, Pontus and Scherrer (2011) stated that these concepts, including discrimination, are subsets of LV and that any one subset is considered LV.

The number of nurses who have experienced LV is consistently overwhelming. Numerous reports (AACN, 2004; ANA, 2011; Becher & Visovsky, 2012; Ceravolo et al., 2012; Christie & Jones, 2013; Ekici & Beder, 2014; Granstra, 2015; Farrell et al., 2006; Johnson, 2009; Lachman, 2014; JCAHO, 2008) have shown that 35% to 85% of nurses have experienced LV and almost 90% (ANA, 2011) have witnessed LV take place toward coworkers. Ekici and Beder (2014) conducted a study on workplace bullying in Australia and found that 82% of nurses have experienced bullying. Bambi et al. (2014) revealed that close to 80% of nurses had experienced some form of LV within the last year. In another Italian study, 43% of nurses experienced verbal violence in their clinical career and that violence correlated to high incidence of psychological problems (Magnavita & Heponiemi, 2011). Canada, the United Kingdom, New Zealand, Turkey, Italy, and Pakistan have reported high occurrences of LV (Johnson, 2009).

There were minimal concrete data to illustrate the local problem. LV has been addressed by the state nursing association as well as the board of nursing, but there is no published data from these entities. Numbers regarding turnover were unable to be

disclosed by the organization where this project will be implemented; however, there have been multiple accounts from staff nurses and nurse managers within the organization that indicate a problem with LV.

Proposed Solutions

One proposed solution to the problem of LV is cognitive rehearsal, which was introduced in the nursing context by Griffin (2004). Cognitive rehearsal is an adopted method from psychology that is used to prevent impulsive responses to situations. Instead of immediately responding or reacting to an event, individuals are coached to not respond so that they may have time to process the occurrence (Griffin, 2004). Griffin explained that, in the case of LV, not impulsively reacting (a conditioned response to affronts) allows an individual to have a moment to process the event and respond in a more meaningful, constructive manner. In Griffin's study, nurses were given an education session on LV and were given cognitive rehearsal cue cards that had various scripted responses to the most common types of LV attacks. The results showed that there was an increase in awareness and the nurses reported a sense of empowerment (Griffin, 2004). Cognitive rehearsal was reexamined by Griffin and Clark (2014) who noted that it was a frequently used, evidence-based method to address incivility among coworkers. Griffin and Clark also stated that the use of a cognitive rehearsal intervention had been duplicated with high success rates in other studies. Embree, Bruner, and White (2013) employed cognitive rehearsal to raise awareness of lateral violence. Although the education was shown to be successful, further work was required as nurses were unsure

of how to cope with other untoward behaviors (Embree et al., 2013; Lasater, Mood, Buchwach, & Dieckmann, 2015).

Emotional intelligence (EI) was noted by Beldoch (1964) and later defined by Salovey and Mayer (1990) to describe how an individual notices his or her emotions, differentiates between the emotions, and uses that information to direct and steer future behaviors or thoughts. There are five key components of EI: self-awareness, self-regulation, motivation, empathy, and social skills (Mindtools, n.d.). Higher levels of EI have been associated with higher functioning in stressful environments (Bennett & Sawatzky, 2013; Littlejohn, 2012). Meires (2018) concluded that situational awareness, stability, and modeling good behaviors are benefits of using EI, which contributes to safety. Bennett and Sawatzky (2013) concluded that to have a bully-free work environment, improving IE among nurse management should be encouraged.

Conflict resolution is a set of skills use to manage conflict healthily and respectfully, which allows for successful communications and growth between two people (Segal & Smith, 2017). Segal and Smith (2017) noted that conflict is a perceived threat, triggers deep emotion, and requires resolution to move forward and disallow escalation of the issue. Bigony et al. (2009) noted that conflict resolution was a proven method to contend with acts of LV. Cognitive rehearsal is a form of conflict resolution.

Many different modalities of education have been employed to attempt to curb incidence of LV. One popular method has been the use of continuing education credits (Bigony et al., 2009; Brunt, 2011; Chu & Evans, 2018; Dahlby & Herrick, 2014; Lasater et al., 2015; Pontus, 2011; Rainford, Wood, McMullen, & Philipsen, 2015) and has been

noted to be successful in decreasing incidence of LV (Dahlby & Herrick, 2014; Griffin, 2004). Other methods include direct mentorship from nursing school (Schneider, 2016). Schneider (2016) noted that there is an important connection between nurses and their instructors, which should be fostered early. This mentorship approach could be applied to a novice or new graduate nurse and a seasoned nurse mentor. Workshops have been used to improve communication among peers by using didactic instruction, role-playing, and discussing individual experiences with LV (Ceravolo et al., 2012). Lachman (2015) made similar recommendations but called for standards and codes of conduct to be established as well as empowerment and skill development. Despite many attempts with various strategies to decrease the incidence of LV, there is limited evidentiary support that there is one particular modality that is successful enough to be standardized in facilities (Lachman, 2015; Vessey et al., 2011). This DNP staff education project addressed the gap in practice by attempting to find a solution to LV based on successful implementations described in previous research. This project was designed to educate nurses to increase their awareness of LV and equip them with strategies to effectively manage incidents of LV.

Local Background and Context

Institutional

The facility where this project, lateral violence in nursing, was implemented is a not-for-profit, religious-based healthcare organization in the Pacific Northwest United States. When the project was presented to the education committee, some of the nurses contributed their experiences with LV. The nurses described several personal accounts of

LV (backbiting, eye-rolling, gossiping, refusal to help, and intimidation) that led to decreased job satisfaction and a desire to leave their jobs. The most disturbing account of LV was described through the tears of two educators: They explained that their coworker had been the victim of repeated incidences of LV and subsequently took her life (personal communication, September 22, 2016). Additionally, a personal interview with one of the facility's nurses revealed that one of the intensive care units had almost 90% turnover and a step-down unit had 25 nurses leave due to the high incidence of LV among coworkers and by management (personal communication, January 23, 2017).

Local

Examples of local incidences of LV have been provided by several nurses who wish to remain anonymous at this time for fear of retribution. All examples were obtained during casual conversations as the researcher mentioned the topic of this project to colleagues.

Nurse one has been a nurse for almost two years. During that time, she has been excluded from a unit clique and knows that she is being talked about behind her back. She overheard one of their conversations where the clique was staring directly at her commenting, "I can't believe she doesn't know that. Did she skip nursing school? She needs to figure it out for herself." Nurse one described the lack of support that she felt from her charge nurse as well as the unit manager because the nurses who were in the unit clique were close friends outside of the workplace and the manager seemed to favor them. This nurse considered transferring jobs to another nursing unit but felt that she would not get a good review from the manager and would not be able to transfer.

Additionally, the job application process was grueling at other organizations which deterred her from seeking employment elsewhere.

Nurse two considered leaving the profession because of the politics of the facility where she works. “Management seems to only care about money and numbers. It is like a hotel instead of a hospital. They keep taking autonomy away from the nurses and replace it with micromanaging. I could make more money and have less stress if I was a bartender”.

Nurse three is a local friend and colleague and has been suffering effects of LV for years at the hand of her nurse manager. She wrote, “Good Evening, here are a few examples of what happened to me prior to my ICU resignation. Please keep names confidential or use pseudonyms as there is still trauma after the events” (personal communication, August 23, 2018). Her story included the following points

> [They mandated] I carry the rapid response pager during my lunch break as there was no one to cover me for a lunch. I went longer than 18 months without a lunch break. The breaks I did have were “covered by my manager” -meaning management carried the clipboard but I was still required to carry the RRT pager and respond to any rapid responses in the hospital. In addition, I had to clock out for my lunch break. Prior to leaving the unit, I stepped down as a charge nurse so I could have an actual lunch break and in hopes the harassment would come to an end. To my surprise, Manager made a public apology, crying, stating she failed me and that I’m no longer going to be a charge nurse. However, this was the first

> time I heard an apology, publicly, in front of 25 peers. My peers felt sorry for her and grew upset as she was crying and felt she failed me.
>
> [However] Her private response to me stepping down was, "I think you should look for other places to practice your leadership." -much different than crying about how she "failed me."
>
> [Regarding the] Flu vaccine- mandating I "mask on" weeks prior to the "mask on" time taking into effect because I don't get a flu shot. When confronted, she said she received an email and I have to wear a mask. After contacting infection control, I had to confirm that it was not mask time and that there were other nurses that didn't get the flu shot whose mask on time was not mandated by management.

Nurse three mentioned how her coworkers noticed that the manager pulled her away from patient care during every shift for the sole purpose of being disruptive to Nurse three. . Nurse three stated that she had to start having a union representative present at any meeting with her manager. When Nurse three confronted the ICU director about the manager, the director's comments were condescending and trivialized the concerns of Nurse three. Additionally, some of Nurse three's private information from human resources had been shared with another peer by the manager for unfounded reasons. When the director was notified of the sensitive information sharing, Nurse three received no support: The director supported the manager's behavior. Nurse three wrote, "As you can see, when confronting the director about Manager as well as about her

sharing my HR file with another peer, I still have no support. So, why would I report the harassment when, so far, I'm getting shut down any time."

These few examples of nurses' experiences with LV have only reinforced the need to reduce incidences of LV as well as my determination to make a change in nursing. If nurses have more awareness that LV is unacceptable behavior, and that awareness can create confidence (empowerment) to address those who commit acts of LV, perhaps the incidences of LV can be reduced.

In the Pacific Northwest region, the only state to have any legislation that covers LV is Washington. The Washington Industrial Safety and Health Act (WISHA) states that employers are required to ensure the safety of their staff and that acts of LV fall under this protection (Matt, 2016). Matt (2016) also noted that defamation lawsuits can be filed against those who slander their coworkers, but could prove more difficult to win depending on the perception of the court. The idea of defamation lawsuits can carry over to any state, but because of the difficulty and time-consuming, expensive nature of this route, this type of lawsuit is a less-than-desirable avenue for justice.

There are no policies to govern acts of lateral violence within the state of Oregon. The Oregon Nurses Association (ONA; 2009) released a fact sheet on nurse bullying as well as their own Nursing Practice Advisory Action Report (ONA; 2012). The recommendation of the ONA (2012) from the report was that organizations implement a policy to address bullying, give materials on nurse bullying to facilities and hospitals, and have various bargaining units develop procedures to handle bullying complaints.

The implementation site for this project does not currently have any policies or standards of practice related to LV. While there is a harassment policy and a violence policy, these do not specifically address the problem of LV. It is the hope that this project will become standard education in the site organization and be the stimulus for the creation of policy and/or a standard of practice.

National

Position statements by various organizations and accrediting bodies (AACN, 2004; ANA, 2015; JCAHO, 2008) condemn the behavior of LV, bullying, and incivility. JCAHO (2008) released a sentinel event alert describing the deleterious effects of nursing's bad behaviors. The American Association for Critical Care Nurses (2004) called for a zero tolerance policy to eradicate LV. The ANA (2015) integrated their Code of Ethics into their position statement on LV to reinforce why LV was inappropriate and intolerable with the most notable sections being Provision 1.1 (Respect for Human Dignity), Provision 1.5 (Relationships with Colleagues and Others), and Provision 5.1 (Duties to Self and Others). The Quality and Safety Education for Nurses Institute (QSEN; n.d.) notes in their Teamwork and Collaboration competency that nurses will

1. Function competently within own scope of practice as a member of the health care team;
2. Assume role of team member or leader based on the situation;
3. Initiate requests for help when appropriate to situation;
4. Clarify roles and accountabilities under conditions of potential overlap in team member functioning;

5. Integrate the contributions of others who play a role in helping patient/family achieve health goals (para. 11).

Perpetrators of LV are also in violation of the International Code of Ethics for Nurses (International Council of Nurses [ICN]; 2012). The fourth element of the code states that the nurse will maintain good working relationships with colleagues and to protect others from untoward behavior. Other ethical violation considerations include the principles of nonmaleficence, beneficence, and justice (Matt, 2012). It would seem that when accrediting bodies step in to change the course of action on any given issue that organizations would take heed. Sadly, this has not been the case.

Definitions of Terms

Lateral violence, because of the word *violence*, may convey the idea of a physical crime to those who have never heard the term before. However, while LV is a form of violence, it is more insidious, it happens over a period of time, and it causes more emotional than physical damage (ANA, 2011). There is a variety of terms that is used to describe LV or that is used interchangeably with LV. A current publication (Petrovic & Scholl, 2018) describes all of the terminologies below as disruptive behavior, and the article aims to find a single definition for all of the synonyms that encompass disruptive behavior.

Bullying: Although definitions of bullying will vary (Johnson, 2009), bullying is described as intimidating, isolating, and demeaning behaviors aimed at either a group or individual by a group or individual in a higher job level within an organization or where

there is a perceived imbalance of power (ANA, 2011, 2015; Ekici & Beder, 2014; Granstra, 2015; Vessey et al., 2011).

Harassment: Pontus and Scherrer (2011) and Vessey et al. (2013) defined harassment as a variety of unwanted behaviors and actions that may include racial or sexual remarks, physical contact, or stalking.

Incivility: Incivility is rude, condescending behavior and general lack of respect for a co-worker such as open criticism, degradation of integrity, or derogatory comments (ANA, 2015; Clark, 2013; Lachman, 2014).

Lateral violence or horizontal violence: These two terms describe the overt or covert commission of verbal or nonverbal acts of aggression (ANA, 2011; Griffin, 2004) between nurses within an organization (Christie & Jones; 2013; Granstra, 2015).

Vertical violence: This term denotes any violent behaviors such as name-calling, belittling, humiliation, withholding information, or eye-rolling that occur between people on different job levels within an organization (Cantey, 2013).

Violence: The World Health Organization (WHO, 2002) defines violence as acts against self or another that result in physical injury, emotional harm, or death.

Workplace aggression: The definition of workplace aggression is physical or nonphysical behaviors from one person to another that cause emotional or physical harm (Farrell, Bobrowski, & Bobrowski, 2006; Fujishiro, Gee, & deCastro, 2011).

Although each term is slightly different, they are frequently used interchangeably, with the exception of *violence* (Matt, 2012). For this project, *lateral violence*was the term

used to represent any nurse to nurse hostility because LV encompasses the majority of the terms above.

Role of the DNP Student

Personal Account

Thirteen years ago, I was a traveling nurse at a hospital in the San Francisco Bay area in a busy intensive care unit. I had two very tenuous patients who were mechanically ventilated, hemodynamically unstable, and required numerous vasoactive, intravenous (IV) drip medications. The staff nurses on the unit did not care for me – they called me names to my face, huddled in a group while they refused to help me, hid my patient's medications from me, and consistently tried to get me fired by complaining to the manager about things that never transpired. On one particular night, I was working in one of my patient's rooms for a long period of time. When I emerged from that room and went into my second patient's room, I noticed that all of the IV rates had been reprogrammed (by someone other than me). The patient's blood pressure was plummeting, and the patient was waking up from sedation. Quickly, I ran to fix the IV pump rates. I overheard the staff nurses laughing and saw them pointing at me as I scrambled to help my patient. From that moment on, I had to sit in between my patient's rooms and made sure that I was able to keep both patients in view at all times. I thought to myself, "What makes me so terrible in these nurses' eyes that they would put a patient's life in danger in an attempt to get me fired?" I had no answer and remain dumbfounded to this day. This event was reported to the unit manager as well as the

house supervisor, but I was told that nothing could be done because there was insufficient evidence that anyone tampered with the IVs. This account is, unfortunately, one of many.

Professional Context

As I contemplated my project topic, I reflected on relevant issues in nursing that I was both witness to and had directly experienced. I wondered why so many nurses, including myself, were dissatisfied at their jobs. I evaluated my thoughts and emotions regarding my disinterest in being a full-time bedside nurse and recalled the day when things changed - when I decided to leave the bedside. As I reflected on so many stories that I have heard (and told) over the last 20 years I arrived at a pointed conclusion: I was tired of being treated poorly by my coworkers or management.

My role in this doctoral project was to educate and empower the nurses within this particular facility. I also felt it was my responsibility to bring to light the dark underbelly of nursing and let those suffering from acts of LV know that they are not alone. While I had a working relationship with my preceptor throughout my clinical rotations and during the implementation of this project, I did not have any prior relationship to the Home Care Services division of the organization or any of the participants in this project. Because I have been the subject of and witness to multiple acts of LV, I may be considered biased towards this project and its outcome.

Role of the Project Team

There was no official team for this project. However, the preparation and implementation was reviewed and guided by the site preceptor, who is also the manager of education and infection prevention. Since the project implementation was an online

learning module there was collaboration with the informatics department. The preceptor was provided with all components of the project, vetted the project, and assisted with implementation. The preceptor reviewed the pretest, posttest, and evaluation for validity using the validation instrument provided by Walden University and conducted a content review of the education module by using another form, which was also provided by Walden University. Once the project was online and open for the nurses to complete, weekly completion rates were gathered by the preceptor. The completion rates were used to evaluate the need to re-inform the nurses that the module was open to complete. After five weeks, the module closed and it was the role of the informatics specialists to pull de-identified data from pretests, posttests, and evaluations and send them to the preceptor.

Summary

LV is a global problem with evidentiary support in the literature (ANA, 2011; Curtis et al., 2006; Ekici & Beder, 2014; Farrell et al., 2006; Johnson, 2009; Miller & Hartung, 2011; Rodwell & Demir, 2012; Walrafen et al., 2012). The numbers in the US indicate that approximately 85% of nurses experience LV (ANA, 2011). While the data are startling, it is offering a tremendous opportunity to fix this long-standing problem. Increasing awareness through education will endeavor to illustrate that LV is a global problem, that the profession is taking notice of the problem of LV, that nurses are not alone in their struggles, that there are attempts being made to reduce the problem, and that there are some tools available which may empower nurses to stand up to their aggressors and decrease the worldwide statistics on LV. The social learning theory, the

theory of reciprocal determinism, and the theory of the nurse as the wounded healer were all used to guide this DNP staff education project.

If the culture of LV remains unchanged, it is conceivable that the nursing profession will suffer greatly. Persisting LV may not only tarnish the image of nursing as a distinguished profession and discipline, but may result in the potential deterioration of nurses, organizations, and patients. The current gap-in-practice, an extensive review of the literature, the approach of the project, the project design and methods, data analysis, and project evaluation plan are discussed in the next section.

Section 3: Collection and Analysis of Evidence

LV affects over 85% of nurses at some point in their career (Christie & Jones, 2013). The purpose of this nursing staff education project was to increase awareness of lateral violence and empower nursing staff to confront their aggressors. The practice-focused question was the following: Will education increase awareness of LV and empower nurses who are victims of LV to confront their aggressors? The nursing shortage has been linked to a stressful work environment, which has been noted to be a precursor to acts of LV (ANA, 2015; Embree & White, 2010; Murray, 2009). By the year 2020, the United States will need to produce 1.13 million new nurses to keep the status quo (McMenamin, 2014). The nursing profession cannot afford to lose nurses due to the impact of LV. Roughly 60% of new nurses will leave their first job due to unsatisfactory working conditions created by LV (Bartholomew 2006; Embree & White, 2010). Mitigating causative and contributing factors, fostering environments of civility and dignity, and using early education on LV could change the course of a nurse's career as well as improve the health of the nursing profession. This section addresses the gap in practice that exists with the issue of LV in nursing. Additionally, I describe the project design and approach, methods, analysis, and evaluation.

Practice-Focused Question

Lateral violence (LV) is common in a local Pacific Northwest health care facility. The types of LV behaviors range in severity from being ignored when asking for help to sabotage. Within various organizations throughout the area, I have witnessed and have been subjected to acts of LV. LV is a topic that is frequently discussed with hopelessness

among many area nurses. Many nurses shrug it off as something that is a part of nursing, while others have recently quit their jobs or taken their life. The literature did not indicate that one method for curbing LV is superior to another or that there are notable success rates with any intervention. Roberts (2015) noted that the empowerment of nurses was one vital component in reducing LV.

The purpose of this DNP staff education project was to increase awareness of lateral violence and empower nursing staff to confront their aggressors. The practice-focused question was the following: Will education increase awareness of LV and empower nurses who are victims of LV to confront their aggressors? Providing information related to LV may increase awareness and offer nurses strategies to combat incidents of LV.

The key term in this project was lateral violence, which was defined as the overt or covert commission of verbal or nonverbal acts of aggression (ANA, 2011; Griffin, 2004) between nurses within an organization (Christie & Jones; 2013; Granstra, 2015). Although there were other terms including horizontal violence, vertical violence, incivility, bullying, harassment, and workplace aggression, lateral violence was used to represent any nurse-to-nurse hostility. Many of the characteristics of the other terms are included in the definition of LV.

Sources of Evidence

To address the practice-focused question, I examined the literature for recommendations. The literature indicated that raising awareness was a viable solution to curbing LV (Bambi et al., 2018; DiMarino, 2011; Etienne, 2014). Other studies indicated

that education (Cantey, 2013; Dahlby & Herrick, 2014; Johnson, 2009; Koch, 2012; Schneider, 2016) as well as cognitive rehearsal (Griffin, 2004; Griffin & Clark, 2014) were effective solutions to combating LV. This DNP staff education project was designed to educate nurses about LV and empower them to confront their aggressors, which may improve job satisfaction, increase patient satisfaction, alleviate organizational costs, and reduce the burden of the nursing shortage.

A comprehensive search of the literature for lateral violence in nursing included the following databases: CINAHL Plus with Full Text, Medscape, Pub Med, Cochrane Reviews, OVID, and the Joanna Briggs Institute. The following search terms were used to access the literature: *nursing*, *lateral violence*, *violence*, *horizontal violence*, *incivility*, *harassment*, *workplace violence*, and *vertical violence*. The inclusion criteria for the search included English-language peer-reviewed articles and education-based materials published between 2010 and 2017. Other pieces of literature outside those dates were used to address the longevity of the problem and to illustrate the lack of a viable solution for LV.

Behaviors of Lateral Violence

Common behaviors associated with LV include nonverbal innuendos (Bigony et al., 2009; Coursey et al., 2013; Embree & White, 2010; Griffin, 2004; Stokowski, 2010; Walrafen et al., 2012), sabotage (Alspach, 2008; Bigony et al., 2009; Embree & White, 2010; Miller & Hartung, 2011; Walrafen et al., 2012), backstabbing (Coursey et al., 2013; Miller & Hartung, 2011; Sauer, 2012; Walrafen et al., 2012), degrading or undermining comments or activities (Alspach, 2008; Becher & Visovsky, 2012; Bigony

et al., 2009; Embree & White, 2010), eye rolling (Becher & Visovsky, 2012; Griffin, 2004), lack of respect for privacy (Bigony et al., 2009; Coursey et al., 2013; Embree & White, 2010; Walrafen et al., 2012), betrayal of confidences (Alspach, 2008; Bigony et al., 2009; Embree & White, 2010), humiliation (Alspach, 2008; Ekici & Beder, 2014; Johnson, 2009; Miller & Hartung, 2011; Reed, 2013; Stokowski, 2010; Vessey et al., 2011), impatience (Griffin, 2004; Stokowski, 2010), blaming (Becher & Visovsky, 2012; Miller & Hartung, 2011; Stokowski, 2010), refusal to assist (Becher & Visovsky, 2012; JCAHO 2008), and intimidation (Becher & Visovsky, 2012; Miller & Hartung, 2011; Reed, 2013). These behaviors can be instigated by senior nurses on junior or novice nurses or by management on staff members (Becher & Visovsky, 2012; Christie & Jones, 2013; Johnson, 2009; Vessey et al., 2011). Because of the hierarchical nature of nursing, the profession has been regarded as being an oppressed group. LV can also occur between nurses of equal job status (Coursey et al., 2013; Croft & Cash, 2012; Curtis et al., 2007; Griffin, 2004; Stanley et al., 2007).

Causes

Causative factors for LV exist on organizational, personal, and cultural levels. Organizational precursors include an imbalance of power from managers to staff, organizational shrinkage, and nurse short-staffing (Embree & White, 2010; Sanner-Stiehr & Ward-Smith, 2014; Sauer, 2012). Personal and workplace culture issues include poor unit dynamics, a culture of avoidance and disrespect, uncooperativeness, low self-esteem, silence, ineffective coping strategies (Embree & White, 2010) and the need for the

aggressor to be in control (Murray, 2009). Any one or a combination of factors can cause LV.

Consequences

The consequences of LV leaves are considerable. Reported psychosocial problems include low self-esteem and depression (Becher & Visovsky, 2012; Embree & White, 2010) as well as anxiety and sleeping disorders (Becher & Visovsky). Psychosocial ailments often lead to other consequences including burnout (Allen et al., 2011; Stamm, 2010), post-traumatic stress (Johnson, 2009; Stamm, 2010), and compassion fatigue (Stamm, 2010). Reported physical ailments include hypertension (Bigony et al., 2009), weight loss or gain (Miller & Hartung, 2011), gastrointestinal disorders (Johnson, 2009; Miller & Hartung, 2011), and headaches (Granstra, 2015; Johnson, 2009). Repercussions of LV also include substance abuse and suicide (Christie & Jones, 2013; Johnson, 2009; Miller & Hartung, 2011; Sanner-Stiehr & Ward-Smith, 2014). There is a positive association between LV and burnout (Allen et al., 2009; Stamm, 2010). Decreases in job satisfaction lead to increases in absenteeism as well as a diminished quality of care (Becher & Visovsky, 2012) and impaired communication within the unit that decreases professional development (Bigony et al., 2009).

Increased turnover and vacancy rates are direct consequences of LV that fiscally impact organizations and affect patients' safety (Bigony et al., 2009; Granstra, 2015; Johnson, 2009; Sauer; 2012; Stokowski, 2010). Curtis et al. (2007) reported that 20% of new nurses left not only their jobs but also the profession within the first year after graduation. Embree and White (2010) noted that 60% of newly graduated nurses leave

their first job within the first year due to LV. Facilities and organizations that are struggling to keep costs down face major complications due to nurse attrition, especially with the cost to onboard new nurses being $22,000 to $145,000 per nurse (Bigony et al., 2009; Christie & Jones, 2013; Hayden, 2016). Another cost to facilities is temporary staffing (either per diem or traveling nurses). The owner of a Pacific Northwest staffing agency stated that

> we have seen needs rise year over year consistently for the last 5 years. We have over 50 open positions at any given time that we are not able to fill. Though there are seasons that the needs tend to flatten out or remain "stable" such as the summer; we continue to see an increased demand constantly (personal communication, August 31, 2018).

This statement illustrates the gap that exists in staffing within the hospitals as well as the shortage outside of the facilities.

LV is a massive problem. Nurses do not like to discuss the issue as evidenced by little movement happening within the nursing community to reduce LV. Evidence from the literature points to education, raising awareness, and finding solutions to the LV problem. The purpose of this DNP staff education project was in direct alignment with the literature. Collection and analysis of data from the implementation of this project address the gap in practice by educating nurses, raising awareness, and equipping nurses with tools to manage LV incidents.

Participants

The project took place within a not-for-profit religious-based health care organization in the Pacific Northwest United States. The population included nursing staff in the Home Care Services division, which encompasses home health, home infusion, and hospice. There were no exclusion criteria for this project with the exception of not being licensed as a nurse. The sample, because it was inclusive of all licensed nursing staff, was a convenience sample. Because all licensed nursing staff were included, the sample size was over 300 nurses and represented the target population because the sample was the target population.

Procedures

Quality improvement through education was the overall design of the project to address the project objectives:

1. Increase awareness of LV through education and
2. Empower victims of LV (nurses) to confront their aggressors.

These objectives were met by constructing an online learning module consisting of 25 PowerPoint slides (see Appendix A) that enabled the nursing staff to log in to the organization's online learning platform to complete the module within a 5-week time frame. Also built into the module was a pretest and posttest composed of 10 questions (see Appendix B) as well as a module evaluation (see Appendix C). The education module was created first. The pretest/posttest was designed from the curriculum plan (Appendix D), which guided the creation of the education module and badge cue card (Appendix E) so that the information learned and tested was consistent. The curriculum

plan content expert summary (see Appendix F and Appendix G) and the content validity index (Appendix H) form were used to evaluate the project before implementation and were completed by the preceptor, who is the manager of home care services and infection control.

Before the module was made available to the nursing staff online, recruitment of participants was executed by posting a flyer (Appendix I) at the facility as well as an advertisement in the circulating monthly division newsletter (Appendix J). Any collected data were de-identified, which was accomplished by the online system used to run the education module to ensure anonymity.

Protections

The implementation site institutional review board (IRB) indicated that they were to be the IRB of record. Through a series of additional classes and forms, IRB approval was granted through the site (IRB approval number STUDY2018000161). The site approval did not, however, nullify the need for approval from the IRB at Walden University. Walden University approval was obtained to ensure the protection of the participants (IRB approval number 05-25-18-0578349). Because there were two IRBs on record, it was the request of the implementation site to use Walden University's informed consent page with the site's time stamp. The modified consent was approved by Walden University's IRB. The finished consent form was the opening page of the education module. The module was not mandatory and was to be completed within a five weeks' time. By entering the training platform and completing the module, the nurses gave implied consent to work through the education module.

The purpose of this DNP staff education project was to increase awareness of LV and thereby reduce LV incidence in the organization. The learning module for LV concluded with the completion of an evaluation of the module. The evaluation was composed of five questions in a Likert-scale format, which allowed for question item analysis. These data were de-identified to protect participants from actual or perceived retribution for answers that were given.

Analysis and Synthesis

Data were protected within the online platform and were only accessible by the informatics specialists who manage the online platform to ensure the integrity of the data. Integrity was also maintained by using only de-identified data. Although there were weekly checks performed to evaluate response rates, no data were pulled until the module time frame had ended.

The education module was offered to all nursing staff and remained open for the nurses to complete on their own time for a period of five weeks. The five-week time frame for the collection of data was to take into consideration any employees who were on vacation. Missing numbers might have also included those out on maternity leave or those who have been out of work due to illness in addition to those who opted to not participate.

During the process of implementation, formative assessments were completed periodically to monitor progress and fix any issues as they occurred. Potential problems with implementation included formatting the PowerPoint slides into the online platform and having a system outage. There were no complications with the implementation.

Evaluation of the entire project took place after the project's finish. Therefore, the evaluation was also summative. This summative evaluation will help to decide if the education project should continue within the organization as routine education.

Possible anticipated problems with the overall project included programming difficulty, delayed vetting of educational materials, dissemination of information to nursing staff, delayed nursing response time, and disengaged learning attempts (not reading all educational material thoroughly). Module completions were checked weekly to determine response rates and prompted a re-release of the newsletter after week two to increase participation. A second release of the division's newsletter was not necessary.

After each nurse completed all of the elements of the online learning module, data from the pretests and posttests and evaluations were extracted and evaluated to discern if there was an increase in awareness of LV. The education module, pretest/posttest, and evaluation were examined through an internal program that is associated with the organization's online learning platform and through an Excel workbook. The informatics specialists pulled de-identified data. Question analysis of the datasets was completed within the online system. All data was forwarded to the site preceptor and subsequently forwarded to the DNP student.

After all course posttests and evaluations were completed, item analysis of the questions was performed. The overall scores from the pretests and posttests were evaluated to determine if the education was effective as evidenced by higher posttest scores than pretest scores by change scores. Additionally, individual questions were analyzed from pretest to posttest to see where significant learning took place. The data

from the evaluation were analyzed to see whether or not awareness of LV has increased and if the nurses felt that they were equipped to stand up to their offender by using mean/central tendency.

The project was evaluated using the results of the online evaluation that was provided within the module. The education module was introduced to the nursing staff via posted flyers at the facility as well as bulletin board announcements that were available to all licensed nursing staff. Instructions for completion were included within the education module itself.

Summary

The first step in defeating the problem of LV is increasing awareness of the problem (Johnson, 2009; Walrafen et al., 2012). An electronic education module with pretest and posttest and a post-module evaluation were administered to an entire facility's nursing staff to increase awareness of LV which will hopefully lower the incidence of LV behaviors in the future as well as empower and equip nurses to stand up to their aggressors. Through the module's creation, vetting, and implementation, formative assessments were conducted so that any concerns may be addressed and fixed as the process unfolded. Once the project was completed, a summative evaluation was completed and will be discussed in later sections of this lateral violence in nursing paper. The following section will discuss the findings of the project and put forth recommendations for future research. Additionally, the following section will also reveal the findings of the project and discuss recommendations to address the gap-in-practice as well as the strengths and limitations of the study.

Section 4: Findings and Recommendations

Lateral violence is widespread and unchecked in area facilities within the Pacific Northwest. Many nurses shared their stories of despair due to the lack of solidarity and support for one another related to episodes of LV. The gap in practice addressed in the project study was the lack of evidence-based strategies to cope with and eliminate LV. Although there were position statements and opinions, no policy or regulation existed for LV at the time of this study (see Ekici, 2014). The purpose of this doctoral nursing staff education project was to increase awareness of LV through education and to equip nurses to confront their aggressors. The practice-focused question was the following: Will education increase awareness of LV and empower nurses who are victims of LV to confront their aggressors?

LV is experienced by 85% of nurses during their careers (Christie & Jones, 2013). Etienne (2014) showed that 48% of nurses experienced LV behaviors within 6 months before the study. Although concrete data were not available for the locality of the Pacific Northwest region of the United States, there were numerous stories shared by local nurses to illustrate the severity of the problem. LV is destructive to the nurse who is directly experiencing LV and may cause psychological (Becher & Visovsky, 2012) and physical (Bigony et al., 2009; Granstra, 2015; Miller & Hartung, 2011) ailments. A workplace that tolerates LV is at risk for increased turnover rates, cost of onboarding new nurses, paying for relief staffing, and decreasing overall patient safety (Hayden, 2016; Jones & Gates, 2007).

Although there was no definitive way to combat LV at the time of this study, proposed solutions included cognitive rehearsal (Griffin, 2004; Griffin & Clark, 2014), emotional intelligence (Bennett & Sawatzky, 2013; Meirs, 2018), educational programs (Bigony et al., 2009; Brunt, 2011; Dahlby & Herrick, 2014; Lasater et al., 2015; Pontus, 2011; Rainford et al., 2015), position statements (AACN, 2004; ANA, 2015; JCAHO, 2008), and zero tolerance policies (AACN, 2004). I took into account the problem of LV, including the scope and severity, longevity, and lack of concrete solutions. To address the problem of LV, I create an education module.

Comparison of pretest and posttest scores as well as item analysis of each question was performed to evaluate overall learning. Additionally, item analysis of the evaluation was completed to assess the nurses' perception regarding increased awareness and empowerment to confront an aggressor. Analysis of the data was completed via reports that were generated by the informatics specialists through the online learning platform at the implementation site.

Findings and Implications

The total number of possible participants was 309 nurses. Of the 309 participants, 55.3% (n = 171) completed the pretests, 52.1% (n = 161) completed the posttest, and 50.2% (n = 155) completed the module evaluation. The overall pretest score was 57.96%, and the overall posttest score was 82.6% (see Figure 1). These data reflected an overall increase of 24.64% from pretest to posttest.

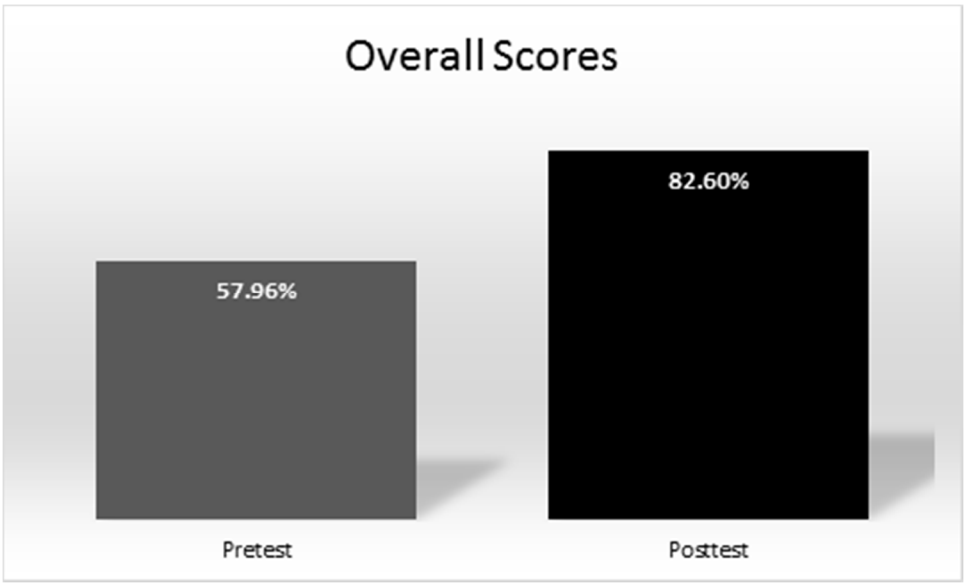

Figure 1. Pretest versus posttest scores of participants.

Each question score was evaluated between pretest and posttest to evaluate the difference in score from question to question. The data showed improvement on every question (see Figure 2).

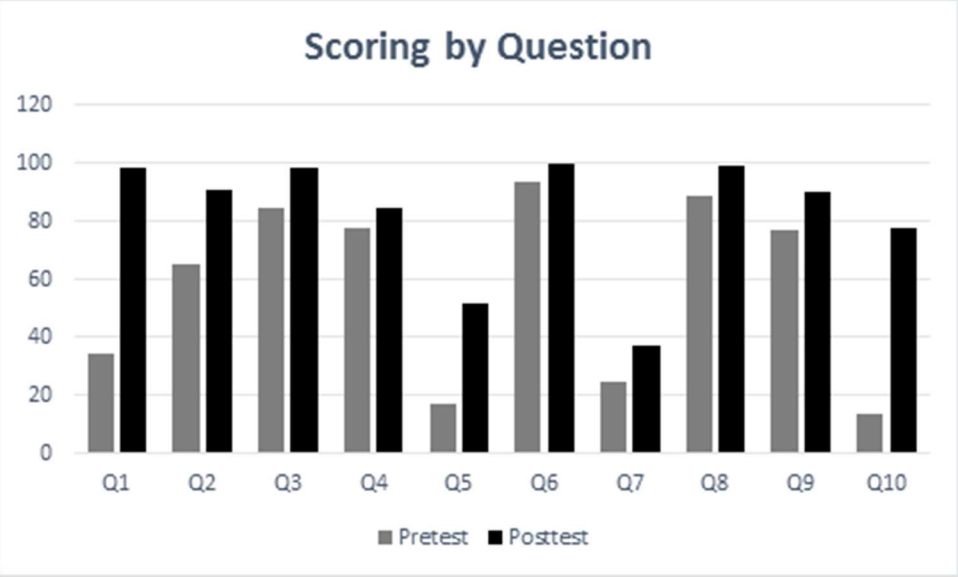

Figure 2. Comparison of pretest/posttest scores by question.

The largest improvement in scores was seen on Questions 1 and 10. Question 1 addressed the percentage of nurses who experience lateral violence in their careers. Only 33.92% answered correctly on the pretest, but 98.14% answered correctly on the posttest. This question was important because it illustrated the lack of understanding (and subsequent learning) of the scope of the problem of LV. Question 1 had a 3-item multiple choice answer. The pretest responses were evenly distributed among the three answers. The change score for this question was 64.22%, which showed an increase in learning and an increase in awareness.

Question 10 addressed knowledge regarding policy on LV. Like Question 1, Question 10 contained three possible answers in a multiple choice format. Only 13.45% of the participants answered correctly on the pretest. The posttest showed dramatic improvement with 77.64% of participants answering correctly for a change score of 64.19%. According to the data from the pretest on this particular question, 69% of the

nurses believed that there was lateral violence policy information available at the Oregon State Board of Nursing website. What the nurses learned, according to the data, was that these policies do not exist. Nurses being unaware of what policies are in place (or not), particularly for their protection, was an important finding for this data point. More nurses are aware of the magnitude of the problem of LV, and they have learned that there is no policy to curb the problem, which could lead to positive social change in the policymaking area.

The smallest improvements were observed in Question 4 with a gain of 6.69% and Question 6 with a gain of 6.43%. Question 4 addressed potential causes of LV in a select-all-that-apply format. Question 6 was a narrative question regarding conflict resolution. Based on the item analysis, questions 4 and 6 should be evaluated for redesign to evaluate difficulty level and ensure comprehension by participants.

The data showed increased learning and awareness. The preexisting knowledge of the participants was 57.96% with net learning of 24.64% after increasing post education knowledge to 82.6%. These percentages indicated a learning gap of 17.4% that should be addressed in future education implementations (see Figure 3).

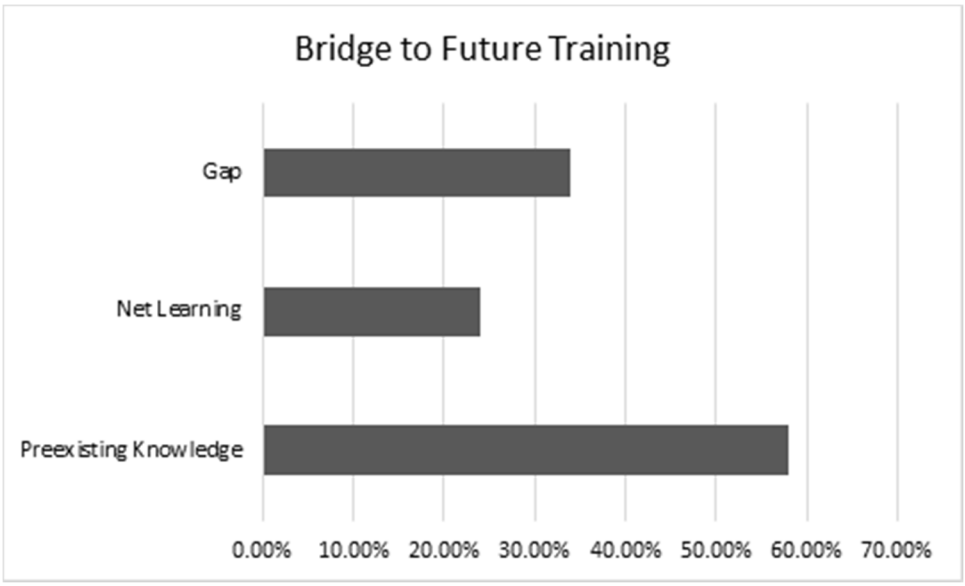

Figure 3. The learning gap that needs to be addressed in future training.

The results of the module evaluation were very positive. The evaluation contained five questions in a Likert-style format with a scale of 1 to 5. Over 50% of the participants responded to the evaluation (n = 155). Out of 155 respondents, 61 (39.35%) felt that they were more knowledgeable about LV, 49 (31.61%) felt that they were better equipped to handle incidents of LV, 49 (31.61%) responded that they were better equipped to handle incidents of LV that were witnessed, 62 (40%) felt that the issue of lateral violence in the workplace is important, and 51 (32.9%) would be interested in attending a workshop on LV (see Figure 4). The percentages represented those who selected 5 on the Likert scale. However, several respondents answered 4, which would indicate positive responses above 50% for all questions except Question 5.

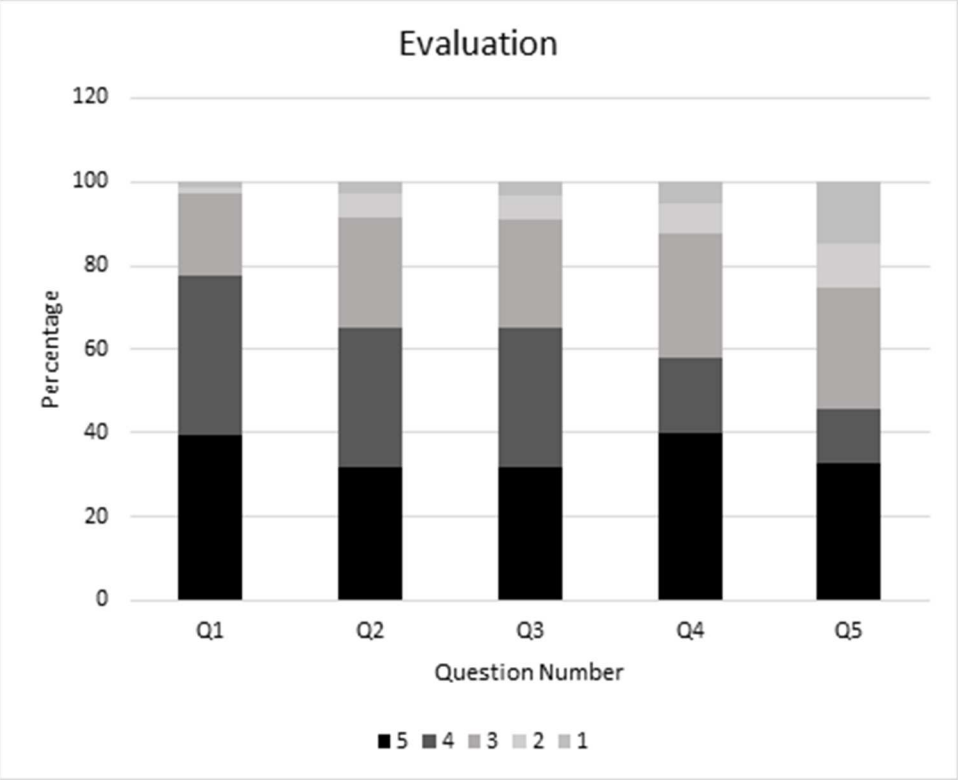

Figure 4. Evaluation percentages based on a Likert scale.

These data indicated that almost 60% of the nurses who participated had concerns regarding LV in their workplace. Addressing the concerns about LV is a good launching point for further investigation and subsequent educational interventions. Although the numbers were lower (45.8%) regarding attending LV workshops or other education in the future, the data still represented a large number of participants. Based on Bandura's (1977) social learning theory, it is plausible that even if a small number of nurses attend a workshop, change can occur. Findings may be used by nurses, management, and administrators as a stimulus for change.

Limitations of this study included the voluntary nature of the education module as well as different completion rates for pretest, posttest, and evaluation. The pretest was

completed by 171 participants, but only 161 of those completed the posttest. Of the 161 participants who completed the posttest, only 155 completed the evaluation. The lack of completion of 10 participants from pretest to posttest could have skewed the results, but not significantly at 3.2%. One unexpected, positive outcome was the response rate of over 50%, even with some participants not completing the posttest or the evaluation. It has been my experience that busy nurses who are already inundated with mandatory continuing education are less likely to spend time on education that is not mandatory.

The findings of this project indicated increased awareness of LV among participants and a desire for change. If behavior can change for the better at an individual level, the behavior of entire units (environments) can change. This notion is consistent with two of the overarching theories of this project: Bandura's (1977) social learning theory and Bandura's (1986) theory of reciprocal determinism.

If the nursing culture can change, it may improve patient safety. Researchers noted that patient safety could be affected by acts of LV (Blair, 2013; JCAHO, 2008; Longo, 2013; Longo & Hain, 2014; Rosenstein & O'Daniel, 2008). Because patient safety is paramount in health care, this project could have an impact on the community by contributing to improve patient safety. Institutions could be improved through patient satisfaction surveys, increased transparency in the delivery of care, reduced cost for replacing nurses due to turnover and attrition, and fewer relief workers needed to fill gaps in staffing. Findings may contribute to change in LV policy at organizational and legislative levels.

Positive social change may occur because nurses' behavior will be changing for the better. Nurses will feel more supported and free from the burden of LV in their daily work lives. Patients will be safer. Interpersonal work relationships, nurse-to-patient relationships, and patient relationships with the facilities could be improved based on improved behavioral standards.

Recommendations

Solutions to address the gap in practice include continued education and workshops on LV. The change score from pretest to posttest was 24.64%. However, there was a 17.4% gap in knowledge that could be addressed by continued education. Because the response rate was high regarding concern for incidents of LV in the workplace, the nurses at the implementation site will be surveyed to obtain more concrete data on the incidence of LV. Once this process is complete, those findings will guide future educational implementations. Education has been recommended in the literature (Bambi et al., 2018, Bigony et al., 2009; Blair, 2013; Chu & Evans, 2018; DiMarino, 2011; Etienne, 2014) and has been shown to increase awareness and decrease incidence of LV (Ceravolo et al., 2012; Dahlby & Herrick, 2014; Embree, Bruner, & White, 2013; Lasater et al., 2015; Pontus, 2011; Rainford et al., 2015). Based on the findings from this project, further education efforts are recommended.

Future implementation of this module or other education on LV will be dependent on the results of a staff survey. The survey will be administered by the manager of Home Care Services to evaluate the incidences of LV within the division. Once the surveys are completed, results will be submitted to the Workplace Violence Committee, and the site

educators will formulate the process of implementation. The result is to create a standard of practice centered on workplace violence.

Contribution of the Doctoral Project Team

While there was no designated project team, there were key players in the implementation of this project: the site preceptor as well as the informatics specialist. The site preceptor, who is also the manager of education and infection prevention, was responsible for granting approval for and vetting the project at all stages of implementation. The informatics specialist converted the educational materials into an online module as well as pulled data once the module was complete. Other individuals who were important were the educators at the facility who initially helped approve my project.

The site preceptor considered this project for future or permanent education at the facility. During the discussion on the future of this project in this organization, it was mentioned that there was a newly formed committee, the Workplace Violence Committee that would take on the data and implementation processes for future efforts to curb incidences of LV. Nurses will receive a survey created by the Home Services division to get more definitive numbers on incidences of LV in the workplace. It was advised that the site use an existing tool, the Lateral Violence in Nursing Survey (LVNS) that was created by Stanley, Martin, Michel, Welton, and Nemeth (2007). Once the survey data is analyzed, it will be used to guide further education on LV. The goal is to create a workplace violence standard of practice.

Strengths and Limitations of the Project

Strengths of this project include the response rate of greater than 50% as well as positive evaluation data. Based on the analysis of the data, this project was, overall, a success in that knowledge and awareness increased. Additionally, nurses reported that they would feel more comfortable addressing their aggressors. Nurses also reported that they would be interested in more education on LV.

The varied response rate between the pretest, posttest, and the evaluation is a limitation as it may have skewed the results regardless of the small percentage of non-completion. Another limitation is that, based on the change scores, some questions on the pretest and posttest may have been at a low difficulty level and should be reevaluated before this test is administered again.

For future projects and/or research on this topic, it is recommended that there be more standardized education on LV. Some of the literature that was reviewed mentioned that management should be a primary target for LV education because they set the tone for behavior on individual units (Becher & Visovsky, 2012; Bennett & Sawatzky, 2013; Ceravolo et al., 2012; Chu & Evans, 2018; Ganz et al., 2015; Rosenstein & O'Daniel, 2008).

Summary

This DNP staff education project, lateral violence in nursing, showed a 24.64% increase in learning from the pretest to the posttest scores. This percentage is a considerable increase in knowledge and, thereby, awareness. Both project goals were met: nurses reported feeling more knowledgeable about LV and felt more equipped to

confront their aggressors. However, while the change score on the tests was notable, there was still a 17.4% learning gap that will still need to be addressed through further education and, possibly, research. The implication of this project is that change is desired and is possible based on the results that showed increased learning, awareness, and perceived readiness to deal with LV. Recommendations include further, routine education and implementation of a standard of practice. The next section will address the dissemination plan for the data obtained from the project, a self-analysis of the researcher, and other insights gained through completion of this DNP staff education project.

Section 5: Dissemination Plan

In this section I discuss the dissemination of the findings from this DNP staff education project to the institution experiencing the problem of LV. Curtis, Fry, Shaban, and Considine (2017) noted that dissemination of information should take into consideration the kind of change that is sought as well as who the end users of this information will be. For this DNP staff education project, the end users were the nurses working in the Home Care Services division of the Pacific Northwest organization. The nurses desired change, and they will be responsible for carrying out the desired change.

Dissemination of the findings from this project is multifaceted. Initially, results will be disseminated to the Home Care Services manager, who was also the site preceptor for this project. The findings will then be presented to other educators in the Home Care Services facility as well as the Workplace Violence Committee so that they may work on a CQI project on LV in the future. The nurses and nurse managers will be able to obtain the results of this project through the newsletter that circulates monthly. It is unclear at this time how findings from this DNP staff education project will be further disseminated because the education on LV is new, the nurses have not been surveyed by the Home Care Services manager, and the reaction of upper management regarding facility-wide implementation is unknown. However, if education is approved for facility-wide implementation, e-mails will be sent to all nursing staff to log in to the online learning platform and complete the learning module. Nurse participation would then become mandatory, and all completions would be tracked for compliance and further CQI endeavors.

Based on the nature of this project, the audiences that would be appropriate for dissemination of this staff education project findings would be all nursing staff, nurse managers, and the chief nursing officer of the facility. The findings may also be shared in a publication such as *The American Journal of Nursing*, *Nursing 2018*, or the *Journal of Nursing Education*. Because LV is a problem that affects the entire nursing population, dissemination of results would be appropriate in any nursing publication.

I will also be speaking on LV in an upcoming conference, Nursing Beyond our Borders, presented by the Lower Columbia Chapter of Infusion Nurses Society. During this experience, I hope to connect with more nurses who are passionate about stopping LV. I would also like to collaborate with some of the authors and researchers whom I discovered while searching the literature for this project. Those authors include Martha Griffin, who wrote about using cognitive rehearsal as a solution to LV, as well as Wanda Christie and Sarah Jones, who wrote about using the theory of the nurse as the wounded healer. The education module in this DNP project will hopefully be implemented for nursing students at my place of employment pending review and approval, and may become a permanent education piece at the implementation site facility.

Analysis of Self

I am a nurse and a practitioner. In this DNP project, I considered myself an expert in my field by being the scholar. This topic resonated with me deeply and became the momentum for this project. I was moved, grateful, disappointed, horrified, and saddened by the nurses who contributed their stories as I shared with them the topic of this DNP project. So many nurses wanted to share their stories, and it was these stories that gave

me inspiration and drive to attempt to change the work environment of nursing. I considered it part of my duty to my profession to make a meaningful contribution to positive social change. Nurses often can decide if one procedure is better than another based on data and statistical analysis. However, the emotional and behavioral side of nursing sometimes gets neglected.

As the project manager in this endeavor, I found that collaboration is key. Working with my preceptor as well as others within the facility was priceless. This project was designed to be delivered through an online platform. This project would have been impossible without the help of the technology experts. It was satisfying to create all of the components of my education module and turn over a completed project to my preceptor.

Completion of this project was difficult. Not only was the doctoral classwork time consuming, but there were many challenges to completing my project. One of the biggest hurdles was life. Work, extenuating circumstances, lack of motivation, and the desire to have some semblance of a personal life were distractions and sources of procrastination. However, nurses prioritize. Sometimes work came first. Sometimes it was another aspect of life, but my desire to see this project to completion motivated me to finish. Time management was paramount when it was time to get work done. Once assignments were submitted, I had to wait for feedback. This was a tense time of ignoring the doubts and insecurities that what I submitted would not be good enough.

With the help of family and friends, I was motivated to finish. Keeping myself on task and avoiding disruptions were excellent strategies for success. One challenge I

experienced while working through this program was firsthand incidents (experienced and witnessed) of LV. Many symptoms that I described in earlier sections were manifesting in me. There was a turning point for me, however, where all of the research and discussions that occurred during this project inspired me to be a living example of everything that LV is not. It was my duty as an expert on this topic to live my words. It was my duty to speak out against my aggressor(s) and to defend those who were unable to do so for themselves. It was incredibly empowering, and people took notice. Some behaviors started to change, although some did not. These trials still come daily, but defending myself without being defensive and taking the higher road have all been valuable lessons taken away from this experience.

Summary

The goals of this staff education DNP project were to increase awareness of LV and to equip nurses to confront their aggressors. These goals were completed by administering an online education module that was bookended by a pretest and posttest. The change scores from the overall scores as well as scores from each question were evaluated. The overall change score from pretest to posttest was 24.64%. Each question score showed an increase, with some showing more of a change than others. The evaluation showed positive responses from the nurses who indicated not only learning but also feeling more equipped to confront their aggressors during incidents of LV.

During this project, many nurses were willing to tell their stories in hopes that someone might understand and some solidarity or catharsis would be achieved. The problem of LV has been persistent for decades; LV is like a silent virus killing off nurses

every year. Nurses have been the targets as well as the perpetrators. It has been my mission to educate nurses and change the tide of nursing culture for the better, but this will require work. Behavior is learned with ease but may be difficult to unlearn or change. There was a notable desire for change indicated in the module evaluation data as well as personal communications with colleagues. Being the practitioner, scholar, and the project manager made me realize that this project is ongoing. This project will not be complete until nurses can treat each other with respect and dignity.

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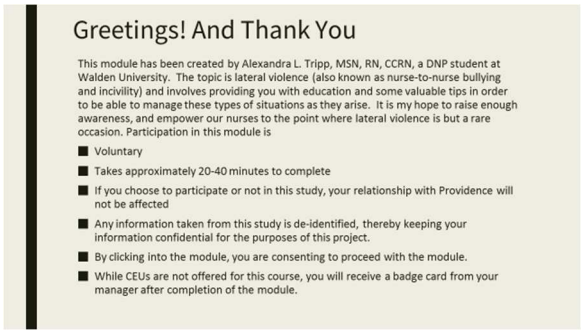
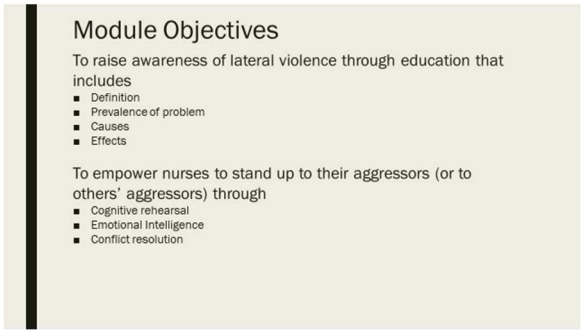
Appendix A: PowerPoint Online Education Module





How many times

Have we heard…

"Nurses eating their young"

"That's just the way it goes in nursing"

"Its been like this forever"

"Nothing will ever change"

"We just deal with it"

….?

Example of Lateral Violence

Judy has been a nurse on a medical surgical unit for almost 3 years, but sometimes she still has questions. One day, Judy asked her co-worker (Michelle) a question regarding a medication. Michelle rolled her eyes and responded, "There's things on the intranet to give you those answers. Shouldn't you know that by now?" Judy was left embarrassed and feeling like she did something wrong.

As this problem persisted, Judy began to feel as though she picked the wrong profession or that maybe she wasn't good enough to be a nurse. Maybe she didn't have the skills necessary to do her job. Judy began to be anxious about coming to work, was nervous asking questions, and was uncertain about interacting with her co-workers.

Michelle was standing around in a group of other co-workers when Judy arrived to work. Judy overheard Michelle and others talking about Judy and how she asks too many questions and "has no idea what she's doing". Judy felt ostracized and unable to cope with her unit anymore. Judy put in for a transfer to another unit.

Definition of Lateral Violence

Lateral violence (LV) is defined as:

Disruptive behavior, that is either **covert** or **overt**, that is imposed onto one nurse by another nurse (Donley, 2012).

Statistics

- Studies have estimated that **up to 85%** of all nurses have experienced lateral violence at some point in their career (ANA, 2011; Christie & Jones, 2013; JCAHO, 2016)
- **20-60% of new nurses** will leave their first nursing job within the first six months of employment (Embree & White, 2010; Oregon Nurses Association, n.d.)
- LV is a contributing factor to the nursing shortage, which is estimated to be **over 1 million by 2020** (McMenamin, 2014).
- LV is a contributing factor to **burnout** and compassion fatigue (Stamm, 2010)
- Compared to women outside the nursing profession, female nurses are **23% more likely** to commit suicide (American Society of Registered Nurses, 2008).
- The cost of turnover and onboarding a new nurse ranges from **$22,000 to $145,000** per nurse (Bigony, et al., 2009; Christie & Jones, 2013; Hayden, 2016).

Behaviors Associated with Lateral Violence

- Nonverbal innuendo (Coursey, 2013)
- Sabotage (Walrafen et al., 2012)
- Backstabbing (Coursey, 2013)
- Degrading or Undermining (Becher & Visovsky, 2012)
- Eye rolling (Becher & Visovsky, 2012)
- Lack of respect for privacy (Coursey, 2013)
- Betrayal of confidences (Embree & White, 2010)
- Humiliation (Ekici & Beder, 2014)
- Blaming (Becher & Visovsky, 2012)
- Refusing to assist (Becher & Visovsky, 2012)
- Intimidation (Becher & Visovsky, 2012)
- Impatience (Griffin, 2004)

Another Example of Lateral Violence

Amanda was very busy in the ICU-1 yesterday with a single patient. When she arrived for her shift today, she noticed that she was given 3 stepdown patients in ICU-2 and another nurse was assigned to the patient that she had yesterday.

Amanda asked the charge nurse if she could have her assignment back from yesterday on ICU-1 because of all of the work she had done, she knew the patient, and it was best for continuity of care.

The charge nurse denied her. When Amanda asked again, the charge nurse said that she could go back to ICU-1. Amanda left ICU-2 and when she arrived on ICU-1, she was given 3 different patients (again) instead of the patient she had the previous day.

Amanda then heard her charge nurse on the phone to the other charge nurse on ICU-2 saying, "Yeah. She is really mad [laughing]. It's hilarious to watch her squirm. 'Whatever you desire princess'".

Amanda informed the charge nurse that she could hear them talking and didn't appreciate it. The charge nurse ignored Amanda and continued her conversation.

Causative factors

- Organizational
  - *Imbalance of power from managers to staff, organizational shrinkage, and nurse short-staffing (Embree & White, 2010; Sanner-Stiehr & Ward-Smith, 2014; Sauer, 2012).*
- Personal/Workplace
  - *Poor unit dynamics, a culture of avoidance and disrespect, uncooperativeness, low self-esteem, silence, and ineffective coping strategies (Embree & White, 2010) and the need for the aggressor to be in control (Murray, 2009).*

Effects

- **Personal**
  - *Anxiety, Depression, Sleep disorders* (Becher & Visovsky, 2012)
  - *Headaches* (Griffin, 2013)
  - *Hypertension* (Vessey et al., 2009)
  - *Weight Gain/Loss, Gastrointestinal problems* (Rider & Hartung, 2012)
- **Professional**
  - *Burnout, Compassion Fatigue* (Warren, 2013)
  - *Errors* (Griffin, 2013)
  - *Leaving Profession* (Embree & White, 2010)
- **Organizational**
  - *Turnover costs* (Hayden, 2014)
  - *Costs for agency nurses* (Jones & Gates, 2007)
  - *Staff retention issues* (Hayden, 2014)
  - *Staffing crisis* (Jones & Gates, 2007)
  - *Overuse of sick time/absenteeism/overtime costs* (Hayden, 2014)

Solutions – Cognitive Rehearsal

What is Cognitive Rehearsal?

Cognitive rehearsal is learning to not immediately react to a verbal affront, but rather step away from the situation, processing the information, quietly rehearsing appropriate responses that diffuse tensions and anger in order to maintain civility and open communication (Griffin, 2004; Longo, 2017).

Example of Cognitive Rehearsal

Tania is a new nurse who's recently completed orientation and is working the night shift on a medical-surgical unit. She's criticized by staff nurses because of her lack of experience and her need to ask for help with some procedures.

One night, she has to insert a nasogastric (NG) tube in a patient, but she hasn't performed this skill outside of the simulation lab in school. She seeks assistance from a more experienced nurse, who says, "What did they teach you at that school?"

As a result of the cognitive rehearsal training Tania had during hospital orientation, she responds calmly, "I was able to practice the skill in the laboratory, but I didn't have the opportunity to place an NG tube in a patient in the practice setting. It would help me to review the procedure with you before going into the patient's room."

With this response, Tania communicated her concerns in a manner that both acknowledged her needs and provided opportunities for her colleague, avoiding a potentially emotional and confrontational situation that might have ultimately affected job performance and patient care. (Longo, 2017, Para 14-17).

Solutions – Conflict Resolution

What is conflict resolution?

Conflict resolution is a set of skills that manages conflict in a healthy and respectful manner that allows for successful communications and growth between two people (Segal & Smith, 2017).

Conflict 101

- A conflict is more than just a disagreement. It is a situation in which one or both parties perceive a threat (whether or not the threat is real).
- Conflicts continue to fester when ignored. Because conflicts involve perceived threats to our well-being and survival, they stay with us until we face and resolve them.
- We respond to conflicts based on our perceptions of the situation, not necessarily to an objective review of the facts. Our perceptions are influenced by our life experiences, culture, values, and beliefs.
- Conflicts trigger strong emotions. If you aren't comfortable with your emotions or able to manage them in times of stress, you won't be able to resolve conflict successfully.
- Conflicts are an opportunity for growth. When you're able to resolve conflict in a relationship, it builds trust. You can feel secure knowing your relationship can survive challenges and disagreements

(Segal & Smith, 2017, para 6)

Examples for Conflict Resolution

Healthy and unhealthy ways of managing and resolving conflict

Unhealthy responses to conflict:	Healthy responses to conflict:
An inability to recognize and respond to the things that matter to the other person	The capacity to empathize with the other person's viewpoint
Explosive, angry, hurtful, and resentful reactions	Calm, non-defensive, and respectful reactions
The withdrawal of love, resulting in rejection, isolation, shaming, and fear of abandonment	A readiness to forgive and forget, and to move past the conflict without holding resentments or anger
An inability to compromise or see the other person's side	The ability to seek compromise and avoid punishing
Feeling fearful or avoiding conflict; expecting a bad outcome	A belief that facing conflict head on is the best thing for both sides

(Segal & Smith, 2017, para 9)

Solutions – Emotional Intelligence

What is Emotional Intelligence (EI)?

Emotional intelligence is the ability to recognize our own emotions, how our emotions affect us personally as well as others, and how our emotions influence our behaviors (Institute for Health and Human Potential, 2017).

Keys to Emotional Intelligence

SELF-AWARENESS

Know one's emotions, strengths, weaknesses, drives, values and goals and recognize their impact on others while using gut feelings to guide decisions.

SELF-REGULATION

Manage or redirect one's disruptive emotions and impulses and adapt to changing circumstances.

SOCIAL SKILL

Manage other's emotions to move people in the desired direction.

EMPATHY

Recognize, understand, and consider other people's feelings especially when making decisions

MOTIVATION

Motivate oneself to achieve for the sake of achievement.

(David, 2014, para 4)

What can YOU do?

- Don't just do something, STAND THERE! Use the tactics mentioned earlier to prevent knee-jerk reactions that inflame situations.
- It is OK to confront your aggressor.
- It is OK to confront **someone else's** aggressor.
- **We are all in this together**.
- Nothing will change unless we all strive for and make a change.
- Change like this does not happen quickly, but it can happen with commitment to yourself, your coworkers, and to change itself!

After Completion of This Module:

- You will receive a badge tag (adapted from Griffin, 2004) with helpful.....this will be available through your managers upon completion of this module.
- Please proceed to the posttest
- Please complete a FIVE question evaluation

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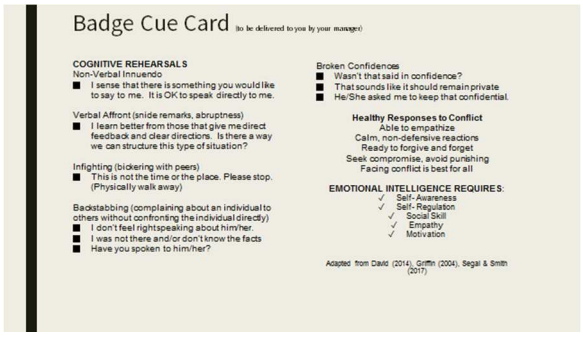
Post test

(To be uploaded and formatted)

Module Evaluation

(To be formatted)

1. After completion of this module, how knowledgeable do you feel about lateral violence?
   1 2 3 4 5
2. Do you feel better equipped to deal with incidences of lateral violence that may be experienced?
   1 2 3 4 5
3. Do you feel better equipped to deal with incidences of lateral violence that may be witnessed?
   1 2 3 4 5
4. How important do you believe the issue of lateral violence to be in your workplace?
   1 2 3 4 5
5. Would you be interested in attending a workshop on lateral violence?
   1 2 3 4 5



Badge Cue Card (to be delivered to you by your manager)

COGNITIVE REHEARSALS

Non-Verbal Innuendo
- I sense that there is something you would like to say to me. It is OK to speak directly to me.

Verbal Affront (snide remarks, abruptness)
- I learn better from those that give me direct feedback and clear directions. Is there a way we can structure this type of situation?

Infighting (bickering with peers)
- This is not the time or the place. Please stop. (Physically walk away)

Backstabbing (complaining about an individual to others without confronting the individual directly)
- I don't feel right speaking about him/her.
- I was not there and/or don't know the facts
- Have you spoken to him/her?

Broken Confidences
- Wasn't that said in confidence?
- That sounds like it should remain private
- He/She asked me to keep that confidential.

Healthy Responses to Conflict

Able to empathize
Calm, non-defensive reactions
Ready to forgive and forget
Seek compromise, avoid punishing
Facing conflict is best for all

EMOTIONAL INTELLIGENCE REQUIRES:
- ✓ Self- Awareness
- ✓ Self- Regulation
- ✓ Social Skill
- ✓ Empathy
- ✓ Motivation

Adapted from David (2014), Griffin (2004), Segal & Smith (2017)

Appendix B: Pretest and Posttest

1. Roughly _____ of nurses experience lateral violence in their careers. (Christie & Jones, 2013)
    a. 50%
    b. 72%
    c. 85%*

2. Causative factors of lateral violence include (select all that apply) (Embree & White, 2010; Sanner-Stiehr & Ward-Smith, 2014; Sauer, 2012)
    a. Imbalance of power from managers to staff*
    b. Staff shortage*
    c. Low self-esteem*
    d. Disrespect*
    e. Regular unit meetings*

3. Which of the following are actions of lateral violence? (Select all that apply) (Bigony et al., 2009; Reed, 2013)
    a. Sabotage*
    b. Non-verbal innuendo*
    c. Lack of respect for privacy*
    d. Humiliation*
    e. Intimidation*

4. Lateral violence can cause (select all that apply) (Becher & Visovsky; Christie & Jones, 2013; Stamm, 2010)
    a. Cost savings for the facility
    b. Substance abuse*
    c. Suicide*
    d. Anxiety and depression*
    e. Post-traumatic stress*

5. Jayne is complaining to Michelle about Cara. Michelle says to Jayne, "I don't feel right about talking about Cara behind her back. Have you spoken to her about this?" This response is an example of (Griffin, 2004; Griffin & Clark, 2014)
    a. Cognitive rehearsal*
    b. Conflict resolution
    c. Emotional intelligence

6. A fellow nurse, James, has not been available to help coworkers on the unit (turning patients, answering call lights, etc). James claims he is contributing, but that he is busy with other tasks and has had personal problems. Some fellow nurses on the unit are upset that he has been lazy and feel that they should talk to the manager about James. You are good friends with James and know he's not lazy but feel that he is being a bit over dramatic about his problems. You brought up the topic with James, but he was defensive and accused you of not being on his side. What can you say to James to resolve this conflict? (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012)
    a. "Stop the shenanigans, James. What's really going on?"
    b. "Everyone has problems. Maybe you should talk to someone."
    c. "I'm glad we are talking about this. I would like to understand what is making you upset." *

7. Knowing and caring for yourself, Seeking to understand then be understood, and clarifying feelings and needs are key steps in the process of (Davidson & Wood, 2004)
    a. Cognitive rehearsal
    b. Conflict resolution*
    c. Emotional intelligence

8. It is OK to confront someone who is committing acts of lateral violence whether it is directed at you or someone else (Thompson, 2013)
    a. True*
    b. False

9. Which of the following are keys to emotional intelligence? (David, 2014)
    a. Empathy*
    b. Self-awareness*
    c. Self-regulation*

10. There are policies that exist for lateral violence in this state that
    a. Can be located on the Oregon State Board of Nursing website
    b. Are listed in the Oregon Nurses Association bylaws
    c. Do not exist*

Appendix C: Evaluation Questions (5-Item Likert Scale)

1. How knowledgeable did you feel about lateral violence before completing this module?
2. How knowledgeable do you feel about lateral violence after completing this module?
3. Do you feel better equipped to deal with incidences (that you either experienced or witnessed) of lateral violence?
4. What is the likelihood that you would confront your aggressor (or someone else's) after completing this module?
5. Would you be interested in attending a workshop on lateral violence?

Appendix D: Curriculum Plan

Objectives	Content Outline	Evidence	Method of Evaluation	Grade of Evidence
I. Increase awareness of lateral violence through education module.	A. Introduction 1. Project significance a. Example of lateral violence b. Definition c. Statistics	b. Donley (2012) c. 1. American Society of Registered Nurses (2008) 2. American Nurses Association (2011) 3. Bigony et al. (2009) 4. Christie & Jones (2013) 5. Embree & White (2010) 6. Hayden (2016) 7. Joint Commission (2016) 8. McMenamin (2014) 9. Oregon Nurses Association (n.d.) 10. Stamm (2010)	Question 1 Question 10	b. V c1. V c2. IV c3. V c4. V c5. V c6. V c7. IV c8. V c9. V c10. V

	d. Behaviors	d. 1. Becher & Visovsky (2012)	Question 3	d1. V
		2. Coursey (2013)		d2. V
		3. Ekici & Beder (2014)		d3. IV
		4. Embree & White (2010)		d4. V
		5. Griffin (2004)		d5. IV
		6. Walrafen et al. (2012)		d6. V
	e. Example of lateral violence			
	f. Causes			f1. V
		f. Embree & White (2010)	Question 2	f2. V
		Murray (2009)		f3. V
		Sanner-Stiehr & Ward-Smith (2014)		f4. IV
	g. Effects			f5. V
		Sauer (2012)	Question 4	g1. V
		g. 1. Becher & Visovsky (2012)		g2. V
		2. Embree & White (2010)		g3. V
		3. Granstra (2015)		g4. V
		4. Hayden (2016)		g5. V
		5. Miller & Hartung (2011)		g6. V

		6. Stamm (2010)		
II. Equip nurses to stand up to their aggressors utilizing education module and badge cue card.	B. Solutions 1. Cognitive rehearsal a. Definition b. Example 2. Conflict resolution c. Definition d. Examples 3. Emotional intelligence e. Definition f. Keys to emotional intelligence 4. Nurse action	a. 1. Griffin (2004) 2. Longo (2017)\ b. 1. Longo (2017) c. 1. Segal & Smith (2017) d. 1. Segal & Smith (2017) e. 1. Institute for Health and Human Potential (2017) f. 1. David (2014)	 Question 5 Question 6 Question 7 Question 9 Question 8	 a1. IV a2. V b1. V c1. IV d1. IV e1. IV f1. IV

Level	Description
I	Experimental study, randomized controlled trial (RCT) Systematic review of RCTs, with or without meta-analysis
II	Quasi-experimental Study Systematic review of a combination of RCTs and quasi-experimental, or quasi-experimental studies only, with or without meta-analysis.

III	Non-experimental study Systematic review of a combination of RCTs, quasi-experimental and non-experimental, or non-experimental studies only, with or without meta-analysis. Qualitative study or systematic review, with or without meta-analysis.
IV	Opinion of respected authorities and/or nationally recognized expert committees/consensus panels based on scientific evidence. Includes: – Clinical practice guidelines – Consensus panels
V	Based on experiential and non-research evidence. Includes: – Literature reviews – Quality improvement, program or financial evaluation – Case reports – Opinion of nationally recognized expert(s) based on experiential evidence

Dearholt, S., Dang, Deborah, & Sigma Theta Tau International. (2012). *Johns Hopkins Nursing Evidence-based Practice : Models and Guidelines*.

Appendix E: Badge Cue Card

COGNITIVE REHEARSALS

Non-Verbal Innuendo

· I sense that there is something you would like to say to me. It is OK to speak directly to me

Verbal Affront (snide remarks, abruptness)

· I learn better from those that give me direct feedback and clear directions. Is there a way we can structure this type of situation?

Infighting (bickering with peers)

· This is not the time or place. Please stop. (Physically walk away)

Broken Confidences

· Was this said in confidence? It sounds like that should remain private.

Backstabbing (complaining about an individual to others without confronting the individual directly)

· I don't feel right speaking about him/her. I was not there and/or don't know the facts. Have you spoken to him/her?

Healthy Response to Conflict	Emotional Intelligence Keys
Empathize	SELF-AWARENESS
Calm, Non-defensive	SELF-REGULATION
Ready to forgive/forget	SOCIAL SKILL
Seek compromise	EMPATHY
Face conflict	MOTIVATION

Adapted from David (2014), Griffin (2004), Segal & Smith (2017)

Appendix F: Content Expert Evaluation of the Curriculum Plan Summary

Not Met = 1 Met = 2
At the conclusion of this educational experience, learners will be able to:

Objective Number	Evaluator 1	Evaluator 2	Evaluator 3	Average Score
1. Increase awareness of lateral violence (as evidenced by higher posttest scores from pretest scores)	2			
2. Equip nurses who are victims of lateral violence to confront their aggressors	2			

Appendix G: Content Expert Evaluation of the Curriculum Plan

Title of Project: Lateral violence: Time for an end to a time-honored tradition?
Student: Alexandra L. Tripp, MSN, RN, CCRN
Date: July 1, 2018

Name of Reviewer: Twilla Harrington, MSN RN CHPN

Products for review: Literature review Matrix, Curriculum Plan with Complete Curriculum Content, Content Expert Evaluation Plan Form

Instructions Please review each objective related to the curriculum plan, content and matrix. The answer will be a "yes" or "no" with comments if there is a problem understanding the content or if the content does not speak to the objective.

Objective 1: Increase awareness of lateral violence (as evidenced by higher posttest scores than pretest)

Met **Not Met**

Comments:

Objective 2: Equip nurses that are victims of lateral violence to confront their aggressors.
Met **Not Met**

Comments:

Appendix H: Pretest/Posttest Calculating the Content Validity Index

To calculate an I-CVI, experts are asked to rate the relevance of each item, usually on a 4-point scale. The scale most often used is: 1=not relevant, 2=somewhat relevant, 3=relevant, 4=highly relevant (Davis, 2012). Then, for each item, the I-CVI is computed as the number of experts giving a rating of either 3 or 4, divided by the number of experts: the proportion in agreement about relevance.

Remember that content validation is of an assessment, i.e., the relevance of the assessment's items for measuring the objectives of the curriculum. List the items in column 1 and the responses of the experts in columns 2-4 (if 3 experts). Then apply the procedure above to compute item CVIs (I-CVIs) for all items and place in column 5. Sum the I-CVIs and divide by the number of items to obtain the scale CVI (S-CVI).

Item	Expert 1	Expert 2	Expert 3	I-CVI
1	4			
2	3			
3	4			
4	4			
5	4			
6	4			
7	4			
8	3			
9	4			
10	4			

Each cell contains a rating (1, 2, 3, or 4) of the item defining that row by the expert defining that column.

Moon 2018

Appendix I: Newsletter

ATTENTION ALL NURSING STAFF!!

LATERAL VIOLENCE EDUCATION

Nurses eating their young (and each other)??

My name is Alexandra Tripp, MSN, RN, CCRN, and I am a doctoral student at Walden University. I have been working on the topic of lateral violence for several years now and would like you to partake in my (very short) education module that will become available in the coming weeks.

Lateral violence affects us all at one time or another in our careers. Acts such as eye-rolling, backbiting, gossiping, scapegoating, and sabotaging (to name a few) all have negative and damaging effects on us as nurses.

Repeated attacks can cause burnout, compassion fatigue, changing jobs, leaving the profession, anxiety, depression, early cardiac disease, other health issues, and even nurses taking their own lives.

I, personally, have suffered multiple episodes of lateral violence. I have witnessed more than I can count. SO, I bring this education to you in an attempt to change the tide and bring more cohesiveness to the nursing profession. Should this implementation be successful, you will be the front-runners of lateral violence education and training. Additionally, the success could lead to policy and procedure at local, state, and national levels.

So, keep an eye on your inbox for the link to HealthStream. I ask you to click into the module and work through 20 brief slides and answer a 5 question evaluation. You could be making a tremendous difference for the discipline of nursing, yourselves and coworkers, and me – just trying to finish my degree!

Upon completion of the module, you will receive a badge tag with helpful tips on diffusing difficult situations that embody lateral violence.

Thank you for wanting to end lateral violence in nursing! And thank you for your time!