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Clinical Resource Practice Scenarios to Mitigate Bullying

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This is to certify that the doctoral study by

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Walden University
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Abstract

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MS, University of Medicine and Dentistry New Jersey, 2005

BSN, Rutgers University, 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Workplace bullying is repeated, aggressive action towards a victim, which especially affects new graduate nurses and can inhibit growth and lead to nursing burnout and staff turnover. The purpose of this Doctor of Nursing Practice project was to develop a clinical resource educational module. The case scenarios were developed using literature on workplace bullying and lateral violence. Clegg's circuits of power theory was applied to frame the organizational authoritative nursing power struggles that exist as a circular flow between different nursing group members, and the American Nurses Association (ANA) Practice Standards and Code of Ethics guided the assertive communication. The case scenarios consisted of 3 vignettes, terms and definitions, a summary of the ANA practice and code of ethical standards, the Appraisal of Guidelines Research and Evaluation (AGREE) II instrument, Workplace Bullying Inventory, Organizational Predictors and Consequences of Bullying Scale, flip cards, and content readability evaluation forms. The AGREE II instrument is a 7-point Likert scale for evaluating clinical guidelines with a threshold standard of 70%. The results of advisory committee members' rigor scores (mean = 50.8, median = 31, *SD* = 3.03) were compared with the scores of nurse evaluators (mean = 50, median = 31, *SD* = 4). The AGREE II reliability score is 0.93, with similar results found for the advisory members (0.939) and the nurse evaluators (0.941). The overall findings suggest that the AGREE II is a viable instrument for evaluating case scenarios, which can be used to improve the workplace environment for nurses by addressing workplace bullying.

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Dedication

I dedicate this paper to my family: Mom, Diane, Dad, Charles, my son Jordan, and my grandchild. Thank you for your support throughout this journey. I am truly blessed to have you in my life.

Special thanks to Dr. Jennings Sanders, Dr. Anderson, and Dr. Brown for your support and understanding during the project. I would also like to thank Dr. Lorraine Steefel for helping me edit this paper.

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I would like to thank my fellow nursing colleagues, who continually encouraged me. It was a very long, hard road, but it was worth the struggle.

I would also like to thank HPAE for giving me the opportunity to complete this project.

Thank you to all the advisory committee members and the nurse evaluators who participated in this project.

Special thanks to my Local for all their encouragement throughout this hugely significant period in my professional development.

God, without your infinite wisdom, I would not have made my dream come true. Thank you for carrying me when I doubted myself.

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Introduction

Workplace bullying consists of acts that have direct emotional impact directed toward an individual over a period of 6 months or more (Einarsen, Hoel, & Notelaers 2009). Bullying is pervasive in healthcare and poses a threat to peer relationships and job satisfaction, and it affects nursing turnover and attrition rates. A lack of response from management and marginalization of the issue by authoritative managers intensifies the effects. The victims of bullying often have difficulty responding to aggressive behavior in the workplace (Griffin & Clarke, 2014; Gillespie et al., 2016; Sanner-Stiehr & Ward-Smith, 2015). There are especially problems with workplace bullying of novice nurses, who are vulnerable to its harmful effects and need strategies to manage such experiences. The bullying of new graduates is common, with 66% of new nurses reporting burnout (Laschinger, Wilk, Cho, & Greco, 2009). New graduates typically intend to leave the profession within 2 years of beginning professional employment (Barber, 2012; Bartholomew, 2012; Griffin, 2004). Early survivors of bullying may either leave the environment or perpetuate bullying behavior themselves, making a zero-tolerance policy regarding this behavior a necessity. Learning how to deal with bullying is key to breaking its cycle, allowing for the development of a healthy work environment.

The purpose of this DNP project was to develop an educational resource module to address bullying in quality improvement training. The social benefits of this project include the education of nurses in recognition of bullying and zero-tolerance approaches to it. In recent years, nursing organizations and the government have set forth

professional practice standards that reflect a zero-tolerance approach to any behavior that disrupts care (American Nurses Association [ANA], 2015). This project also promotes ethical and moral decision-making skills that will help to address inappropriate behaviors.

Problem Statement

The Bureau of Labor Statistics (2014) indicated that nursing jobs had grown from 2,751 to 31,903 by the end of 2014. However, the Bureau of Labor Statistics predicted that bullying will play a significant role in the registered nurse (RN) shortage expected by 2020. A nursing shortage will affect future nursing positions and the continuity of care to the community, and by 2020, baby boomer nurses will have reached retirement age, further reducing the healthcare workforce.

The economic costs of workplace bullying, and nursing turnover can impact healthcare organizations. Johnston, Phanhtharath, and Jackson (2010) estimated that the organizational costs of bullying are between 30,000 and 100,000 U.S. dollars per event. Additionally, hospital turnover costs for bedside nursing range from 37,700 to 58,400 U.S. dollars annually (Colossi, 2016). Cost-savings from RN attrition would save hospital corporations an average of 373,200 U.S. dollars each year (Colossi, 2016). Decreased nursing productivity, low morale, and absenteeism all incur costs to the hospital and decrease the quality of care and patient safety (Delaney & Zager, 2010; Johnson & Rea, 2009; Stagg, Sheridan, Jones & Speroni 2011).

Bullying victims require a supportive atmosphere to express concerns about clinical issues that impact their well-being. Victims of bullying often feel demoralized and experience stress symptoms such as high blood pressure, fatigue, and depression

(Buddin et al., 2017; Einarsen, Hoel, & Notepapers, 2009; Griffin, 2004). Bullying occurs in all professions, including nursing. Nearly 65% of the respondents to a survey at a large medical center claimed to have seen horizontal bullying among coworkers (Townsend, 2012). New graduate nurses also consider leaving the nursing profession after 1 year of employment due to aggressive bullying from coworkers (Buddin et al., 2017; Townsend, 2012). Bullying can cause self-esteem issues, making it especially challenging for new graduates, who lack confidence and need positive feedback about their clinical performance (Townsend, 2012; Sanner-Stiehr & Smith, 2017). Newly licensed nurses are vulnerable to workplace bullying during the new hire orientation period, and higher levels of bullying are reported throughout the first 2 years of employment (Griffin, 2004; Gillespie et al., 2016; Hutchinson et al., 2010). Recent strategies suggested by the nursing literature recommend developing educational modules to aid in recognition of bullying behaviors.

This project addresses bullying and lateral violence during new hire orientation. Health Professionals and Allied Employees (HPAE) is the largest union of RNs and healthcare professionals in New Jersey. It has 22 local chapters and approximately 13,000 members. Different locals successfully negotiated contact language to reflect safe staffing ratios while in the hospital, limiting floating to different areas outside of their floating districts. By limiting compulsory overtime and floating, the members are better able to provide quality patient care. In 2008, the New Jersey Prevention of Violence in Health Care Facilities Act was passed by the New Jersey legislature and signed by the governor

(HPAE, 2019). This law directs facilities within New Jersey to create programs to combat physical violence against employees.

For the past 10 years, I have been the president for the local 5135 chapter of HPAE. I meet with nurses during orientation and introduce them to the Prison Nurses Union. Local members asked for a module due to complaints about increasing nursing hostility. As president of Local HPAE 5135, it is my responsibility to address issues that can affect my members. Thus, I developed an educational module to address workplace bullying.

Purpose Statement

Workplace bullying is pervasive and can negatively impact nursing practice and professionals (Becher & Vislosky 2012; Griffin, 2004). It can disrupt team performance (Cochran & Elder, 2015), leading to burnout, intimation, and staff turnover. Bullying can also cause physical and psychological stress to the victim. Physical stress may be expressed as chronic migraine headaches, elevated blood pressure, feelings of worthlessness, panic attacks, and anxiety (Radwan & Shosha, 2019). Psychological stress can affect job performance and increase absenteeism, intention-to-leave, and turnover rates (Wolf, Perhats, Clark, Moon, & Zavotsky, 2018). Acts of workplace bullying can be obvious, deliberate actions against an individual and or groups of people (Radwan & Shosha, 2019), which may be witnessed or unwitnessed (Griffin & Clarke, 2014; Hutchinson et al., 2010). Aggressive behaviors, including verbal and physical threats, are used to intimidate and embarrass coworkers (George & Davis, 2013; Griffin, 2004; Kern et al., 2014). Social isolation can also be an act of bullying, including withholding

pertinent care information, ignoring phone calls, and failing to respond to requests for help (George & Davis, 2013; Griffin & Clarke, 2014). Perpetrators may also use destabilization techniques to humiliate victims such as making extreme criticisms, removing responsibility, assigning unreasonable caseloads, and imposing unrealistic deadlines (Berry, Gillespie, Gates, & Schafer, 2012; Griffin & Clark, 2014; Vessey, Demarco, & DiFazio, 2010). Many novice nurses describe aggressive, hostile behaviors from their senior coworkers (Hegney, Tuckett, Parker & Eley, Vessey, Demarco & DeFazio, 2010).

The purpose of this capstone project was to develop a clinical practice scenario module to address workplace bullying. It includes three practice scenarios for content, handouts for dealing with conflict, and flip cards of the 10 most common inappropriate behaviors. The practice scenarios can used as problem-based scenarios to be role played during clinical orientation. Role play during clinical simulation provides nurses with an opportunity to gain experience in unfamiliar situations (Griffin & Clark, 2014; Radwan & Shosha, 2018). The material developed for this project is intended to aid nurses in dealing with workplace bullying and lateral violence in the workplace. Development of the educational content aligns with The ANA Practice Standards and American Association of Critical Care Nurses and the ANA Code of Ethics, which encourage the addressing of inappropriate behavior. Five advisory members evaluated the content and approved the educational package. The advisory committee validated the relevant peer-reviewed nursing journal articles based on the hierarchy of evidence recommended by Fineout-Overholt, Melnyk, Stillwell, and Williamsons (2010). The committee members found the

content to be suitable for training. The content serves as an education tool, providing nurses with the skills to recognize and assertively respond to bullying behaviors.

Project Objectives

New nurses need strategies to identify and manage workplace bullying. The objectives for this projected are grounded in evidence-base practice, which supports developing solutions to identify bullying in the workplace. Behaviors including incivility, backstabbing, sabotage, nonverbal innuendo, undermining, infighting, scapegoating, and broken confidences are common workplace bullying practices (Griffin, 2004; Griffin & Clarke, 2014). The objectives for this project are as follows:

- Develop an educational practice scenario module based on the current literature on workplace lateral violence and bullying (the ANA Professional Standards Code of Ethics offers assertive communication skills to address and respond to inappropriate behaviors).
- Validate all material for appropriateness for clinical use.
- Develop, implement, and evaluate plans for a graduate nursing educational training program.

Practice-Focused Questions

The practice-focused questions for the educational project are as follows:

- What content must be included in the practice scenarios module?
- What educational strategies have been demonstrated effective in current evidence-based literature?
- Do the educational activities align with current evidence-based practice?

- Does the educational content meet the content requirements derived from the experts' review?

Nature of the Doctoral Study

The aim of this study was to develop a clinical practice scenario module as part of a training program for nurses to recognize and deescalate bullying and lateral violence in the workplace. The project is based on peer-reviewed literature on lateral violence, horizontal violence, workplace bullying, workplace violence prevention programs, and the ANA 2015 Professional Standards Code of Ethics. An integrative literature review was conducted using the hierarchy of evidence by Fineout-Overholt et al. (2010). the following databases were utilized: CINAHL Plus, Medline, and ProQuest. The keywords were as follows: *lateral violence, horizontal violence, novice nurse, burnout, marginalization, nurse oppression*, and *nurse empowerment*. These terms were combined with *workplace violence, bullying, oppressed group behaviors, program development, simulation targets, antecedents*, and *circuits of power*. The inclusion criteria specified peer-reviewed RN research journals published in 2004-2018 and written in the English language. The criteria excluded literature reviews, essays, and peer-reviewed articles not written in the English language. I reviewed the abstracts for relevance and applicability. As the project developer, I also reviewed the position statements of professional nursing organizations such as ANA, American Association of Colleges of Nursing [AACN], American Association of Critical Care Nurses [AACN], and The Joint Commission for initial guidance in addressing the issue of bullying in the workplace and effective alleviation strategies.

All material was developed from the hierarchy of evidence. Research indicated that practice scenarios in simulations can support clinical and nurse educators in the translation of evidence for clinical practice (Parker et al., 2014; Smith et al., 2016). High quality simulation education must link care situations to learning objectives (Doolen et al., 2016). Additionally, prebriefing and debriefing simulation prepare students for activities and illuminate the relevance of the learning objectives (Page-Cutrara, 2014). Prebriefing scenarios initiate clinical thinking, which enhances clinical judgment (Hakojärvi et al., 2014; Page-Cutrara, 2014). Debriefing clinical problem-based scenarios allows for the expansion of the discussion, which aides in the retention of material (Neill & Wotton, 2011). Critical thinking and problem-solving skills are also strengthened when supported by peer-reviewed articles, increasing the value of evidence-based practice (Hakojärvi et al., 2014; Leach et al., 2016; Peterson, 2008; Smith et al., 2016).

The case scenarios used assertive communication as a guide to respond to the vignettes, based on the ANA Practice Standards and Code of Ethics. Additionally, Clegg (1989) proposed the circuits of power to represent organizational power among nursing group members. The circuits clarify the power struggles between senior management and subordinates. Each circuit teaches about the characteristics of the relationships between the different groups. Power influences access to resources and how power is used to engage different groups. Change is possible when group members collaboratively resist the status quo. The ANA Scope and Standards of Practice Code of Ethics provides guidance on managing bullying situations, using assertive communication to deescalate conflict. In this project, I used specific examples of situations to articulate strategies for

recognizing bullying. The strategies include the use of the ANA Practice Standards Code of Ethics as an assertive response to inappropriate situations.

Flips cards were also developed for this practice scenario module as a visual aid. The 10 most frequently observed bullying behaviors in the workplace were selected. Each card had a corresponding response, using the ANA Code of Ethics as a reference. Several scholars have used these guides as a tool to help nurses respond to inappropriate behaviors (Griffin, 2004; Hutchinson et al., 2008; Stagg et al., 2011).

The contents of the module were reviewed by an advisory panel of five HPAE State Executive Council members with experience in developing bullying programs for their locals. The advisory panel members were selected for their experience in developing violence prevention programs. The inclusion criteria specified that they should be RNs with more than 5 years of experience in psychiatric, medical, and or surgical nursing and expertise in developing violence prevention programs at their local levels. The experts anonymously provided their demographic information, including details of their age, race, marital status, years of experience, and highest level of education. The panel members reviewed the educational content using the Appraisal of Guidelines Research and Evaluation (AGREE II) instrument, which is a 7-point Likert scale to determine the appropriateness of guidelines and training material. The instrument consists of 23 items, organized into six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence (Brouwers et al., 2012).

The panel members evaluated the literature review material and provided feedback on the project. Permission to use copyrighted material was obtained using the Walden's Institutional Review Board (IRB) procedure. Informed consent was obtained from all participants before initiating the project-related procedures via a secure e-mail link. The five panel members used the Workplace Bullying Inventory Assessment Scale and the Organizational Predictors and Consequences of Bullying Assessment Scale developed by Hutchinson, Wilke, and Vickers (2010). The advisory panel experts met regularly to review the clinical material and provided feedback on the progress of the project. They reviewed the content over a 2-week period and returned the results to me by secured e-mail. Content approval was obtained from the advisory members. All results were secured on an encrypted computer, supplied by me.

For this project, a pre- and post-design was used to compare the means of a single group. A group of five nurses were asked to evaluate the project. They followed the same procedure as the advisory members did. Data were gathered using a secure and encrypted computer. Statistical analysis includes mean, median and standard deviation (Polit & Beck, 2010). The data were reviewed and coded into the main categories, based on the AGREE II instrument Likert scale results. The results aided in answering the practice questions.

Significance

New graduates need educational programs to aid their recognition of inappropriate behaviors and enable professional responses to them (Griffin & Clarke, 2014). Training can lead to improvements in knowledge, confidence, and skills building

as well as the development of professional ethical behaviors. Stakeholders want educational programs that help new graduates' transition into practice.

My project may expand on recognizing workplace bullying in nursing. The educational material for this project was supported by the AGREE II instrument. This project is significant in using a guideline instrument to present an educational program that can enable nurses to understand how bullying can affect their work performance. This project also provided an opportunity to collaborate with other professionals on nursing research. Organizational investment in clinical ladder programs provides a basis for professional growth.

The literature also supports the introduction of evidence-based practice into clinical practice settings, which this project contributes to. Changes based on evidence-based practice research can help to sustain changes learned from performing clinical research (Leach, Hofmeyer, & Bobridge, 2016). Research has suggested that access to critical appraisal tools helped students with the uptake of clinical evidence-based practice (Leach et al., 2010). Thus, introducing students to practice research can aid the transition from student nurse to graduate nurse. Further, role-playing simulations have provided students with real-time interactions in safe environments that lead to insights into the situation (Gillespie et al., 2015; Smith, Gillespie, Brown, & Grubb, 2016). Debriefing sessions also allow exploration of how the role play simulation can be addressed. The findings from the nursing literature also indicate that addressing ethical nursing practices demonstrates respect, fosters morale, and supports a civil working environment (ANA 2015; Smith et al., 2016).

Summary

This project involved the use of practice scenarios to help new graduate nurses identify and manage workplace bullying in a quality improvement training module. As a result, the findings could positively affect participants' work environment and communication between colleagues. The practice scenarios simulation module could be expanded to all newly hired employees for the mitigation of workplace bullying. Future evaluation of the educational program could add to the growing body of evidence-based knowledge on conflict resolution.

Section 2: Background and Context

Introduction

Inappropriate relationships between colleagues can lead to poor job satisfaction and patient safety concerns. Additionally, all healthcare team members' contributions should be valued. This section provides the context of workplace bullying as it relates to the development of the practice scenarios module. Workplace bullying and lateral violence education for new graduates was developed as part of a quality improvement module. Five advisory members of the HPAE union used the relevant literature to aid in the development of this clinical resource module. The practice-focused questions on the educational resource project were

1. What content must be included in the practice scenario module?
2. What educational strategies have been demonstrated as effective?
3. Do the educational activities align with current evidence-based practice?
4. Does the educational content meet the content requirements derived from the experts' review?

The ANA Code of Ethics provided guidance for appropriate professional responses to the flip card representation of the offence behavior. Skills development also included education that incorporates assertive communication to reduce conflict (see Lachman, 2015).

Concepts, Models, and Theories

Circuits of Power

The circuits of power theory imply that power is controlled by authoritative administrators (eg. senior managers) within an organization (Clegg, 1989). Authoritative power can make victims of bullying feel isolated from their peers and devalued as members of the healthcare team (Clegg, 1989; Hutchinson et al., 2010). Additionally, organizational culture influences the social culture of the group members. Abuse of power affects the group's social culture and the organizational culture.

With the circuits of power theory, Clegg (1989) explained the complex evolution of power within an organization by looking at the synergistic integrative nature of power (see Appendix A). Clegg (1989) postulated that power is fixed and contained within a forcefield—power flowing through a circuit forcefield represents authoritative power. For example, whoever controls the unit has the power to delegate assignments within the workgroup. Organizations achieve stability by fixing power within the predictable circuits of authoritative power. In hospitals, authoritative power is held by nurse managers, unit managers, charge nurses, and so on (Clegg, 1989). Authoritative power serves as a catalyst for bullying behaviors (see Appendix A.)

The microsystem of power includes the perpetrator and targets of bullying practices. Perpetrators of bullying behaviors operate at various levels of the organization (Johnson, 2009; Johnson & Rea, 2009). This circuit illuminates the feelings of powerlessness felt by bullied nursing staff. Targets comply with a clique's moral code within the circuit. Obedience to power defines the meaning of practice rules and group

membership categories locally within the unit (Hutchinson et al., 2010). Coworkers and subordinates work together to form the unit alliance, which is the basis of a clique membership. For example, nurses from one unit do not typically socialize with other nursing units. Cliques are a group of individuals who regularly interact with one another in a unit. Clique members are responsible for assigning work assignments within the unit. For example, if an RN is not a part of the clique, the RN is assigned the most difficult work assignment. Cliques control the unit's power, flow, and work, which can be damaging to new nurses (Murray, 2009).

The depositional (social) circuit of power provides the basis for the rules of the organization, group membership, and the meaning of relationships in the power circuit. The circuit is comprised of the senior level management and divisional management. A large organization lends a hand in developing bureaucratic authoritative power control, whereas senior management enforces the rules of the organizational culture. Bullying behaviors become the norm when cliques align with management (Clegg, 1989).

The facilitative circuit represents financial incentives and defines the system of reward and punishment (Clegg, 1989). This circuit power derives from the use of organizational incentives, such as tolerance and reward, the misuse of legitimate authority, and the normalization of lateral violence. Clegg's (1989) implied that bullying practices arise from breaching the rules of the established organizational code of conduct. Furthermore, bullying behaviors may be reinforced by the organization (Clegg, 1989). Disciplinary techniques may include progressive discipline that deals with job-related behaviors that do not meet performance standards (Clegg, 1989). Supervisors may use

progressive discipline to control nurses. However, excessive progressive discipline may explain why nurses remain silent, as speaking out can make this worse. The bullied person becomes more ostracized within the organization; for example, a nurse may be negatively labeled by coworkers by not conforming to the clique's mentality (Clegg, 1989).

The circuit of power provides an alternative theory to explain how roles affect organizational power. Authoritative control is an increasing problem in the modern work setting (Einarsen, Hoel, & Notelaers 2009; George & Davis, 2013; Griffin, 2014). Inappropriate workplace ethics allow individuals to engage in abusive acts against coworkers, which support the clique's attitude and behaviors. Bullying in nursing is seen as an oppressed group behavior (Griffin, 2014). Oppressed group behaviors can manifest as lateral violence or horizontal violence in the nursing units (Aiken et al., 2012; Buddin et al., 2013; Griffin, 2014; Oh, Dong-Choon, & Young- Joo, 2016). With the circuits of power theory, Clegg (1993) provided a broader outline of bullying as an organizational phenomenon that is better understood when viewing how power runs through each organizational subunit (Griffin & Clark, 2014; Hutchinson, Vickers, Jackson, & Wilkes, 2005). The circuits of power model explains how bullying can become normalized within an organizational culture that it is almost invisible (Griffin & Clark, 2014; Hutchinson et al., 2005).

Clegg's model provided the theoretical foundation for this project. The practice scenarios represent Clegg's three power assertion positions. The episodic position explores how authoritative power upholds unit members' respect. Social power defines

group status and organizational rules of engagement. Senior management enforces the rules of engagement. Finally, facilitative incentives define punishment and reward within the context of the organizational power. In this section, the incentive features are tolerance, reward, misuse of legitimate power, and normalization of lateral violence behaviors. Using Clegg's theory, the case studies shed light on how workplace bullying contributes to group dynamics, which control the overall culture of the workplace.

Definition of Terms

The following words and phrases are defined for the purposes of this DNP project:

Circuits of power: The complex evolution of power within an organization, which explains the synergistic, integrative nature of power. For Clegg (1989), power is designed to flow through a forcefield and is fixed and constituted within the forcefield. Organizations achieve stability by fixing power within the predictable circuits of authoritative power.

Health Professional and Allied Employee (HPAE): The largest professional nurses' union in the state of New Jersey. The union supports legislation on nursing ratios, retention, and unsafe practices (HPAE, 2017).

Horizontal violence: Intergroup rivalry directed toward other members of the group (Embree & White, 2007, 2010) and manifested by scapegoating, criticism, infighting, and sabotage (Embree & White, 2010; Johnson & Rea, 2009).

Lateral violence: Occurs when victims of a situation begin turning against group members in the same profession. It is also manifest as verbal affront, undermining,

scapegoating, backstabbing, broken confidences, and failure to respect privacy (Embree & White, 2010).

Sabotage: The deliberate undermining of a coworker's activities to delay treatment and inhibit satisfactory job performance (Stagg, Sheridan, Jones, & Speroni, 2011).

Undermining: An activity undertaken to undermine the outcomes of work tasks performed by a colleague. This intends to damage the colleague's work performance (Stagg et al., 2011).

Workplace bullying: A collective expression for inappropriate, hostile behaviors enacted by coworkers, supervisors, and subordinates (Fox & Stallsworth, 2005; Hutchinson et al., 2010; Neilson et al., 2010). It may include intentional verbal abuse or disrespectful conduct with the intent to threaten, intimidate, and/or humiliate a colleague (Workplace Bullying Institute, 2012).

Workplace incivility: This refers to deviant, discourteous behaviors in violation of expected workplace conduct, with the intent to harm the target (Rocker, 2009; see Appendix B).

Zero tolerance policy: This is a set of policies that outlines inappropriate behaviors that impact professional responsibilities and impede patient care. The policy further defines different types of violence in the workplace and provides guidance on managing this (ANA, 2016, Occupational Safety Health Administration, 2017)

Relevance to Nursing Practice

Employers have a legal responsibility to maintain a working environment free from all known hazards (ANA 2012; National Institute Workplace Violence, 2012; The Joint Commission, 2008). The employer is also responsible for enacting policies that prevent significant risks to the public. Workplace bullying programs must define recognizable hazards within an organization. For instance, according to the Bureau of Justice, an estimated 1.8 million workdays are lost each year by victims of violence in the workplace (Orlando- Russo, 2009; National Institute Workplace Violence, 2012; Waldman, Kelly, Aurora, & Smith, 2009). Issues relating to nursing retention can have a significant impact on an organization's financial budget (Baillien, De Cuyper, & De Witte, 2011; Baillien & De Witte, 2009; Barber, 2012; National Institute of Workplace Violence, 2012). Litigation settlements for bullying average $500,000 for out-of-court settlements. The average jury settlement allotment is estimated to be nearly 3 million U.S. dollars (National Institute Workplace Violence, 2012; Neumann, 2012; Workplace Bullying Institute, 2011). This highlights the need for nurse training about bullying.

Local Background and Context

To understand the issue in this project, it is essential to grasp the causes of bullying and lateral violence in healthcare organizations. Disruptive behaviors can be complex and operate at multiple levels. New nurses will leave a unit within a year if the nurses are victims of bullying on a nursing floor. Thus, nursing retention is affected workplace bullying. The primary perpetrators of workplace bullying are often the

mentors assigned to supervise the novice nurses (Berry, Gillespie, Gates & Schafer, 2012).

Multiple studies have highlighted bullying as an occupational stressor for novice nurses (Berry et al., 2012; Johnson & Rae, 2009, Laschinger, Grau, Finnegan, & Wilk, 2010; Simon, 2008). Additionally, there is a link between intention-to-leave and poor patient outcomes, with nursing productivity directly affecting the demands on novice nurses and their ability to manage their case workload (Berry et al., 2012). Furthermore, the literature substantiates that stress-related illnesses and nursing turnover affect patient care by decreasing productivity (Hutchinson et al., 2010; Longo & Sherman, 2008; Rocker, 2008; Stagg & Sheridan, 2010). Employees' organizational commitment may decline overtime, in the presence of workplace bullying, which is contrary to the zero tolerance policies (Einarsen, Hoel, Zapf, & Cooper, 2003; Einarsen, Hoel, & Notelaers, 2009; Hutchinson et al., 2005).

Further, new graduate nurses experience burnout within 2 years of professional nursing employment. *Burnout* is defined in nursing as a syndrome of cynicism, emotional exhaustion, and professional inefficacy (Laschinger, Finegan, & Wilk, 2009; Leiter & Maslach, 2004). High nursing workloads and inadequate professional support contribute to higher levels of burnout and absenteeism (Kassem, 2015; Oh et al. 2016). Laschinger et al. (2009) found that 66% of new graduates reported burnout and associated this with negative workplace conditions. Beecroft et al. (2008) also found high turnover rates, with 30% of new graduates experiencing disempowerment in the workplace.

Uncivil behavior between staff members contributes to burnout, with insufficient support and stress in the workplace having a particular impact. *Uncivil behavior* is defined as discourteous, rude treatment, evidencing a lack of respect for fellow colleagues (Anderson & Pearson, 1999; Laschinger et al., 2009). Several studies have linked incivility to decreased job satisfaction, stress, and intention-to-leave (Cortina et al, 2001; Laschinger et al., 2009; McKenna et al. 2003; Smith, Andrusyszyn, & Laschinger, 2010). As targets of bullying, novice nurses are unable to react against their perpetrators due to the power imbalance between them (Berry et al., 2012; Griffin, 2004). A lack of prior mentoring experience by senior nurses may contribute to bullying when orienting new nurses (Benner et al. 2010; Trewick, 2008; Walrath et al., 2010). However, if allowed to flourish in the treatment of novice nurses, the bullying will continue to increase in the profession.

Psychological Effects of Bullying

Research has revealed longitudinal associations between exposure to workplace bullying and the symptoms of psychological bullying (Nielsen et al., 2012). In a time-lag study between baseline and 2 years with 1,755 Norwegian employees, exposure to bullying behavior odds ratio was found to predict psychological distress at baseline. Psychological distress (OR = 2.49, 95%; CI = 1.64–3.80) and victimization (OR = 2.61, 95%; CI = 1.42–4.81) at baseline were associated with an increased risk of becoming a target of bullying behaviors at follow-up. Physiology distress (OR = 2.51, 95%; CI = 1.39–4.52) and psychological distress (OR = 2.51, 95% CI = 1.39–4.52) were both found to be associated with victimization. The negative effects of stress can have serious

consequences for the victim's mental health. Preemptive measures to prevent workplace bullying can provide treatment alternatives for employees suffering psychological distress.

Wright and Khatri (2015) examined the relationship between three types of bullying (personal, work, and physical intimidation). They examined the impact on nurses' job performance and on their mental and physical health. The acts of workplace bullying could be covert and subtle, making them difficult to identify (Hutchinson et al., 2010; Stagg & Sheridan 2010). The researchers used two scales: The Negative Acts Questionnaire – Revised and the Psychological/Behavior Scale and Medical Errors Scale modified version, developed by Rosenstein and O'Daniel (2008). There were 241 responses from nurses, giving a response rate of 23%. Cronbach's alpha reliability and validity measures as reported by the researchers were as follows: personal bullying .95, work-related .84, medical errors .91, and physical intimidation .66. The results indicated a negative association with age (t = -3.12, p = <.001), while physical intimidation was positively associated with age (t = 1.948, p = <.05). Work-related bullying significance was found with behavioral responses, but significance did not have a direct relationship to medical errors. On the other hand, person-related bullying had a significant relationship with psychological/behavioral responses to medical errors.

Intention-to-Leave

Simons (2008) conducted a qualitative, descriptive study of 511 randomly selected new graduate nurses in Massachusetts, examining bullying behaviors and the relationship with intention-to-leave. New graduates were chosen from the Massachusetts

Nursing Registry for 2001-2003 and they were 93% female and 37% male. Of these, 75% worked in the acute care setting, and 12% were from nursing homes. Simons (2008) used the revised Negative Acts Questionnaire and found that 31% of the respondents reported bullying acts within six months. A Cronbach's score of 0.88 was reported on The Negative Acts Questionnaire scale. The results (n = 159, SD = 357.2) with a final score of 231) suggest that bullying is commonplace in the nursing workforce.

Berry, Gillespie, Gates, and Schafer (2012) found that one-third of new graduate nurses intend to leave in their first year of nursing due to workplace bullying, with the economic costs of workplace bullying and nursing turnover having a devastating effect on healthcare organizations. This internet-based descriptive cross-sectional study examined the prevalence of workplace bullying on novice nurses' productivity. Permission was obtained from the IRB committee as per protocol. There were responses from 190 new graduates to the Healthcare Productivity Survey, The Negative Acts Questionnaire – Revised, and a demographic survey. The findings suggest that a majority of the novice nurses (72.6%, n = 147) had experienced workplace bullying in the previous six months, either as direct targets (57.9%, n = 114) or witnesses (14.7%, n = 29) (Berry et al. 2012). The researchers found that 21.3% (n = 43) had been bullied daily over a six-month period. Many of the nurses 44.7% (n = 88) reported repeated acts over a six-month period and did not experience bullying 55.3% (n= 109) and 72.6% did experience bullying (Berry et. al; 2012). Berry et al. (2012) found that nursing colleagues were responsible for most of the acts (63%, n = 126). The findings also suggest that lower work productivity is directly caused by workplace bullying (r =−.322, p = .045).

Role of the Doctor of Nursing Practice Student

Student Context

I have been working as an Advanced Practice Nurse for Rutgers University Correctional Healthcare for the past 11 years. For the past eight years, I have been the President of the Local 5135 HPAE in the prison system and a member of the HPAE State Executive Council. I have assisted with HPAE successfully negotiated three contracts for our local union members Advanced Practice Nurses and Registered Nurses. Prior to this, I worked for Hackensack Jersey Shore Meridian Healthcare System for 11 years as a staff nurse, until 2007. I also worked for Brookdale Community College as a nighttime clinical instructor for nine years, leaving in 2015. Hackensack Jersey Shore Meridian hospital employs many new graduate nurses in the region. Thus, in an effort to create a lasting clinical project, team members decided to focus on opportunities to empower new nurses and increase retention rates. Many new nurses leave the profession because they lack the strategies to address the problem of bullying. This project may benefit future researchers by proposing an alternate method of addressing bullying in the workplace.

Role of the Project Team

The project team included 10 nurses, five of whom were advisory nurses and Local Presidents of the HPAE. Nurse evaluators were not involved in the initial development of this project. Advisory members provided feedback based on peer-reviewed nursing literature. All materials produced were approved by the advisory members. The nurse evaluators provided feedback on the material approved by the advisory members. The results compared the AGREE II scores and content evaluation

scores. Final analysis of the scores was found to support the AGREE II guidelines assessment. The AGREE II guidelines assessment can be applied to the case study development.

Summary

Social change will begin by building a coalition within nursing and in the wider community. Nurses must be able to communicate civilly with their colleagues. According to American Association of Critical Care Nurses (2016), establishing and sustaining relationships between colleagues is a core competency for healthcare professionals. Upholding ethical principles improves patient safety and decreases negative patient outcomes. The role of the DNP nurse is essential for creating new job opportunities. The DNP prepared nurse can advance the issues of health advocacy to meet the needs of vulnerable groups. The educational preparedness of the DNP nurse can affect change in healthcare legislation. Furthermore, DNP nurses can provide cost savings through initiatives to address bullying via occupational health and/or nursing education. The looming primary care shortage provides the DNP nurse with the opportunity to advocate for the ability to practice to the fullest capacity based educational preparedness and advance the scope of practice (Bruflat & Wade, 2009). Educators of nursing should collaborate with Advanced Practice Nurses to aid in solving the issue of bullying in the workplace.

The translation of science into clinical practice can be challenging. Many beside nurses have limited experience of conducting clinical nursing research. Thus,

collaborative partnerships are needed to advance nursing research, beginning by educating staff members about the importance of research in clinical nursing.

Section 3: Collection and Analysis of Evidence

Introduction

A recurrent discussion among HPAE members of my local chapter is retention of nurses and the mitigation of bullying and violence in the workplace. Members of the State Executive Council include local presidents and grievance chairs from their respective locals; thus, HPAE plays an integral role in shaping New Jersey's policies on workplace violence. As president of the HPAE chapter, I have participated in meetings with state senators and assemblymen to support legislation on healthy work environments. Members have testified to the New Jersey legislature about unhealthy work environments and violence in the workplace and the negative effects on nursing staff.

The purpose of this project was to develop a clinical resource module using practice scenarios as part of an educational training program for new graduate nurses and practicing nurses. The practice-focused questions for the educational resource project are as follows:

1. What content must be included in the practice scenarios module?
2. What educational strategies have been demonstrated effective in current evidence-based literature?
3. Do the educational activities align with current evidence-based practice?
4. Does the educational content meet the content requirements derived from the experts' review?

Evidence-based literature and the ANA Practice Standards and Code of Ethics guides were used. The plan was to develop practice case studies and disseminate the findings of the expert panel to the State Executive Council members, using the AGREE II tool. HPAE offers continuing medical education credits for members. This section outlines the process of development of the evaluation and implementation plan, which was to (a) assemble an advisory committee of HPAE members; (b) review the literature for relevant evidence (hierarchy of evidence); (c) develop the clinical resource manual, including the practice scenarios flip cards and terms test; (d) obtain content validation using the advisory committee experts; and (e) develop the implementation and evaluation plan.

Sources of Evidence

Literature Search

An extensive literature search was performed in CINAHL Plus with the full-text database, Medline, and ProQuest, using the keywords *lateral violence, horizontal violence, novice nurse, burnout, program development, simulation, nurse oppression, nurse empowerment, workplace violence, bullying, oppressed group behaviors, nurses' incivility, aggression, targets, antecedents*, and *circuits of power*. I also used a keyword search with the following terms: *literature parameters, antecedents, personality traits of those bullied, personality trait of the perpetrator*, and *organizational culture*. Terms were combined using Boolean strings to finalize the articles to be cited in the literature review. A total of 200 peer-reviewed journal articles, published in 2004-2018, were identified. Unit-based program development helps to engage new members of the team while providing a supportive educational environment. The information obtained was utilized

to develop the educational module. Evidence-based practice literature was gathered to support the practice scenario module.

Prior to assembling the expert panel, I was asked to develop a table to present the findings of the literature review, using Fineout-Overholt et al. (2010; see Appendix N). Permission was obtained for use of copyrighted materials including the Workplace Bullying Inventory, the Organizational Predictors and Consequences of Bullying Assessment Scale (Hutchinson et al., 2010; see Appendix F), the AGREE II instrument (see Appendix M), and the ANA (2015) position statement on incivility, bullying, and workplace violence (see Appendix K). A demographics sheet and terms test were developed for this project. The evaluation table provided an overview of the literature matrix and the level of evidence needed for the development of the project.

The literature review included 16 peer-reviewed articles published within the previous 10 years. Position statements from leading nursing organizations regarding bullying in the workplace were also included in the literature review. The case practice scenarios are concurrent with the literature and aligned with nursing professional standards and regulatory bodies. The advisory committee members suggested the following criteria for the practice scenarios: the DNP candidate must develop a minimum of three practice scenarios, and no more than six, and a terms test must be included in the project. Visual aide cards were developed to help participants recognize the 10 most common behaviors.

The breakdown of the literature evidence is all 16 studies were Level III under the hierarchy of evidence, which is the following:

- Level I: Evidence from a systematic review or meta-analysis of randomized controlled trials or clinical practice guidelines based on systematic reviews of randomized controlled trials.
- Level II: Evidence from at least one well-designed randomized controlled trial.
- Level III: Evidence from well-designed controlled trials without randomization.
- Level IV: Evidence from well-designed case-control and cohort studies.
- Level V: Evidence from systematic reviews of descriptive or qualitative studies.
- Level VI: Evidence from a single descriptive or qualitative study.
- Level VII: Evidence from authority opinions and reports from experts. (Fineout-Overholt et al., 2010)

The study designs noted during the literature review were as follows: one exploratory descriptive, one quasi-experimental, two cross-sectional, four descriptive non-experimental, three qualitative, two quantitative, and three mixed methods. Eight position statements were chosen for the project. These were aligned with the literature, stressing a zero-tolerance stance on bullying in the workplace.

At the suggestion of the several advisory committee members, a content readability form was added to the AGREE II results. The advisory experts evaluated the case scenarios using the content expert and the readability evaluation developed by Travale (2007). Permission was obtained (see Appendix J) for the use of the content

evaluation form. Each of the case studies and pictorial flip cards were evaluated by the nurse experts for content readability. The content expert evaluation consisted of eight questions, modified from the original form developed by Travale (2007). The evaluation comprised a 5-point Likert scale of *strongly disagree* to *strongly agree*. Similarly, the content readability form comprised eight questions, also modified from the original. All questions relating to the content and readability forms were modified by me as per the recommendations of the advisory members.

Assembling an Expert Panel

As recommended by the vice president of HPAE, the expert panel consisted of five State Executive Council members. Expert panel members are essential in the process of gaining trust, support, and buy-in from stakeholders. The expert panel members aided in the advancement of this project, from implementation through the evaluation phases (Hodges & Videto, 2011). Members of the committee bring together different skill sets from local leadership and throughout the organization. This type of collegial membership enhances sharing and learning of practices.

The vice president acted as the resource and figurehead of the projects and as a resource for development of educational programs. The advisory members provided specific expert knowledge about their local chapter's educational needs and specific bullying and violence issues pertinent to them. The inclusion criteria as follows: RNs and licensed practical nurses with more than 5 years' experience of psychiatric, medical, and/or surgical nursing as well as expertise in developing a violence prevention program.

The experts and evaluators provided anonymous demographic information, including their age, race, marital status, years of experience, and highest level of education. The content and readability forms were added to final revision work, as per the suggestions from the advisory members. All materials were delivered via a secure link e-mailed by me. Participants were asked to look over and respond to the material within 2 weeks and then e-mail the results back via the link. I collected and secured the material on a self-supplied encrypted computer. When all the members had returned their evaluations, the content was reviewed for revisions. The revisions were then approved by the advisory committee. The final draft of the project was reviewed and evaluated by 5 nurse evaluators who were not involved in the initial phase of the project. This process mirrored that described above.

Literature Related to Workplace Bullying

There are potentially serious mental and physiological consequences as well as ethical and legal ramifications of workplace bullying (Matt, 2012). Research has shown that the negative impact of bullying is problematic due to the global shortage of nurses (Jackson, Claire, & Mannix, 2002). Bullying has various meanings in the context of the workplace: aggression, incivility, mobbing, horizontal, lateral violence, and intimidation. The behavior can have negative implications for patients' welfare, both directly and indirectly (Matt, 2012). On a personal level, targets of bullying can manifest psychological and physiological symptoms. These demoralizing experiences can affect nursing turnover rates and intention-to-leave, contributing to understaffing and the global nursing shortage (Matt, 2012).

Research has highlighted the ways bullying can be managed. In a study on experiences of bullying in the work environment, 99 nurses' responses suggested that nurses brought concerns about bullying to the nurse managers, but the managers deflected the issue back onto the staff (Gaffney et al., 2011). However, issues of bullying can be managed in ways like nurses taking greater responsibility for their actions (Gaffney et al., 2011). Leadership can also enforce professional behavior standards to build a sympathetic infrastructure that respects the working environment. Further, nurse managers and leaders must work with front-line managers to discuss triggers and solutions as well as incorporate strategies at the unit level to preserve quality nursing care at the bedside (Gaffney et al., 2011).

The ANA has a code of professional conduct by which all nurses must abide, which can also be applied to workplace bullying. Four principles are addressed in nursing school: respect for autonomy, nonmaleficence, beneficence, and justice. *Nonmaleficence* means that an individual must do no harm others (Matt, 2012). Nurses who engage in bullying violate this principle by targeting coworkers with a specific intent to intimidate, threaten, and humiliate. *Beneficence* requires the nurse to engage in behaviors to prevent harm and promote a healthy work environment (Matt, 2012). Nurses who practice inappropriate behaviors and bullying behavior are in violation of this. *Justice* involves fair treatment to all people, regardless of ethnicity, gender, and sexual orientation (Beauchamp & Childress, 2009; Matt, 2012). All workers have the right to a safe and healthy work environment, which injustice prohibits.

Perpetrators of inappropriate behavior lack virtue and moral character, which goes against the Code of Ethics (Lachman, 2015). There are 6 virtues of moral character: *respect, compassion, discernment, integrity, trustworthiness,* and *conscience*. *Respect* means respecting a person's autonomy and protecting then from harm (Beauchamp & Childress, 2009). As healthcare professional we must uphold this ethical principal regardless of our beliefs. *Compassion* is the ability to focus on others in their time of need, responding with respect, dignity, sympathy, and tenderness (Beauchamp & Childress, 2009). Not showing emotion means a lack of compassion and moral character (Matt, 2012). Additionally, the ability to make fitting judgments defines rational decision-making without fear or personal attachment (Beauchamp & Childress, 2009). Nurses are responsible for making good decisions and engaging in inappropriate behaviors—such as withholding critical information and sabotage—can compromise a person's judgment. *Integrity* refers to faithfulness to moral values and positive commitment to change and standing up for an individual's rights (Beauchamp & Childress, 2009). For example, a nurse who uses his or her religious beliefs as justification for not advocating for another's right to self-determination, or who witnesses bullying and does not report it or intervene, lacks conscience and exhibits weak character. *Trustworthiness* is a virtue to which a person has confidence another person to make decision on the behalf of them. For example, making you friend as the power of attorney over your estate if you become incapacitated due to an illness (Beauchamp & Childress, 2009). *Conscience* refers to a form of self-reflection on moral judgment (Beauchamp &

Childress, 2009) Another example for conscience would be people knowing the difference between right and wrong based lesson learned from your past.

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Scope of practice standards. The ANA standards serve as an assertive communication guide. The standards are used in this project to assist nursing staff in responding to inappropriate behaviors in the professional environment. Flips cards have been developed for the 10 most frequently observed bullying behaviors, using the ANA standards to guide the responses. Inappropriate behaviors that violate the ANA Code of Ethics for professional behavior will not be tolerated in the workplace. Respect is a key principle of good communication between colleagues, families, and individuals, according to the Code of Ethics (2001). This code establishes the responsibility of a nurse to maintain relationships with colleagues and individuals. Nurses must commit to fair treatment of all people and aid in the resolution of any conflict arising between colleagues (ANA, 2016). The standards of conduct prohibit any form of harassment, intimidation, bullying, incivility, and lateral or horizontal violence in the workplace. Thus, it is imperative that nurses take a moral stance against bullying. Collaboration requires mutual trust and respect between colleagues and family members. The standards outline collaborative practice between treating parties to include shared decision-making processes and trust and respect amongst participants. Inappropriate behaviors interfere with partnerships and may lead to medical errors when the behavior is not corrected.

Nursing communication. Nursing leadership plays a role in preventing bullying. The leadership defines professional nursing behaviors and hold staff members

accountable for their actions. The leadership seeks opportunities to articulate acceptable communication and professional behaviors. Effective communication clearly conveys decision-making rationales. Collaboration enables improvements in quality of care and facilitates conflict resolution. Standards 11, 12, and 13 and provisions 1, 5, and 6 establish the framework for professional nursing conduct.

Standard 11: Communication. Standard 11 requires nurses to formulate effective communication competences for the different areas of nursing practice. This standard defines professional communication amongst nursing professionals. The nurse must be able to assess the communication needs of healthcare members, families, and clients. They must seek out opportunities to improve conflict resolution skills and communication between colleagues and families. Nurses must support a communication process that encourages the disclosure of concerns that impede care and transition in care delivery. Communication should also contribute to professional growth of the team members.

Standard 12: Leadership. Standard 12 establishes the nursing leadership's responsibility to guide staff members towards the organizational vision, goals, and plans. The leadership acts as a change agent within an organization. Nurse leaders must develop communication and conflict resolution skills that reflect professional respect, trust, and dignity. The nursing leadership seeks opportunities to mentor new nurses.

Standard 13: Collaboration. Professional collaboration concerns the negotiation techniques employed to resolve conflict in the workplace. Professionals use consensus-building to resolve conflict. A nurse should adhere to the organizational code of conduct,

zero-tolerance policy, and professional standards governing appropriate behaviors. Nursing professionals should create a workplace that promotes dignity, respect, and trust.

Provisions 1, 5, and 6: Code of Ethics. Provision 1 establishes the relationship between colleagues and peers. It precludes any form of harassment or threatening behavior in the nursing environment. Provision 5 mandates the preservation of integrity, with zero tolerance for any form of verbal abuse between coworkers. Provision 6 of the Code of Ethics mandates nursing responsibility for the working and moral environment and for respectful interactions between colleagues and peers.

As a resource for cognitive rehearsal training, nurses are given the ANA Scope of Practice Standards 11, 12, and 13 and the ANA Code of Ethics for Nurses, which establishes a framework for professional nursing conduct. Participants engaging in the practice scenarios will refer to these as a follow-up after roleplaying of each case scenario. The Scope of Practice Standard 11 requires nurses to formulate effective communication competencies that contribute to professional growth among nursing professionals and to seek out opportunities to improve conflict resolution skills and communication between colleagues and families. Standard 12 reiterates the importance of developing good communication and establishes nursing leadership's responsibility for guiding staff members to develop communication and conflict resolution skills that reflect professional respect, trust, and dignity. Standard 13 encourages professional collaboration that employs negotiation techniques to resolve conflicts in the workplace and the use of consensus-building to resolve conflict. In short, nurses must adhere to the organizational

code of conduct, a zero-tolerance policy on bullying, and the professional standards governing behaviors to create a workplace that promotes dignity, respect, and trust.

The ANA Code of Ethics for Nurses reinforces the public policy statement made by The Joint Commission and the ANA, both mandates a zero-tolerance policy that aims to prevent bullying in the workplace. The code of ethics, specifically Provision 1, establishes the responsibility of nurses to uphold respectful relationships between colleagues and for the fair treatment of all people and the resolution of conflict between individuals, opposing any form of harassment, intimidation, bullying, incivility, and lateral/horizontal violence. Provision 5 mandates the preservation of integrity that involves zero tolerance for any form of verbal abuse between coworkers. Provision 6 mandates nurses' responsibility for the moral working environment, including respectful interactions between colleagues and peers.

Analysis and Synthesis

The practice scenario module was designed to use the ANA Professional Standards as a guide to assertive communication. Professional standards are an integral aspect of ethical practices. New graduate nurses lack experience and expertise in handling bullying behaviors, as compared to expert nursing staff members.

A literature review was conducted using peer-reviewed nursing literature on the concepts of bullying, burnout, horizontal violence, empowerment, healthy work environment, nurse residency programs, and interventions related to incivility. Articles were obtained via MEDLINE-EBSCOhost PsyInfo and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases. The inclusion criteria for this project

sought peer-reviewed research on newly graduated RNs, published between 2004 and 2017 and written in the English language. Clegg's circuits of power served as the theoretical underpinning for the project. An internet search was conducted to gather reports from professional organizations such as the American Association of Colleges of Nursing, The Joint Commission, and the National Council of State Boards of Nursing. The exclusion criteria cited articles focusing on a single group subspecialty, essays, and literature reviews written in a foreign language. The reports' reference lists were assessed using the literature assessment tool of Fineout-Overholt et al. (2010).

Data Analysis Evaluation Tool

All participants were supplied with detailed description of the procedural provided with the case scenarios module and asked to return their review within 30 days of receipt. Permission was obtained from the AGREE II developers for its use in this project. The AGREE II assessment tool comprises 23 items, based on six domains (see Appendix C). There are weighted anchors of 1-7, indicating "strongly disagree" to "strongly agree." Participants were emailed the supporting documents via secure email, and they were provided with prepaid stamped envelopes. The advisors and nurse evaluators used the AGREE II instrument to make comments and suggestions about the case scenarios. Domain scores were calculated by summing up the individual items in a single domain. The final domain scores were the total percentage of the maximum possible score. The developers of the AGREE II suggested a quality threshold of the domain three score of >70%. Our AGREE II quality threshold result was 80% for our sample participants. The committee members recommended using mean, median, and

standard deviations to represent the quality threshold. A further refinement was suggested by the advisory members, namely the adding of a content readability form for the scenarios and flip cards. Weighted anchors 1-5 “strongly disagree” to “strongly agree” permission was obtained for use of the modified version of Travale’s tool. Once received, the material was labeled according to the weighted anchor responses. Domain scores were calculated by summing up all the scores in each of the six domains. This procedure was completed by both advisory members and nurse evaluators. The student researcher collected all the generated materials on a secure and encrypted laptop computer. The comments and recommendations made by the participants aided in the selection of the case studies; and the advisory members guided the selection of the three case scenarios. Comments from the evaluation helped with revision of the case studies to produce a cohesive project. The final case scenarios were then changed to reflect the nurses’ recommendations.

Relationship Development with Institutional Stakeholders

I currently hold the position of President of the HPAE Local 5135. I have positive relationships with the institutional stakeholders at my chosen site. I actively participate in various local engagement processes. I was recently elected as co-chair of the educational development committee for our union.

Ethical Protection of Participants

Healthcare Insurance Portability and Accountability Act protocols require that all participants be informed of ethical measures taken to protect their privacy (Burns & Grove, 2009). The IRB; (approval no. 11-14-18-0326830) at Walden University reviewed

the IRB application and the project commenced on November 14, 2018. The DNP candidate compared the advisory members' mean results against those of the nurse evaluators. An informed consent form was given to all participants before initiating related procedures. The results were secured in a lock box upon receipt by the researcher. All materials needed to complete this project were supplied by the researcher.

Recruitment for this research relied on the advisory committee team members versus the nurse evaluators pre- and post-test design studies to compare results from Group A (advisory members) and Group B (nurse evaluators). The descriptive statistics included standard deviation, mean, mode, median, and percentages to describe single group nurses' statistical results. Data analysis was conducted using IBM SPSS Statistics 25 on a secure encrypted computer. Demographic information was collected and categorized as previously stated.

Evaluation of the Plan

The evaluation of the plan utilized the AGREE II results of the six domains from the committee members and the nurse evaluators. The success of the project hinged on the overall agreement of content from both the advisory and nurse evaluator members. The evaluation processes were as follows: formative, process, impact, and outcome. The formative evaluation was based on the results of the AGREE II instrument and the content evaluations. The formative phase allowed for modification of the practice scenarios module by the advisory committee members (Moore et al., 2015). It also maximized the likelihood of project success (Centers for Disease Control and Prevention, 2018). This formative phase occurred throughout the continuum of the project. The

process phase concerned the results of the AGREE II domain sections and content validation. This ensured the reliability of the instrument's results. The responses and/or modifications from the participants emphasized during this process phase supported the project's objectives and practice focus questions. An impact evaluation provided the evidence for usage of the case scenarios module, supported that AGREE II could be used for the evaluation of case scenarios module (Centers for Disease Control and Prevention, 2018). Finally, the outcomes evaluation process culminated with the final agreement and selection of the case scenarios modifications and recommendations, as per the AGREE II results and the content and readability results (Centers for Disease Control and Prevention, 2018). This enabled the answering of the practice questions.

The project entailed the use of a pretest/posttest design to collect the data. The data analysis concerned descriptive statistics (mean, median, and standard deviation) to describe the single group comparison of the AGREE II and content results. All calculated results were compared nurse elevators' results to the advisory members. This type of formative evaluation simply assesses knowledge of the material's content validity and ensures its usability. Final dissemination of the evidence hinged on the reliability of the evidence. The researcher will present the final report at a later date to a full State Executive Council members' meeting.

Summary

The educational module was evaluated by HPAE State Executive Council advisory committee nursing members. The advisory committee and the nurses were emailed a packet containing the consent to participation form and the materials included

in the module. The experts were asked to review this case scenario module within 30 days and to return the results to the DNP via a secure survey link. Participants were also provided with prepaid envelopes to return the materials. Descriptive statistics were included in the project results. Data analysis was conducted using IBM SPSS Statistics 25 on a secure encrypted computer. Demographic information was collected and categorized, as previously stated. The results will be presented to stakeholders later. This evaluation serves as a determinant future for suitability for submission for a case scenario to obtain continuing medical education credits.

Section 4: Findings and Recommendations

Introduction

Volunteers were asked to evaluate the overall practice case scenarios module. The material presented for review included case scenarios; flip cards; terms test; demographics; the literature evaluation matrix; and the ANA position statements on incivility, bullying and workplace violence, including the Code of Ethics, Workplace Bullying Scale, and Organizational predictors and Consequences of Bullying Scale. All data analysis was conducted as per the AGREE II instrument recommendations, with this instrument utilized for the appraisal of guidelines for research and evaluation. The AGREE II developers reported reliability as 0.98. The AGREE II instrument is comprised of 23 items based on six quality domains. The weight anchors scoring system was as follows: 1 (*strongly disagree*), 2 (*moderately disagree*), 3 (*somewhat disagree*), 4 (*agree*), 5 (*somewhat agree*), 6 (*moderately agree*), and 7 (*strongly agree*). Standard descriptive analysis was used to summarize the results from all 10 participants. The data collected from the evaluators were used to answer the following practice questions.

Practice-Focused Question 1: What Content Must Be Included in the Practice Scenarios Module?

Educational material used to develop this project was based on peer-reviewed nursing literature. The content of the educational practice scenarios aligns with the ANA Code of Ethics (2005) and the position statements on lateral violence in the workplace from various nursing organizations. The ANA (2005) strongly recommends addressing incivility using a problem-based learning scenario strategy. For example, Griffin (2004)

used cognitive rehearsal with scripted scenarios to assess retention of learned objectives. Twenty-six nurses were taught to use cognitive rehearsal as a shield against lateral violence during a simulation of learning and socialization exercises. One year later, the same nurses were interviewed again in four focus groups. The results indicated that clinical simulation using the intervention of cognitive rehearsal aided in improving conflict management of lateral violence and socialization skills (Griffin, 2004).

In another study, Clarke, Kane, Rajacich, and Lafreniere (2013) used problem-based scenarios to prepare Generation X nurses to deescalate workplace incivility issues in the workplace. Favorable results were reported by the researchers, with 40% of the students able to respond appropriately to bullying behaviors. Of the respondents, 19% indicated that there was a need for nursing management to intervene. During the debriefing session, the students strongly agreed that the aggressor should be held accountable for their actions and a corrective action plan immediately developed and implemented. Clarke et al. (2013) also recommended reflection during the debriefing session, noting that this improves retention of the learned material.

Practice-Focused Question 2: What Educational Strategies Have Been Demonstrated Effective in Current Evidence-Based Literature?

A comprehensive literature review was performed in the field of programs for prevention and managing workplace bullying. Several management themes emerged for the following interventions: journal clubs, peer groups and mentoring programs, cognitive rehearsal, conflict management, and assertive management. For example, Kerber, Jenkins, Woith, and Kim (2012) studied 79 undergraduate nursing students in a

civility journal club and found that the students were better able to recognize and respond to uncivil behaviors in the work environment. Chips and McRury (2012) also evaluated a program that sought to combat bullying and found that it improved participants' coping skills and could be used to teach conflict resolution. Thus, peer groups are a valuable tool for intervening in such situations and building social capital (Chips & McRury, 2012). The advisory committee members strongly supported practical programs that can be used at the bedside.

The literature also supported cognitive rehearsal and conflict management as ways to address workplace bullying. Griffin and Clark (2014) updated the use of cognitive rehearsal as a viable evidence-based strategy. Additionally, Layne et al. (2018) evaluated the effectiveness of a professionalism taskforce on negative behaviors using interdisciplinary group members solve the conflict. Using a pretest–posttest design, 1,980 respondents completed the pre survey, and 1,423 completed the post survey. Reductions in lateral aggression and vertical aggression were reported ($X^2 = 5.65$, $p < 0.017$). As well as contributing factors associated with negative behaviors ($X^2 = 9.03$, $p < 0.003$; Layne et al., 2018). Implications for nursing management is to implement policies that relate to reducing negative behaviors in healthcare.

Finally, the literature highlighted assertive management as a method to address workplace bullying. Karakos and Okalnili (2015) researched the impact of assertive training on mobbing in healthcare. In this study, 30 nurses received assertiveness training. Six months after completion of the training sessions, the participants completed the Rathus Assertiveness Inventory Scale. Positive results were reported in assertiveness

and mobbing scores (p =.000). Participants reported a decrease in mobbing (p =.01) and the researchers attributed this finding to the transference of knowledge due to assertive training (Karakos & Okalnili, 2015).

Practice-Focused Question 3: Do the Educational Activities Align with Current Evidence-Based Practice?

The case scenarios were developed because the local HPAE chapter requested a training module for reducing workplace bullying for members. It is important to develop educational activities that align with current evidence-based practice. As previously stated, the advisory committee suggested using a literature matrix for the development of the project. A comprehensive literature search was conducted, and literature hierarchy was developed. The committee members suggested that three case scenarios should realistically reflect how new graduate nurses are indoctrinated into nursing practice.

Practice-Focused Question 4: Does the Educational Content Meet the Content Requirements Derived from the Experts' Review?

The level of agreement on the content was assessed using the results of the AGREE II instrument and the content readability form. The AGREE II advisory rigor scores and the nurse evaluators' rigor scores are similar. The domain three rigors scores were calculated, with rigor scores of 84% for both advisory members and nurse evaluators of this project. Content readability scores for the case scenarios resulted in similarities between advisory results and the nurse evaluator scores. The quality threshold was met according to the AGREE II calculations, with >70%. The AGREE II reliability score was 0.93, with similar results for the advisory members (0.939) and the nurse

evaluators (0.941). All recommendations were considered. Similar reliability scores were noted for the advisory members and nurse evaluators. Reliability is the degree of accuracy with which an instrument measures the attributes (Polit & Beck, 2010).

Case Scenarios

The theoretical underpinning of this project was Clegg's (1989) circuits of power, which is focused on the forces of authoritative power and control in a synergistic catalysis for bullying behaviors and the control of power within the unit. Three theoretical positions exist within this model: (episodic) overt, (depositional) social, and (facilitative) economic. The episodic power is located on the micro level of the organizational unit, which includes the nursing personnel at the unit level. In other words, the power composition relates to the perpetrators' (e.g., nurse managers and senior staff members) power and control over their targets. Perpetrators of bullying and other disruptive, uncivil behaviors can exist at all levels of an organization (Buddin et al., 2013, Johnson & Rea, 2009). In the episodic power circuit grid, bullied staff members feel powerless against their perpetrators. They are expected to obey and to comply with the demands of unit culture, relationships, practice rules, and membership categories (Hutchinson et al., 2010). There are also alliances within this microsystem between coworkers and subordinates, and the normalization of bullying practices occurs at this level of practice (Hutchinson et al., 2010). Clique alliances regularly assert power and control the rules of practice. For example, an agency RN may be assigned to a unit due to a call-out, not being part of the clique and being assigned the most difficult assignment

on the unit “Nurses eat their young” (Gillespie, Grubb, Brown, Boesch & Ulrich, 2017 p. 11).

The social aspect of the circuits of power forms the basis of the organizational rules and defines group memberships and alliances in the circuit grid. The social aspect of membership is composed of the following members’ senior level and divisional level managers. Large organizational structures tend to have more bureaucratic authoritative power than smaller organizations, although this can arise in all types of organizational structure (Clegg, 1989). For example, senior managers control and enforce the rules of the organizational culture. The clique’s members often become the “favorites” of the managers, benefiting from social interaction outside of work (Clegg, 1989).

The economic system defines the facilitative power base, also known as the rewards and punishment system in an organization. The nursing literature emphasizes that bullying behaviors breach the rules of established professional conduct (ANA, 2015). The rewards and punishment systems feature of this organizational style includes tolerance and rewards, misuse of legitimate authority, and the normalization of lateral/horizontal violence in the work unit. Tolerance and reward can mean that although a clique member is frequently late when scheduled to work and goes unpunished, another nurse would be reprimanded for doing the same thing. Thus, this behavior is rewarded by the lack of reprimand. Misuse of legitimate authority could involve using a job tile to obtain a more favorable position for a family member when asked by others for the same courtesy. Progressive discipline is used by managers to deal with job-related issues or behaviors that do not meet the expected performance standards (Clegg, 1989). This type

of discipline may explain why nurses remain silent, as speaking out can make the situation worse.

Based on Clegg's (1989) circuits of power, three scenarios were developed. Case Scenario 1 describes the experience of new graduate nurses during orientation into an intensive care unit nurse internship program. The example illustrates different bullying techniques that could be employed to undermine a new graduate's work performance. The example further details the progressive escalation of such bullying techniques throughout the six-week training program.

Case Scenario 2 continues to follow "Jennifer Rose" through her orientation period. The situation is escalating during orientation progressive aggression toward the new nurse during the preceptorship. In this example, hostile body language, bickering, rudeness, isolation, failure to assist when help is needed, and a lack of respect are prominent. The nurse is powerless against her aggressive preceptor.

Case Scenario 3 demonstrates yet further progression of the aggressive behavior. The target has alerted the unit manager about the problems, but the manager has done nothing to intervene. The new graduate nurse has thus not received the support she needs from management. The resolution made by the new nurse is to quit her job.

The scenarios are based on the real-life experiences of the research team members and were developed to help participants recognize types of workplace bullying. They are based on the domains of competence, personal attacks, and work performance. When engaging in the educational program, participants can role-play each example depicted in the case scenarios to examine these overt and covert bullying behaviors such as sabotage,

incivility, verbal and physical threats, and the undermining of job tasks (Ceravola, Schwartz, Futz-Ramos, & Castner, 2012).

The case scenarios provide nurses with an opportunity to reflect on their current practice experience and discuss the ramifications of bullying. Active listening plays an important role in this activity, as listening to the perceptions of others allows for active exchange of communication between the groups (Ceravola et al., 2012). Using professional communication standards as the basis for managing negative situations, the nurses are encouraged to propose alternative solutions to bullying in each scenario. Open discussion throughout the roleplaying exercises facilitates learning of new communication strategies to combat bullying within a secure environment, while allowing the freedom to express their concerns and expectations about conflict resolution. Furthermore, the case scenarios illuminate the impact of bullying on nursing practice, nurse burnout, and intention-to-leave.

Flip cards were also developed for this project to reflect the 10 most frequently observed bullying behaviors in the workplace, using the ANA standards to guide the responses. A bullying behavior and scenario, with a suggested response to each situation, was included for each of the 10. The bases of the written responses were obtained from the ANA Code of Ethics. Numerous authors have used these guides to propose responses to inappropriate behavior (e.g., Griffin, 2004; Hutchinson et al., 2008; Stagg et al., 2011). The case scenarios and flip cards are available in Appendix G. Organizational investment in clinical ladder programs may provide beside nurses with the opportunities to improve clinical translation.

Findings and Implications

Clinical Findings

The results gathered by the AGREE II instrument's 23 items and six domains are as follows. Demographic composition of this project included 10 participants all females with six of the 10 having a baccalaureate of science in nursing and the other four holding associates applied science in nursing degrees. In terms of racial composition, the group comprised four White, four African American, and two Asian-American people. Four of the group members were married, three divorced, and three unmarried. The group members' respective years of experience ranged from 1 to 19, with an average of 15 years' experience of nursing. Hospital, correctional, and office settings were all represented.

The advisor scope and purpose scores were as follows: one in five somewhat agreed (n = 20%), three moderately agreed (n = 80%), and one strongly agreed (n = 20%). The stakeholder involvement results were similar, with four of the five moderately agreeing (n = 80%) and one strongly agreeing (n = 20%) in each domain. The rigor results for the advisory group and the nurse evaluator group are presented in Tables 1 and 2. The results for the domains of advisory clarity, applicability, and recommendations were also similar, with three of the five moderately agreeing (n = 60%) and two strongly agreeing (n = 40%). Finally, the overall findings (mean = 9, median = 9, SD = 0) and recommendations were suggested to the content, which is reflective of evidence-based practice with modifications five of five (n = 100%). The trends of AGREE II results of the nurse evaluators were similar in all aspects each category as mentioned.

Table 1

Advisory Nurse AGREE II Results

Nurse	Mean	Median	*SD*
Scope and practice	19.2	18	1.64
Stakeholder	18.6	18	1.34
Rigors	50.8	31	3.03
Clarity	188.8	19	0.44
Applicability	6.75	6.75	0.44
Editorial	12.8	12	1.09
Guideline assessment	12.8	12	1.09
Overall	9	9	9

Table 2

Nurse Evaluators AGREE II Results

Nurse	Mean	Median	*SD*
Scope and practice	30.6	18	1.51
Stakeholder	30	30	2.12
Rigors	50	31	4
Clarity	30.6	19	1.34
Applicability	6.75	6.75	0.44
Editorial	32	13	1.41
Guideline assessment	32	13	1.41
Overall	9	9	0

In summary, the results of the AGREE II instrument suggest that the content is relevant to current nursing practice. It meets the criteria for the development of a clinical project based on solid clinically based evidence. The pre- and post-terms test results (n = 10, 100%) did not indicate any differences. Tables 3 and 4 show the three rigors scores for the AGREE II domain.

Table 3

Advisory Committee Rigors Scores

Valid	Frequency	Percent	Valid percentage	Cumulative percentage
Somewhat agree	1	20.0	20.0	20.0
Moderate agree	3	60.0	60.0	80.0
Strongly agree	1	20.0	20.0	00.0
Total	5	100.0	100.0	100.0

Table 4

Nurse Evaluators' Rigors Scores

Valid	Frequency	Percent	Valid percentage	Cumulative percentage
Somewhat agree	1	20.0	20.0	20.0
Moderate agree	3	60.0	60.0	80.0
Strongly agree	1	20.0	20.0	00.0
Total	5	100.0	100.0	100.0

Content and readability for the flip cards and case scenarios are based on a 1-5 anchored Likert scale, from "strongly disapprove" to "strongly approve," based on Travale. In Case Study 1, all five advisory members indicated approval in response to Question 1. For the second question, two of the five advisory members said that they "moderately" approved, while the other three indicated that they approved. For Questions 3 and 4, two of the advisory members said that they moderately approved, while the other three indicated that they approved. For Questions 6 and 7, all five indicated approval for both questions. The overall statistical analysis reflects case scenarios advisory members (mean = 25, median = 39, *SD* = 1.32) and nurse evaluators (mean = 29, median = 39, *SD* = 0) were similar in results.

For the flip card, all five advisory members answered that they approved. In response to Question 2, two said that they moderately approved and three answered strongly approved. For Questions 3, 4, and 5, four of the five said that they moderately approved. There were similar results for Questions 6 and 7, with which all five indicated approval. In summary, the flip cards advisory members results (mean = 34, median = 24, *SD* = 1.41) and nurse results (mean = 34, median = 25, *SD* = 0) were similar in results. The case scenarios and the flip cards had similar levels of content reliability (0.939).

Nursing Implications Recommendations

The driving force of this project were the multiple complaints received from fellow union nurses regarding incivility and bullying in the nursing units. The members sought more union education regarding bullying interventions. As the Local 5135 President, I searched for evidence-based strategies to help reduce conflict and investigated the relevant professional standards and code of ethics.

Establishing and sustaining a healthy work environment is paramount for healthcare members to maintain. The professional standards and code of ethics presented in this module reflect the findings of evidence-based research. The standards have been designed to align closely with core competencies for healthcare professionals, as per the Institute of Medicine recommendations (American Association of Critical Care Nurses, 2005; ANA, 2015). Delivering patient-centered care demands the cooperation of members of various disciples, the utilization of evidence-based practice, and the employment of nursing informatics to improve patient outcomes. The American Association of Critical Care Nurses and ANA assert the importance of various essential

qualities for maintaining healthy work environments, including communication, collaboration, effective decision-making, appropriate staffing, recognition, and authentic leadership. The ANA position statement advocates a zero-tolerance response to workplace violence and incivility. Individuals have a dual role in creating and sustaining a culture that respects all members of the interdisciplinary team. Stakeholders and CEOs have a responsibility to educate employees and address issues of uncivil and disruptive behaviors.

Research. Bullying has detrimental consequences for recruitment and retention. New graduate nurses are the primary targets of this type of inappropriate behavior, and dysfunctional work groups are the underpinning of root cause analysis issues and the key to prevent errors (Makary & Daniel, 2013). In the past, healthcare institutions have often denied the existence of bullying in nursing or accepted it as the normal professional conduct (Gaffney et al., 2012). Multiple studies have investigated interventional strategies to address the issue, including educational and situational awareness, conflict and assertive management training, various leadership styles, and zero-tolerance policies (Makary & Daniel, 2013). Finally, the negative impacts of bullying include physical and psychological health issues for the victims. For example, reducing stress by directly addressing the issue.

Nursing Education

Undergraduate nursing schools are fostering educational initiatives to better understand the issue of disruptive and uncivil behaviors, and nursing schools are developing core nursing competency requirements to improve understanding of bullying

in the profession (Doolen et al., 2016; Wolf et al., 2017; Weaver, 2013). Simulation exercises are being employed, and the outcomes of teaching teamwork and collaboration have positive outcomes regarding interpersonal teamwork (Barton, Bruce & Schreiber, 2018; Institute of Medicine, 2011). Weaver (2013) concludes that integrated teamwork competency aids in recruitment and retention in healthcare.

Conflict

Conflict and assistive management training are approaches centered on cognitive rehearsals as a means to achieve primary bullying prevention. "Cognitive rehearsal" is a psychological technique that involves rehearsing an intervention prior to the real-world encounter. Griffin (2004) found that cognitive rehearsal benefited 26 RNs in raising awareness of lateral violence. Roberts et al. (2009) saw similar effects when using cognitive rehearsal as an intervention. However, the literature does not support a single intervention or sole remedy to combating bullying (Johnson & Rea, 2009; Simons et al., 201; Vessey et al., 2012).

Leadership Styles

The literature overwhelmingly supports the use of the authentic leadership style as best practice (ANA, 2015, American Association of Critical Care Nurses, 2005, 2016; Institute of Medicine, 2008). Nursing organizational position statements define "authentic leadership" as focusing on relationship building. For example, such a nurse manager takes the time to identify the strengths and weaknesses of their individual personnel. If deficiencies or poor performance arise, an individualized plan of corrective action plan

can thus be established. The alternative to this is progressive discipline, which does not remedy the issues at hand (HPAE, 2019).

Physical/Physical Effects

The negative effects of lateral violence, horizontal violence, and bullying are well documented in the literature. The reported consequences of bullying include anxiety, depression, alcohol abuse, tobacco use, and, in severe cases, suicide (Castronovo et al., 2015; Gaffney et al., 2012). Chronic physiological and physical stress can lead to increased absenteeism, medication errors, poor patient outcomes, and even resignations (Institute of Medicine, 2008, Institute for Safe Medication Practice, 2004, the Centers for Medicare & Medicaid, 2014; Department of Health and Human Services, 2013).

Zero-Tolerance Policies

Regulatory agencies such as The Joint Commission, the Center of Medicare and Medicaid Services, and the Department of Health and Human Services all have zero-tolerance policies on maladaptive disruptive behaviors (Kennedy et al; 2012). Zero-tolerance policies delineate the responsibilities of employers for established professional behaviors (American Association of Critical Care Nurses, 2016; Centers for Medicare & Medicaid, 2014; Department of Health and Human Services, 2013; Kennedy et al, 2012). Kennedy et al. (2012) note that the attrition rate for medical surgical nursing can be costly to the hospital system, with estimated replacement costs of approximately $92,000 USD for the national average (Bureau of Labor Statistics, 2014). The higher replacement costs are more than $145,000 USD for specialty nurse positions (Bureau of Labor Statistics, 2014; Kennedy et al., 2012). The Joint Commission (2008), as acknowledged

in the Sentinel Event Alert, found lateral violence and bullying to be causative factors influencing retention rates among young nursing professionals. In addition, poor communication between colleagues increases incidences of patient medical errors. Wilson and Phelps (2013) reported that bullying leads to new graduates asking fewer questions, which can in turn lead to serious adverse patient outcomes.

The Affordable Care Act (2010) established patient-centered care initiatives. Incentive payments to hospitals are based on quality of care, clinical practices that follows evidence-based practice. For example, readmission for the same medical issue is not tolerated and the hospital bears the cost for readmission. The Valued Based Purchasing Program has strengthened patient satisfaction scores since the enactment of the Affordable Care Act (Centers for Medicare & Medicaid Services, 2015), as this program uses quality measures to establish reimbursements of payments for hospital stays. Specifically, with re-admission for the same hospitalization within three days, the hospital is required to return payment. In 2005, the Deficit Reduction Act incentive payments 'were developed by the Department of Health and Human Services for all hospitals to participate. The Inpatient Prospective Payment System was introduced by the Department of Health and Human Services in 2007, and all hospitals are subjected to and must adhere to its rules to receive full payment (Department of Health and Human Services, 2013). In 2013, the Department of Health and Human Services implemented a national survey to address patients' concerns about the quality of hospital care. The Hospital Consumer Assessment of Healthcare Providers and Systems is administered

between 48 hours and six weeks after discharge and is publicly reported on each hospital's care website.

Social Change

Social change in terms of lateral violence and bullying begins when individuals acknowledge one another's right to respect and dignity. The social impact of disruptive behaviors includes impaired professional practice and poor patient outcomes. As healthcare practitioners, we all must respond to lateral violence it is our ethical obligation. Healthcare organizations and professionals should advocate for changes in education and policy to aid in the recognition and elimination of lateral violence and bullying. Empowerment is gained through understanding and knowledge is the key to sustainable conflict resolution.

Strengths and Limitations of this Project

Strengths

The expansion of knowledge provides practitioners with the opportunity to make sound clinical decisions regarding disruptive behaviors. The advisory committee members reviewed the module and affirmed the content was suitable for an education module. The content stressed the need to expand knowledge of workplace bullying. The module provided a realistic viewpoint on how lateral violence influences clinical decisions and how it can impact a practitioner's ability to cope.

Limitations

The limitations of this project relate to its small convenience sample size. Limited sample sizes can affect the reliability of a study. As a result, this project does not measure

the full knowledge expansion. The validity for this project will hinge on piloting of this project with another group nurse evaluators.

Remediation of Future Work

Future work should include the use of different terms tests for the pre- and post-test. I would not use the AGREE II 23-item questionnaire, as this was designed for guideline validation and not specifically this type of application. Thus, the results did indicate that the AGREE II 23 questionnaire was reliable. I would recommend using the AGREE II short form, which was simplified for this application.

Summary

There is a culture of bullying within the nursing profession. To eradicate this, nursing education should include curricula based on appropriate evidence-based guidelines. Simulation and debriefing exercises can enable better understanding of phenomena such as bullying. The sustaining of a healthy work environment is a shared goal of in all areas of the profession. Dysfunctional work groups erode morale and create financial burdens on the healthcare system. Healthcare entities including The Joint Commission, the Centers for Medicare and Medicaid Services, and the Department of Health and Human Services, The Joint Commission all have zero-tolerance policies that enforce standards by which all covered entities must abide to receive reimbursement for services rendered. Authentic leadership is strongly advocated in the nursing literature. The overall goal of this project is to empower nurses with the skills needed to resolve conflict in a professional manner.

Section 5: Dissemination Plan

My plan for dissemination is to present the DNP project to the State Executive Council. Once it has been approved, the HPAE can submit paperwork for the case scenarios module for continuing education. The intention of this presentation will be to develop the project into a continuing education program for union members. The project can then be used during orientation for new graduates and other professionals for renewal of their licenses.

Analysis of Self

Self-Practitioner Analysis

This project has helped me grow as a nurse practitioner and develop my evidence-based practice, which are essential for establishing and sustaining healthy work environments (Institute of Medicine, 2011). As president of my local HPAE chapter, it is also essential that I am familiar with the current scholarly works involving lateral violence and bullying. In 2003, 26 states enacted legislation against workplace bullying, with the Healthy Workplace Bill designed to criminalize workplace bullying (Workplace Bullying Institute, 2014). New Jersey introduced the bill into law in 2011, and members of HPAE—the largest nursing union in the state of New Jersey—were instrumental in getting this bill passed.

Scholar

This DNP project has also facilitated my growth as a scholar and a nursing professional. This was the first project in which I was engaged as the developer, coordinator, and researcher, and it gave me the opportunity to explore a new area of

research. Scholarship is not solely focused on what people learn but also how they translate the evidence into something meaningful for others (Zaccangnini & White, 2015). True scholarship means someone's ability to believe in him or herself and to recognize that, as an individual, he or she can make changes one step at a time. Morality begins at the level of the self.

Project Developer

As the developer of this project, I used my personal experience to transform this project into a viable learning tool. I learned how to search the literature for answers to my questions. Disruptive behaviors impair professional practice and must be addressed. Although no single solution exists to this complex problem of negative human behavior, there is a consensus in the literature around confronting the behavior directly and establishing policies that address the issue. I learned to accept feedback based on the merit of clarifying issues.

Future Professional Development

My plans for my future professional development involve working with the HPAE educational department on issues of health and safety. My next professional goal is to negotiate a new nursing contract with my current employer that will bring equality to local HPAE chapter members. Additionally, the essential responsibility of a DNP is to understand and respect the skills, roles, and abilities of interprofessional team members (Zaccangnini & White, 2015). I found the DNP principles essential to my development as a leader and my understanding of the meaning of respect.

Summary

In conclusion, I used evidence-based practice to design a case scenarios module to raise new graduate nurses' awareness of workplace bullying. This project addresses local HPAE members' need for realistic case scenarios to address bullying in nursing organizations. This case practice scenarios module is an example of the expectations of the DNP-prepared nurse, which is to identify a clinical practice problem and develop a solution or strategies to improve practice or patient safety outcomes regarding horizontal violence in the workplace (Zaccangnini & White, 2011).

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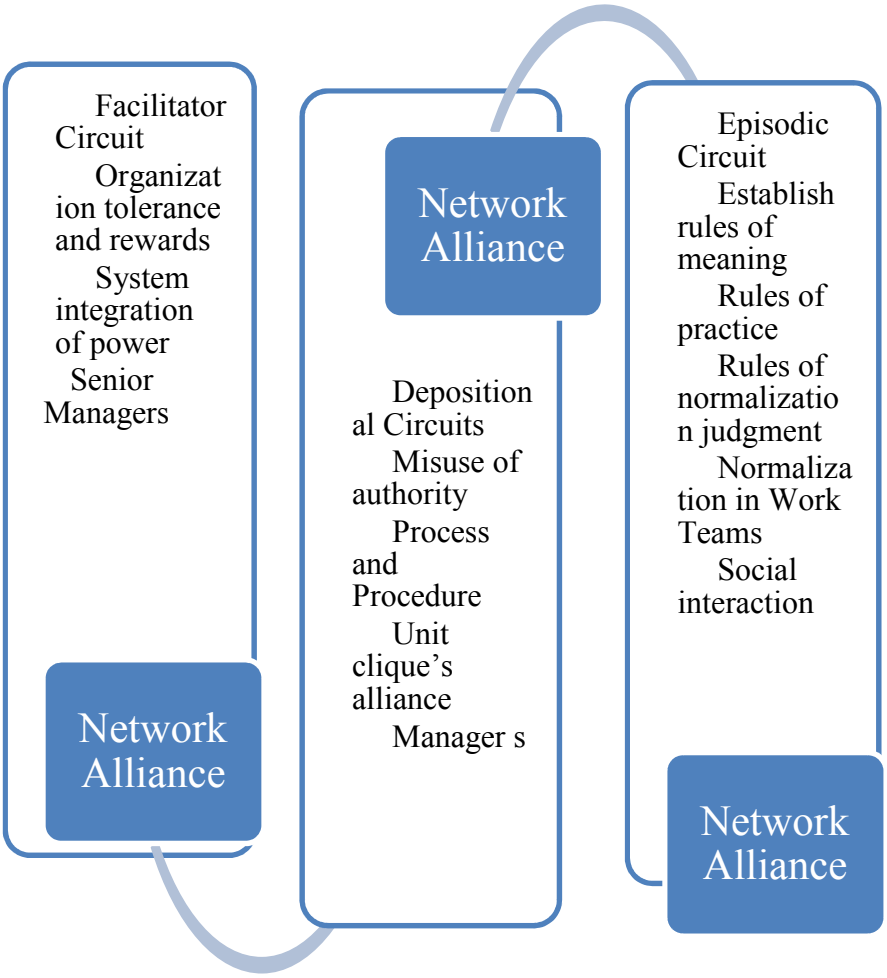
Appendix A: Circuits of Power



Appendix B: Terms and Definitions Used in Module

Aggressive behavior: Aggressive behaviors are negative behaviors directed toward individuals and/or group members (Longo & Sherman, 2010).

Belittling behavior: Belittling behavior is a behavior which makes an individual feel less than human (Embree, White, 2010).

Beneficence: Requires a nurse to engage in behaviors to prevent harm and to promote a healthy work environment (Matt, 2012).

Burnout: A syndrome of cynicism, emotional exhaustion, and professional inefficacy directed to towards an individual (Laschinger, Finegan, Wilk, 2009; Leiter & Maslach, 2005).

Circuits of Power: The complex evolution of power within an organization, which explains the synergistic, integration nature of power. Per Clegg (1989), power is designed to flow through a force field and is fixed and constituted within the force field. Organizations achieve stability by fixing power within the predictable circuits of authoritative power (Clegg, 1989).

Cognitive Rehearsal: An educational technique using scripted responses to contact bullying behaviors within the workplace (Griffin, 2004).

Compassion: Is the ability to focuses on others in times of need, responding with respect, dignity, sympathy, and tenderness (Beauchamp & Childress, 2009).

Condescending Behavior: Behavior intended to make a person feel inferior about not knowing something, which humiliates and degrades individuals (Rowell, 2008).

Criticism: M*aking* rude and demeaning comments about one's work (Griffin, 2004; Longo, 2013; Roberts, 2015).

Depositional Circuit of Power: Authority based on rules of the organization, group membership, and the meaning of the relationships (Clegg, 1989).

Disruptive Behavior: Behavior which disrupts and interferes with a person's ability to function within the working environment (Embree & White, 2010).

Disrespectful Conduct: Rude and condescending behavior to individuals, for example, humiliation intends to hurt the pride or dignity of an individual (Cox, 1991, Embree & White, 2010).

Group Level Antecedents: Consist of the causes of group level dysfunction within the work group (Heames & Harvey, 2006).

Group Level Consequences: The results of dysfunctional workgroups that influence the development of toxic work environments (Heames & Harvey, 2006) The demands of the jobs can all influence the type of managerial leadership, which leads to the causes of a dysfunctional workgroup (Einarsen, Hoel, Zapf, & Cooper, 2003; Hoel, 2010; Heames & Harvey, 2006).

Facilitative Circuits: A system of rewards and punishment that can used reward employees for bad behavior (Clegg, 1989).

Healthy Working Environments: Surroundings that empower nursing staff to build a culture of safety at work (American Association of Critical Care Nurses, 2009).

Health Professional and Allied Employee: The largest professional nurse's union in the state of New Jersey. The union supports legislation regarding nursing ratios, retention, unsafe practices (HPAE, 2019).

Horizontal Violence: Represents intergroup rivalry directed toward members of the same group (Embree & White, 2007, 2010), manifested by scapegoating, criticism, infighting, and sabotage (Embree & White, 2010; Johnson & Rea, 2009; Stanley, Martin, Michel, Welton, & Nemonh, 2007).

Individual antecedent: Represents the causes of workplace bullying that can influence fear of retaliation (Einarsen & Hoel, 2003; Matthiesen & Einarsen, 2003).

Incivility: Inappropriate and discourteous behavior that is rude and offensive towards others (Embree & White, 2010).

Inpatient Prospective Payment System: The system that reimburses hospitals for inpatient care. Inpatient Prospective Payment System will not reimburse the hospitals at a high rate when conditions occur while hospitalized for improper medical management such as urinary tract infections relating to indwelling catchers, retained surgical instruments, surgical site infections, hospital acquired pressure ulcers III & IV, blood incompatibilities, poor glycemic control, trauma, and falls (Center for Medicare and Medicaid, 2013).

Intimidation: Making a person afraid by using physical and or verbal threats (Embree & White, 2010). Intimidation in nursing relates to behaviors that cause doubt in self-worth and or one's ability to perform a job task (Clark, 2008, Lamotage, 2010).

Infighting: Arguing fighting amongst peers of the same group membership (Becher & Vislosky, 2012; Griffin, 2004; Roberts, 2015).

Introverts: Vulnerable targets of bullying that don't want to speak up about issues. They are afraid to cause trouble (Persson et al., 2009).

Justice: It involves the fair treatment to all people, regardless of ethnicity, gender, and sexual orientation (Beauchamp & Childress, 2009; Matt, 2012).

Lateral Violence: Occurs when victims of a situation begin turning against group members of the same profession; one group is at a higher level than the other (Embree & White, 2010, Rowell, 2008); manifested as verbal affront, undermining, scapegoating, backstabbing, broken confidence, and failure to respect privacy (Embree & White, 2010; Johnson & Rea, 2009; Stanley, Martin, Michel, Welton, & Nemonh, 2007).

Laissez-Faire Leadership: A leadership style in which leaders fail to perform their duties (Hoel et al, 2009).

Low Agreeability: Low levels of introversion, unwillingness to agree with the dominant culture. Low levels of consciousness may not recognize that bullying is occurring in the context of the workplace (Persson et al., 2009).

Meaningful Conflict Resolution: Supports resolution by using communication between team members to overcome conflict within an organization (Porto & Lauve, 2006).

Nonmaleficence: Means an individual can do no harm to another (Matt, 2012).

Neuroticism: Refers to characterization of personality traits of instability, anxiety, and aggression (Persson et al., 2009).

Non-Contingent Punishment Leadership: A management style which does not relate to the targeted behavior (Hoel et al., 2010).

Nonverbal Innuendo: Inappropriate behavior when responding to someone, for example, rolling one's eyes during a conversation while looking at another coworker standing by (Stagg, Sheridan, Jones, & Speroni, 2011).

Negative Acts: Relate to how an individual experiences anxiety, sadness, anger, and fear (Persson et al., 2009).

Participative Leadership: Values employee participation and involvement (Hoel et al., 2010).

Power *Imbalance:* Power disparity is between staff members and management, which can also develop between formal sources such as board members of an organization and contacts with influential people (Einarsen et al., 2004).

PsyCap: Acts a moderator between stress and incivility but can also have influence on perceived organizational climate and job performance (Luthans et al., 2008b, Robert et al., 2011).

Organizational Level Antecedents: Explore the causes of management leadership styles that can influence perceptions of bullying (Hoel et al., 2010).

Organizational Level Consequences: Demonstrate how leadership styles can influence the abuse of power and promotes competitiveness among the staff members (Hoel et al., 2010).

Sabotage: The deliberate undermining of a coworker's activities that can delay treatment and inhibit obtaining job performance (Stagg, Sheridan, Jones, & Speroni,

2011).

Societal Level Antecedents: Defines the societal influences that can cause bullying in the workplace (Vega & Comer, 2005).

Societal Level Consequences: Define the societal consequences that can affect work environments (Vega & Comer, 2005).

Structural Empowerment: Empowerment technique used to provide nurses with accessing information, resources, opportunity, and support within the structure of the nursing organization (Lachman, 2014).

Threatening: Refers to the expression of intent to harm and/or punish an individual in the context of the workplace (Griffin, 2004).

Toxic Working Environments: Surroundings with working conditions that intend to threaten, intimidate, and humiliate individuals (WBI, 2012), rife with unwarranted inappropriate behaviors that lead to decreased work productivity mental and physical distress (Embree & White, 2010).

Uncivil Behavior: Discourteous, rude behavior that shows a lack of respect towards fellow colleagues (Anderson & Pearson, 1999; Laschinger, Finnegan, & Wilk, 2009).

Undermining: An activity used by fellow colleagues to undermine the work tasks performed by a fellow colleague and intends to cause harm to work performance (Stagg, Sheridan, Jones, & Speroni, 2011).

Verbal Aggression. Directs harmful words towards individuals or groups of people in the work setting (Embree & White, 2010).

Workplace Bullying. A collective expression of inappropriate, hostile behaviors on the part of coworkers, supervisors, and subordinates (Neilson et al., 2010; Fox & Stalls worth, 2005; Hutchinson et al., 2010) that includes intentional verbal abuse and disrespectful conduct with the intent to threaten, intimidate, and humiliate a colleague (Workplace Bullying Institute, 2012).

Workplace victimization represents the repeated emotional, psychological and physical abuse experienced by the target over time by coworkers (Aquino and Lamertz, 2004).

Zero Tolerance Policy. A set of policies that outlines inappropriate behaviors that impact professional behaviors and patient care (ANA, 2011; Bond & Thomas, 2009; NIOSA, 2006; Occupational Safety Health Administration, 2006). The policy further defines different types of violence in the workplace and provides guidance in handling violence and inappropriate behaviors in the workplace (Occupational Safety Health Administration; 2006; Workplace Bullying Institute, 2007).

Workplace Incivility. Deviant, discourteous behaviors in violation of expected workplace conduct with intent to harm the target (Rocker, 2008).

Violence Protection Plan. Strategies mandated by Occupational Safety Health Administration (National Institute Occupational Health and Safety 2019; Occupational Safety Health Administration, 2013). That outline the protocols, procedures, and training relating to addressing violence in the workplace. Violence protection plans are incorporated in the zero-tolerance policy (ANA, 2011; AMA 2011; NIOSHA, 2019; Occupational Safety Health Administration, 2013).

Appendix C: Case Scenarios

The scenarios are based on real life experiences of the research team members, developed to help participants recognize types of bullying in the workplace. When used as part of an educational program, participants can role play bullying in each example shown in a case scenario. The examples will allow them to interact and to engage in a meaningful examination of overt and covert bullying (Ceravola, Schwartz, Futz-Ramos, & Castner, 2012).

Use of the case scenarios provides nurses the opportunity to reflect upon their current practice experience and discuss the ramifications of bullying in practice. Active listening plays an important role in engaging in this activity, as listening to the perceptions of others allows for active exchange of communication (Ceravola, Schwartz, Futz-Ramos, & Castner, 2012). Using professional communication standards as the basis for managing negative situations, the nurses are encouraged to interject alternative solutions to bullying in each scenario. Open discussion throughout the role-playing exercise facilitates learning new communication strategies to combat bullying within a secure environment that allows for freedom to express concerns and expectations about conflict resolution. Furthermore, the case scenarios illuminate the impact of bullying on nursing and burnout and its impact on to the intent to leave.

When using the case scenarios, nurses are provided with hard copies of the American Nurses Association *Scope of Practice Standards of Communication* (2010) to help answer related questions and flip cards that describe possible actions toward various types of bullying behaviors. Herein, possible answers to the questions are provided and flip cards that correspond with possible actions toward the type of bullying are referenced in parentheses.

Scenario #1

Jennifer Rose, a 25-year-old graduate of an Associate Degree in Nursing (ADN) program, was hired to work in the ICU at a regional trauma center in New Jersey, beginning with an eight-week internship program designed to assist new graduates.

Jennifer's preceptor, Deborah Smith, RN, BSN, has 15 years of ICU experience as well as experience mentoring new graduate nurses.

Two weeks into the internship program, Jennifer overhears nurses talking in the lounge about her progress in the program. Ms. Smith voices her opinion that Jennifer is not going to make it through the program. Ms. Smith states, "Jennifer does not ask any questions, and she thinks she knows it all." "Next week I am going to give her a heavy assignment because she needs to feel the full weight of a heavy one." "My aim is to make a new grad an ICU nurse or I break them." (Flip Card – Sabotage)

Jennifer runs into to the bathroom upset and crying. After she pulls herself together, she takes report from the off-going shift. Within an hour of receiving a patient who was awake and alert, the patient became delusional. Jennifer reviewed the medication record for potential drug interactions, although per report, no mention was made of any drugs given within the previous hour. Next, she reviewed the medication record with her preceptor Ms. Smith and found that the patient had received morphine.

Ms. Smith confronted Jennifer at the nurse's station, saying, "You are stupid." "You failed to check the written record of medication administration at report." "If you had, you would have been looking for any potential side effects and responded to the beginnings of the patient's change in mental status." (Flip Card – Verbal Aggression)

Ms. Smith informed the nurse manager about the incident, telling her that Jennifer is incapable of assessing changes in her patient's condition. She asks, "What kind of new graduates are we accepting in the ICU program?" "They need at least two years of experience on a Medical Surgical unit before trying this program."

Questions:

1. What was the type of bullying attack?
    a. Attack on person
    b. Attack on competence
    c. Attack through work tasks

(**Answers:** The attack described in scenario #1 shows all three types of attack on Jennifer. The attack on Jennifer as a person occurred when the preceptor called Jennifer

stupid. It became an attack on her competence when the preceptor complained to the nurse manager that Jennifer is incapable of assessing changes in her patient's condition. This scenario included an attack on her work tasks when the preceptor criticized Jennifer for not checking the patient's written record of medication administration.)

2. How should Jennifer respond to her preceptor's words?

(**Answers**: Jennifer should use therapeutic communication to respond to the preceptor's unacceptable and potentially harmful behavior. She could say, for example, "Ms. Smith, when you criticize me in front of others, it makes me feel less than human." "In the future, I would prefer that you take me aside to discuss these issues about my professional responsibilities." "I do respond well to constructive criticism, but the criticism that you use is not conducive to learning." "We can plan a corrective action to correct the deficiencies in my nursing performance."

(If these behaviors continue, Jennifer should consider discussing them with Smith's supervisor.)

3. Describe how the *American Nurses Association Scope of Practice* Standards of Communication 11-13 (2010) relate to bullying in this scenario.

(Answers: As provided in the handout*,* the *American Nurses Association Scope of Practice Standards of Communication* (2010) #11 discusses the appropriate use of communication in the professional environment and states that nurses are expected to uphold a therapeutic relationship with all individuals including colleagues' family members and clients. In the previous scenario, the preceptor exhibited a total lack of respect towards the new nurse. She violated Standard 11, which requires nurses to communicate in of appropriate manner. As seen in the provided facility's code of conduct, her attitude was threatening, which is also a violation of the facility's code of conduct, which prohibits any form of threatening behavior verbal/psychological harassment. All members of the care team must adhere to it as outlined by their facility, which they are required to review as a part of their condition of employment. Violation of this code results in termination.

Per *American Nurses Association Scope of Practice Standards of Communication* (2010) # 12, nurses must communicate effectively and develop skills to resolve conflict in the workplace. In this scenario, respect, trust, and dignity for a fellow colleague are lacking. Leadership is lacking accountability on the part of Ms. Smith's actions, as she as a leader should demonstrate professional behavior. Furthermore, the nurse manager, who has a responsibility to demonstrate and oversee all behaviors on the unit did not respond by deescalating this situation.

The *American Nurses Association Scope of Practice Standards of Communication* (2010) # 13 calls for collaboration, which is lacking. In this scenario, the preceptor is not collaborating with the new nurse. Ms. Smith has the responsibility to communicate important information to Jennifer; however, she is undermining Jennifer's ability. As a preceptor, Ms. Smith is responsible to participate in care and collaborate with Jennifer. Rather than chastise her, the preceptor should be helping Jennifer understand where she made her error. Collaboration begins with understanding where the knowledge deficit occurred and formulating a corrective action plan.

In this scenario, the senior nurse used power to control the situation. A power imbalance can occur when a more senior nurse berates a junior nurse in front of colleagues. Jennifer is the powerless victim, whose inability to respond results in her development of a poor coping strategy. If uncorrected, Jennifer will lose confidence in her ability to perform her duties, which will impair her job performance. This may lead to burnout and/or intent to leave.)

Scenario #2

Jennifer Rose is now in her fourth week of the internship program. She is giving shift report to another nurse, which she believes to be very thorough. The report includes: Ms. Brown is a 47-year-old African American female admitted to the medical ICU for a possible myocardial infection (MI). She has a medical history of hypertension, diabetes, obesity, glaucoma, asthma, and spinal stenosis. In 2010, Ms. Brown underwent gastric bypass surgery. Although she has no personal prior medical history of MI, her family history shows females suffering MI at age 47.

Brown's vital signs are blood pressure: 90/60; heart rate 100; respiratory rate 22; oral temperature 98.6; pulse oximetry 98. Upon admission, Brown was alert and oriented; had ST-T wave elevation in leads II, III, and AVF, but no complaints of chest pain. She showed A Fib 100 on the monitor, no ectopic beats noted on the heart monitor. Her lungs are clear bilaterally' abdomen soft, round, and non-tender in all four quadrants with formed bowel movement prior to admission. She has a urinary catheter size 16 French secured with amber urine in the bag. The patient can move all extremities. Labs are pending now.

The patient's medications include: Bystolic 10 mg by mouth daily, Symbicort 80/4.5mcg 1 puff bid; Onglzya 5mg by mouth daily; Travatan 1 drop both eyes at bedtime; Xopenex 0.83% 2 puffs as needed for wheezing; Aspirin 325mg by mouth daily; Nuv Ring insert one monthly.

When report is completed, Jennifer turns to her preceptor Deborah and asks, "Did I do a better job at giving report today?" In front of the nursing station, Deborah responds, "You have improved somewhat?" "You still need work, but I guess they did not teach you this in your Associates Degree program." Deborah is raising her eyebrows and making faces at Jennifer. In front of others, Deborah is abrupt, her responses lack openness, and she makes snide remarks. (Flip Card – Infighting) When Jennifer asks Deborah a question about the care of this patient, Deborah turns and walks away, becoming unavailable. (Flip Card – Undermining Activity) Jennifer overhears Deborah complaining to colleagues and anyone who will listen about Jennifer's poor job performance.

Questions

1. What was the type of bullying attack?
    a. Attack on person
    b. Attack on work tasks
    c. Attack on competence

(**Answers:** The attack described in scenario #2 shows all three types of attack on Jennifer. The attack on Jennifer as a person and on her work, task occurred when the

preceptor tells her that she still needs work, but "I guess they did not teach you this in your ADN program." This is also an attack on Jennifer's competence, which escalated when the preceptor complains about Jennifer's poor performance to colleagues.)

2. How should Jennifer have responded to her preceptor's words?

(**Answers**: Jennifer should use therapeutic observation and communication to prepare her responses to the criticism she receives from the preceptor. She should document the encounters with her preceptor. If therapeutic communication does not alleviate the bullying, Jennifer should verbalize concerns to line management and, if necessary, to Human Resources. She can ask for a change in preceptor.)

3. Describe how the *American Nurses Association Scope of Practice* Standards of Communication 11-13 (2010) relate to bullying in this scenario.

(Answers: As provided in the handout*,* the *American Nurses Association Scope of Practice Standards of Communication* (2010) #11 discusses the obligation of nurses to create a healthful, supportive work environment using communication. Here, Ms. Smith is not using effective communication. Rather than resolving conflict, she is creating conflict. She is not adhering to the ANA standards and the Code of Conduct, which governs behaviors among peers and colleagues to create a safe working environment. Per the ANA, nurses must communicate unethical behaviors to their superior; therefore, Jennifer should consider discussing her preceptor's conduct with her superior.

Per the *American Nurses Association Scope of Practice Standards of Communication* (2010) #12, leadership must provide direction to enhance team building within the nursing environment. Here, leadership has not addressed the issue of inappropriate behavior and conduct. No progressive steps have been taken by management to prevent escalation of the inappropriate behavior.

Per the *American Nurses Association Scope of Practice Standards of Communication* (2010) #13, nurses collaborate with others in the conduct of nursing practice.

In this scenario, the preceptor does not collaborate with her in the care of the patient; rather, she makes herself unavailable when Jennifer asks for help. She criticizes

rather than mentors Jennifer. The preceptor complains to colleagues about Jennifer, further dispelling any chance of teamwork and collaboration.

Scenario #3

Three months have passed since Jennifer completed the eight weeks training in ICU internship program. Speaking with another coworker, Jennifer states, “Since I’ve completed orientation, I have been getting the worse patient assignments.” “It seems the families are very difficult, and the patients require a lot of care.” Then, Dr. Man yelled at me for trying to clarify an order. (Flip Card – Non-verbal Innuendo) To make matters worse, he ridiculed me in front of other staff members and the assistant manager just stood there. (Flip Card – Undermining Activity) Jennifer’s coworker replied, “First, if you’re not in the clique, then you get all of the bad assignments.” “Secondly, Dr. Man does this a lot.” “Since he’s on the Board of Governors, management is afraid of him.” Jennifer responded, “I just want to quit this job; I can’t take it anymore!"

Questions:

1. What type of workplace bullying is this?
   a. Attack on person
   b. Attack on work tasks
   c. Attack on competence

   (**Answers:** The attack described in scenario #3 shows an attack on Jennifer as a person. Because she is not part of the clique, she receives the most difficult assignments. Dr. Man also attacks Jennifer as a person, ridiculing her because she tried to do her job. Management fears this physician, so they allow his bullying behavior to continue.)

2. How can Jennifer respond to these situations?

(**Answers:** Jennifer can become a change agent for team building by engaging staff in conversation about collaboration, which could help to alleviate cliques. She could report her concerns about inappropriate behavior of other nurses in cliques and Dr. Man’s bullying behavior to top management, relating the effects of these behaviors to decreased quality and safety of patient care.)

3. Describe how the *American Nurses Association Scope of Practice* Standards of Communication 11-13 (2010) relate to bullying in this scenario.

(Answers: As provided in the handout, the *American Nurses Association Scope of Practice Standards of Communication* (2010) #11 stresses the importance of effective communication since this ultimately results in the type of care patients receive. Here, Dr. Man denigrates Jennifer for clarifying an order. Good communication aids in the clarification of orders. Jennifer needs to develop a plan of action for effective communication with Dr. Man. If possible, Jennifer could try speaking with Dr. Man, saying that she is seeking clarification to learn from him and prevent errors. Perhaps, she should try to develop a forum where nurses can discuss difficult issues and situations.

Per the *American Nurses Association Scope of Practice Standards of Communication* (2010) #13, leadership should support the integrity of the nurse. Preservation of integrity serves as a guide for keeping professional dignity and aids in the well-being of the nurse (ANA, 2010). Here, leadership failed Jennifer by not advocating for her when Dr. Man bullied her.

Per the *American Nurses Association Scope of Practice Standards of Communication* (2010) #13, collaboration is key to a successful work environment. Dr. Man's bullying tactics negate collaboration. It is not possible to work collaboratively with a bully. The power differential here is with Dr. Man as well as with the nurse manager who allows Jennifer to receive the worst patient assignments.

Appendix D: ANA Code of Ethics

SUMMARY OF RELEVANT ANA PUBLICATIONS AND INITIATIVES 2015

The Code makes explicit the primary goals, values, and obligations of the nursing profession. ANA believes that The Code is nonnegotiable and that each nurse has an obligation and is expected to uphold and adhere to its ethical precepts. Four provisions within The Code speak to the obligation of registered nurses to act in a manner that is consistent with maintaining patient, coworker, and personal safety, civility, and respect:

- Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person. Specifically, this provision reminds nurses that all individuals with whom the nurse interacts are to be respected, including coworkers. Fair and kind treatment, best resolution of conflicts, and promotion of a culture of civility are stressed. Bullying, harassment, violence, and other unacceptable behaviors are not to be tolerated.
- Provision 3: The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
- Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care. The nurse achieves this participation through both individual and collective action. Specifically, this provision addresses creation of a safe health care environment in which nurses are supported in attaining and maintaining a higher moral code. This environment may be accomplished through a variety of practices, including health and safety initiatives, policies addressing discrimination, and incivility position statements (ANA, 2015a).

2015 publication: not part of the Job: how to take a stand against violence In the Work setting. This book serves as a resource to identify actions and best practices that nurses and their employers can enact to reduce workplace violence. It examines risk factors, worker rights, legal issues, worksite analysis, hazard prevention and control, training and education, and program evaluations. It also emphasizes the establishment of beneficial collaborations and provides case studies for further assistance (Lipscomb & London, 2015).

2015 publication: nursing: scope and standards of practice, ANA's Nursing: Scope and Standards of Practice is the consummate resource for professional nursing practice. It examines the who, what, where, when, why, and how of nursing practice in measurable, specific competencies that serve as evidence of compliance. Six standards in this publication address the obligation of RNs to act in a manner that is consistent with maintaining the personal safety, civility, and respect of patients, coworkers, and other individuals:

- Standard 7 (Ethics): The RN practices ethically. This standard includes integrating social justice, practicing self-reflection, advocating for the rights of others, and respecting the dignity of all people.
- Standard 8 (Culturally Congruent Practice): The RN practices in a manner that is congruent with cultural diversity and inclusion principles.
- Standard 9 (Communication): The RN communicates effectively in all areas of practice. This standard asks that RNs assess their own communication skills with patients, families, and coworkers while improving their personal communication and conflict resolution skills.
- Standard 10 (Collaboration): The RN collaborates with the health care consumer and other key stakeholders in the conduct of nursing practice. This standard asks the RN to practice effective (a) conflict management and resolution, (b) engagement, (c) consensus building, and (d) group dynamics and strategies.

- Standard 11 (Leadership): The RN leads within the professional practice setting and the profession. This standard requires the RN to treat coworkers with respect, trust, and dignity.
- Standard 12 (Education): The RN seeks knowledge and competence that reflects current nursing practice and promotes futuristic thinking. This standard requires the RN to mentor and acclimate nurses who are new to their roles, to practice lifelong learning through self-reflection, and to share educational experiences with peers (ANA, 2015c).

Significance of the ANA Scope and Standards of Practice and the Nursing Code of Ethics. The ANA Scope and Standards of Practice and the Nursing Code of Ethics serve as resources for cognitive rehearsal training (the case scenarios), as they provide a framework for professional behavior. Participants will refer to these handouts for role playing and emulate the tenants in them about how to respond to instances of workplace bullying.

The ANA Scope and Standards of Practice is a social contract with society that provides the goals, values, and ethical concepts that directly pertain to the profession of nursing (Lachman, 2009). The ANA believes that this Code for Nurses is nonnegotiable; each nurse has an obligation to uphold and adhere to the code of ethics. Any form of harassment, intimidation, bullying, incivility, and lateral/ horizontal violence in the workplace are prohibited. Inappropriate behaviors are not being tolerate.

Nursing Standard 11: Communication

Standard 11 requires nurses to formulate effective communication competences between the different areas of nursing practice. This standard articulates professional communication among nursing professionals. The nurse must be able to assess the communication needs of healthcare members, families, and clients. The nurse must seek out opportunities to improve conflict resolution skills and communication between colleagues and families. Nurses must support a communication process that discloses concerns that impede care and transition in care delivery. Communication should contribute to professional growth of the team members.

Nursing Standard 12: Leadership

Standard 12 establishes nursing leadership's responsibility to guide staff members toward the organizational vision, goals, and plan. Leadership acts as a change agent within an organization. Nurse leaders must develop a set of communication and conflict resolution skills that reflect professional respect, trust, and, dignity. Nursing leadership seeks opportunities to mentor colleagues for the advancement of quality of nursing care.

Nursing Standard 13: Communication

Professional collaboration employs negotiation techniques needed to resolve conflicts in the workplace. Professionals will use consensus-building to resolve conflict at work. The nurse will adhere to the organizational code of conduct, zero tolerance policy, and professional standards that govern behaviors. Nursing professionals will create a workplace that promotes dignity, respect, and trust.

Code of Ethics: Provision 1, 5, and 6

The ANA Code of Ethics for Nurses reinforces the public policy statement made by the Joint Commission and the ANA that mandates a zero-tolerance policy to end workplace bullying. Provision 1 establishes the responsibility of nurses to uphold respectful relationships with colleagues and individuals, fair treatment of all people, the resolution of conflict between colleagues and individuals, and the preclusion of any form of harassment, intimidation, bullying, incivility, and lateral/horizontal violence in the work environment.

Appendix E: Workplace Bullying Quiz

Please take this quiz before and after you have read the case scenarios. Please circle the best answer.

1. The hidden costs of bullying and harassment can have a significate impact on organizational expenses. What type of complications can come from this example of bullying?

A. Damage to health caused by stress

B. Increased turnover and absenteeism.

C. Lack of employee engagement and productivity 0

D. All the above

Answer D all the above

Workplace incivility also creates a heavy financial burden for health care organizations. Some estimates suggest that the annual cost of lost employee productivity due to workplace incivility may be as high as $12,000 per nurse (Lewis & Malachi, 2011).

2. Several subordinates come to you regarding negative statements that Nurse Brenda has been saying about her co-workers. One of the subordinate's adds, "I have also noticed that when I ask Nurse Brenda questions regarding procedures, she raises her eyebrows when addressing my questions. She makes me feel like she does not value my input into patient care "What form of bullying is the above example?" Choose your answer.

A. Nonverbal innuendo

B. Verbal Affront

C. Scapegoating

Answer A nonverbal innuendo (Inappropriate behavior when responding to someone, for example, rolling one's eyes during a conversation while looking at another coworker standing by [Stagg, Sheridan, Jones, & Speroni, 2011]).

3. Manipulation of the work environment by others in charge.

Changing work assignments as favor because he or she is part of the social clique.

Constantly complaining about a person's job performance.

Rose tells another coworker: "I hate following after Rose; I always must verify the information that she gave in report."

Coworker: responds "She will never make it through orientation!"

What kind of example best exemplifies responses from above?

A. Authentic leadership

B. Backstabbing

C. Mobbing

Answer B Backstabbing (The humiliation and putting down of colleagues through rudeness talking behind your back [Chu &Evans, 2016, Griffin, 2004]).

4. A fellow colleagues informs you that she is gay. The colleague tell you this personal information in confidence. Gossiping and making snide remarks behind a fellow colleague's back. This is an example of what?

A. Broken confidence

B. Failure to respect privacy

D. Backstabbing

Answer: B. Failure to Respect Privacy (Divulging information to another person without their consent to discuss [Griffin, 2004, Hutchinson, 2008]).

5. Jen is discussing with Rick her personal information. Jen is off for 2 days. When Jen returns to work. People are snickering and laughing behind her back. Jen states "I feel so embraced! "I just don't know what to do about this problem?'' This is what type of example

A. Incivility

B. Sabotage

C. Broken Confidence

Answer C Broken Confidence

6. Shift report is given to the oncoming shift promptly at 7pm.

Jen: Gives report to Carlos the new graduate nurse.

Carlos: Asks Jen what are the pertinent lab values for this patient today?

Jen: Responds “go look it up yourself.”

Is the above an example of what form of bullying?

A. Sabotage

B. Withholding Info

C. Scapegoating

Answer: B Withholding Information (The information can be about a patient or a procedure. It can be overt or covert such as deliberately not telling another nurse that a patient has limited sight on the right side [Sheridan- Leos, 2008]).

7. Deliberately setting a nurse up for failure which can lead to a negative outcome in care is an example of what form of bullying? This form of bullying can be either overt or covert.

A. Infighting

B. Sabotage

C. Undermining

Answer B Sabotage (The deliberate undermining of a coworker’s activities that can delay treatment and inhibit obtaining job performance [Stagg, Sheridan, Jones, & Speroni, 2011]).

8. Deliberately bickering with your nursing peers.

Laughing at a fellow colleague when reprimanded by the nursing supervisor for failure to complete a task assigned.

Unprofessional behaviors such as overtly criticizing another work in public areas.

What type of bullying example is this?

A. Non-Verbal Innuendo

B. Verbal Affront

C. Infighting

Answer C Infighting (Arguing fighting amongst peers of the same group membership [Becher & Vislosky, 2012; Griffin, 2004; Roberts, 2015]).

9. Continued inappropriate comments to your fellow coworkers.

Never having pleasant things to say about anyone or anything.

Walking away when a colleague asks for assistance.

Deliberately making myself unavailable and constantly making facial gestures.

What type of bullying is an example of?

A. Incivility

B. Nonverbal Innuendo

C. Undermining Activities

Answer: A Incivility (Inappropriate and discourteous behavior that is rude and offensive towards others [Embree & White, 2010]).

10. Intentionally setting up nurse for a negative outcome.

Pulling pranks on a fellow college to make then look incompetent.

What is this an example of?

A. Incivility

B. Undermining

C. Offensive behavior

Answer: B Undermining (An activity used by fellow colleagues to undermine the work tasks performed by a fellow colleague and intends to cause harm to work performance [Stagg, Sheridan, Jones, & Speroni, 2011]).

Appendix F: Workplace Bullying Inventory & Occupational Predictors and

Consequences of Bullying Scale Permission

Fwd: Re: permission to use your WBI *2*

From: [redacted]
To: Sabrina Brown Oliver

Hello Sabrina
Thank you for your query. We are pleased for you to use our measures if they suit your project. All we ask is that you cite our authorship in publications.
I have attached a copy of the WBI which measures several bullying acts. I have also attached the set of measures we employed to test our model of workplace climate and bullying, which has a shorter of bullying measures.
Both instruments have been employed in several studies of the health workforce in the US and Canada, with similar results to our work here in Australia.
When we originally developed the WBI we did not sum the sub-scales instead we examined prevalence of exposure to each type of behaviour. Again, there is work underway at present examining whether there are dilution issues with summing the scores.
I would be happy to answer any further questions and wish you will with your study.
Regards
Marie

----- Original Message -----
From: "Pietrangelo, Lee A" [redacted]
Date: Thursday, September 6, 2012 11:40 pm
Subject: permission to use your WBI
To: "[redacted]

> Dr. Hutchinson,
>
> Good morning from Pittsburgh, Pennsylvania in the United States.
> I am an internal medicine physician and have taken a year to
> complete an academic fellowship in Patient Safety through our
> national Veterans Health Administration hospital here in
> Pittsburgh. I have focused my attention on the problem of
> bullying in healthcare, and have seen the extensive work you
> have done as a global expert leading the charge to prevent and
> eliminate bullying as a patient safety issue.
>
> I have been working with our IRB here to deploy a survey to the
> hospital staff here re bullying. I know you have developed a

> Workplace Bullying Inventory, and I am interested to see if the
> survey is available for shared use by others in the field for
> further research and study. I would like to possibly deploy it
> as a validated instrument for my own work, and was wondering if
> you could send me a copy of the inventory and allow me to use
> it, if it fits into my project goals.
>
> I look forward to hearing from you when you have time, and using
> your WBI if available for shared use currently.
>
> It has been great to see all of your extraordinary work on this topic.
>
> Thank you.
>
> Most respectfully,
> Lee
> Lee Pietrangelo, M.D.

Appendix G: Workplace Bullying Inventory

The Workplace Bullying Inventory (WBI)

At work during the past year, have you experienced any of the following?
Please read each item and use a cross to indicate whether you experienced it:
1= Never
2= A few times a year
3= Monthly
4= Weekly
5= Daily

	1	**2**	**3**	**4**	**5**
My reputation was damaged by false allegations	1	2	3	4	5
My achievements and contributions were ignored	1	2	3	4	5
My abilities were questioned	1	2	3	4	5
I was given work above my skill level and refused help	1	2	3	4	5
I was denied development opportunities	1	2	3	4	5
I was ignored	1	2	3	4	5
I was belittled in front of others	1	2	3	4	5
I was watched and followed	1	2	3	4	5
I was blamed	1	2	3	4	5
I was publicly humiliated	1	2	3	4	5
I was threatened	1	2	3	4	5
My work was excessively scrutinized	1	2	3	4	5
My work was organized to inconvenience me	1	2	3	4	5
My work life was made difficult	1	2	3	4	5
I was excluded from receiving information	1	2	3	4	5
My work was organized to isolate me	1	2	3	4	5

Organisational Predictors and Consequences of Bullying Scale (OPCBS)

The following items are about your experience and consequences of workplace bullying
Please read each item and use a cross to indicate whether you experienced it:

1= Never
2= A few times a year
3= Monthly
4= Weekly
5= Daily

	1	2	3	4	5
I was blamed	1	2	3	4	5
My work was excessively scrutinized	1	2	3	4	5
I was excluded from receiving information	1	2	3	4	5
I was watched and followed	1	2	3	4	5
I was publicly humiliated	1	2	3	4	5
I was threatened	1	2	3	4	5
I was ignored	1	2	3	4	5
I was denied career development opportunities	1	2	3	4	5
I was given demeaning work below my skill level	*1*	*2*	*3*	*4*	*5*
My family and friends encourage me to resign	1	2	3	4	5
I am tired but find it hard to sleep	1	2	3	4	5
I can't enjoy the company of family and friends	1	2	3	4	5
I have considered taking my own life	1	2	3	4	5
I have begun to doubt my sanity	1	2	3	4	5
I used to want a career, now I just hope to get through the day	1	2	3	4	5
I spend everyday at work watching my back	1	2	3	4	5
When I see the bully my heart races and I panic	1	2	3	4	5
I don't put myself forward to be involved in things anymore	1	2	3	4	5
I just want to pull the covers over my head and not get up	1	2	3	4	5
I regularly try and avoid working with the bully	1	2	3	4	5

Organizational Predictors and Consequences of Bullying Scale: Factor loadings and Cronbach's alpha scores

Item	Factor Loadings	Cronbach's alpha
Factor 1: Psychosocial distress		
I can't enjoy the company of family and friends	0.73	
I have begun to doubt my sanity	0.74	
My family and friends encourage me to resign	0.65	
I am tired but find it hard to sleep	0.85	
I have considered taking my own life	0.82	
I just want to pull the covers over my head and not get up	0.67	0.88
Factor 2: Bullying acts		
I was blamed	0.78	
My work was excessively scrutinized	0.81	
I was excluded from receiving information	0.78	
I was watched and followed	0.78	
I was publicly humiliated	0.80	
I was threatened	0.76	
I was ignored	0.76	
I was denied career development opportunities	0.69	
I was given demeaning work below my skill level	0.67	0.92
Factor 3: Avoidance and withdrawal at work		
When I see the bully my heart races and I panic	0.80	
I used to want a career, now I just hope to get through the day	0.85	
I spend every day at work watching my back	0.85	
I don't put myself forward to be involved in things anymore	0.83	
I regularly try and avoid working with the bully	0.78	0.91
Factor 4: Misuse of legitimate authority, processes, and procedures		
Meetings called to manage personal injury or illness used to bully	0.69	
Records of meetings are falsified	0.76	
Threats and intimidation are used	0.77	
You are summoned to meetings without notice and intimidated	0.76	
You are denied an advocate to support you	0.69	
Junior managers are led into taking part in the bullying	0.79	
Performance appraisal is used as an opportunity to bully	0.73	
Organisational policies and procedures are not followed	0.75	0.90
Factor 5: Informal Organizational Alliances		
There is a hierarchy of bullies who support each other	*0.87*	
They have mates in higher places that cover up for them	0.87	
They organise work to allow a group to target someone	0.89	
They gang up on you	0.73	
They build alliances by promoting those who support them	0.81	
Senior bullies hide the truth from formal investigations	0.76	0.92
Factor 6: Organisational tolerance and reward of bullying		
Bullies control the allocation of work	0.76	
Bullies promote those who stay silent about bullying	0.83	
Bullies obstruct change that may reduce their control	0.80	
Managers hide bullying under the guise of legitimate change	0.78	
Regardless of what they do bullies get promoted	0.68	

Restructure is used to force out those not supportive of bullies	0.87	0.91
Factor 7: Normalizations of bullying behaviours in work teams		
A change of tactics is used to keep people on edge	0.73	
There is a constant “array” of little things that all add up	0.73	
New people are tested to see if they will turn a blind eye to bullying	0.69	
Less subtle bullying is done in front of those who don't speak out	0.81	
Others are led into playing a part in bullying	0.82	0.85

Hutchinson, M., Vickers, M.H., Jackson, D., & Wilkes, L. (2006). The development of a multidimensional workplace bullying instrument in nursing. *Proceedings from the Association on Employment Practices and Principles (AEPP), Fourteenth Annual International Conference,* (pp. 70-76). New York City, NY: Publisher.

Appendix H: Flip Card Content Readability Form

Evaluation Form: Readability: Content Expert for Mitigate Workplace Bullying in New Graduate Flip Card

Please circle and complete this 5-point Likert scale provided below with the meaning 1 being strongly disagree through 5 meaning you strongly agree with the statement.

1. Was this flip card easily to read?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

2. Do the flip card aid in recognition of the 10 most frequent bullying behaviors?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

3. Is the content of this case studies helpful with the flip cards?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

4. Did the case studies have enough relevant intern information?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

5. Were you able to understand the different types of bullying in the case studies?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

6. Did pictorial flip cards aid in responding to question associated with this case study project?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

7. What did you like about the pictorial flip cards were the picture appropriate?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

8. Did you read any author bias?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

Appendix I: Case Scenarios Evaluation Form

Evaluation Form: Readability: Case Scenarios Expert for Mitigate Workplace Bullying in New Graduate

Please circle and complete this 5-point Likert Scale provided below with one meaning you strongly disagree through five meaning you strongly agree with the statement.

1. Are case studies effective at recognizing and eliciting a defense against this behavior?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

2. Are case scenarios effective at demonstrating bullying such as backstabbing, verbal abuse, lateral and horizontal violence?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

3. Are you able understand why using the (ANA Scope of Practice Standards) is an assertive communication tool.

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

4. Is the assertive communication technique used in this project beneficial in de-escalation of a hostile situation?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

5. Are the visual aid cards helpful at recognizing content and was it up-to-date and reflected of current practice?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

6. Does the interactive case scenarios promote critical thinking?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

7. Would you recommend the use of this educational tool for a novice nurses educational training?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

8. Did you read any author bias?

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

Appendix J: Slack Permission

May 5, 2016

Sabrina R. Brown Oliver
Walden University

Reference #: J19356004
Material Requested: Appendices A and B
Usage Requested: Clinical project
Citation: Travale I. (2007). Computer-Assisted Instruction for Novice Nurses in Critical Care. Journal of Continuing Education Nurse 38(3) 132-138

Dear Sabrina:

Permission is granted for the requested materials and usage listed above, subject to the following conditions:

- Permission is granted for **one-time use only**. Permission does not apply to future editions, revisions, or derivative works.
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Name on the card: _____ SVC Code: _____

Please sign and date below, keep a copy for your records, and fax to Attn: Permissions Department. Please include your reference number on all correspondence and payment information. A copy of this form **MUST** accompany payment.

Requestor accepts conditions above: Signature Sabrina R. Brown Oliver Date: 05/1/2016

Appendix K: ANA Permission

--Original Message-----
From: Copyright [redacted]
To: Sabrina Oliver <[redacted]
Sent: Fri, Jan 15, 2016 12:49 pm
Subject: RE: permission to reprint

Good Afternoon Ms. Oliver:

Please forgive my delay in responding to your permissions request.

Yes, you may reproduce the content. There are only 9 provisions in ANA's ***Code of Ethics for Nurses.*** However, permission is granted for one print and/or electronic edition only, and does not extend to revisions, and future works, nor does it extend to derivative works or worldwide distribution indifferent languages.

We will waive the permissions fee being the materials is used for educational purposes.

Thanking you in advance.

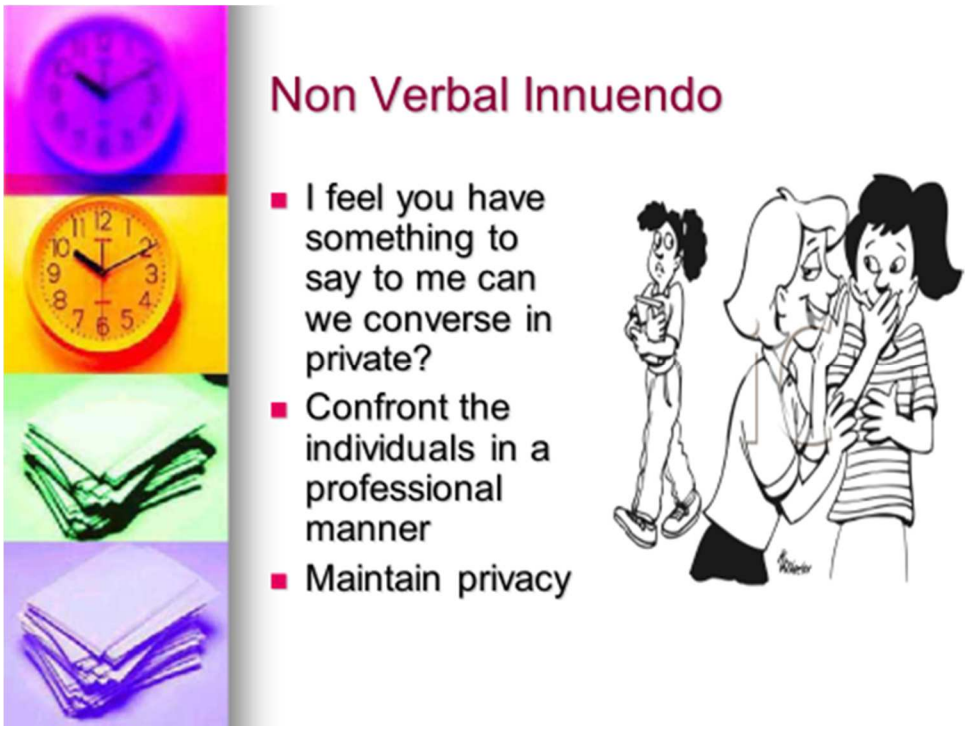
Regards,
Cynthia

From: Sabrina Oliver [[redacted]
Sent: Tuesday, December 22, 2015 3:37 PM
To: Copyright
Subject: permission to reprint

Hello, my name Sabrina R. Brown Oliver

I am doctorate student at Walden University. I would like to obtain permission to use the code of ethic reprint provisions 11, 12 and 13 in my thesis paper on workplace bullying. The code of ethics is integral part of nursing and serves as the basis of elevating professionalism in nursing.
Thank you for your consideration.
Sabrina R. Brown Oliver RN APN-BC

Appendix L: Flip Cards




Sabotage
Can we debrief about the situation later?
Lend mentoring support when needed


Undermining Activity
We can deconstruct this situation in post conference.
Lend assisted when needed
Ask for help
Report unsafe practices
Don't be a bystander

Verbal Aggression

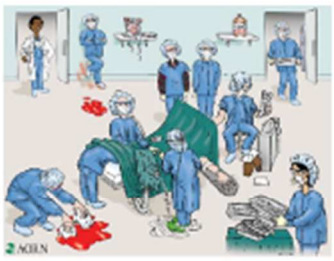
- Address the situation in a professional manner
- Work cooperatively co workers
- Respect personal space

Infighting

- Don't criticize in public
- Address coworkers by their first names
- Speak with respect to other professionals and to the public

Scapegoating

- Accept responsibility for your actions
- Learn from your mistakes



Backstabbing

- Address the situation prompt
- Respect privacy
- Don't standby and let this happen

Withholding Information

- Remember your oath to provide nursing care
- Be honest and direct with answers when responding

Broken Confidences

- Remember you are bound by HIPPA
- ANA Code of Ethic
- Respect privacy
- Respect

Reference

- American Nurses Association. (2011). Retrieved from http://nursingworld.org/MainMenuCategories/WorkplaceSafety/workplaceviolenc

Reference

- American Nurses Association. (2010). Nursing: scope and standards of practice. (2nd Ed.). Silver Spring, MD: American Nurses Association.

- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: and intervention for newly licensed nurses. Journal of Continuing Education in Nursing, 35(6), 257-263.

Hyperlinks

- http://nursing.advanceweb.com/SharedResources/Images/2012/022012/DealingWithBullying_300x.jpg
- http://www.iclipart.com/search.php?x=97&y=9&keys=275626&andor=AND&cat=All&tl=clipart&id=111_10_3_17
- http://thumbs.dreamstime.com/z/sabotage-2176894.jpg
- http://www.keen.com/CommunityServer/UserBlogs/Crystal_of_Light_and_Love_5/Be-Careful-What-You-Believe-To-Be-True/default.aspx
- http://www.southjerseyrn.com/tag/vertical-bullying/

Appendix M: AGREE II and Permission

SUGGESTED CITATION:
Brouwers MC, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, Fervers B, Graham I, Grimshaw J, Hanna SE. The global rating scale complements the AGREE II in advancing the quality of practice guidelines. J Clin Epidemiol 2012;65(5):526-34; doi: 10.1016/j.jclinepi.2011.10.008

FUNDING:
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For more information about the AGREE GRS, please contact the AGREE project office at agree@mcmaster.ca or visit the AGREE website at www.agreetrust.org

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Dr. P. Littlejohns, King's College London, London, UK
Ms. J Makarski, McMaster University, Hamilton, Ontario, Canada
Dr. L. Zitzelsberger, Quebec, Canada

v) Other Considerations when Applying the AGREE II

On occasion, some AGREE II items may not be applicable to the particular guideline under review. For example, guidelines narrow in scope may not provide the full range of options for the management of the condition (see item 16). The AGREE II does not include a "*Not Applicable*" response item in its scale. There are different strategies to manage this situation including having appraisers skip that item in the assessment process or rating the item as 1 (absence of information) and providing context about the score. *Regardless of strategy chosen, decisions should be made in advance, described in an explicit manner, and if items are skipped, appropriate modifications to calculating the domain scores should be implemented. As a principle, excluding items in the appraisal process is discouraged.*

IV. Scoring the AGREE II

A quality score is calculated for each of the six AGREE II domains. The six domain scores are independent and should not be aggregated into a single quality score.

i) Calculating Domain Scores

Domain scores are calculated by summing up all the scores of the individual items in a domain and by scaling the total as a percentage of the maximum possible score for that domain.

Example:

If 4 appraisers give the following scores for Domain 1 (Scope & Purpose):

	Item 1	Item 2	Item 3	**Total**
Appraiser 1	5	6	6	**17**
Appraiser 2	6	6	7	**19**
Appraiser 3	2	4	3	**9**
Appraiser 4	3	3	2	**8**
Total	**16**	**19**	**18**	**53**

Maximum possible score = 7 (strongly agree) x 3 (items) x 4 (appraisers) = 84
Minimum possible score = 1 (strongly disagree) x 3 (items) x 4 (appraisers) = 12

The scaled domain score will be:

$$\frac{\text{Obtained score} - \text{Minimum possible score}}{\text{Maximum possible score} - \text{Minimum possible score}}$$

$$\frac{53 - 12}{84 - 12} \times 100 = \frac{41}{72} \times 100 = 0.5694 \times 100 = 57\ \%$$

AGREE II INSTRUMENT

DOMAIN 1. SCOPE AND PURPOSE

1. The overall objective(s) of the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

2. The health question(s) covered by the guideline is (are) specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

3. The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 2. STAKEHOLDER INVOLVEMENT

4. The guideline development group includes individuals from all relevant professional groups.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

5. The views and preferences of the target population (patients, public, etc.) have been sought.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

6. The target users of the guideline are clearly defined.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 3. RIGOUR OF DEVELOPMENT

7. Systematic methods were used to search for evidence.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

8. The criteria for selecting the evidence are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

9. The strengths and limitations of the body of evidence are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 3. RIGOUR OF DEVELOPMENT continued

10. The methods for formulating the recommendations are clearly described.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

11. The health benefits, side effects, and risks have been considered in formulating the recommendations.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

12. There is an explicit link between the recommendations and the supporting evidence.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 3. RIGOUR OF DEVELOPMENT continued

13. The guideline has been externally reviewed by experts prior to its publication.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

14. A procedure for updating the guideline is provided.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 4. CLARITY OF PRESENTATION

15. The recommendations are specific and unambiguous.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

16. The different options for management of the condition or health issue are clearly presented.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

17. Key recommendations are easily identifiable.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 5. APPLICABILITY

18. The guideline describes facilitators and barriers to its application.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

19. The guideline provides advice and/or tools on how the recommendations can be put into practice.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

20. The potential resource implications of applying the recommendations have been considered.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 5. APPLICABILITY continued

21. The guideline presents monitoring and/or auditing criteria.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

DOMAIN 6. EDITORIAL INDEPENDENCE

22. The views of the funding body have not influenced the content of the guideline.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

23. Competing interests of guideline development group members have been recorded and addressed.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

Comments

OVERALL GUIDELINE ASSESSMENT

For each question, please choose the response which best characterizes the guideline assessed:

1. Rate the overall quality of this guideline.

1 Lowest possible quality	2	3	4	5	6	7 Highest possible quality

2. I would recommend this guideline for use.

Yes	
Yes, with modifications	
No	

NOTES

Appendix N: Levels of Evidence

Table N1

Hierarchy of Evidence

Author (Year)	Study Design	Method Sample	Setting Major Variables Studied	Measurement	Data Analysis	Findings	Appraisal: Worth to practice
Budin et al. (2013)	Descriptive non-experimental	380 nurse managers	68 Magnet Hospital	Verbal Abuse	Verbal Abuse among nursing colleagues	+ lateral and horizontal amongst nursing profession Strategies to support nurses	Level III
Ebrahimi et al. (2018)	Qualitative	18 Graduate Nurses	Hospital overt and convert Behaviors	Lateral violence	Content Analysis	4 categories extracted from survey. + lateral and horizontal violence against new nurses	Level III
Embree et al. (2013)	Quantitative	135 Registered Nurses	Critical Access Hospital Nurse to Nurse Lateral Violence (NNLV)	Lateral Violence Nurse workplace scale Silence the self-work scale	Independe nt T test pre and posttest survey data	Expand curriculum to increase awareness Organization must every account for their behaviors	Level III
Gilbert (2016)	Descriptive, Non-experimental , 4th wave survey	380 nurse managers	Incivility	Nurse Incivility Scale (NIS),	Verbal abuse and incivility among colleagues	49% of nurses reported verbal abuse	Level III
Griffin (2004)	Cognitive Rehearsal (CR) Exploratory Descriptive applied intervention	26 graduate nurses	Lateral violence	Exploratory descriptive applied intention (CR)	Video Tape Focus group	+ cognitive helped Increased retention of knowledge	Level III

Author (Year)	Study Design	Method Sample	Setting Major Variables Studied	Measurement	Data Analysis	Findings	Appraisal: Worth to practice
Hickson, (2013)	Descriptive non-experiment survey	1165 nurses Registered nurse's hospital system	249 employed by magnet hospital 939 non-Magnet	Nursing hostility	Negative Act Survey revised via online	Nurses at magnet hospital (48%) reported less hostility than non-magnet hospital (49) (p= .42)	Level III
Kile et al. (2019)	Mixed Methods pilot study Qualitative and Quantitative	32 Post Anesthesia Care Unit (PACU) nurses in magnet hospital	Incivility	Nurse Incivility Scale (NIS), the NDNQI Index of Work Satisfaction Nurse Interaction subscale, and two open-ended questions	Cognitive Rehearsal	+ cognitive rehearsal in managing nurse-to-nurse incivility	Level III
Keller (2016)	Descriptive non-experimental survey III B	707 nurses	Single magnet Hospital	Bullying	Negative Acts Survey revised	Limited to single magnet hospital 66% either experience or witness bullying at work Many nurses reported anxiety (59%), low self-esteem (50%), loss of confidence (963%), and loss of job satisfaction (83%). Impaired communicati on (72%)	Level III

Author (Year)	Study Design	Method Sample	Setting Major Variables Studied	Measurement	Data Analysis	Findings	Appraisal: Worth to practice
Laschinger and Grau (2012)	Cross sectional	165 RN new graduates	Hospital	Job characteristics Quality of interpersonal relationships organizational culture	Workload Control rewards sense of community fairness	Areas of work fit life are manageable Fairness b-.56	Level III
Laschinger et al. (2012)	Cross sectional	343 RN's	Hospital	Leadership	Authentic leadership	T1 authentic leaders >T2 exposure to workplace bullying b=-.26	Level III
Myers (2016)	Qualitative III B	126 nurses	Hospital setting 1 magnet non-unionized, religious based, Nonunion magnet hospital private and unionized hospital non-magnet	Horizontal Violence	Horizontal Violence	Identify embedded culture of horizontal in organizational culture. Nurses inappropriate communication between colleagues	Level III
O'Connell et al. (2017)	Quantitative Pre/post test III B	Military peri anesthesia nursing	Military Facility	Prevalence of lateral violence in the military	Negative Acts Questionnaire—Revised.	Lateral violence Occurs in the military.	Level III
Sanner-Stiehr and Smith (2017)	Quantitative	Nursing prelicensure programs.		Code Conduct	Literature review	Strategies to improved behaviors in nursing education	Level III
Sellers et al. (2012)	Descriptive survey	2659 RN Non-Union and unionized nurses	19 hospitals in New York	Horizontal Violence	Briles Sabotage Savvy Quiz	Union vs nonunion nurses experience < Horizontal Violence	Level III
Stagg et al. (2011)	Quasi experiential	62 RN	Hospital Nurse	Cognitive rehearsal	Workplace bullying survey	80% nurses reported bullying Cognitive rehearsal helped with retention of knowledge	Level III

Author (Year)	Study Design	Method Sample	Setting Major Variables Studied	Measurement	Data Analysis	Findings	Appraisal: Worth to practice
Volz (2017)	Descriptive, cross sessional design	122 MD, NP	Emergency Room	Workplace violence	Negative Acts Questionnaire—Revised.	Violence experienced did have a negative impact on patient care and personal health.	Level III

Note. Hierarchy of evidence evaluated using Fineout-Overholt et al. (2010).

Table N2

Position Statements

Author (Year)	Study design, Evidence level, Quality Assessment	Method Sample	Appraisal
American Nurses Association (2015)	Code of Ethic Policy	Conscious panel	Level VII
American Nurses Association (2015b)	Incivility bullying and workplace violence Position statement	Conscious panel	Level VII
American Nurses Credentialing Center (Nd)	Position Statement	Conscious panel	Level VII
American Psychiatric Nurses Association (2008)	Position Statement	Conscious panel	Level VII
Health Professional and Allied Employee Union	Position Statement	Conscious panel	Level VII
Healthy Work Environment	Position Statement	Conscious panel	Level VII
National Council of Board of Nursing	Position Statement	Conscious panel	Level VII
American Association of Critical Nurses (2016)	Executive Summary	Conscious panel	Level VII

Note. Hierarchy of evidence evaluated using Fineout-Overholt et al. (2010).