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Perceptions of Nurses' Abilities to Provide Safe Care in Unhealthy Work Environments

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2020

Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

As many as 90% of nurses report working in an environment where their peers engage in passively and overtly violent activities against other nurses. Working in such an environment is unhealthy and has consequences for the career trajectory of nursing. There is a lack of literature available that specifically addresses nurses' perceptions of their abilities to provide safe patient care in unhealthy work environments. The purpose of this phenomenological study was to explore the lived experiences of nurses who have experienced lateral violence and their perceptions of their ability to provide safe care. Husserl's philosophy of phenomenology was used as the conceptual framework and Freire's theory of pedagogical oppression and empowerment was used as the theoretical framework of this study. Semistructured telephone interviews were conducted with 13 registered nurses who experienced lateral violence. I then analyzed verbatim transcriptions of the interviews using manual coding. Categorization of data into 5 themes was accomplished utilizing interpretative phenomenological analysis. The themes included lateral violence, responses to lateral violence, oppressive group behavior, unsafe care, and coping. Recommendations based on this research included acknowledging that lateral violence is often present in the workplace, taking a clear stand against it, supporting the victim by directly confronting the perpetrator, and providing support services to the victim. Results from this study can be used to promote positive social change by informing nurses of the dangers of lateral violence and by encouraging a change of culture in work environments where nurses support each other. In doing so, nurses may be better equipped to address patient needs and provide safe care.

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Dedication

This study is dedicated to all nurses who entered the nursing profession with the intention of caring and advocating for patients, but were forced to endure the abuse of lateral violence. Thank you for your service and commitment to patient safety.

Acknowledgments

I would like to thank my husband, Brian, and my children, Caitlin, Meagan, Kristen, and Brynn for their patience and support while I was on this journey. Your sacrifices and understanding allowed me to persevere, even when times were tough.

I would like to acknowledge the immense amount of support that I received from Dr. Mary Martin. Whether it was a phone call or email, you were always able to provide the encouragement that I needed. Thank you so much for all of your insight. I would like to thank Dr. Anna Valdez, who provided me with so much useful advice on performing qualitative studies and data interpretation. Thank you taking the time to speak with me, especially when data collection was difficult. I would also like to thank Dr. Maria Ojeda for providing valuable input into the quality of this work. I will forever be grateful to all of you.

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Chapter 1: Introduction to the Study

Introduction

Patient safety is a primary concern of healthcare facilities and is predicated by healthy work environments (Burns, Gonzalez, Hoffman, & Fulginiti, 2018). Healthy work environments have been characterized as safe and empowering, and facilitate optimum patient care (Huddleston & Gray, 2016). Healthy work environments in healthcare require strong working relationships among colleagues, decision-making that involves the input of clinical nurses, and organizations that address concerns identified by clinical nurses (Burns et al., 2018). Unhealthy work environments are described as workplaces that possess behaviors that are abusive, poor communication among colleagues, lack of respect, unwillingness to promote positive change, weak leadership, a sense of untrustworthiness, and other behaviors that are in conflict with the mission and values with the organization (Carpenter & Dawson, 2015). Unhealthy work environments can result in risks for nurses, such as lateral violence, stress, fatigue, and injury to both nurses and their patients (Carpenter & Dawson, 2015).

Lateral violence is defined as "behaviors intended to demean, undermine, and/or belittle a targeted individual working at the same professional level" (Sanner-Stiehr & Ward-Smith (2017, p. 1). Lateral violence is a commonplace behavior reported by nurses, leading to consequences such as physiological symptoms, psychological symptoms, increased staff turnover, and adverse patient events (Houck & Colbert, 2017; Oh, Uhm, & Yoon, 2016; Wright & Khatri, 2015). Behaviors associated with lateral violence contribute to an unhealthy work environment and poor patient outcomes (The

Joint Commission, 2008). Healthy work environments in healthcare are establishments that possess policies, procedures, and processes that empower nurses to maintain personal satisfaction and achieve organizational objectives (Huddleston & Gray, 2016). Incidences of lateral violence are characteristic of an unhealthy work environment (Huddleston & Gray, 2016). The Joint Commission (2016) reported that lateral violence can result in nurses experiencing decreased morale, increased absenteeism, poor teamwork among peers, decreased quality of care for patients, and an increased risk of harm and infection for patients. While patient safety is a priority for all nurses, lateral violence may impact a nurse's ability to competently care for patients and ensure patient safety. Patient safety is a concept that is dependent on factors such as effective communication and team relationships (Kim, Lyder, McNeese-Smith, Leach, & Needleman, 2015). Purpora, Blegan, and Stotts (2015) noted that nurses who experienced lateral violence reported poor peer relationships, provided a lower quality of care, and a had a higher likelihood to provide care that resulted in errors or adverse events.

The purpose of this qualitative phenomenological study was to explore registered nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. While there is an abundance of literature available that describes the devastating effects of lateral violence on nurses (Houck & Colbert, 2017; Oh et al., 2016), Wright & Khatri, 2015), there is a lack of literature available that specifically addresses nurses' perceptions of their abilities to provide safe patient care while working in work environments that are unhealthy. This

research addresses this gap in the literature by providing details of the lived experiences of nurses who have worked in unhealthy work environments and their perceptions of the quality of care that they were able to provide to their patients.

The following sections include a background of lateral violence, the problem statement and the purpose for this study. Additionally, I explain this study's significance and describe how lateral violence impacts the nurses who experience it. The conceptual and theoretical framework are identified, the nature of the study is described, and its significance is explained.

Background

Poor communication among nurses has been determined to be a significant risk factor for placing a patient at risk for unintentional harm (The Joint Commission, 2016). According to Flynn-Makic (2018), nurses who fear questioning orders risk omission of care or errors. Lack of collaboration may lead to neglected patient care, patient falls, or injury to the nurse. Near misses or errors may not be reported because of fear of punishment. Furthermore, this psychological stress can affect a nurse's technical skills, leading to patient injury (Flynn-Makic, 2018).

Houck and Colbert (2017) sought to discover what was known about the relationship between nurses who experience lateral violence and patient safety by conducting an integrative review of published quantitative and qualitative articles. The authors concluded that there was a strong association between workplace bullying and work dissatisfaction, burnout, and intent to leave, but studies examining the association between lateral violence and patient safety were nonspecific or limited. One quantitative

study (Spence-Laschinger, 2014) was identified in which nurses experiencing lateral violence reported performing actions that could compromise patient care.

Taylor (2016) presented a qualitative study from two hospital units examining horizontal violence and nurses' perceptions of the phenomenon. The author reported five themes. The first theme was that behaviors were minimized and not recognized. Hospital staff were unclear regarding lateral violence policies and reportable events. According to Taylor, as behaviors associated with lateral violence continued without repercussion, staff members began to accept it as a norm and avoided collaboration with peers. The second theme, as noted by Taylor, was that fear prevented reporting. Nurses feared that reporting lateral violence may cause them to be labeled as untrustworthy or that reporting the behavior would not result in a positive change. The third theme per Taylor was that nurses cope with lateral violence with avoidance and isolation. The nurses interviewed reported staying away from nurses that harassed them and also noted that witnesses of lateral violence would not intervene on the victim's behalf. The fourth theme was a lack of respect and support (Taylor, 2016). Nurses reported feeling no respect for their profession and felt unsupported when assistance was needed. The fifth theme was organizational chaos (Taylor, 2016). Nurses reported a lack of equipment, supplies, and resources that would enable them to be more successful in the workplace. Taylor concluded that nurses do not often recognize lateral violence when it is witnessed or experienced and feel that the behavior is acceptable and unchangeable.

Clark and Kenski (2017) found that the incidence of lateral violence was high among newly-licensed nurses and was associated with a lack of job satisfaction,

increased burnout, decreased commitment to the workplace, and a higher intent to leave, all which are factors that influence patients' safety while hospitalized. The researchers further identified that a lack of support among nurses in the workplace was also a factor that influenced the likelihood of experiencing lateral violence. Reporting the behavior to supervisors was generally avoided by the nurses in the study because of peer pressure, fear of repercussions in reporting, and lack of guidelines in addressing the behavior. Based on their findings, Clark and Kenski suggested that the effects of lateral violence can influence the entire nursing workforce and lead to negative outcomes, and that improving workplace relationships may significantly affect the job outcomes for new nurses.

Oh, Uhm, and Yoon (2016) tested a model assessing the association between lateral workplace bullying with job stress, intent to leave, and patient safety issues. For their research, Oh et al. identified patient safety issues as wrong medications or doses, nosocomial infections, complaints from patients, and patient falls with injuries. The results of the study supported the hypothesis that workplace bullying, job stress, and the intent to leave may be associated with patient safety issues (Oh et al., 2016).

Wright and Khatri (2015) examined the relationship between bullying and psychological and behavioral responses among nurses in one hospital system. Wright and Khatri noted that nurses' roles in healthcare greatly contribute to the delivery of quality healthcare. To ensure the health of nurses, healthcare organizations need to eliminate the influences that negatively impact nurses' job satisfaction and their overall health (Wright & Khatri, 2015). Wright and Khatri concluded that bullying behaviors in

the workplace were present among nurses and affected stress levels, anxiety, and medical error rates. They also suggested that developing a collaborative working environment, free from lateral violence, may be necessary to create a hospital culture that is safe for both patients and nurses.

Durmus, Topcu, and Yildirim (2018) described behaviors of lateral violence experienced by nurses working in Turkish hospitals and the effects of these behaviors on nurses' mental health, physiological health, and work performance. Durmus et al. reported that the most common mental health symptoms included a feeling of sadness and reliving the experience repeatedly. The most common physiological symptoms that the researchers identified included headaches, fatigue, and stress. The most common work performance complaints, identified in the study, included a decreased commitment to the workplace and conflict with coworkers. Their correlation analysis revealed a positive correlation between lateral violence and the deterioration of a nurses' physical health, emotional health, and work performance. Durmus et al. concluded that it was important to reduce nurses' exposure to lateral violence and that the development of workplace policies addressing the behavior were necessary.

Purpora, Blegen, and Stotts (2015) acknowledged that there was a lack of data available regarding lateral violence and its consequences in relation to the quality and safety of patient care. Purpora el al. described the relationships among lateral violence, peer interactions, and the quality and safety of patient care. Purpora et al. reported a positive correlation between lateral violence and errors or adverse events. Thus, Purpora et al. concluded that lateral violence impacted coworkers' relationships and the quality of

patient care and that supportive working relationships were necessary to mitigate the effects of lateral violence on patient care.

Due to the ramifications of lateral violence on nurses and the workplace, additional studies are needed to gain an understanding of this problem and offer effective solutions (Lashinger & Nosko, 2015; Morrison, Lindo, Aiken, & Chin, 2017). My review of the literature indicated a gap regarding nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. Houck and Colbert (2017) noted that the gaps in the literature were associated with the lack of available data regarding lateral violence among nurses and patient safety. This study addresses this literature gap and may provide data that is useful to organizations who face lateral violence. The results of this study may help organizations reduce the effects of lateral violence and prevent its consequences on employees.

The purpose of this qualitative phenomenological study was to explore nurses' who have experienced lateral violence and their perceptions of their ability to provide safe care while being employed in unhealthy work environments. In the following sections, I present the problem statement about unhealthy work environments and their impact on nurses' ability to provide safe patient care, detail how I conducted the study, and describe the significance of the study. Information in this chapter also includes operational definitions, and a discussion of the assumptions, delimitations, and limitations of the study.

Problem Statement

Lateral violence is a significant, persistent, and universal nursing issue that is well-documented in the literature and indicative of an unhealthy work environment (Huddleston & Gray, 2016). Victims of lateral violence often display physical, emotional, and psychological symptoms (Houck & Colbert, 2017). Over time, lateral violence contributes to decreased job satisfaction, poor retention, increased risk for job-related errors, delays in patient care, and poor patient outcomes (Longo & Hain, 2014). Since 2004, the World Health Organization (WHO) has highlighted patient safety as a global healthcare issue. Patient safety is a multifaceted concept, which is mediated by factors such as barriers in communication, collaborative peer relationships, and systemic influences (Kim, DaSilva, Gustafson, Noqueira, & Harlin, & Paul, 2015). Although the threat to patient safety is evident, nurses' perceptions of their abilities to provide safe patient care while experiencing lateral violence has not been well explored.

Hubbard (2014) and Cowin and Eager (2013) noted that the pressure of lateral violence on nurses could lead to errors in patient care that can lead to patient harm or death. Research by Hutchinson and Jackson (2013) and Spence-Laschinger (2014) further demonstrated that workplace mistreatment and lateral violence were associated with poor patient care outcomes. The Joint Commission (2016) reported consequences such as underreporting of safety and quality concerns and increases in harm, errors, infections, and costs.

Numerous qualitative studies exist describing nurses' experiences with lateral violence. Myers et al. (2016) researched nurses from three hospitals in New York State

and their experiences with lateral violence. They found that all of the nurses interviewed

had experienced or witnessed lateral violence, despite working in different hospitals, on

various units, and holding positions that included staff nursing, nursing management, and

nursing education. Myers et al. reported that the most common examples of lateral

violence reported were bullying, pressuring nurses to act a certain way, and back-

stabbing. The most frequent suggestion by nurses to prevent or eliminate lateral violence

was education (Myers et al., 2016).

Johnson (2018) explored 13 nurses' perceptions of lateral violence, and how these

perceptions affected their responses to lateral violence. The themes identified in this

study were that lateral violence was targeted at nurses who were deemed different than

the majority, was used by some nurses as a means to belittle another nurse's job

performance, and was perceived as an unchangeable element in the nursing culture

(Johnson, 2018). The majority of nurses interviewed reported that the only effective

means to resolve issues associated with lateral violence was to leave their workplace by

transferring to another unit or another hospital (Johnson, 2018).

Parizad, Hassankhani, Rahmani, Mohammadi, Lopez, and Cleary (2017)

examined Iranian nurses' experiences of unprofessional behaviors in emergency

departments. The underlying theme of their study was workplace communication and the

two subthemes were unprofessional behavior and stressors in the workplace. They found

that conflict occurred when a lack of cooperation among nurses was present, and it was

exacerbated by the high acuity setting of the emergency department. A lack of

cooperation was described by the participants of the study as unfair blaming, shaming,

and demeaning behaviors. Parishad et al. concluded found that participants identified

teamwork and collaboration as factors necessary to prevent unprofessional behavior in

the workplace.

Mammen, Hills, and Lam (2018) explored the experiences of 8 novice registered

nurses who were previously employed under a graduate nursing program in Australia.

Mammen et al. identified four themes in their study: vulnerability, self-actualization,

changing expectations, and a desire to be respected and supported. Participants in

Mammen et al.'s study expressed optimism when first notified of employment as

graduate nurses, but reported that these feelings were quickly replaced with feelings of

vulnerability, such as discomfort, incompetence, intimidation, and stress. When

encountering lateral violence, the researchers reported that the new graduate nurses

reported feeling belittled and unsafe, and using internal drives and external support to

achieve self-actualization. The researchers further identified that participants reported a

discrepancy between their practice expectations and the reality of working. In that the

concept of lateral violence was understood by the participants, but they did not expect to

actually encounter it in the workplace. Last, Mammen et al. found that all of the

participants believed that the root of lateral violence was a lack of respect, support, and

sharing of information.

Although qualitative studies on nurses' experiences with lateral violence are

available, there is limited research exploring nurses' perceptions of their abilities to

provide safe patient care while working in unhealthy work environments (Houck &

Colbert, 2017). While the influence of lateral violence on patient safety is suggested in

the literature, qualitative research is needed to provide a detailed exploration nurses'

experiences with unhealthy work environments. Further, more data is needed on nurses'

perceptions on how lateral violence impacts their ability to provide safe patient care.

Purpose of the Study

Healthy work environments enable nurses to utilize their knowledge, skills, and

capabilities to meet the needs of patients (Halm, 2019). Health care facilities that

promote healthy work environments offer increased safety and quality of care to patients

and report higher patient satisfaction with nursing care (Halm, 2019). Unhealthy work

environments may lead to workplace distractions and disruptive or violent behaviors,

resulting in a lack of employee satisfaction, retention, productivity, and quality patient

care (American Association of Nurse Anesthetists [AACA], 2018). Lateral violence is

considered a violent behavior that is associated with employees' exposure to unhealthy

work environments (Carpenter & Dawson, 2015). Lateral violence contributes to

medical errors, poor patient satisfaction, and jeopardized safety for nurses and patients

(AACA, 2018, para 4).

The purpose of this qualitative phenomenological study was to explore nurses'

perceptions of their ability to provide safe care in unhealthy work environments, among

those who have experienced lateral violence. Many registered nurses today endure a

hostile working environment, resulting from coworker behavior (Joint Commission,

2016). This behavior may pose as a distraction to victimized nurses and prevent them

from addressing the needs of patients (Wallace & Gipson, 2017). The persistent nature of

lateral violence necessitates the creation of healthy work environments to improve patient

care outcomes and may be achieved by ensuring that policies and procedures addressing lateral violence are present and that they are properly enforced (Ross, 2017). A gap in the literature exists regarding the associations between lateral violence and patient safety (Houck & Colbert, 2017), and this research attempted to gain a better understanding of nurses' experiences with lateral violence and their abilities to provide safe patient care through qualitative means.

Research Question

Research Question 1: Among nurses who have experienced lateral violence, what are nurses' perceptions of their ability to provide safe care in unhealthy work environments?

Conceptual Framework of the Study

Phenomenology is a philosophical method used to study an experience (Smith, Flowers, & Larkin, 2012). Of particular interest is what the experience of human life is to an individual and why different life events or phenomena matter (Smith et al., 2012). Husserl's (1982) view of phenomenology relied of the rejection of objectivity. The ultimate purpose of phenomenology was to describe and analyze human consciousness. Husserl's premise was that the world can be recognized as experiences. These experiences are interpreted by observation of the objects and events that create the experience (Porter & Robinson, 2011, p. 52). Husserl (1982) asserted that the observer should seek a deeper meaning in an experience instead of assessing it at face value. Husserl attempted to go beyond the superficial surface of an experience to find a deeper meaning (Porter & Robinson, 2011).

Theoretical Framework of the Study

Freire's *Pedagogy of the Oppressed* (1970) outlines oppression and liberation. According to Freire, the key to liberation is an increased awareness and thought process of an individual. This occurs when the student can create a partnership with the teacher, facilitating empowerment. Freire stated that the oppressed could save themselves from oppression, but this could only happen when they develop a critical understanding of reality, which would then lead to action being taken. Freire described the psychological and sociological behaviors that are frequently manifested by those who are oppressed and, as a result, are controlled by others perceived to have more power. Henceforth, I will refer to the theory in Freire's book as the theory of pedagogical oppression and empowerment. According to Griffin and Clark (2014), the term lateral violence evolved from the oppression theory and referred to actions that are often described as bullying-type behaviors that the oppressed group exhibit toward each other as a result of being members of a powerless group. Nurses most vulnerable to unhealthy work environments often include those new to the nursing practice, those new to a particular area of practice, transitioning to a new health care environment, and those who float or work per-diem (Griffin & Clark, 2014).

Nature of Study

This study was conducted using a qualitative phenomenological approach. Phenomenology was an appropriate design for this study because researchers can utilize this method to identify a phenomenon through how it is perceived by the individual experiencing it (Matthews, 2006; van Manen, 2014). This is accomplished by collecting

information and perceptions through inductive, qualitative means, such as interviews, discussions and participant observation, and presenting it from the participant's point of view (Matthews, 2006; van Manen, 2014). Phenomenology is also concerned with studying an experience from the perspective of the individual, and avoiding researcher assumptions with the use of bracketing (Husserl, 1982). Phenomenological research is used to answer questions that are considered important (Cohen, Kahn, & Steeves, 2012) and illuminating the meaning imbued in experiences from a nurse's work environment may help to answer the research question regarding nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. Phenomenological qualitative research is an effective method of presenting a new perspective of a phenomenon that has been previously studied, like lateral violence (Cohen et al., 2012).

The research setting included the websites of various nursing organizations and nurse-specific Facebook pages with instructions to contact me via email. Prior to interaction with participants, approval was obtained from the Institutional Review Board Internal Review Board (IRB) at Walden University. Informed consent was obtained prior to the onset of the study.

The target population was registered nurses who had been employed as a staff nurses for at least 1 year, had experienced lateral violence, and had remained in the workplace for at least 6 months after experiencing lateral violence. For this study, I interviewed 13 participants. The sample size of 13 participants is an appropriate number for a qualitative study (Boddy, 2016). Purposive homogenous sampling was used to find

13 nurses who had experienced lateral violence in the workplace and retained their position for at least 6 months afterward. Purposive sampling allows the researcher to select participants who can provide the most detailed information that pertains to the research question (Etikan, Musa, & Alkassim, 2016.

Data collection involved a phenomenological approach to gain a deeper understanding of the lived experiences as described by the participant. I used five semi-structured interview questions in the interview protocol (see Appendix A) as an aid for participants to describe their lived experiences with lateral violence and patient safety. All objective and subjective data was recorded and included my own thoughts and feelings as the research evolved. The participants' texts were analyzed for themes and were coded to appropriately reflect their narratives.

Data interpretation was performed using interpretative phenomenological analysis (IPA). IPA was utilized to discover how a lived experience is interpreted by an individual through deep reflective inquiry (Willig & Rogers, 2017). In IPA, the researcher attempts to bracket predefined assumptions so that data collection can be truly exploratory, without insight from the researcher (Sorsa, Kiikkala, Astedt-Kurki, 2015). Bracketing allows the researcher to understand what is essential to a phenomenon without prejudice (Sorsa et al., 2015). By interpreting data through close engagement with the participant, the researcher will become transformed in some way. IPA was originally developed as a means of research in the field of experiential psychology (Smith, 1996). It has become a means to interpret circumstances in health and social sciences that are complex or produce a strong emotional response (Tuffour, 2017). It can facilitate

qualitative researchers in creating thorough accounts of experiences in lateral violence among nurses and how it has impacted their abilities to perform safe patient care (Tuffour, 2017). Studies of this nature can assist in filling a gap in the literature regarding lateral violence and threats to patient safety.

The interviews were audio recorded to ensure that the participants' words were documented verbatim. Nonverbal data that was observed was recorded immediately, to assist in inductively analyzing the data and to identify themes that may not have emerged in the spoken word (Ross, 2017). Immediate recording also facilitates a more authentic representation of the experiences and reduces researcher bias (Ross, 2017). Handwritten coding for themes were utilized and NVivo was used as a software analysis program.

Definitions

The following terms and definitions were used in this study:

Healthy work environment: A healthy work environment is defined as a workplace supportive of "physical, mental, and social well-being," supporting optimal health and safety (WHO, 2010).

Lateral violence: Lateral violence is defined as "behaviors intended to demean, undermine, and/or belittle a targeted individual working at the same professional level" (Sanner-Stiehr & Ward-Smith (2017, p.1). For the purposes of this study, the terms lateral violence, lateral hostility, bullying, horizontal violence, workplace aggression, incivility, mobbing, and colleague violence were used interchangeably. For simplicity, the term lateral violence was chosen to be used exclusively.

Patient safety: Patient safety is defined as the "absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum" (WHO, 2018, para. 3)

Assumptions

Researchers' assumptions influence the choices that are made in regard to the topic of study, research questions, the study design, and the findings that are reported (Helmich, Boerebach, Arah, & Lingard, 2015). Assumptions regarding theories, study setting, population, sampling, data collection, and analysis infer a focus in a study and accommodate a specific conclusion (Helmich et al., 2015). Researchers must exercise caution because every assumption made increases the potential of eliminating appropriate alternatives (Helmich et al., 2015).

There are several assumptions included in this study. The first assumption is that the participants will share their lived experiences in an honest and clear fashion. A second assumption is that the sample size will be representative of the population of interest. A third assumption is that the researcher will exhibit competency with the research process and the instrumentation used.

Scope and Delimitations

The scope of this study included staff nurses who have worked in unhealthy work environments. Inclusion criteria required that all participants must be 18 years of age or older, are registered nurses who have been employed as a staff nurses for at least 1 year, have experienced lateral violence, and have remained in the workplace for at least 6 months after experiencing lateral violence. Exclusion criteria included less than 1 year of

experience as a registered nurse, not experiencing lateral violence, resigning from the

workplace within 6 months of experiencing lateral violence, and not willing to be

recorded. I obtained informed consent from each participant. The consent form included

a statement informing potential participants that if they do not meet the eligibility

requirements of the study, they will be withdrawn from the research. When the consent

form was completed, the potential participants were screened by the use of a

demographics form (See Appendix D), which included questions regarding years as a

nurse, whether or not lateral violence was experienced, employment status 6 months after

experiencing lateral violence, and willingness to be audiotaped or audio and videotaped.

I informed the participants of the risks and benefits of participating in this study. All

participants agreed to be audio taped only and agreed to have their interviews transcribed

verbatim.

Limitations

Bias is a potential limitation in qualitative research. As a registered nurse who

has witnessed later violence, I had to prevent my own reactions and responses from

resulting in the participants altering their responses. Strategies to prevent my bias as

interviewer included the avoidance of leading questions, notetaking instead of relying

solely on an audio recorder, and providing the participants with an opportunity to clarify

their thoughts (see Alshenqeeti, 2014).

Another possible limitation that could influence this study was transferability.

Transferability is established by providing evidence that the results of a qualitative study

could be applied to other contexts, situations, or populations (Lincoln & Guba, 1985).

The possibility existed that the experiences described by the participants would not be transferable to a larger population of nurses. Thick description is a technique described by Lincoln and Guba (1985), in which the researcher provides an account of the participant's experiences that is detailed and robust. This includes discussing any aspect of data collection that may aid in providing a more complete understanding of the research setting (Lincoln & Guba, 1985, p. 316). This enables the readers of the research to determine the transferability of the study themselves.

Significance

Promoting a healthy work environment is a necessity in health care facilities. The health of a work environment can be determined by staffing and resource adequacy, collaboration and respect among nurses and physicians, supportive and competent leadership, administration's recognition of staff achievements, staff participation in administrative decisions, staff access to education, and the institution's commitment to quality (Swiger, Patrician, Miltner, Raju, Breckinridge-Sproat, & Loan, 2017). Work environments possessing these traits are associated with more positive clinical, patient, and organizational outcomes (Swiger et al., 2017).

Unhealthy work environments are described as stressful, complex, lacking in resources, lacking in respect among workers, lacking in appropriate staffing, and high-pressured interactions (Copanitsanou, Fotos, & Brokalaki, 2017). Unhealthy workplaces are considered unethical in the nursing profession (ANA, 2015). The Code of Ethics for Nurses specifies that nurses are to practice with compassion and respect for the individual characteristics of every person (ANA, 2015). This includes treating colleagues with

dignity and respect and taking action to prevent harm to others to ensure a civil culture (ANA, 2015). Lateral violence reflects a lack of respect among coworkers and can be damaging to nurses and their ability to care for patients (ANA, n.d.).

Lateral violence among nurses is a prevalent issue that contributes to physiologic, emotional, and psychological disturbances among those being victimized (Houck & Colbert, 2017). A lack of job satisfaction, frequent nurse turnover, and an intent to leave the workplace are also associated with lateral violence (Sanner-Stiehr and Ward-Smith, 2017). This behavior is so prevalent in the nursing profession that the American Nursing Association (2015) released a position statement regarding lateral violence, which stated that no element of violence would be tolerated, workplaces should create a culture of respect, and evidence-based strategies to prevent and mitigate bullying and lateral violence must be implemented in workplaces.

While there is an abundance of literature available regarding the effects of lateral violence on nurses, a gap in the literature exists regarding specific associations between lateral violence and patient safety outcomes. Details regarding how lateral violence as an aspect in a nurse's work environment impacts patient safety remains unclear (Houck & Colbert, 2016). Findings can be used to improve patient safety through early identification of lateral violence. Clarifying nurses' perceptions may provide enlightening details to administrators and nurse managers that can be a force that leads to a higher quality of patient care, as they evaluate opportunities to create safe working environments for registered nurses and to avoid harm to patients.

Summary

In Chapter 1, I provided an introduction to this qualitative phenomenological research study on nurses' perceptions of their ability to provide safe care in unhealthy work environments among those who have experienced lateral violence. Lateral violence is a form of abuse among nurses that has impacted nurses physically and emotionally. Despite efforts to eliminate the behavior, it remains a prevalent issue. While research is available describing the behavior and its effects on nurses and organizations, a gap in the literature remains regarding nurses' perceptions of their abilities to provide safe patient care after experiencing lateral violence. Nurses play a vital role in preventing patient errors and advocating for safe patient care, making further research to fill this gap in the literature vital. I used phenomenology as a conceptual framework and Freire's theory of pedagogical oppression and empowerment as the theoretical framework. I provide an exhaustive literature review in Chapter 2, specifying what is currently known about lateral violence.

Chapter 2: Literature Review

Introduction

Fostering a safe environment in healthcare settings encourages comprehensive, safe, and thorough care (Huddleson & Gray, 2016). The American Association of Critical Care Nurses (2018) has identified six standards to facilitate a healthy working environment. These standards include skilled communication among colleagues; true collaboration among colleagues; effective decision-making regarding policies, clinical care, and leadership; appropriate staffing; meaningful recognition of the values that colleagues possess; and authentic leadership. Characteristics of an unhealthy working environment include abusive behavior, disrespect, lack of trust, rigidity to change, poor communication and weak leadership with no vision (Huddleston and Gray 2016). Lateral violence in the workplace is a strong indicator of an unhealthy work environment and influences the performance of nurses (Huddleson & Gray, 2016; Rainford, Wood, McMullen, & Philipsen, 2015, The Joint Commission, 2008).

The phenomenon of lateral violence is frequently reported and has been present in nursing literature for over 30 years. Meissner (1986) described the phenomenon of nurses "eating their young," (p. 1) in which nurse educators assigned nursing students overwhelming amounts of studying and written assignments. The abuse continued as these students became novice nurses and nursing administrators and colleagues presented them with unrealistic expectations, which resulted in frustration, burnout, and resignation from the workplace (Meissner, 1986). As lateral violence remained a persistent, prevailing issue among nurses, the need to develop interventions to prevent or address

lateral violence became evident (Tricco et al., 2018). In 2004, Griffin conducted a study

in which newly graduated nurses were educated on lateral violence and the use of

cognitive rehearsal techniques. Overall, the retention rate among these nurses increased

and their cognitive strategies were reported to be effective in providing the empowerment

needed to confront the offending nurses (Griffin). Since 2004, several researchers have

also utilized cognitive rehearsal in studies and concluded that it was an effective

intervention in addressing lateral violence (Balevre, Balevre, & Chesire, 2018; Clark,

Ahten, & Macy, 2013; Embree, Bruner, & White, 2013; Stagg, Sheridan, Jones, &

Speroni, 2013).

Despite the reported effectiveness of cognitive rehearsal strategies, lateral

violence remains a significant problem among nurses (Wolf et al., 2017). In a literature

review conducted by Bambi et al. (2018a), the overall percentage of lateral violence

among nurses was reported to be between 67.5% and 90.4%. Nurses' experiences with

lateral violence can produce negative effects (Yun & Kang, 2018) and may include

physiological and psychological symptoms such as headaches, fatigue, indigestion,

disturbances in sleep, anger, anxiety, and depression (Hutchinson, Wilkes, Jackson, &

Vickers, 2010; Spence-Laschinger, & Nosko, 2015). Victims of lateral violence often

experience high levels of stress, burnout, and a lack of commitment to the workplace

(Giorgi, Mancuso, Perez, D'Antonio, Mucci, Cupelli, Arcangeli, 2016; Houck & Colbert,

2017).

Lateral violence also contributes to a decline in effective health care by creating

an unsafe working environment, in which the abused nurses develop avoidant behaviors

to cope with the physiological and psychological symptoms experienced (Rainford et al., 2015). Avoidant behaviors may include resignation from a position, sick leave, tardiness, substance abuse, excessive excuses for being absent, or leaving the profession (Zia-ud-Din, Arif, & Shabbir, 2017). When nurses leave their employment because of lateral violence, it may result in increased workloads and contribute to diminished morale among the remaining nurses, thus perpetuating the cycle of lateral violence (Rainford et al., 2015). Research by Purpora, Blegen, and Stotts (2015) supported the hypothesis that increases in lateral violence decreased the quality of patient care and increased errors and adverse events among patients. While there is an expanding body of research correlating negative workplace behaviors with the quality and safety of patient care, it is unclear exactly how the work environment effects patient safety (Houck & Colbert, 2017). In this phenomenological study, I will interview nurses who are willing to share their lived experiences of their abilities to provide safe patient care while experiencing lateral violence.

In this chapter, I explain my literature search strategy, including the search engines and data bases utilized for data and the search terms and processes used. I review Husserl's (1927) phenomenology, the conceptual framework used in the study, and Freire's theory of pedagogical oppression and empowerment, the theoretical framework used in the study, and how both relate to my research. I then provide an exhaustive literature review of current research on lateral violence, including healthy work environments, the history of lateral violence, contributing factors, consequences of lateral violence on the nurse, the workplace, and the patient, and strategies to prevent

lateral violence. Finally, I provide a summary of the chapter and provide justification for the study.

Literature Search Strategy

Data collection was performed by an electronic search on the databases CINAHL (Cumulative Index to Nursing & Allied Health Literature), PsychINFO, Cochrane, and Ovid, and the search engine Google Scholar between 2010 and 2018. A search of position statements by the American Nurses Association was also done. Various search strategies were used to find relationships between the following words: *nursing* AND *healthy work environments* OR *unhealthy work environments nursing* AND *lateral violence,* OR *lateral hostility*, OR *bullying*, OR *horizontal violence*, OR *workplace aggression*, OR *incivility*, OR *mobbing*, OR *colleague violence,* and *patient safety*, OR *safety outcomes*, OR *medical errors*. The search was limited to the English language.

Conceptual Framework

Husserl's Phenomenology

Husserl proposed that lived experiences should take a higher priority over the world as it actually exists (Porter & Robinson, 2011). Husserl's (1927) view of phenomenology rejected objectivity, and relied on describing and analyzing human consciousness. Husserl's (1927) premise was that the world, as humans know it, is identified in experiences, even though access to scientific procedures are available. He further proposed that humans do not interpret experiences independently, but consider objects and events that comprise the experience (Porter & Robinson, 2011). Husserl's investigations attempted to go beyond the superficial surface of an experience to find a

deeper meaning (Porter & Robinson, 2011). To accomplish this, Husserl proposed two methods (Porter & Robinson, 2011). The first method involved describing a phenomenon as it is immediately interpreted and bracketing the experience to allow for authentic knowledge of the world, through epochē reduction. The bracketing procedure in epochē reduction allows one to concentrate on meanings present in the mind and set aside beliefs, assumptions, and commitments. The second method is known as the eidetic reduction, in which a direct description of objects and meanings is provided. The relationship between consciousness and ideal objects can then be exposed (Porter & Robinson, 2011).

Theoretical Framework

Freire's Theory of Pedagogical Oppression and Empowerment

Freire's (1970) perspective of education involved the traditional belief that the teacher, in the role of the oppressor, maintained control and power, while the student, in the role of the oppressed, was the passive follower. The student was considered an empty vessel that the teacher could fill with his or her own knowledge (Freire, 1970). The oppressed student was only able to end the cycle of oppression by understanding the environment in which he or she living and observe the world independently of the oppressor (Freire, 1970). Freire believed that education was the impetus for change and empowerment. In Freire's view, liberation could be obtained by the development of critical thinking skills and the collaboration between the teacher and the learner.

The oppressed.

The oppressed are the central figures in Freire's work (Freire, 1970). Freire believed that oppression is a self-sustaining behavior because the oppressed is immersed in situations that support the belief that oppression cannot be overcome. The oppressors manipulate the oppressed into believing that they are unable to think for themselves. The only way that the oppressed can break this cycle of thought is to learn how to think independently.

The oppressors.

According to Freire (1970), the oppressors view the oppressed as objects, not humans, and implement educational programs that foster division and discourage the oppressed from learning techniques that promote independent thinking. The oppressors search for means of empowering themselves and rendering the oppressed helpless. Freire viewed the oppressors as a group of people who aimed to take advantage of the oppressed.

Oppression.

Oppression is a state of society in which the oppressed become engulfed in a system that prevents them from advancing socially or professionally and prevents free will (Freire, 1970). It is a violent act perpetrated by the oppressor, who convince the oppressed that they are unable to think or act independent of them. As a result, the oppressed believe that oppression is a result of their own actions and are responsible for the abuse that they endure. One of Freire's goals was to enable the oppressed to understand the true cause of oppression and rally against it.

Oppression and lateral violence.

In a literature review, Roberts (2015) noted that Freire's (1970) theory was the most commonly cited theoretical explanation for lateral violence. Powerlessness and fear were reported as the basis for a cycle in which aggression is turned inward toward one's own group instead of the more powerful perpetrators. Aggression prevented the weaker group from establishing a sense of unity or cohesiveness that was necessary to gain power (Freire, 1970). Blackstock, Salami, and Cummings (2018) acknowledged that Freire's (1970) theory supported the idea that lateral violence related to oppression was a result of a lack of recognition and value. To counter this, Blackstock et al. (2018) recommended advocacy by nurse managers to reduce or eliminate power inequalities that render registered nurses powerless and oppressed. This advocacy was seen as a possibility to facilitate a new understanding of lateral violence and the creation of effective anti-lateral violence policies.

Lateral violence is posited to be a consequence of oppression that results from behaviors demonstrated that undermine and disempower those who are perceived to be weaker (Freire, 1970). Research by Longo, Cassidy, and Sherman (2016) studied charge nurses and their experiences with lateral violence and utilized Freire's (1970) theory as a theoretical framework. The authors concluded that charge nurses, who carry more responsibility than staff nurses, experience lateral violence similar to staff nurses. Insulting behaviors, withholding information, and criticism resulted in a low self-worth, all resulting in a lack of empowerment for charge nurses. Longo et al., (2016) suggested that the need for empowerment for charge nurses was necessary to properly address

lateral violence and may be accomplished if nurse managers demonstrated support and respect for the charge nurses.

Oppressed groups often cope with their own frustrations by directing acts of hostility towards each other (Freire, 1970). Purpora et al. (2015), utilized Freire's (1970) theoretical framework in their study to demonstrate that nurses who experienced lateral violence perceived work relationships as poor, quality of patient care to be lacking, and a higher likelihood of errors and adverse events in the workplace. The results provided evidence to support Freire's theory for this study that lateral violence negatively impacts peer relationships. To moderate this effect, nurses need to acknowledge that lateral violence is present in their workplace and impacts the health of nurses and patients. Once determined, a focus on fostering supportive peer relationships should be developed. Supportive peer relationships may prevent nurses from directing their frustrations towards each other and provide camaraderie necessary to remain productive.

Using Freire's (1970) theoretical framework, Morrison et al. (2017) explored lateral violence among nurses at a Jamaican hospital. Morrison et al. (2017) noted that in Freire's (1970) theory, the oppressor achieves control by humiliating colleagues and that the oppressed eventually begins to imitate the oppressors. In this mixed methods research, lateral violence was found to be a pervasive occurrence and that the victims often accepted the abuse as a rite of passage, became disengaged at work, observed that team work was minimal or nonexistent, did not communicate with peers, and often used excuses to not go to work (Morrison et al., 2017). The authors concluded that a workplace environment that facilitated oppression among its workers contributed to the

erosion of professionalism among nurses and recommended interventions that increased productivity, improved the quality of patient care, and minimized resignation from the workplace.

Nemeth, Stanley, Martin, Mueller, Layne, and Wallston (2017) noted that nurses have frequently utilized Freire's theory of pedagogical oppression and empowerment to explain lateral violence among nurses. This theory contributed to the creation of the Lateral Violence in Nursing Survey (LVNS), a tool formulated for nurse researchers to evaluate the prevalence, severity and causes of lateral violence in various healthcare settings. The purpose of this research was to identify the psychometric qualities of LVNS inquiries to determine the reliability and validity of the survey for utilization within large teaching hospitals. Nemeth et al. (2017) concluded that use of this tool may be effective among nurse managers who were attempting to develop a more positive workplace environment and establish zero-tolerance policies for lateral violence.

Members of oppressed groups often direct their frustrations at each other because they are unable to directly address those who have created the conflict (Freire, 1970). Research by Kaiser (2017) aimed to examine the impact of leadership styles on the rate of lateral violence among nurses and noted that the oppression theory is a factor that influences lateral violence. The author concluded that although leadership styles did not specifically influence incidences of lateral violence, the behaviors of nurse managers impacted the level of lateral violence between staff nurses. Lateral violence was most strongly influenced by the relationship between management and nursing staff and the level of staff empowerment experienced by nursing staff.

Literature Review

Healthy Work Environments

Healthy work environments enable nurses to maintain the mission and values of an organization and demonstrate personal satisfaction from their work (Kieft, deBrouwer, Francke, & Delnoij, 2014). Healthy work environments for nurses are characterized by strong professional relationships among colleagues, a supportive management style, a work schedule that is balanced and fair, an appropriate match between a nurse's responsibilities and his or her skill level, appropriate timing to meet patients' needs, professional autonomy, adequate resources, and opportunities for professional advancement (Copanitsanou et al., 2017). A healthy work environment fosters a climate in which nurses are encouraged to use their skills and clinical knowledge to provide quality patient care (Huddleston & Gray, 2016). The benefits of healthy work environments include increased nurse satisfaction, increased recruitment and retention of nursing staff, decreased stress levels, and better health outcomes for nurses (Copanitsanou et al., 2017).

Unhealthy work environments lack strong leadership, values, and a drive for change (Huddleston & Gray, 2016). Unhealthy work environments are workplaces in which nurses feel stressed, abused and disrespected, fearful of reporting grievances, and feel hopeless for positive change (Huddleston & Gray, 2016). Incidences of lateral violence are indicative of an unhealthy work environment (Armmer, 2017). Wolf, Perhats, Delao, and Clark (2017) performed qualitative research to describe the experiences of emergency department nurses regarding their sources of work-related

stress and its effects on patient care, work performance, and personal life. Wolf et al. reported that the nurses described work stresses as unfair and physically and emotionally overwhelming. Overworked staff and competitive nursing led to lateral violence, which increased stress and an intent to leave the workplace (Wolf et al., 2017).

DeCieri, Sheehan, Donohue, Shea, & Cooper (2019) examined characteristics of work environments that were associated with lateral violence among nurses in Australia. DeCieri et al. reported that nurses had a higher likelihood of experiencing lateral violence in public hospitals. DeCieri et al. suggested that the intensity of nursing care required by patients contributed to incidences of lateral violence. The lack of organizational structure and power dynamics that resulted from poor leadership in public hospitals also contributed to the likelihood of nurses experiencing lateral violence (DeCieri et al., 2019).

Olsen, Bjaalid, and Mikkelsen (2017) studied lateral violence and its relation to work environments and different consequences among nurses from 4 Norwegian hospitals. Olsen et al. reported that colleague support and mentorship decreased the likelihood of lateral violence and increased the level of job performance, job satisfaction, and work ability. Increased job demands and institutional stress increased the likelihood of experiencing lateral violence (Olsen et al., 2017). Olsen et al. suggested that high levels of work-related conflicts interfere with the ability to appropriately perform patient care and lead to higher degrees of stress and long-term sick leave.

History of Lateral Violence

Anecdotal evidence suggested that lateral violence was acknowledged as a hindrance for nurses as early as 1909. In an article in the New York Times (Anonymous, 1909, SM8), the author described incidences in which head nurses abused and humiliated their staff nurses by belittling them in front of doctors, providing little, if any, rest time or break time, and criticizing their actions, even if performed correctly. The author described the head nurses as tyrants who were often less educated than the staff nurses they abused and suggested that their actions could endanger the lives of patients. Staff nurses who dared to confront the charge nurse or complain to others about their workplace situations risked termination of their employment. The author suggested minimizing the charge nurses' authority by transferring power to boards of directors.

Kohnke (1981) believed that the dynamics of lateral violence among nurses were similar to the generation-to-generation cycle of child abuse. The parent-child relationship was often influenced by the way the parents themselves were cared for as children. Similarly, seasoned nurses were unwilling to offer aid to novice nurses because nobody helped them when they lacked experience. Kohnke (1981) believed that seasoned nurses projected their own frustrations and insecurities on novice nurses because they were not in a position to defend themselves. The more abusive the hierarchy was to its staff, the higher the risks that patients would be affected by these negative workplace actions. Kohnke (1981) suggested that lateral violence remained persistent because is became accepted as a professional norm and was carried out without punishment.

Research related to lateral violence was introduced by Leymann (1990), a German industrial psychologist who described workplace hostilities by workers towards individuals or groups in factories. According to Leymann (1990), the hostile exchanges could persist for years, and could have been halted by management if there was a desire to do so. The victims are abused until there is a loss of all coping mechanisms. Leymann (1990) describes four critical incident phases related to workplace hostilities. In the original critical incident, a work-related conflict occurs and disapproval for the victim is established. The second phase involves actions against the victim that are intended to destroy his or her reputation, limit his or her ability to communicate effectively with others, isolate him or her from others, and prevent him or her from being assigned meaningful work. The victim also experiences violence or threats of violence. The third phase involves the involvement of management. During this phase, management often sides against the victim and determines that the abuse is a result of the victim's own personality and work performance deficits. The final phase involves the victim's reassignment to degrading work tasks, long-term sick leave, the victim remaining employed but not assigned work tasks, or expulsion from work. Leymann (1990) reported psychological, social, and physical effects associated with hostile work environments, including depression, helplessness, rage, social isolation, stigmatizing, social maladjustment, and suicide.

Literature regarding lateral violence began to increase. Freshwater (2000) acknowledged that reports of lateral violence among nurses were increasing and lateral violence was finally identified as a concept in nursing. Quine (2001) reported that 50%

of nurses studied experienced lateral violence, and 25% of those nurses described feelings of depression, feeling unwanted or devalued, and difficulties sleeping. Almost 80% of nurses who experienced lateral violence reported that their complaints of lateral violence remained unresolved by administration. Research by McKenna, Smith, Poole, and Coverdale (2003) demonstrated that lateral violence was a common experience for nurses, especially in their first year of employment. McKenna et al. (2003) noted that nurses were unprepared for the psychological abuse that they experienced and were often unable to cope with the consequences of the abuse, resulting in underreporting of such incidences to nursing management. Recommendations for the creation of primary prevention programs, appropriate reporting mechanisms, and supportive services resulted from this study.

The Joint Commission (2008) identified lateral violence as a behavior that undermined the culture of safety in healthcare facilities. A root cause identified as a precursor to lateral violence was a history of tolerance and indifference to intimidating and offensive behaviors. The Joint Commission (2008, para. 5) noted that organizations indirectly condoned lateral violence by failing to address it through formal systems. Victims were often reported to be those who lacked interpersonal skills or coping mechanisms, and were unable to appropriately address conflict (The Joint Commission, 2008, para. 5). The Joint Commission (2008, para. 8) required a code of conduct and a process for addressing incidents of lateral violence. Suggested actions to combat lateral violence included staff education, accountability, skills-based training, reporting and

surveillance systems, and non-confrontational interventional strategies (The Joint Commission, 2008, para. 9).

In response to the growing evidence that lateral violence was commonplace in the nursing profession, the American Nurses Association (2015) released a position statement stressing the moral, legal, and ethical responsibilities of nurses, employers, and educators to maintain a safe workplace. The American Nurses Association (2015) recommended the use of evidence-based strategies to prevent lateral violence. These strategies were classified as primary, secondary, and tertiary prevention methods. Primary methods included strengthening of interpersonal and intrapersonal relationships among staff and coworkers. Nurses were provided with recommendations to develop clear communication skills, become knowledgeable about their facilities' anti-violence policies, develop established code words to use when there is a threat of violence, and to collaborate with others to advocate for a violence-free workplace. Other primary recommendations for employers included developing a clear mission plan that includes a culture of respect and safety and the development of orientation programs for new employees that stress the mission plan. Employees should also develop programs to support nurses who experience lateral violence. Secondary prevention methods to reduce the negative impact of lateral violence for nurses included responding directly to their perpetrator or reporting incidents of lateral violence to the appropriate resource. Secondary prevention methods for employers included utilizing empirical measures to assess episodes of lateral violence and developing actions plans to address them. Employers were also provided recommendations to provide stress-reduction and anti-

fatigue techniques to employees. Tertiary prevention techniques to reduce the

consequences of lateral violence for nurses included participation in post-incident

meetings and utilizing counseling services. Tertiary prevention techniques for employers

included improvement of anti-violence programs, support for nurses who have

experienced lateral violence and conducting root-cause analyses after events occur.

Despite these recommendations, lateral violence continued to remain a presence

in the nursing profession. Lateral violence has been found to have a prevalence of up to

87% (Bambi et al., 2018a). In a cross-hospital exploration of nurses' experiences with

lateral violence, Myers et al. (2016) reported that, despite working in different healthcare

settings, nurses described similar experiences with lateral violence. These experiences

included gossip, lying, backstabbing, denial of vacation time, sharing personal

information, unrealistic expectations of novice nurses, disrespect in front of others,

criticism, and deliberately not assisting nurses in need. Nurses desired a change in the

culture of violence and requested tactics to reduce lateral violence in their workplaces.

Bambi et al. (2018b) reported the presence of lateral violence among nurses in all health

care settings that were studied. Nurses who experienced lateral violence were more

likely to report a desire to leave the profession, to request a transfer to another unit, or to

leave their place of employment and more than half of the participants in the study that

reported lateral violence reported anxiety, reduced commitment to the organization, and

sleep disorders.

Contributing Factors

Organizational culture.

One of the most influential organizational factors related to lateral violence is the nursing organizational culture (An & Kang, 2016). Organizational culture refers to the values, cultures, norms, and beliefs of the members of an organization. Organizational culture can be further classified as hierarchy-oriented, innovation-oriented, task-oriented, or relation-oriented culture (Pilch & Turska, 2015; Yun & Kang, 2014). Pilch and Turska (2015) described hierarchy-oriented culture as one in which a high degree of control and rivalry is present. Innovation-oriented culture is characterized by flexibility and a desire to make change (Yun & Kang, 2014). Task-oriented culture focuses on the productivity of the organization (Yun & Kang, 2014). Relation-oriented culture is characterized by mutual trust and respect of coworkers and may be the most moderating factor for lateral violence among nurses (Yun & Kang, 2014).

Organizational cultures that encourage motivation by use of aggressive behaviors such as rudeness or incivility indirectly support lateral violence (Pilch & Turska, 2015). A study by An and Kang (2016) demonstrated a higher prevalence of lateral violence among hierarchy-oriented organizational cultures. Nurses working in a hierarchy-oriented organization are often viewed as less important than physicians and devalued in the workplace, leading to self-defeating behaviors (Rainford, Wood, McMullen, & Philipsen, 2015; Adriaenssens, De Gucht, & Maes, 2015).

A healthcare facility utilizing a relation-oriented culture relies on employee safety and an environment in which colleagues are supportive and trustworthy (Dupree, 2016).

A culture of safety provides nurses with the freedom to openly communicate and provide patient care within a civil working environment. Maintaining positive work environments, providing effective interdisciplinary teams, and effective resolutions of disruptive behaviors are necessary in healthcare settings (Pfeifer & Vessey, 2017).

Leadership style.

Research on leadership styles have identified a laissez-faire leadership style as a powerful influence in the prevalence of lateral violence (Nielsen, 2013; Aasland, Skogstad, Notelaers, Nielsen, & Einarsen, 2010). According to Tsuno & Kawakami (2015), laissez-faire is a passive, avoidant leadership style, in which managers are present in the workplace, but fail to uphold their managerial responsibilities. Negative consequences among employees, such as increased role stress, interpersonal conflicts, emotional exhaustion, reduced job satisfaction, and health problems, have been associated with laissez-faire leadership styles (Skogstad, Nielson, & Einarsen, 2017). A manager may fail to make critical decisions or fail to provide feedback to employees, leading to employee frustration and conflict. Avoidance of conflict in the workplace by management may convey the message that lateral violence is condoned, thus perpetrating the behavior. The perpetrator may escalate conflicts by partaking in more openly aggressive behaviors because of the belief that there will be no repercussions (Agnotnes, Einarsen, Hetland, & Skogstad, 2018).

Working conditions.

Working conditions refer to job tasks, team work, expectations about career growth, and motivation, all of which may be contributing factors to lateral violence

(Blackstock et al., 2018). Giorgi et al. (2016) suggested that poor organizational climate, including negative leadership, a lack of support, minimal job involvement, a lack of autonomy, and negative communication are all antecedents of lateral violence. Boeteng and Adams (2016) concluded that a high workload created pressure for nurses and conflict arose when work could not be completed and was left for nurses working the next shift. Conflict also arose when peers focused on their own workload and failed to provide assistance to other nurses in need. Hamblin, Essenmacher, Ager, Upfal, Luborsky, Russell and Arnetz (2015) identified patient assignments, limited resources, and high workload as contributing factors to lateral violence. Patient assignments involved conflicts between nurses over patients assigned to a nurse for a shift, escalating to lateral violence. Limited resources contributed to lateral violence as a result of competition among nurses for equipment or other materials necessary to provide care. High workload refers to lateral violence resulting from an overabundance of work demands, combined with low resources or limited time. Yokoyama, Yamamoto-Mitani, Suzuki, Takai, Igarashi, Noguchi-Watanabe (2016) noted that staff shortage was associated with lateral violence, which may lead to staff turnover, thus worsening staff shortages and leading to increases in lateral violence. Yokoyama et al. (2016) also suggested that a work culture that does not permit personal days diminished nurses' lack of opportunities to request days off from work for sick or personal reasons, also contributing to lateral violence.

Consequences of Lateral Violence

    The victim.

Lateral violence may affect the psychological wellbeing and behaviorism of nurses. Nurses who have experienced lateral violence often suffer from negative effects related to their mental health (Vignoli, Guglielmi, Balducci, &, Bonfiglioli, 2015; Wright & Khatri, 2015). Common psychological symptoms resulting from lateral violence include loss of self-confidence, rage, guilty feelings, anxiety, depression, and post-traumatic stress disorder (Bardakçı & Günüşen, 2016; Lashinger & Nosko, 2015). Research by Chirila and Duffy (2016) suggested that the negative effects of lateral violence may result in anger, reexperiencing the moment of violence in a recurrent manner, repeated nightmares, distressing thoughts, and flashbacks. Bambi et al. (2018) reported psychological symptoms associated with lateral violence to be anxiety, insomnia, restlessness, failure, emotional exhaustion, distrust, and impaired concentration. Irritability, aggressiveness, an inability to relax, excessively double-checking work, increased use of tobacco, and isolation were noted to be behavioral changes associated with lateral violence (Bambi, et al.,2018b). Research by Durmus, Topcu, and Yildirim (2018) noted that seven percent of nurses who experienced lateral violence reported suicidal ideation as a means to escape the behavior.

Lateral violence also affects the physical well-being of the nurses being victimized. Durmus et al. (2018) reported the physical complaints of nurses experiencing lateral violence as stress, fatigue, headaches, and gastrointestinal complaints. Bambi et

al. (2018b) reported the following physical symptoms associated with victimization from lateral violence: sleep disturbances, fatigue, exhaustion, gastrointestinal disorders, headaches, muscular tension, sensation of difficulty breathing, chest pain, and palpitations. Eriksen, Høgh, and Hansen (2016) reported that victims of lateral violence reported worse self-rated health than those who did not experience lateral violence and female nurses who experienced lateral violence were more likely to use antidepressants as compared to female nurses who did not experience lateral violence. Da Silva Joao and Saldanha Portelada (2016) reported a positive correlation between stomach upset, decreased appetite, overeating, and headaches with lateral violence.

The workplace.

The effects of lateral violence may have a profound impact on the workplace as well. Houck and Colbert (2017) and Verkuil, Atasayi, and Molendijk (2015) reported that lateral violence was associated with work dissatisfaction, increased staff turnover, an intent to leave, and a risk of diminished safety outcomes. Ramacciati, Ceccagnoli, Addey, Lumini, and Rasero (2017) and Bambi et al. (2014) reported that the turnover intention and the desire to leave the nursing profession were positively related to lateral violence. Zia-ud-Din et al. (2017) identified a significant relationship between lateral violence and employee absenteeism. The authors also suggested that a lack of organizational commitment, resulting from lateral violence, also contributed to employee absenteeism. Lateral violence has the potential to create a hostile working environment (Morrison et al., 2017), resulting in behaviors such as professional disengagement, retaliation, avoidance, and intent to resign.

The patient.

Lateral violence has been identified as a mediating factor for negative patient outcomes (Oh, Uhm, & Yoon, 2016). Nurses who experience lateral violence have reported an increased frequency in adverse patient events (Purpura, et al., 2015). According to Zhang et al. (2014), lateral violence is associated with job satisfaction and intent to leave. Increased job turnover rates increased the organizational burden and decreased nursing care continuity, resulting in a decline in patient care. (Oh et al., 2016) noted that nurses who intended to leave their workplace because of lateral violence had higher rates of dissatisfaction and burnout, increasing the likelihood of threats to patient safety. Houck and Colbert (2017) identified a positive relationship between lateral violence and patient falls, errors in treatment or medication administration, delayed care, adverse events, and patient mortality. Lateral violence also contributed to altered thinking, which may affect decision making, assessments, and reactions that may alter the ability to provide safe patient care (Houck and Colbert, 2017). Najafi, Khoshknab, Ahmadi, Dalvandi, and Rahgozar (2018) identified inhibitions to communication as a consequence of lateral violence that impacted patient safety. Nurses who are victims of lateral violence may feel intimidated by the perpetrators and avoid seeking clarification, use silence, or avoid communication, posing a threat to patient safety.

Strategies to Prevent Lateral Violence

Lateral violence includes behaviors such backstabbing, bullying, failing to respect the privacy of others, infighting, using innuendo, ostracizing, sabotaging others' abilities to be successful, verbal affronts, and withholding information (Coursey, Rodriguez,

Dieckmann, & Austin, 2013). These behaviors have become commonplace and detrimental to the health of nurses who are exposed to the behavior (Olender, 2017), rendering it necessary to develop strategies to prevent, address, and eliminate its occurrence. In 2008, the Joint Commission advised all healthcare facilities to develop policies and procedures to address lateral violence, prompting a necessity to identify effective means to prevent or eliminate its occurrence.

Cognitive rehearsal.

Cognitive rehearsal techniques have been utilized to change human behavior by introducing responses or instructions directing an individual on how to address specific situations (Griffin & Clark, 2014). Griffin (2004) utilized cognitive rehearsal to develop an intervention for 26 newly-hired nurses that including a class on lateral violence and the development cue cards that contained appropriate responses for behaviors associated with lateral violence, such as nonverbal innuendo, verbal affront, undermining actions, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences. The newly-hired nurses were encouraged to address episodes of lateral violence with the responses on the cue cards. One year following the intervention, a videotaped focus group was conducted with the nurses. 96% had witnessed lateral violence, and 46% reported that the lateral violence was directed towards them. All of the nurses addressed the perpetrators, used the information on the cue cards as a guide, and reported that the lateral violence stopped once the perpetrator was confronted. Although Griffin and Clark noted that the intervention may have increased awareness of lateral violence among nurses, the study was limited by its

small sample size. It is also unclear as to whether the cognitive rehearsal technique itself was important, or the study simply provided knowledge of lateral violence to the participants.

Strategies involving cognitive rehearsal have been replicated since 2004 with similar results. To prevent lateral violence and promote respect among coworkers, Ceravalo, Schwartz, Foltz-Ramos, and Castner (2012) developed workshops for nurses in a Northeast hospital system to be implemented over a three-year period. The workshops were designed to increase assertiveness in nurses experiencing lateral violence, through communication and conflict resolution. Memory aides and acronyms were created to assist nurses in standardizing their communication with other, thus encouraging nurses to speak up instead of remaining silent, and encouraging effective communication, instead of behaviors associated with lateral violence. After completion of the workshop, verbal abuse between nurses decreased from 90% to 76% and nurses reported feeling more capable of addressing perpetrators of lateral violence. Nursing turnover and vacancy rates in the hospital system also decreased during the three-year period.

This study validated prior studies describing lateral violence as a pervasive behavior among nurses and that verbal abuse was experienced in 90% of the nursing population (Ceravalo et al., 2012). This study was limited by 3 factors. Compared to pre-hospital surveys in this study, the post-surveys had a lower response rate, a single hospital system was assessed in this study, and the possibility existed that turnover rates were influenced by factors other than lateral violence.

Kile, Eaton, deValpine, and Gilbert (2018) developed an intervention to increase recognition of lateral violence and how to properly confront perpetrators using cognitive rehearsal. The participants, nurses from a hospital in Virginia, completed a lateral violence seminar and then engaged in role-play. Prior to engaging in the intervention and following the intervention, the nurses were asked how they handled incidents of lateral violence and how lateral violence affected their job satisfaction. Kile et al. reported that, after the intervention, the participants were better able to recognize lateral violence and confront it. The participants also reported a decrease in lateral violence over time. The results of this study supported prior studies that suggested the effectiveness of education and cognitive rehearsal to address lateral violence (Kile et al., 2018). This study was limited by its small sample size of 17 participants and the possibility that social desirability bias influenced participants' responses.

Conflict management.

Leon-Perez, Notelaers, and Leon-Rubio (2016) assessed the effectiveness of a conflict management skills training intervention that focused on interpersonal skills, such as emotional regulation, interpersonal communication and assertiveness, and problem-solving skills among co-workers in a healthcare facility. Each participant received eight training sessions, in which conflict resolution was taught by discussing and role-playing different ways that episodes of lateral violence could be addressed. A session was held two months after the intervention to assess the difficulties encountered when applying conflict resolution skills. Participants reported that the training reduced incidents of conflicts with coworkers (Leon-Perez et al., 2016). Rates of absenteeism and the request

for third party interventions to mediate work conflicts also decreased (Leon-Perez et al., 2016). This study addressed the impact of conflict management training in health care settings and addressed a gap in the literature, as Leon-Perez et al. reported that little research had been done to explore the impact of conflict management training. This study was limited in that participants' prior experiences and skills associated with conflict management were not addressed prior to the onset of the study.

Pines, Cook, Norgan, Canchola, Richardson, and Jones (2014) developed a two-semester pilot project using simulated experiences to educate nursing students on managing lateral violence when they entered the workplace. The pilot project used various scenarios for learning resiliency, empowerment, and personal styles of conflict management, based upon curriculum from the PENN Resiliency Program and TeamSTEPPS. Although Pines et al. (2014) noted there were no significant changes in the subjects' perceived empowerment and stress resiliency after training, they suggested that conflict management skills may be beneficial to prepare students for the challenges of lateral violence in healthcare settings.

The climate for conflict management refers to the employees' assessments of how fair and predicable an organization's conflict management procedures are (Rivlin, 2001). Einarsen, Skogstad, Rørvik, Lande, and Nielsen (2018) examined the relationship between the climate for conflict management and rate of lateral violence and level of work engagement, and whether the climate for conflict management was a moderator of lateral violence. Einarsen et al. reported that a climate for conflict management was related to fewer reports of lateral violence and that the climate for conflict management

moderated the relationship between lateral violence and work engagement. Einarsen et al. suggested that their findings demonstrated that organizational measures may prevent lateral violence and affect how employees react when encountering lateral violence. Managers may contribute to lower incidences of lateral violence by focusing on addressing the behavior through fair and effective means (Einarsen et al.). Einarsen et al. noted that there is little known regarding preventative factors for lateral violence and this study attempted to fill this gap in the literature. A limitation in this study was that causal conclusions could not be reached from this study and it could not be determined whether dissatisfaction in the workplace led to lateral violence, or if lateral violence led to dissatisfaction in the workplace.

Problem-based learning.

Problem-based learning is a teaching method that is commonly used with nursing students due to its applicability of real-life challenges and dilemmas in safe settings (Alexander, McDaniel, & Baldwin, 2005). Problem-based learning encourages students to consider various solutions to situations that may be encountered in the workplace. Billings and Halstead (2011) noted that problem-based learning is a strategy that facilitates students' competencies in a discipline, to apply knowledge in clinical settings, and develop long-term learning skills.

Clark, Ahten, and Macy (2013) developed a problem-based learning scenario for 65 senior students in a nursing program, in which faculty presented a lecture on lateral violence prior to the scenario. The authors noted that problem-based learning may provide a strategy for novice nurses who are involved in situations involving lateral

violence. Students utilized the knowledge obtained from the presentation to analyze a problem-based scenario, involving actors portraying a charge nurse and two staff nurses acting out a situation involving lateral violence. The students observed the scenario and provided written feedback on the effectiveness of the scenario and participated in small group debriefing discussions. The students reported that the scenario provided them with an awareness of lateral violence and a need to be aware of one's own behaviors. The students also reported the importance of the role of nurse manager to mediate coworker conflicts.

In a follow-up study 10 months later, Clark, Ahten, and Macy (2014), described how the knowledge gained from the problem-based learning scenario impacted the students, who had graduated from nursing school and were employed as novice nurses. 30 nurses participated in this study. The majority of the participants reported that they had experienced lateral violence and most of them utilized the information from the problem-based learning scenario to address the encounters. The participants also noted that they were able to identify behaviors associated with lateral violence with ease, and did not assume that these behaviors were normal experiences for novice nurses (Clark et al., 2014). Clark et al. concluded that the problem-based learning classroom scenario was effective in educating nursing students about lateral violence and preparing them for the behaviors that may be encountered as they began their nursing careers. In this study, students in a leadership course learned about lateral violence, its impact on nursing practice, and ways to prevent it. This study was limited in that a convenience sample of

nursing students from a single nursing program were used in this study. The findings may not be representative of students from other nursing programs.

Educational courses in healthcare settings.

Nikstaitis and Simko (2014) developed a pilot research to determine if workplace interventions increased nurses' awareness of lateral violence and the perceived source of lateral violence, and whether the interventions decreased the incidence of lateral violence. Interventions included case studies, a review of literature on lateral violence, recommendations for a healthy work environment, and group discussions for nurses working in an intensive care unit. Pre and post-test assessments were performed and the authors reported that, after the intervention, nurses were better able to identify instances of lateral violence and that instances of lateral violence decreased. Nikstaitis and Simko concluded that an increased awareness of lateral violence was necessary to ensure a safe workplace. Although Nikstaitis and Simko noted that the intervention provided benefit to the participants of the study, the intervention was only 60 minutes in length and some aspects of importance needed to be removed due to lack of time. The study was also conducted in one unit of a hospital, and findings may not be applicable to other units or other hospitals.

Role of nurses as leaders.

Nurses have the capabilities to make positive changes for the profession. Nurse leaders have a responsibility to create healthy work and educational environments (Rutherford, Gillespie, & Smith, 2019). By creating a civil working environment by

mitigating lateral violence, nurses can become more productive and develop professionally (Rutherford et al., 2019).

Parker, Harrington, Smith, Sellers, and Millenbach (2016) performed a case study that examined lateral violence interventions created by nursing professional development specialists in a New York hospital. The committees implemented changes to decrease the presence of lateral violence in the workplace, using a multidimensional approach. One aspect involved an educational intervention with a goal of increasing awareness and managing lateral violence by addressing conflicts, managing one's emotions, and maintaining a professional image. Another aspect involved a review of the hospital' code of behavior, existing hospital policies, performance standards, a review of leadership competencies, and a review of the mission statement. The final aspect aimed to sustain a culture of teamwork and collaboration by providing newly-hired nurses with resources available for support and TeamSTEPPS training for all nurses in the organization. TeamSTEPPS is a strategy used by nurses to objectively clarify concerns by placing the focus on patient safety. As compared to other New York State hospitals, Parker et al. reported that the hospital in the study had more nurses employed with a bachelor's degree or higher, more nurses employed full-time, had less reports of lateral violence, had a higher number of nurses employed at the same facility for five years, and had a higher number of staff members who were aware of the hospital's lateral violence policy. This study demonstrated the successful implementation of a strategy integrating the services of many disciplines in one hospital. It is unclear as to whether this approach would be effective or feasible in other healthcare facilities.

In a qualitative study, Skarbek, Johnson, and Dawson (2015) sought to explore the perspectives of six nurse managers from different health care facilities in relation to lateral violence, effective interventions to prevent it, and factors that facilitated a civil working environment. The authors reported that the participants believed that antibullying programs were less effective than direct nurse manager intervention involving the perpetrator and the victim. The authors concluded that the culture of lateral violence could be changed, but it may require nurse managers to be better educated in identifying lateral violence and addressing the behavior with all staff involved in the behavior. This research was successful in gaining insights regarding lateral violence from nurse managers, but was limited to the insights of those working in nonrural hospitals.

Zero-tolerance policy and procedure intervention.

The commitment of an organization is necessary to successfully implement a zero-tolerance lateral violence policy (Hoffman & Chunta, 2016). The policy must contain clear guidelines, should be shared with all employees, and have consequences for violations of professional conduct (Hoffman & Chunta, 2016). To adhere to a zero-tolerance policy, nursing administration needs to address all complaints, make corrective actions when appropriate, strictly adhere to policies, and make changes to policies, if necessary (Hoffman & Chunta, 2016).

In a mixed-methods study performed by Bloom (2018), 57% of nurses interviewed reported that zero-tolerance policies for lateral violence were somewhat helpful, but only when nurse managers enforced these policies. In a literature review,

Bambi et al. (2018a) reported a lack of evidence supporting the effectiveness of policies

and procedures in the prevention of lateral violence. Similarly, Castronovo, Pullizi, and

Evans (2016) reported that policies and procedures to prevent lateral violence were

limited and rarely effective. Those policies that were effective required strong

enforcement by administrators. Castronovo et al. (2016), proposed a solution to lateral

violence in which a survey would be developed to measure nurses' perspective of lateral

violence. The survey would resemble the Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS) survey, which is a standardized, publicly reported

survey of patients' perceptions of their hospital experience (Centers for Medicare and

Medicaid Services, 2015). HCAHPS surveys allow comparisons of patient's experiences

to be made among hospitals throughout the United States. Since 2007, hospitals subject

to the Inpatient Prospective Payment System (IPPS) were required to distribute HCAHPS

surveys to receive full reimbursement, pursuant to IPPS. These surveys provided

incentive for hospitals to increase patients' perceptions of quality care (Centers for

Medicare and Medicaid Services, 2015). Castronovo et al. believed that if similar

incentives existed to eliminate lateral violence, it would result in a greater focus on

implementing zero-tolerance policies for lateral violence. Castronovo et al. noted that

they were unable to identify individuals in various Centers, Bureaus, or Services that

could implement this survey because lateral violence prevention was not in their

jurisdiction. The authors concluded that policies and procedures alone do not provide

enough of an incentive to prevent lateral violence and that genuine change would only

occur when reimbursements and hospital reputations were diminished because of the

behavior. Although Castronovo et al. provided a clear rationale for this study, there were

limitations. Nurses were not guaranteed confidentiality in their responses, thus limiting

the response rate and disclosure of information. Castronovo et al. also reported that

implementing this process would be difficult because hospitals may be unwilling to

submit data regarding lateral violence that could damage their reputation or pose as a

financial risk.

Teamwork.

Logan and Malone (2017) studied the impact of teamwork on lateral violence,

using 128 nurses from two hospitals and having them complete an attitude about

teamwork survey, team characteristics survey, and a negative intention questionnaire.

Thirty-one nurses reported being the victim of lateral violence within the last 6 months.

Almost all of the participants agreed or strongly agreed that teamwork contributed to

better patient care, communication among coworkers was essential, and that each

member of the team needed to invest time and commitment into making the team

effective. The participants identified teamwork characteristics, such as communication,

cooperation, balanced participation, and conflict management as factors that lessened

lateral violence. Logan and Malone (2017) noted that nurse managers could enhance

teamwork by developing proper policies and training. The results of this study were

consistent with prior studies regarding perceptions, attitudes, and experiences of nurses

who experienced lateral violence (Logan & Malone, 2017). This study was limited in

that the participants were chosen from 2 hospitals in close proximity to each other, which

may limit the generalizability of the study.

Summary

In this chapter, I discussed the search strategy that I used to locate research pertaining to my topic, including the databases accessed and the search terms utilized. Husserl's (1927) phenomenology was selected for use as the conceptual framework, as it encouraged the participants to engage in reflection on the thoughts and feelings associated with their experiences of lateral violence and patient safety. The theoretical framework selected was Freire's theory of pedagogical oppression and empowerment, because it emphasizes the powerlessness experienced by nurses the and lack of recognition and value awarded to them. I provided an in-depth history of lateral violence in the nursing profession. I then summarized the literature on lateral violence by dividing research into subtopics, including contributing factors, consequences, and strategies to prevent it. Contributing factors included the organizational culture of the healthcare facility (Pilch & Turska, 2015), leadership styles of nursing managers (Tsuno & Kawakami (2015), and working conditions (Boeteng & Adams, 2015). Consequences of lateral violence could be observed in the victim (Wright & Khatri, 2015), the workplace (Houck and Colbert (2017), and the patient (Oh, et al., 2016). Strategies to prevent lateral violence included cognitive rehearsal (Griffin, 2004), conflict management (Leon-Perez, et al., 2016), problem-based learning (Billings and Halstead, 2011), educational interventions (Nikstaitis and Simko, 2014), interventions by managers (Rutherford et al., 2019), zero-tolerance policies and procedures (Hoffman & Chunta, 2016), and teamwork (Logan and Malone, 2017).

Lateral violence is a well-documented issue in nursing that can cause physical and emotional distress to nurses and can potentially impair their ability to safely perform patient care. It has been recognized as a challenge in the workplace that is embedded in the nursing culture, allowing it to perpetuate a cycle of unprofessional behavior (Tricco et al., 2018). In many instances, nurses have reported being both the perpetrator and the victim in varying circumstances throughout their careers (Bambi, Guazzini, DeFelippis, Lucchini, & Rasero, 2017). All nurses need a safe and cooperative workplace that provides the support necessary to excel and provide patients with the most appropriate care possible. As the number of nurses reporting dissatisfaction with the profession due to lateral violence increases, unsafe job performance becomes an unacceptable risk (Bowllan, 2015). Despite this risk, attempts to prevent or resolve lateral violence have rarely proven to be effective, contributing to the continuance of the behavior. (Bambi, et al., 2017). Studies that present strategies to prevent lateral violence are present in the literature and possess weaknesses. Limitations exist in the research regarding the effectiveness of interventions (Griffin & Clark, 2014), rendering the need for additional research. Limitations exist in which research was performed with a small number of participants or in a limited number of healthcare facilities (Ceravalo et al., 2012; Clark et al., 2014; Kile et al., 2018; Logan & Malone, 2017; Nikstaitis & Simko, 2014; Parker et al., 2016; Skarbek et al., 2015). Social desirability bias was a possible limitation in a cognitive rehearsal intervention (Kile et al., 2018). In other studies, it could not be determined if the interventions were effective, or if other factors contributed to a decrease in lateral violence (Einarsen et al., 2018; Leon-Perez et al., 2016). In a pilot study by

Pines et al., (2016) to address conflict management by interventions, no significant decreases in lateral violence were reported. Another study implementing an interventional technique to combat lateral violence lasted 60 minutes, and lacked proper time to address pertinent data relevant to the problem (Nikstaitis & Simko, 2014). A final limitation involved the reluctance of a healthcare facility to disclose information because of fear of negative consequences regarding reputation and finances (Castronovo et al., 2016).

Although patient safety is at the forefront of attention in healthcare settings, there is a lack of available data exploring the relationship between lateral violence and patient safety (Houck & Colbert, 2017; Layne, Nemeth, Mueller, Schaffner, Stanley, Martin, Wallston, 2019). The intent of this phenomenological research was to address this gap in the literature by exploring the lived experiences of nurses who have endured lateral violence, and their perceptions of the threat to patient safety that these experiences contributed to. In Chapter 3, I will describe the research method for the study including the procedures for recruiting participants, data collection, and analyses.

Chapter 3: Research Method

Introduction

The purpose of this qualitative phenomenological study was to explore nurses'

perceptions of their ability to provide safe care in unhealthy work environments, among

those who have experienced lateral violence. An operational definition for *lateral*

violence is "behaviors intended to demean, undermine, and/or belittle a targeted

individual working at the same professional level" (Sanner-Stiehr & Ward-Smith, 2017,

p. 1). *Patient safety* is defined as the "absence of preventable harm to a patient and

reduction of risk of unnecessary harm associated with health care to an acceptable

minimum" (WHO, 2018, para. 3). Using a phenomenological design, I explored nurses'

perceptions of their ability to provide safe care in unhealthy work environments, among

those who have experienced lateral violence. The findings of this study can add to prior

knowledge utilized by nursing administration to prevent or address lateral violence

among nurses. In this chapter, I describe the research method, research design, the

population, recruitment methods, sample size, and my rationale for selecting them. I also

address the interview questions and my role as the interviewer and researcher. Finally, I

provide the analysis of data, trustworthiness, and ethical practices utilized for this

research.

Research Design and Rationale

The following research question guided the study: Among nurses who have

experienced lateral violence, what are nurses' perceptions of their ability to provide safe

care in unhealthy work environments? The research design chosen for this study was a

phenomenological design, suggested by Creswell and Creswell (2018), as a framework for inquiry with psychological and philosophical underpinnings. Qualitative research is conducted to find the meaning that individuals or groups attribute to a given problem (Creswell & Creswell, 2018). My goal in this study was to explore nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. To explore these perceptions, a qualitative phenomenological approach using semistructured was utilized. Semistructured interviews can facilitate understanding and empathy, thus creating quality data (Smith et al., 2012). Phenomenological research describes what an experience is like, what the experiences means, and how the lived world presents itself to the participant (Rodriguez & Smith, 2018). Phenomenology was the chosen approach, using Husserl's philosophy, because it supports impartiality (Rodriguez & Smith, 2018). All preconceived notions, and biases are set aside and the researcher must consider his or her own perceptions to enhance neutrality (Rodriguez & Smith, 2018). The intent of this research was to explore nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. Phenomenology using Husserl's (1927) philosophy is effective in this research because the intent was to capture the true lived experiences of nurses who have experienced lateral violence.

Role of the Researcher

I was the primary researcher and data collector for this study. Data was collected with in-depth, semistructured interviews. In-depth interviews allow researchers to explore experiences of others in detail and learn to see the world from different

perspectives (Rubin & Rubin, 2012). In-depth interviews present personal and ethical dilemmas, which necessitate the disclosure of researchers' biases, values, and personal background that may influence data analysis and interpretations (Creswell & Creswell, 2018). The completion of this study was motivated by my own experiences with lateral violence in nursing, thus creating a potential for bias. Husserl (1927) suggested that researchers bracket their biases, a method in which the researcher uses a series of reductions to avoid the distraction of assumptions and preconceptions and return to the experience of the phenomenon. I bracketed biases by journaling my own thoughts, opinions, and emotions as they appeared throughout the research. By journaling my ideas, I developed a better understanding of the extent of my biases and reduced assumptions (Smith et al., 2012). For the duration of each interview, I allowed the participant to speak freely, without interruption. Clarifying questions were asked if responses were vague.

I addressed issues related to confidentiality by providing participants with verbal and written guarantees that data that may lead to their identification, including names and places of employment will be omitted from the study. Each participant was assigned an identification number that was used in the data collection, analysis, and reporting process. Data with identifying factors was stored in a secure area separate from interview data.

Ethical issues had a potential to arise as a result of my own experiences with lateral violence in the nursing profession. To prevent ethical issues that were present as a result of my experiences with lateral violence, my relationship with the participants was

limited to this study. There were no personal friends or work colleagues recruited as participants for this study.

To prevent my influence on the participants, I did not offer an opinion, attempt to share personal experiences with lateral violence, or try to interpret participants' statements. I did not attempt to complete the participants' sentences or thoughts.   The participants were informed that interviews were conducted by a registered nurse for doctoral research purposes to prevent them from withholding information or altering the details of their experiences.

Another ethical issue that was addressed was the potential for a negative emotional response from the participant that could result from speaking of experiences with lateral violence. IRB approval was obtained prior to initiating interviews to ascertain the ethical treatment of participants. Participants were provided with information regarding accesses for support, should the interview result in distress. The participants were also advised that they had the authority to end an interview at any time without a threat of repercussions.

Methodology

A qualitative, phenomenological approach was utilized to explore the perceptions of nurses regarding their ability to provide safe care in unhealthy work environments. There were other qualitative approaches that were not suitable for the research that I conducted. Grounded theory research was not appropriate because the goal of the research did not include creating new theories based on the data that was obtained. Ethnographic studies were also not appropriate because it was not feasible to be present

in the field and observe episodes of lateral violence. Park and Ono (2016) noted that perpetrators of lateral violence often ensure that their behaviors are not witnessed, making it difficult to observe.

Participants Selection Logic

For my qualitative phenomenological study, research participants were recruited through purposive sampling. According to Laerd (2012), purposive homogenous sampling aims to obtain a sample of participants that share similar characteristics or traits, like age, gender background, or occupation. A homogeneous sample is often chosen when the research question that is being addressed is specific to those with similar characteristics or traits, which can then be examined in detail.

According to Patton (2015), criterion sampling involves identifying participants that exhibit predetermined characteristics that would provide robust data for a specific study. For my research, inclusion criteria included being 18 years of age or older, being employed as a staff nurse, for at least one year, having experienced lateral violence, and having remained in the workplace for at least 6 months after experiencing lateral violence. There were no limitations on gender or specialty in nursing. Exclusion criteria included less than 1 year of experience as a registered nurse, not experiencing lateral violence, resigning from the workplace within 6 months of experiencing lateral violence, and not willing to be audio or audio and video recorded. No participant was known to me on a personal or professional basis. Klitzman (2013) noted that the selection of one's students, employees, or work colleagues increases the potential for coercion and undue influence, and may be considered a conflict of interest in research.

A flyer was posted on the websites of various nursing organizations and nurse-specific Facebook pages that instructed participants to contact me and schedule an appointment for participation (See Appendix B for the recruitment flyer). Interviews were conducted until thematic saturation was achieved. Patton (2015) noted that sample size depends on what information is needed, the purpose of the research, what is at stake, what will be useful and credible, and what can be done with available time and resources. The sample size can be augmented, depending on what is learned during the research. Based on what is learned, fieldwork is conducted and inquiry deepens. For this study, I planned to interview approximately 10 participants. The sample size was not rigid and could to be augmented, depending on the data that was yielded and whether or not data saturation was achieved (Patton, 2015). Participants expressing interest in this study were given an email address in which to contact me.

Instrumentation

Semistructured interviews were utilized in this study to answer the research question: Among nurses who have experienced lateral violence, what are nurses' perceptions of their ability to provide safe care in unhealthy work environments? Semistructured interviews are used when the researcher is focusing on a specific topic and prepares interview questions, probes, and follow-up questions in advance (Rubin & Rubin, 2012). This method allows the researcher to collect open-ended data and to explore participant thoughts, feelings and beliefs about a particular topic that may be personal or sensitive (Creswell & Creswell, 2018). The researcher's goal was to describe a lived event in concrete terms and can accomplish this by gathering personal experiences

through descriptions of lived-through moments, experiential anecdotal accounts, and remembered stories of life experiences (Patton, 2015).

All interviews were audio recorded, utilizing an audio recorder. A copy of all audio recordings was secured on Dropbox, a cloud-based service. Audio recordings were submitted to Rev.com for verbatim transcription. Information stored on Rev.com was password-protected.

Researcher-Developed Instruments

The purpose of my study was to explore nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. Semistructured interviews were used to elicit thick descriptions from the participants and to delve deeper with probing questions if responses did provide enough details. See Appendix A for the interview template.

There is a gap in the literature regarding qualitative research exploring nurses' perceptions of their ability to provide safe care in unhealthy work environments, such as work environments where lateral violence is present. The interview questions were created in an attempt to fill the gap in the literature by giving the participants an opportunity to describe their experiences with lateral violence thoroughly. Qualitative validity and an assessment of the accuracy of findings were accounted for by addressing factors such as credibility, transferability, confirmability, and dependability (Creswell & Creswell, 2018). Appendix B contains the recruitment flyer.

Procedures for Recruitment, Participation, and Data Collection

The procedure for recruiting research participants involved posting a short

explanation of the study on nursing websites and nurse-specific Facebook pages

(Appendix B). After initial contact was made by a nurse interested in participating in the

study, an email was sent to the participant, which included the purpose of the study and

definitions of lateral violence, patient safety, and healthy work environments (Appendix

C). A consent form was also be emailed to the potential participants. The consent form

included a statement informing potential participants that they would be withdrawn from

the study if they did not meet the eligibility requirements. After signing the consent

form, a demographics form was emailed to potential participants to assess their eligibility

to participate in the study, including amount of years employed as a nurse, whether or not

lateral violence was experienced, and whether the potential participant remained in the

workplace at least 6 months after lateral violence was experienced (Appendix D). The

potential participants had the opportunity to ask questions and clarify any information

that was unclear regarding the research process. If the potential participants completed

the consent form and met criteria, as evidenced by the responses on the demographics

form, a time was determined to conduct the interview. At this time the decision to

conduct face-to-face interviews, telephone interviews, or video interviews was

determined. Data collection was accomplished with an audio recorder.

Semistructured interviews were conducted using predetermined questions. All

interviews were audio recorded and transcribed verbatim, using Rev.com. Interviews

were tentatively scheduled for 60 minutes, but the participants were informed that the

interviews may take more or less time depending on the amount and quality of data that the participant were willing to share. Participants were informed that they had the right to terminate the interview process at any time. Participants were informed that they had the option to receive transcripts of the interview, if desired.

Data Analysis

After completing the interviews and transcribing them verbatim using a transcription service, data analysis was performed using IPA. IPA coincides with Husserl's philosophy in that researchers using IPA are focused on the significance of a phenomena for an individual and how they react to it (Smith et al., 2012). I utilized the 6 steps for IPA noted by Smith et al (2012). Step 1 involves reading and rereading transcripts so that the researcher is immersed in the original data. This step also involves listening to the audio recordings, recording recollections of the interview, and noting observations about the transcripts to assist the researcher in bracketing them. Step 2 is initial noting, in which content and language in the transcripts are explored. This process ensures a greater familiarity with the data and begins the process of identifying specific ways that the participant talks about an issue. The goal is to produce a detailed set of notes on the data. The notes will include descriptive comments, linguistic comments, and conceptual comments. These approaches allow the researcher to explore different possibilities of the meaning of the participants' words (Eatough & Smith, 2017). Step 3 involves developing emergent themes. This step involves the analysis of notes as opposed to the transcript. Identifying emergent themes involves a recall about what was learned through note-taking. This process involves reducing an interview into parts, but these

parts will come together as a whole during the final analysis (Smith et al., 2012, p. 91).

Step 4 involves searching for connections across emergent themes. In this step the aim is

to look for ways to connect the themes together to illustrate each participant's most

interesting and important aspects. Step 5 involves repeating steps 1 through 4 on each

new interview. Step 6 involves looking for patterns among different participants to

identify the similarities and differences.

Researchers use computer-assisting software to identify common themes found in

the data (Creswell and Creswell, 2018). After hand-coding the data, I entered the data

into NVivo, a qualitative software program. NVivo offers security with the confidential

data that is inputted. As a last step in coding, peer review was performed to ensure the

accuracy of the coding information.

<div align="center">**Issues of Trustworthiness**</div>

Reputable qualitative research requires trustworthy data collection and reporting.

Trustworthiness involves the methods that qualitative researchers employ to affirm that

the findings reported are true to participants' experiences (Ravitch & Carl, 2016). To

ensure that standards of trustworthiness have been followed in qualitative research, there

are four criteria that must be met: credibility, transferability, dependability, and

confirmability (Ravitch & Carl, 2016).

Credibility

Credibility describes the confidence that the qualitative researcher possesses in

the truth of the research study's findings (Ravitch & Carl, 2016). Credibility is

associated with the research design and the researcher's instruments and data (Ravitch &

Carl, 2016). Methods of ensuring credibility include member checking, triangulation,

providing thick descriptions, and utilizing peer debriefing (Ravitch & Carl, 2016).

Member checking involves returning data to participants to assess for accuracy with their

experiences (Birt, Scott, Campbell, & Walter, 2016). In this research, participants were

provided with the opportunity to receive a copy of their transcripts to ensure that their

responses truly reflected their experiences with unhealthy work environments and patient

safety. Triangulation involves using multiple data sources in an investigation to produce

understanding and to ensure that an account is rich and well-developed (Lincoln & Guba,

2015). Triangulation was accomplished in this study by interviewing a number of

participants that enabled thematic saturation to be achieved. Thick descriptions by

participants was facilitated by asking appropriate main, follow-up, and probing questions

(Rubin & Rubin, 2012). Peer debriefing is intended to create an opportunity for peers to

challenge the researcher's interpretations of the research process, including the setting,

the participants, the overall context, research questions, study design, participant

engagement, and interpretations (Ravitch & Carl, 2016). Peer debriefing by my research

committee was incorporated into this study for credibility.

Transferability

Transferability describes how the qualitative researcher demonstrates that the

findings in research can be applied to other situations, populations, or phenomena

(Ravitch & Carl, 2016). This can be accomplished in qualitative research by providing

data with thick description that so that anybody reading the research can make

comparisons based on the context of the information provided (Ravitch & Carl). In this research, data was collected until thematic saturation is achieved.

Dependability

Dependability refers to the extent that the study could be repeated by other researchers with consistent findings. (Ravitch & Carl, 2016). Dependability for this study was established by the chair and the methodologist of my dissertation committee, who reviewed the study results to ensure that the data provided was trustworthy and supported the conclusions that were made. Triangulation and audit trails are methods used to ensure dependability in qualitative research. Triangulation was employed by comparing fieldnotes with the participants' responses. Audit trails describe how data was collected and analyzed in a transparent manner (Ravitch & Carl, 2016). In this research, rationales for how themes emerged from individual codes were provided. In this way, I was able to clarify my decisions and demonstrate how the analysis was logical, based on the narratives of the participants (Creswell & Creswell, 2018).

Confirmability

Confirmability is the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Lincoln and Guba, 2015). Ravitch and Carl (2016) noted that processes to achieve confirmability include reflexive journaling and an audit trial. Reflexive journaling was used to document emerging thoughts and shapes the goals and significance of a study (Ravitch & Carl, 2015). An audit trail allows the researcher to create logical steps for the data analysis and provides clarity in reporting and explaining the research (Ravitch & Carl, 2015). For this research,

reflexive journaling and an audit trail were completed throughout the research process and were reviewed when interpreting interviews to prevent bias.

Intercoder and Intracoder Reliability

I was the primary researcher for this qualitative phenomenological study. An intracoder reliability approach was utilized for this study, as I was the only researcher collecting and analyzing the data. This approach examines whether the same coder rates the data in the same way throughout the coding process (Lazar, Feng, & Hochheiser, 2017). In order to achieve reliable coding from the same coder, I abided by a set of explicit coding instructions from the beginning of the coding process (Lazar et al., 2017).

Ethical Procedures

Rubin and Rubin (2012) noted that it is the responsibility of all researchers to assure participants that they will be safe from harm, to avoid deception or pressuring the participants in any way, to treat the participants with respect, and to keep any promises made to the participants. To ensure that this research is conducted ethically, I carefully adhered to ethical principles, and followed recommendations made by my dissertation committee and the IRB. To gain a comprehensive understanding of ethical procedures, I have completed the "Protecting Human Research Participants" certification through the National Institute of Health (NIH) with an assigned certification number of 2019861. I screened each potential participant prior to beginning interview questions, to ensure that they were emotionally and cognitively able to provide informed consent to participate in this qualitative study (American Counseling Association [ACA], 2014). Personal colleagues were not recruited, as this could have influenced the quality of the interview.

The participant completed an informed consent form and met the criteria of the participant screening, which was provided on the demographics sheet. The informed consent provided details regarding the purpose, limitations, benefits, risks, time commitment, confidentiality policies, and an explanation of the option to withdraw from the study at any point. The consent also included a statement informing potential participants that they would be withdrawn from the research if they did not meet the eligibility criteria. After completing the informed consent, demographic information was collected by a form emailed to the potential participants. The criteria included being a nurse for at least one year, having experienced lateral violence, and remaining in the workplace for at least 6 months after experiencing lateral violence. The participant also had to be willing to be audiotaped or audio and videotaped. If any participants opted to withdraw from the study, I would thank them for their time, stop all contact, and destroy any data that was collected.

All consenting participants who participated in the study was informed of the procedure to retain the data in a locked computer and filing cabinet for 5 years, as required by the IRB. Information on how data was disseminated was also provided. Participants were labeled Participant 1, Participant 2 and so on to ensure confidentiality. Contact information was provided to each participant for crisis counseling, in the rare event the participant required counseling that was related to this study. Each participant received a $25 gift card, which was distributed at the beginning of the interview, to prevent coercion.

Summary

This chapter described the primary methodology for my phenomenological study, including the research design, instrumentation, and recruitment methods. Measures to establish trustworthiness and ethical considerations were also addressed. Chapter 4 will provide the recruitment and data collection information for this study, as well as the data analysis, results, and evidence of credibility, transferability, dependability, and confirmability.

Chapter 4: Results

Introduction

There is a vast amount of literature regarding lateral violence in the nursing

profession, but there is a dearth of research regarding nurses' abilities to provide quality

patient care after experiencing lateral violence. The purpose of this qualitative

phenomenological study was to explore registered nurses' perceptions of their ability to

provide safe care in unhealthy work environments, among those who have experienced

lateral violence. Results from this study elucidate the perceptions of nurses' delivery of

safe patient care after experiencing lateral violence in a manner that has not yet been

researched.

Research Question

The research question directing this study was: Among nurses who have

experienced lateral violence, what are nurses' perceptions of their ability to provide safe

care in unhealthy work environments? In this chapter, I will present the findings of this

phenomenological study, the setting in which the study took place, demographic

information, methods of data collection, data analysis, evidence of trustworthiness, and

the results of the data collection.

Setting

Recruitment for this study occurred between November, 2019 and January, 2020.

A flyer was posted on the websites of various nursing organizations and nurse-specific

Facebook pages that instructed the participants to contact me via email to schedule an

appointment for an interview. All interviews were audio recorded utilizing an audio recorder. Audio recordings were submitted to Rev.com for verbatim transcription.

Demographics

I interviewed 13 participants for this study. Inclusion criteria required that all participants be 18 years of age or older, were registered nurses who had been employed as staff nurses for at least 1 year, had experienced lateral violence, and had remained in the workplace for at least 6 months after experiencing lateral violence. All 13 participants were female. Participant ages ranged from 25 to 65 years of age. Years of experience as a registered nurse ranged from 3 to 37 years. All participants experienced lateral violence at some point during their career and remained in the workplace after experiencing lateral violence for at least 6 months (Table 1).

Table 1

Demographic Information of Participants

Demographic information	Number of participants (*n*=13)
Gender	
Female	13
Male	0
Current age range (y)	
18-25	0
25-35	2
35-45	2
45-55	6
55-65	2
65+	1
Years of experience as a Registered Nurse	
<3	1
3-5	3
5-10	0
10-15	2
15-20	1
20-25	1
25-30	2
30-35	2
35+	1
Experienced lateral violence in the workplace	
Yes	13
No	0
Remained in the workplace for at least 6 months after experiencing lateral violence	
Yes	13
No	0

Data Collection

Participants

During the recruitment process, 18 participants initially volunteered to participate in this study. Of the 18 participants, 13 signed and returned the consent form and scheduled an interview. All 13 participants who signed the consent form met the inclusion criteria of being 18 years of age or older, being employed as a staff nurse for at least 1 year, having experienced lateral violence, and having remained in the workplace for at least 6 months after experiencing lateral violence.

Location, Frequency, and Duration of Data Collection

To complete data collection for this study, I interviewed 13 registered nurses who had experienced lateral violence. Prior to conducting interviews, permission to collect data from human subjects was granted by the IRB of Walden University. IRB approval number 10-03-19-0611383 was received on October 3, 2019. After IRB approval was obtained, a flyer was posted on the websites of various nursing organizations and nurse-specific Facebook pages that instructed participants to contact me via email and schedule an appointment for participation (see Appendix B for the recruitment flyer). Participants expressing interest in this study were advised to contact me using the email address provided on the flyer. After initial contact was made by a nurse interested in participating in the study, an email was sent to the participant, which included the purpose of the study and definitions of lateral violence, patient safety, and healthy work environments (Appendix C). A consent form was emailed to the potential participants. The consent form included a statement informing potential participants that they would

be withdrawn from the study if they did not meet the eligibility requirements. After

signing the consent form, a demographics form was emailed to potential participants to

assess their eligibility to participate in the study, including amount of years employed as

a nurse, whether or not lateral violence was experienced, and whether the potential

participant remained in the workplace at least 6 months after lateral violence was

experienced (Appendix D). The potential participants had the opportunity to ask

questions and clarify any information that was unclear regarding the research process. If

the potential participants completed the consent form and met criteria, as evidenced by

the responses on the demographics form, a time was determined to conduct the interview.

At this time the decision as to whether a telephone, face-to-face, or Zoom interview was

determined. To complete data collection for this study, I interviewed 13 registered nurses

who had experienced lateral violence. All interviews were conducted between November

10, 2019 and January 25, 2020. All 13 participants agreed only to telephone interviews.

Interviews were audio taped with an audio recorder and transcribed verbatim using

Rev.com. These transcriptions were transmitted confidentially through Rev's password

protected website on a password protected computer. Completed verbatim transcripts

were then sent to a password protected email and were accessed and downloaded onto a

password protected computer and stored in Dropbox.

I used semi structured interviews to ask open-ended questions to encourage

participants to describe their experiences and to remain focused on the topic. This

method was beneficial in directing the participants to elaborate on their perceptions of

safe patient care, rather than simply focusing on experiencing lateral violence. During

the interview process, I asked participants to describe one or two occurrences in which

lateral violence was experienced. I then asked how the participants reacted in those

situations. I further asked participants to describe their interactions with patients during

times when lateral violence was experienced and their perceptions of their quality of

patient care delivery after experiencing lateral violence. Finally, I asked each participant

if there was anything else that they wanted to add to the interview.

Variations in Data Collection

Prior to the recruitment process, participants were offered the options of an audio

interview, an audio and video interview, or a face-to-face interview. Although audio and

video or face-to-face interviews may have yielded more information, all 13 participants

opted for audio-only interviews. Variations in the length of the interviews differed

among participants based on the details provided of their experiences. Some of the

participants required further probing of their responses when statements were unclear or

lacked details necessary to articulate their thoughts.

Data Analysis

Coding Process

Data analysis began upon completion of the first interview, and utilized the 6

steps for IPA, as described by Smith et al (2012). The first transcript was read and reread

and the audio recording was listened to, in order to be immersed in the data (Smith et al.,

2012). The next step involved initial noting and coding of the first interview to be further

familiarized with the data. The content and language of the participant was explored in

depth to gain a familiarity with the participant and the described experiences (Smith et

al., 2012). Detailed notes were taken during this step that including preliminary codes and descriptive comments. The third step involved developing emergent themes from the notes taken in the second step (Smith et al., 2012). This step involved the analysis of the codes and descriptive comments that were extracted from the interview. This step required reducing the interview into individual questions to ensure that distinct themes that were emerging. The fourth step involved searching for connections across emergent themes for the first interview. This connected the themes together to illustrate the most relevant experiences that were expressed by the participant (Smith et al., 2012). The fifth step involved repeating Steps 1 through 4 for each new interview (Smith et al., 2012). The final step involved reassessing the detailed notes that were taken for all of the interviews and identifying similar patterns among all of the interviews (Smith et al., 2012). Each interview question was written out and each participant was assigned a number between 1 and 13. Beneath each question, the descriptive notes and codes for each participant were listed. The document was reviewed for patterns of similarity.

After hand-coding the data, I entered the data into NVivo 12, a qualitative software program. This software allowed me to identify patterns among data and codes of the 13 participants. These patterns led to the development of the themes that answered the research question: Among nurses who have experienced lateral violence, what are nurses' perceptions of their ability to provide safe care in unhealthy work environments (See Table 2).

Table 2
Main Themes/Subthemes

Main themes	Subthemes
Lateral Violence	
	Unhelpful
	Reported for things that were not true
	Laugh or gossip about me behind my back
	Prevent access to supplies needed to work
	Group of nurses ganging up on me
	Unfair scheduling or policies
	Yelled at/Berated by other nurses
	Given assignments not qualified to do
	Discredited in front of patients
	Sabotaged work
	Hazing
Responses to Lateral Violence	
	Anger
	Frustration
	Tried to defend self
	Kept proof of actions/ Meticulous notes
	Fear
	Burnt out
	Not trusting self
Oppressive Group Behavior	
	Lack of patient trust
	Lack self-confidence
	Afraid to ask for help
	Preoccupied with lateral violence
	No support
Unsafe Care	
	Late delivery of care
	Less hands-on care
	Standards of care not maintained
	Jeopardized safety
	Medication errors
	Poor assessments
	Prolonged times performing patient care
Coping	
	Find a mentor
	Speak to a manager
	Self-care
	Education
	Confront the problem
	Focus on patient care
	Quit

Evidence of Trustworthiness

Trustworthiness of qualitative data refers to the degree of confidence in data collection, interpretation, and methods used for quality assurance (Polit & Beck, 2019). Trustworthiness of qualitative research is necessary to demonstrate integrity of the findings. Four pertinent components of data trustworthiness include credibility, transferability, dependability, and confirmability.

Credibility

In this research, member checking was encouraged because participants were provided with the opportunity to receive a copy of their transcripts to ensure that their responses truly reflected their experiences with unhealthy work environments and patient safety (Ravitch & Carl, 2016). One participant requested a copy of her transcript, but did not request any changes be made. Triangulation was accomplished in this study by interviewing a number of participants that enabled thematic saturation to be achieved (Ravitch & Carl, 2016). Thick descriptions by participants was facilitated by asking appropriate main, follow-up, and probing questions (Ravitch & Carl, 2016). Peer debriefing by my research committee was incorporated into this study, using the recommendation of Ravitch and Carl (2016) to challenge my interpretations of the research process, including the setting, the participants, the overall context, research questions, study design, participant engagement, and interpretations.

Transferability

Transferability was accomplished by providing data with thick description that so that the reader could make comparisons based on the context of the information provided.

In this research, data was collected until thematic saturation was achieved. Recruitment of registered nurses from different specialties of nursing throughout the United States contributed to geographic diversity and specialty diversity and allowed the nursing profession to be viewed as a whole.

Dependability

Dependability for this study was established by the chair of my dissertation committee, who reviewed the study results to ensure that the data provided was trustworthy and supported the conclusions that were made. Triangulation and audit trails are methods used to ensure dependability in qualitative research. Triangulation was employed by comparing fieldnotes in the form of reflective journaling with the participants' responses. Audit trails described how data was collected and analyzed in a transparent manner (Ravitch & Carl, 2016). In this research, themes emerged from individual hand coding. I was able to clarify my decisions and demonstrate how the analysis was logical, based on the narratives of the participants (Creswell & Creswell, 2018).

Confirmability

Reflexive journaling was used to document emerging thoughts and shapes the goals and significance of a study (Ravitch & Carl, 2015). An audit trail allowed me to create logical steps for the data analysis and provides clarity in reporting and explaining the research (Ravitch & Carl, 2015). For this research, reflexive journaling and an audit trail were completed throughout the research process and were reviewed when interpreting interviews to prevent bias.

Intercoder and Intracoder Reliability

I am the primary researcher for this qualitative, phenomenological study. An intracoder reliability approach was utilized for this study, as I was the only researcher collecting and analyzing the data. This approach examines whether the same coder rates the data in the same way throughout the coding process (Lazar, Feng, & Hochheiser, 2017). In order to achieve reliable coding from the same coder, I adhered to a set of explicit coding instructions from the beginning of the coding process (Lazar et al., 2017).

Results

After the completion of data collection and data analysis, thematic saturation was accomplished and five themes emerged. Themes were developed through review and manual coding of the interview transcripts. These themes included: lateral violence, responses to lateral violence, oppressive group behavior, unsafe care, and coping.

Theme 1: Lateral Violence

Participants shared a variety of examples of lateral violence that they experienced. An example of lateral violence was unhelpfulness. Participant 1 noted:

> several nurses ... I was new, they decided that I needed to try to learn things the
>
> hard way because I was new, and they told the PCAs not to help me. So I would
>
> ask a PCA for something, and PCA would just walk by like I hadn't spoken.

Participant 3 stated, "If I asked for help cleaning a patient or something, they would pretend that they did not hear me. It was very upsetting." Another example of lateral violence offered by the participants was being reported for things that were not true. Participant 2 noted, "I went to my director of nursing and instead of helping me, she

wrote up a performance improvement plan because she had all of these statements from everybody saying these things that I had supposedly done that I didn't do." Similarly, Participant 6 stated, "But this is what I mean- she would make up new rules just for me or elevate matters to the nurse manager for no reason at all." Another example of lateral violence was laughing or gossiping behind one's back. Participant 3 described the situation as the following, "I became aware that some of the nurses were making fun of me. Like they would mimic me when I was talking or they would laugh at me behind my back." Some participants reported acts of lateral violence as preventing access to needed supplies needed to work. For example, Participant 2 noted that, "They would make sure that I didn't have the equipment that I needed to do my job." Participant 9 further stated that:

> If she wants something she can get what she wants in my room and I wouldn't say anything to the point that I have to face my director because I'm tired of his asking it to me, if is in my room and I need it too.

Another example of lateral violence that was described was being ganged up upon. Participant 3 describes episodes of lateral violence in the following way: "If I went into the break room, they would stretch their legs on the chair so I couldn't sit down." Participant 4 described experiences with another nurse in which, "sometimes she could get other people to corroborate her stories and other times not so much, but she would try to bring people into her crowd to get me into trouble." Other nurses described lateral violence as unfair scheduling or policies. Participant 8 describes an experience with unfair policies in the following manner:

In the assignment we were not given equal opportunity, in the sense that when she

likes the person she's going to give you the right salary, the right timing for work,

you're going to get praised the right way. But if you are not her favorite, I don't

think you are given opportunities to get the right praise that you deserve.

Participant 10 described her experiences with unfair scheduling:

I experienced lateral violence with my charge nurse before about my work

scheduling requests. I always tell her that I don't like working three days in a row,

but each and every time the schedule comes out, it still would be three days in a

row. I don't know why. I think she does it intentionally and I keep telling her I

don't want it. But she would still put it in. I don't know why.

Some participants described acts of lateral violence as being yelled at or berated by other

nurses. Participant 7 noted a verbal interaction with a nurse and was told:

'Well this is an ICU patient and you're going to get an ICU report'. And

continued to berate me for like 10 minutes on the phone. And I was like, What is

wrong with you? Why do you even feel like this appropriate?

Participant 12 described a similar experience of being berated in which:

I would ask a lot of questions and sometimes the older nurses, the more

experienced ones would get angry with me because they feel like along with their

responsibilities, that I was now an extra responsibility on them too. I feel like

they felt like I was burdening them and the responses that they gave me was they

would almost yell or give me nippy responses.

Another example of lateral violence was described by Participant 2, in which "I was given assignments that I wasn't qualified to do. I was set up to fail." Participant 4 described a situation in which she was discredited in front of patients in the following way, "So I worked in one hospital setting with a nurse that did not like me. She would tell patients that I didn't know what I was doing." Having work sabotaged by another nurse was another example of lateral violence. Participant 4 described the following situation:

> She would call the unit and she would pretend to be patients and she would say she was canceling surgeries or canceling procedures and then when patients showed up or they didn't understand their instructions basically made me look bad and made me look like I didn't make calls. Meanwhile, it was because she canceled these things and it was just ridiculous.

A final example of lateral violence was hazing. Participant 1 noted," I was new, and they told the PCAs not to help me. So I would ask a PCA for something, and the PCA would just walk by like I hadn't spoken. It was kind of like hazing." Participant 3 stated, "I went to the unit educator, but she was not helpful at all. Said it was hazing and it would stop when I was considered part of the group."

Theme 2: Responses to Lateral Violence

Experiencing lateral violence is distressing for nurses. Participants were questioned about their responses to lateral violence. One response was anger. Participant 1 noted that:

When I realized that they were hazing me, I got angry because I realized that it was wrong. And I understood that, I guess they did that to everybody, but that's just not what you're supposed to do to other people.

Another response was frustration. Participant 1 described her feelings of frustration in the following way:

And I understood that, I guess they did that to everybody, but that's just not what you're supposed to do to other people. And it was really frustrating because I was a new grad and I had been used to long-term care patients and I'd never been in that situation before.

Participant 3 had similar feelings of frustration and described the following experience:

I was upset and frustrated. I figured that this was the way it had to be. I learned about bullying/lateral violence in school, but I kind of figured somebody would be there to stick up for you if you needed help.

A third response to lateral violence described by the participants was trying to defend oneself. Participant 6 noted that:

I would try to defend myself in these situations. Because I knew I was not wrong. I would try to explain my side of the story. In the situation with the cardiac monitor, the nurse I gave report to even told the charge nurse that she was aware of the pauses but that did not seem to matter. She was not going to see things from my perspective. I wanted to keep my job, so I would just let the matter drop.

Participant 10 described a situation in which she tried to defend herself in the following

statement:

> I called her, I told her I want to talk to her, just me and her and we talk on the
>
> hallway and I told her my ... I gave her a piece of my mind. I told her, listen, I
>
> don't have anything against you. I don't know what you have against me.

Another response to lateral violence was keeping proof of actions. Participant 4 offered

an example of keeping proof:

> So what I started to do to save myself with my job, I start to keep meticulous
>
> notes, I kept faxes. Like if I faxed something like a referral, I used to keep copies
>
> of the faxes. When there was something scheduled, I'd keep a paper trail.
>
> Anything I could do at that point just to make sure that I had proof.

Additionally, Participant 4 responded that, "I had drawers full of files. I felt I had to keep

them." Participant 6 noted that, "I spent too much time making sure my charting was

perfect." Fear was another reaction to lateral violence. Participant 5 stated that "I

became very nervous, very worried about my license, on edge all the own time."

Participant 13 similarly expressed that "It's just whenever I'm doing something, I'm

shaking." Feeling burnt out was a reaction described by Participant 5, "I eventually burnt

out. Little things kept getting worse and worse and worse." A final response to lateral

violence was not trusting oneself. Participant 2 described the experience in the following

way, "the whole feeling is that you start not trusting yourself. You start questioning your

sanity. You start thinking, is it me? Am I a bad nurse? Am I not doing what I should be

doing?"

Theme 3: Oppressed Group Behavior

After experiencing lateral violence, all of the participants remained in the workplace for at least 6 months. During this time period, all the participants were working while suffering the abuse of lateral violence. When asked to describe interactions with patients during times when they experienced lateral violence, the participants had varied responses. One response was a lack of patient trust. Participant 3 stated that:

I think I did the best I could under the circumstances. But patients are not stupid, they could probably sense that something wasn't right. So for example, if I was unsure about something, a normal response would be to go get help. But I would figure it out myself. If I did not look confident, the patients didn't really trust me.

Participant 7 noted that "They see it, they sense it. And I know that they do. And it's not good for patients when they feel like their nurse is either stressed or upset or preoccupied with something other than taking care of them." A lack of self-confidence was another result of oppressed group behavior. Participant 6 stated that "I felt like I was a danger to patients." Participant 9 noted that "I overthink small jobs because I can't think straight." Being afraid of asking for help was also noted as a result of working while experiencing lateral violence. Participant 3 described a situation in which she did not ask for help:

I had to do wound care for a patient (It was ordered twice a day). I didn't really understand how to do the dressing. But I was afraid to ask because they would say that I took care of the patient so many times and I never thought of asking how to do it right. So I just did it the way I thought was right.

Working while experiencing lateral violence results in preoccupation with the behavior among some participants. Participant 9 described being preoccupied in the workplace while experiencing lateral violence:

> You can't think you can't concentrate; you can't do your work right. You make mistakes. You act nervous because you are stressed. You look over your shoulder for somebody trying to catch you in a mistake. Then you make more mistakes. I overthink small jobs because I can't think straight.

Participant 13 stated that lateral violence "Initially it had an effect on my handling of patients. It did have an effect initially. There was no concentration. I stuttered in front of the patient's families. I dropped things. I sounded very unsure of myself." A final experience of working while experiencing lateral violence was a lack of support. Participant 1 described an event that occurred while experiencing lateral violence in which she received no support:

> The patient was trying to escape the unit and they said 'Don't let him on the elevator,' and I was trying to come off and nobody tried to help me and I got hurt in the process, between the elevator and the patient. I got pretty hurt.

Participant 3 stated that "the care would have been better if I was able to collaborate with nurses and felt ok asking questions".

Theme 4: Unsafe Care

Nurses have a responsibility to provide quality care to patients. Lateral violence poses an unnecessary stressor to nurses who need to focus on patient safety. Participants in this study were asked to describe their perceptions of their quality of patient care

delivery after experiencing lateral violence. One example of unsafe care involved late

delivery of care. Participant 5 noted that "medications were delivered late because of my

hesitance.' Participant 10 stated that "I was late giving meds, I got patients to CT scan

late, I missed signs of patients declining that I ordinarily wouldn't miss." Another

example of unsafe care was less hands-on care. Participant 4 noted that:

> I took too much time basically charting and just trying to prove what I was doing
>
> instead of actually staying in the room and taking care of the patients. I just spent
>
> more time documenting every action I made. So I don't think that was benefiting a
>
> patient.

Participant 6 also noted that "I spent too much time making sure my charting was perfect.

But that meant less hands-on care." Failure to maintain standards of care was an example

of unsafe care that was offered by participants. For example, Participant 13 stated that "I

skipped safety checks, like double endorsements for blood because I was too afraid to ask

for assistance. Nobody was hurt, but they could have." Another example of unsafe care

was jeopardized safety. Participant 1 noted that:

> Taking care of everybody and everything and you don't have the support of your
>
> peers and you don't have the support of your aides and you don't have help from
>
> management or anyone and you just feel overwhelmed. And that puts patient care
>
> and safety in jeopardy.

Another example of jeopardized safety was described by Participant 2:

> I knew what my state of mind was and I knew how easy it was to make a mistake,
>
> and so I consciously made sure that I didn't make any mistakes and that really

wasn't fair. Still, my director found errors, like increased wounds and infections. Even though I documented, these things did happen on my watch.

Medication errors were described as an example of unsafe care. Participant 11 noted that

I was written up for mistakes that I should not have made. Had I asked the right people the right questions, I wouldn't have made mistakes. But I was afraid to ask. I knew I would be harassed. Small things, like the wrong IV, titrating Pitocin too slowly. Things like that.

Another example of unsafe care described was poor patient assessments. Participant 10 stated that while being unfairly assigned to work 3 days in a row, "I missed signs of patients declining that I ordinarily wouldn't miss." A final example of unsafe care was prolonged times performing patient care. Participant 5 noted that "The only thing is that care took longer. Too long."

Theme 5: Coping

As a final question, participants were asked if they had anything that they would like to add to the interview. Interestingly, each participant offered advice as to how to cope with lateral violence. One method of coping was to find a mentor. Participant 1 stated "find that nurse that has the heart because there's one on every unit that's not going to let you down." Participant 3 noted that victims of lateral violence should "Find that one person that will guide and support you." Participant 8 suggested the "best way to do is to figure out who is the right person that can help you." Another suggestion for coping with lateral violence was to speak to a manager. Participant 9 advised those experiencing lateral violence to "speak up for yourself and then if it doesn't resolve then you go higher,

to your supervisor." Participant 11 noted "It really goes back to the culture of the unit. Do they feel they can go to the manager and see if the manager can get hashed out, or have a talk with the staff?" Another coping mechanism was self-care. Participant 4 noted that a nurse experiencing lateral violence has to "find a way of enduring their abuse and somehow getting past it so you can do your job." Participant 5 noted that "some of these kids are young, and some of them aren't really prepared and to have someone attack you, you have to be strong." Participant 12 recommended that nurses "Be patient with themselves." Education was another recommendation for coping with lateral violence. Participant 3 recommended that nurses should "always ask questions." Other participants recommended confronting the problem. Participant 7 noted that "when you have a bully, bullies are bullies until they're put in their place." Participant 10 suggested confronting the abuser and stating "I feel like you have something against me. I have nothing I'm just here to learn and nothing else." Another suggestion for coping with lateral violence was focusing on patient care. Participant 3 noted that "Caring is what nursing is all about." Participant 11 noted that "We got to make sure the patient is safe." One final suggestion for coping with lateral violence was to quit. Participant 9 noted "I took me five years to give up. I left the hospital and ICU all together and went to work in mental help."
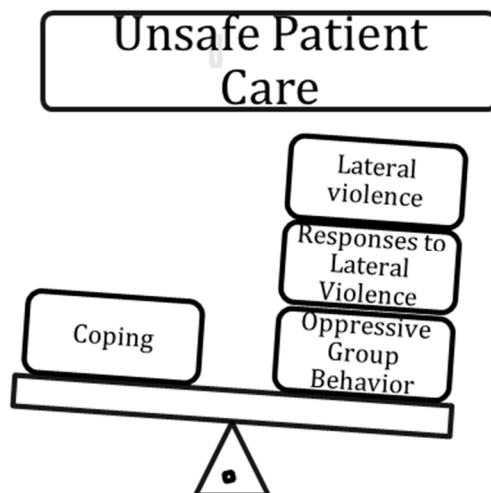
Figure 1.

Five common themes.

Summary

The research question informing this study was: Among nurses who have experienced lateral violence, what are nurses' perceptions of their ability to provide safe care in unhealthy work environments? Five themes emerged from the interviews conducted with the 13 participants. Lateral violence was experienced by participants in several ways. Nurses described experiences in which they were intentionally ignored, even when it was obvious that help was required. Performance reports were submitted to nurses for events that did not occur. Nurses described humiliating experiences where they were gossiped about and laughed at. Abusive nurses would take equipment that was needed and prevent the victims from performing patient care. Groups of nurses would gang up on the victim, at times even stretching their legs on chairs to prevent the victim from sitting down. Nurses would yell and discredit the victims in front of other people.

Work performed by the victim was sabotaged, leading to a delay in patient care and redundant work for the victim.

Responses to lateral violence included emotional reactions that ranged from anger, to frustration, to fear. Some nurses tried to defend themselves by confronting the perpetrator. Others learned to protect themselves from rumors and lies by securing proof of their actions to ensure that could not be unfairly accused of wrongdoings. The constant abused endured by nurses led some of them to become burnt out or not trust in their own job performance.

Interactions with patients became difficult when nurses were experiencing lateral violence. Some nurses felt that their patients did not trust their competence as a nurse. Others lacked confidence that they could appropriately care for patients. Lateral violence resulted in some nurses being afraid to ask for help from their own colleagues, while others felt that they could not concentrate on the care that the patients required because they were too preoccupied with the abuse that they were enduring from other nurses. Finally, some nurses expressed the feeling of isolation resulting from the lack of support from colleagues.

Nurses perceptions of their abilities to provide care after experiencing lateral violence portrayed a bleak situation. Care was reported to be late and less care was delivered. Standards of care were not maintained because hospital policies and procedures were not maintained. Some nurses described instances where they jeopardized patient care and safety. Medication errors were made, assessments were poor, and patient care was unnecessarily prolonged.

Nurses provided coping techniques that they would recommend to other nurses experiencing lateral violence. Finding a mentor, speaking to a manager, focusing on oneself, becoming educated, and confronting the perpetrator were all suggestions that were made. One nurse recommended leaving the workplace and finding something better.

In this chapter, I discussed the data analysis process which included the interview settings, demographic information of the participants, the data collection process, and results. Evidence of trustworthiness during the data collection process was provided and the responses offered by the research participants provided the data to answer the research question directing this study. Chapter 5 will provide a discussion and conclusion of the study, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore registered nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. While available literature details the devastating effects of lateral violence on nurses (Houck & Colbert, 2017; Oh et al., 2016; Wright & Khatri, 2015), there is a lack of literature available that specifically addresses nurses' perceptions of their abilities to provide safe patient care while working in work environments that are unhealthy. This research addresses this gap in the literature by providing details of the lived experiences of nurses who have worked in unhealthy work environments and their perceptions of the quality of care that they were able to provide to their patients.

Findings can be used to improve patient safety through early identification of lateral violence. Clarifying nurses' perceptions may provide enlightening details to administrators and nurse managers that can be a force that leads to a higher quality of patient care, as they evaluate opportunities to create safe working environments for registered nurses and to avoid harm to patients. This may lead to social change within healthcare organizations where nurses may share their experiences to help create preventative measures and effective coping strategies for addressing lateral violence. I conducted semistructured interviews with 13 nurses sharing their experiences with lateral violence. Fundamental findings from my study included five major themes that described

the lived experiences of nurses: lateral violence, responses to lateral violence, oppressive group behavior, unsafe care, and coping.

Interpretation of the Findings

Husserl's phenomenology provided the conceptual framework for this study. It requires a neutral view of a phenomena by bracketing out the researcher's own experiences by using reduction, themes, textual descriptions, and structural description to develop an overall essence of the experience (Creswell & Creswell, 2018). This study enabled nurses to describe their lived experiences of lateral violence in a manner that elucidates the phenomena of providing safe patient care while experiencing lateral violence.

Freire's theory of pedagogical oppression and empowerment provided the theoretical framework for this study. Freire stated that those who are oppressed can save themselves from oppressive systems, but can only do so when they understand their reality. This understanding of reality is the catalyst for change. Freire noted that those who are oppressed often exhibit changes in their psychological and social behavior and, as a result, are controlled by others perceived to have more power.

Giorgi et al. (2016) aimed to develop a model focused on the interaction between lateral violence and burnout in healthcare settings. They found that a workplace with a lack of support and negative communication were antecedents of lateral violence. These findings coincided with findings from my study in which several participants reported poor communication with coworkers and a lack of support, while describing situations in which they experienced lateral violence. Some participants described feeling burnt out

because there was no support from other nurses, working too many consecutive days, or because the stress of lateral violence continued to escalate.

Najafi, et al (2018) identified a lack of communication as a consequence of lateral violence that impacted patient safety. Logan and Malone (2017) noted that teamwork contributed to better patient care. Nurses who are victims of lateral violence may avoid communication with other nurses, which threatens patient safety. Participants in my study noted a lack of communication and teamwork. For example, participants reported having nobody to turn to, a lack of peer support, a lack of intervention when lateral violence was experienced, a lack of support from management, a lack of collaboration with other nurses, only receiving assistance during emergencies, and a refusal to answer questions.

Bardakçı & Günüşen (2016) aimed to determine the influence of lateral violence on nurses' psychological distress. Bardakçı & Günüşen reported that common psychological symptoms resulting from lateral violence included loss of self-confidence, rage, guilty feelings, anxiety, depression, and post-traumatic stress disorder. Similarly, the participants in my study reported feelings of anxiety, guilt, anger, loss of self-confidence, and fear as reactions to experiencing lateral violence. The overwhelming emotions experiencing as a result of lateral violence were also described as the antecedent for post-traumatic stress disorder in one of the participants. Durmus et al. (2018) and Da Silva Joao and Saldanha Portelada (2016) reported gastrointestinal complaints as a physical symptom reported by nurses experiencing lateral violence. One

participant in my study specifically described stomach pain as a reaction to experiencing lateral violence.

A study by Bambi et al. (2018b) aimed to investigate prevalence and risk factors of lateral violence among nurses in health care facilities. Excessively double-checking work was noted to be a behavioral change associated with lateral violence (Bambi et al., 2018b). In my study, participants reported behaviors such as constantly reviewing charting, overthinking small tasks, and keeping excessive amounts of files as proof of work that ultimately limited the amount of time that they spent performing direct patient care.

A positive relationship was identified between lateral violence and errors in treatment or medication administration, delayed care, and adverse events (Houck and Colbert, 2017). Similarly, participants in my study reported increased wounds and infections in patients, incorrect wound treatment, blood cultures drawn improperly, late administration of medications, administration of the wrong medications or the wrong dose of medications, patients having tests or treatments administered late, and missing signs of clinical decline. These errors are representative of unsafe patient care.

Zia-ud-Din et al. (2017) identified a significant relationship between lateral violence and employee absenteeism. These results differed from the responses in my study. When questioned about responses of lateral violence, no participant reported calling in sick or using personal time. Despite reports of feeling overwhelmed, being scheduled to work excessive hours for several consecutive days, given assignments that

the participant was not qualified to do, or forced to work extra shifts with little notice, the participants all chose to report to work as scheduled.

The involvement of leadership in preventing lateral violence is present in the literature. Conflict management is a strategy to prevent lateral violence that includes effective leadership (Yun & Kang, 2014). Nurse managers can influence the presence or absence of lateral violence by preventing, condoning, or engaging in the behavior (Woodrow & Guest, 2017). Logan and Malone (2017) noted that nurse managers could enhance teamwork, and possibly decrease lateral violence, by developing proper policies and training. A surprising finding in this research was that none of the 13 participants found support through their nurse managers. Some participants noted the futility in requesting support from their nurse managers because it would serve no purpose or it would create a more inflammatory work situation. Other managers defended the actions of the abuser or encouraged the victim to find a new workplace. No participant identified a situation in which their manager confronted the abuser and demanded a resolution to lateral violence. In some situations, participants reported that approaching their manager led to punitive responses for themselves, like being forced to take additional classes or being labeled as incompetent.

Limitations of the Study

Limitations were identified in this study. Although the nurses interviewed in this study had a wide range of experiences from various healthcare settings, the results of this study may not represent the experiences of all nurses who have experienced lateral violence. Another limitation was the absence of male nurses in this study. Although the

study was available to both male and female nurses, only female nurses participated in this study. Obtaining experiences from male nurses may have led to a more comprehensive study that better reflected the perceptions of nurses who have experienced lateral violence. While performing qualitative research, there is a risk of researcher bias. As a registered nurse who has experienced and witnessed lateral violence, there was a risk that my personal experiences and feelings could have created bias during the data collection and data analysis process. To prevent this from interfering with the study, an independent analysis of the interview transcripts was performed by my dissertation committee to ascertain that personal bias did not influence the interviews or data analysis. Finally, face-to-face interviews or video recordings may have been effective in identifying themes that had not emerged in the spoken word. Since all interviews were performed by telephone, all data analysis relied on verbal exchange, preventing behavior and body language from being observed.

Recommendations

I conducted this study to bring attention to nurses who have experienced lateral violence and their perceptions of their abilities to provide safe patient care. While there is an abundance of literature available regarding the effects of lateral violence on nurses, there is a lack of data regarding specific associations between lateral violence and patient safety outcomes. Patient safety is a core concern in hospitals and nurses are expected to behave professionally by collaborating with others to provide safe patient care. Recognizing that lateral violence is actively present in healthcare settings is essential in preventing the behavior from occurring or, at minimum, minimizing its effects on nurses

who are experiencing it and still providing patient care. Copanitsanou et al. (2017) acknowledged that healthy work environments require support by colleagues and managers, a reasonable work schedule, an appropriate match between a nurse's responsibilities and his or her skill level, reasonable time and resources to provide patient care, professional autonomy, and opportunities for professional advancement. Several examples provided by the participants in my study demonstrated how lateral violence nurtured an unhealthy work environment that facilitated unsafe patient care. Shielding nurses from lateral violence and its effects may prove to be beneficial.

Recommendations for methods to eliminate lateral violence in the workplace are encouraged in healthcare facilities to provide a healthy workplace that promotes positive patient outcomes. The American Nurses Association (2015) responded to the growing evidence of lateral violence among nurses by recommending evidence-based strategies. These strategies included creating better relationships among coworkers and managers, directly addressing the perpetrator of lateral violence by the victim or the manager, and reducing the negative effects of lateral violence experienced by nurses. By acknowledging that lateral violence is often present in the workplace, taking a clear stand against it, supporting the victim by directly confronting the perpetrator, and providing support services to the victim, healthcare facilities may be better prepared to address this ongoing behavior. This in turn may lead to more collaborative workplaces, in which nurses are able to turn to each other for guidance, provide care in a more productive manner, identify ongoing dilemmas in the workplace and solve them together, and provide the safe and effective care that patients deserve.

A lack of literature describing nurses' perceptions of their ability to provide safe care in unhealthy work environments directed the creation of my study. Utilizing the data collected from nurses who experienced lateral violence, recommendations for future research include: additional qualitative studies to validate the research with a larger participant pool that includes male nurses, conducting face-to-face interviews that capture nonverbal cues that may reveal additional themes, and conducting interviews in separate studies with nurses who are new to the profession and those who are experienced nurses. These studies may provide benefit to nursing administrations, by providing a better understanding of the devastating effects of lateral violence, including how nursing care and patient outcomes are impacted by the behavior.

Implications

Results from this study are reflected in the literature that lateral violence is a behavior that is frequently reported in healthcare settings and that it can affect the physical and emotional wellbeing of nurses. As a response to the ongoing dilemma of lateral violence, several strategies have been implemented in workplaces to prevent lateral violence. These strategies include cognitive rehearsal techniques, conflict management, problem-based learning, educational courses for leaders, and zero-tolerance policies. Despite these efforts to eliminate lateral violence, rates of nurses complaining of exposure to lateral violence are staggering. In addition to its effects on nurses, lateral violence has also been identified as a mediating factor that can affect patient safety. Nurses have described feelings of fear, anger, frustration, burnout, and a lack of support after experiencing lateral violence. These effects of lateral violence influence their

ability to effectively communicate and collaborate with coworkers, leading to opportunities in which errors may occur. These hindrances impact the ability to provide safe and effective patient care, resulting in medication errors, late delivery of care, less hands-on care, missed signs of patient decline, and poor patient assessments.

My study has implications for social change because it contributes to knowledge about nurses' perceptions of their ability to provide of safe patient care after experiencing lateral violence. By providing insight into nurses lived experiences with lateral violence, nurses and nurse managers will view this behavior from the perspective of the victims. With this data, nurses and nurse managers may collaborate to develop an understanding regarding how lateral violence effects nurses and their quality of patient care. By increasing knowledge of nurses' perceptions of their ability to provide safe patient care after being exposed to lateral violence, nurses and nursing leadership may develop a better understanding into why lateral violence is not acceptable behavior or a rite of passage. Instead, lateral violence results in negative consequences to both the nurse experiencing it, and the patients who are under his or her care. This may affect how nursing leadership views the mission and values of the workplace, develops policies and procedures regarding lateral violence, and how they respond to complaints of lateral violence. This may also affect how staff nurses communicate with and respect each other, as they develop an understanding that lateral violence is unprofessional and unacceptable behavior. This may fundamentally change nurses' views of lateral violence, resulting in future generations of nurses experiencing a more civil working environment and having the capability to provide safe patient care. Husserl (1982) noted

that to understand a phenomenon, the observer needs to identify a deeper meaning in an experience instead of assessing the superficial appearance. Husserl (1982) sought to find a deeper meaning in an experience. My study offers valuable insights into nurses' experiences with lateral violence that may be utilized to assist in eliminating the behavior and enhancing the safety of patient care.

Conclusion

My study examined nurses' perceptions of their ability to provide safe care in unhealthy work environments after experiencing lateral violence. By acquiring a deeper understanding of lateral violence among nurses, positive social change may be promoted by enlightening nurse managers and nurses of the danger of lateral violence and by encouraging a change of culture in work environments where nurses support each other. In doing so, nurses may be better equipped to address patient needs and provide safe care.

Lateral violence is behavior that has impacted nurses to an extent that they suffer physical and psychological consequences. It has become so ingrained in the culture of nursing that is often viewed as a norm or an initiation, making it difficult for victims to find support or a means to make it end. Clear and convincing literature has emerged that delineates the effects of lateral violence on the nurse, the workplace, and the patient. Throughout this abuse, nurses are expected to attend work as scheduled and provide care to patients that meets or exceeds the expectations of the healthcare facility. Providing quality care to a patient while experiencing lateral violence is an unrealistic expectation that must be acknowledged by nursing administration and policy makers. Policies, procedures, education, behavioral strategies, and support addressing lateral violence must

be available to all nurses and strictly enforced to ensure that a culture of safety is

maintained for nurses as well as patients receiving their care.

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Appendix A: Interview Protocol

Introduction

Thank you for taking the time to meet with me today to assist in my doctoral

dissertation research.

Prior to Beginning

As you know this is being recorded. If at any time you wish to not answer a question or

stop the interview process you may do so. Being in this interview would not pose any

risks beyond those of typical daily life. There is no personal benefit to you; however, this

research may have a positive impact on nursing in the future. Interview recordings and

full transcripts will be shared with each interviewee, upon request. Transcripts will

identify participants as Participant 1, Participant 2, etc. and my analysis will be shared

with the faculty of my university. The interview recording and transcript will be

destroyed in 5 years' time, as required by Walden University.

Introductory Statement

The purpose of this study is to explore registered nurses' perceptions of their ability to

provide safe care in unhealthy work environments, among those who have experienced

lateral violence. As a registered nurse who has experienced lateral violence, you will be

able to provide unique experiences that will benefit me in exploring how lateral violence

influences your ability to provide safe patient care.

Interview Questions

1. Think back and please describe 1 or 2 occurrences in which you experienced lateral violence.

2. How did you react in these situations?

3. Can you describe your interactions with patients during times when you experienced lateral violence?

4. Can you describe your perceptions of your quality of patient care delivery after experiencing lateral violence?

5. Is there anything else that you would like to add to this interview today?

Closing Statement

Thank you for taking the time to meet with me and share your personal experiences.

Before we close, do you have any questions regarding the interview?

Appendix B: Recruitment Flyer

Registered Nurses Needed for Research Study

Seeking RNs who have experienced lateral violence to participate in a one-on-one interview lasting approximately 60 minutes

Study Purpose
To explore Registered Nurses' perceptions of their ability to provide safe patient care while experiencing lateral violence

Inclusion Criteria
- Being employed as a staff nurses with a minimum of one year experience as a registered nurse and be 18 years of age or older
- Experienced lateral violence and remained in the workplace for at least 6 months afterwards

A $25 gift card will be provided to all who are interviewed

Qualified participants contact Jacqueline Flannery
jacqueline.flannery@waldenu.edu

Appendix C: Recruitment Email

My name is Jackie Flannery and I am a PhD student at Walden University. The proposed research described below is being conducted as a part of my doctoral research and is not affiliated with any hospital.

The purpose of this study is to explore registered nurses' perceptions of their ability to provide safe care in unhealthy work environments, among those who have experienced lateral violence. The benefit of your participation in this study is to provide insight into experiencing lateral violence and your ability to provide safe patient care. As a registered nurse, you provide insight into your individual experiences with lateral violence that may influence change in health care organizations where lateral violence occurs. If you have been employed as a registered nurse for at least one year in a healthcare organization where you have experienced lateral violence, your participation is requested.

To ensure understanding of the study, I am providing definitions for the terms healthy work environment, lateral violence, and patient safety:

Healthy work environment: A workplace supportive of physical, mental, and social well-being, supporting optimal health and safety.

Lateral violence: Behaviors intended to demean, undermine, and/or belittle a targeted individual working at the same professional level.

Patient safety: The absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum.

A consent form is attached for review which you must sign and email back to me prior to the interview. After the consent form is signed, I will also have you complete a brief demographic survey. An interview can then be scheduled. While the preferred method of interviewing would be in person, an online interview or a telephone interview is also possible. This interview should take no longer than 60 minutes of your time. Each participant will be asked a series of open-ended questions regarding their perceptions of their ability to provide safe patient care while experiencing lateral violence. Your participation in this study is voluntary and can be ended at any time during the interview process

If you are interested in participating in this study, please email me at jacqueline.flannery@waldenu.edu and I will respond to set up a day and time to meet. Thank you for your consideration in participating in this study!

Sincerely,

Jackie Flannery, RN, Walden University

Appendix D: Demographics Sheet

Demographics Sheet

Please indicate your gender

□ Female   □ Male

Current age range

□ 18-25   □ 25-35   □ 35-45   □ 45-55   □ 55-65   □ > 65

 How many years have you been a nurse? _____

Have you experienced lateral violence in the workplace?

□ Yes   □ No

Have you remained in the workplace after experiencing lateral violence for at least 6

months?

□ Yes   □ No

Are you willing to be audio and videotaped during this interview?

□ Yes   □ No

Are you willing to be audiotaped during this interview?

□ Yes   □ No