An Educational Program About Horizontal Violence in Nursing: Verbal Abuse and Strategies to

Eliminate the Behavior

by

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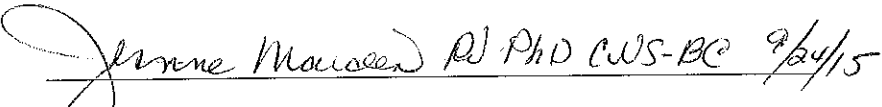
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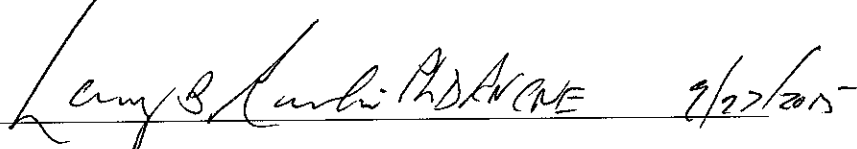
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Abstract

Horizontal violence among nurses is cited as one of leading causes of the dissatisfaction among nurses and consequently creates a crippling effect on the nursing shortage and turnover. To increase retention rates of nurses in the profession and improve satisfaction, healthcare organizations need to maintain a safe environment where nurses can provide care to patients. Research on horizontal violence has been around for more than 30 years, but little information on how to handle horizontal violent situations has been done. The purpose of this project is to develop an educational program about horizontal violence and strategies to eliminate the behavior. The information will be delivered in an educational course format. The course will use a pre- and post-survey to evaluate the effectiveness of the 1-hour informational project on nurses' exposure, understanding and approach of horizontal violence. A comparison of the pre- and post-surveys will be conducted initially after three months of taking the course then yearly to assess and ensure the confidence the nurses' gain in confronting horizontal violence. Moreover, with the implementation and awareness that the course will provide, the prevalence of horizontal violence should drastically decrease over time. The educational project's design is based on a compilation of scholarly publications. The aim is to equip the nurses with comprehensive strategies to reduce horizontal violent incidences.

Keywords: Horizontal violence, lateral violence, verbal abuse, nurse to nurse, new nurse, novice nurse, strategies for nurses, teaching strategies

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Chapter One

Introduction

The need for nurses is ever increasing as many nurses are nearing retirement. With the persistent shortage of nurses in the United States it is imperative to nurture and guide novice nurses in the profession so that they may carry the torch and continue to care for our population in need of healthcare. Horizontal violence among nurses is cited as the forefront of dissatisfaction among new nurses (King-Jones, 2011). Consequently, dissatisfaction at work leads to turnover at the organizational level and causes new nurses distress and some to quit the profession (King-Jones, 2011; Rowe & Sherlock, 2005; Simons & Mawn, 2010). Absenteeism as a result of horizontal violence has cost organizations an annual loss of $191,489 (Simons & Mawn, 2010).

Horizontal violence is a term used to describe inter-group hostility (Hastie, 2009). It is adverse behavior and treatment between individuals or group members (Hastie, 2009; Simons & Mawn, 2010). The term is interchangeable with lateral violence. Horizontal violence is defined as harassment that can be psychologically damaging and includes verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendos, exclusion, denial of access to opportunities, disinterest, discouragement, and withholding of information amongst groups of people or individuals (Hastie, 2009; McKenna, Smith, Poole & Coverdale, 2003).

Nursing horizontal violence in nursing has been in the literature for nearly thirty years; however, the investigative research and implementation of supportive structures regarding horizontal violence have been sporadic.

Significance of the Problem

Over the decades, nurses have been subjected to verbal and physical attacks from colleagues and physicians alike. Horizontal violence has been an ongoing cycle and has left many nurses perplexed as to why it happens and many are ill-equipped to handle the conflict (Sofield & Salmond, 2003). Research has shown that verbal and/or physical abuse and the intent of a nurse to leave the organization are considerably related (Sofield & Salmond, 2003). New nurses are the prime victims of abuse from other colleagues and are the least researched nursing population with regard to abuse in the workplace (Griffin, 2011; Simons & Mawn, 2010). Additionally, the cost of horizontal violence is wide-ranging. Horizontal violence affects at the microscopic level of nursing care to the macro-level of an institution. Of new nurses who experience a form of violence, 60% terminate employment within the first 6 months, leading the organizations to rehire and train new nurses (McKenna, Smith, Poole, & Coverdale, 2003; Rowe & Sherlock, 2005). Economic costs for nurse turnovers are costly for an organization, reporting a loss of $22,000 to more than $64,000 per nurse (Sheridan-Leos, 2008).

Horizontal violence can be conveyed in various ways, but according to Griffin (2004), the 10 most frequent forms of violence in the nursing profession are: Nonverbal innuendos, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken promises. Among the various types of horizontal violence, covert behaviors are more detrimental to the new nurse than openly aggressive behavior (McKenna, Smith, Poole, & Coverdale, 2003; Griffin, 2011). When the violence is covert, nurses tend to accept the violence in fear of further intimidation (Sheridan-Leos, 2008). The effects are so detrimental that nurses experience physical, physiological, and psychological consequences. Nurses enduring horizontal violence exhibit weigh loss or gain,

high blood pressure, heart palpitations, and gastrointestinal irritation (Sheridan-Leos, 2008).

Nurses are also dealing with depression, acute anxiety, low self-esteem and posttraumatic stress

disorder (PTSD) when faced with horizontal violence (McKenna, Smith, Poole & Coverdale,

2003; Sheridan-Leos, 2008). Additionally, acts of horizontal violence can in turn affect the

nurse so much so that the nurse does not perform at their best resulting in poor patient outcomes

and potentially providing care that can cause harm to the patient (Rowe & Sherlock, 2005;

Sheridan-Leos, 2008; Walrafen, Brewer & Mulvenon, 2012).

Statement of the Problem

Verbal abuse among nurses in the acute care setting can cause frustration and distress and

as a result can lead to a crippling effect of the nursing shortage and turnover (Sofield & Salmond,

2003). Furthermore, according to Sofield (2003), the dissatisfaction of the nursing environment

can dissuade other individuals who are thinking about entering the nursing field. With current

concerns for work safety and employee preservation, it is important to investigate the magnitude

and effects of verbal abuse on the new practicing nurse and provide them with the strategies to

confront the disruptive behavior and eliminate it in the nursing work force.

There have been many studies conducted nationally and internationally to assess and

evaluate negative interactions or violence against nurses. Hostility towards nurses are well

explored (i.e. physician to nurse, patient to nurse, and patient's family to nurse), but more

awareness and education programs regarding horizontal / lateral violence are needed (Rowe &

Sherlock, 2005). Assessment of horizontal violence prevalence among new nurses and the level

of distress it imposes on nursing practice, and instruction on effective strategies against lateral

violence in the United States are required (Dimarino, 2011; McKenna, et al., 2003; Rowe & Sherlock, 2005).

Horizontal violence provides an unsafe environment for nurses to practice clinical care that The Joint Commission (2008) has mandated that all organizations create and implement practices and methods to reduce horizontal violence and provide a culture of effective communication and professional code of conduct. It is imperative that nurses recognize horizontal violence and are given tools to ultimately eradicate the damaging problem.

Statement of the Purpose

The purpose of this project were to reveal the characteristics and prevalence of horizontal violence and develop a program that would provide tools for nurses with a focus on new nurses to confront and abolish the behavior in the acute care settings. For this project, the verbal abuse experienced by nurses was assessed and distress from the abuse was explored in the workplace among nurses practicing in the hospital setting. The aim of this project was to examine and reduce the incidence and impact of verbal abuse that nurses are subjected to and increase retention among the nursing field in the acute care setting.

Chapter Two

Literature Review

Historically, nurses have endured abuse from other interdisciplinary teams, notably from physicians. However, recent research has shown that substantial abuse toward nurses was done by other nursing colleagues (Embree & White, 2010). Negative verbal interactions and interpersonal aggression among nurses can create a distressful workplace for the nurse. It is only in the past two decades researchers have begun to take notice of negative interpersonal nursing interactions and the association and detrimental effects it has on the nursing profession (Embree & White, 2010). Search for articles and research publications was done through search databases: CINAHL, ProQuest and Ebsco through the Point Loma of Nazarene University Library and were published from 1999 to the present. Keywords and phrases used to acquire the literature for review were: *Horizontal violence, lateral violence, verbal abuse, nurse to nurse, new nurse, novice nurse, strategies for nurses,* and *teaching strategies.*

Horizontal Violence

Horizontal violence can be carried out against individuals or groups or people in various forms (Hastie, 2009). In the healthcare setting, non-physical abuse is more prevalent and performed than physical (Simons & Mawn, 2010; McKenna, et al., 2003). For the nursing profession, horizontal violence can be expressed by gossiping, the silent treatment or other passive-aggressive conduct and can be psychologically damaging (Rowe & Sherlock, 2005). Examples of horizontal abuse encountered by nurses are verbal threats, intimidation, humiliation, excessive criticism, innuendos, exclusion, denial of access to opportunities, disinterest, discouragement and withholding of information (Hastie, 2009; McKenna, et al., 2003).

Horizontal abuse regrettably, has been an unspoken culture. Deliberate or surreptitious communication through words, tone, or manner that is perceived as disparage, intimidating, patronizing, threatening, accusatory or disrespectful can be considered abusive for a nurse (Embree & White, 2010). According to Simons and Mawn (2010), horizontal violence differs from bullying in that horizontal violence can be a one-time isolated occurrence without authority control between the nurses whereas bullying is considered repeated offenses over a 6 month period (Simons & Mawn, 2010). Inconsistencies in the definition of horizontal violence revealed a scarcity of available evidence that made research of literature and assimilation of horizontal violence and verbal abuse arduous (Embree & White, 2010).

Recent studies have indicated that victims of horizontal violence share the same symptoms of persons with post-traumatic stress disorder (Embree & White, 2010; McKenna, et al., 2003; Rocker, 2008; Simons & Mawn, 2010). Rocker (2008), stated that horizontal violence can cause physical as well as psychological effects synonymous with PTSD such as hyper-arousal, constant anxiety, avoidance of the traumatizing event and flashback. Events of a horizontal violent occurrence can impact a nurse with negative psychological memories so that he or she may not be able to fully function as a safe and effective nurse (McKenna, et al., 2003; Rocker, 2008).

In the descriptive study conducted by McKenna, et al. (2003), anonymous surveys (n= 1169) were mailed to new graduate nurses in New Zealand to assess type and frequency of conflict between experienced nurses and new graduates (response rate 47%). Importantly, the research of interpersonal conflict among nursing was a section from a national survey that explored the impact of interpersonal conflict between patients and nursing colleagues against newly licensed registered nurses. Scores from the participants in the Impact of Event Scale were

tantamount with symptoms of post-traumatic stress disorder (McKenna, et al., 2003). The study found that the most common distressing interactions between nurses involved rudeness, abusive or humiliating comments (McKenna, et al., 2003). The research illustrated the severity of horizontal violence which can impact an individual nurse and cause the nurse to consider leaving the unit, the profession or have increase absenteeism from work. According to McKenna and associates (2003), one of the limits of the study was the initiating factor that precipitated the horizontal violence, the use of self-report and lack of collaborative information.

Simons and Mawn (2010) conducted a qualitative descriptive study on bullying in the workplace for novice nurses from Massachusetts based on Benner's model of novice to expert. From the data, four themes were noted after the analysis; structural bullying, nurses "eating their young", feeling out of the clique and leaving the job (Simons & Mawn, 2010, p. 305). Although the authors were investigating bullying in the workplace, a common denominator for all four themes was a form of negative verbal interaction between the nurses and therefore included as valid research background for this study (Simons & Mawn, 2010). Verbal abuse was noted either covertly or overtly toward the new graduate from a more seasoned nurse (Simons & Mawn, 2010). Written narratives of the study were compiled and processed via content analysis and themes mentioned earlier of bullying were consequence from the analysis. The original design of the study did not fully accommodate the overwhelming response of the 36% answered narratives nor during the open-ended section of the survey did they define *bullying* or elicit responses in relation to the definition (Simons & Mawn, 2010). The survey enabled the nurses to share personal experiences of workplace bullying and confirm that bullying exists in the nurses' places of work. Additionally, Simons and Mawn (2010), found a divergence among the nurses

and their understanding of the definition of bullying and the impact it may have in the workplace.

In Australia, Ferrell (1999) conducted a follow-up study on an original qualitative study of aggression towards nurses. The study pointed out that nurses found aggression from fellow nurses to be more difficult to handle than when received from the patients or physicians (Farrell, 1999). A total of 270 nurses from Tasmania anonymously participated and worked in different clinical settings (Farrell, 1999). Interestingly, nurse to nurse aggression, which was not scored the highest, but considered the most distressing, was in the form of rudeness and abusive language (Farrell, 1999). The study did not indicate the level of experience the nurses had as a nurse, nor did the study have a substantial sample size to determine which clinical settings had the most prevalence of nurse to nurse aggression (Farrell, 1999).

A study by Rowe and Sherlock (2005) explored the stress and verbal abuse nurses were associating with one another. Participants answered surveys that included a Verbal Abuse Scale and the Verbal Abuse Survey adopted by Cox (1987) and Manderino and Berkey (1997). A response rate of 69% made the research noteworthy. Survey results indicated the greatest source of verbal abuse was from nursing colleagues at 27% (Rowe & Sherlock, 2005). Verbal aggression was categorized and rated according to how often it occurred and how stressful it was to the individual. Of the participating nurses in the study, 75% of them revealed they had been spoken to in a verbally aggressive manner by another nurse (Rowe & Sherlock, 2005). The most prevalent type of verbal aggression was anger. Although majority of the nurses who participated stated that they had a good handle of the situation, it was noted that 13% of nurses felt it had impeded the delivery of their care to the patient (Rowe & Sherlock, 2005). Rowe and Sherlock (2005) indicated that verbal abuse was an indisputable problem and can have financial setback to

the healthcare industry in terms of providing poor quality of care to the patients, increase job turnover leading to expensive recruitment and training and discord among nurses.

In a study focused on experiences of verbal abuse conducted by Sofield and Salmond (2003), it was important to note that 91% of nurses indicated they endured verbal abuse in the past month. Using a descriptive correlation design, the authors were able to examine the perceived verbal abuse and the intent of that individual to leave the institution in a metropolitan suburb in the Northeast (Sofield & Salmond, 2003). A verbal abuse survey was used and was pre-tested on 30 nurses before being used on the randomly selected nurses provided by Human Resources of a three-hospital health system (Sofield & Salmond, 2003). Results indicated that most nurses experienced between 1 and 5 incidences of verbal abuse a month (Sofield & Salmond, 2003). Additionally, precipitating factors were included in the study and yielded a result of 42% stating a stressful event took place prior to the verbal abuse (Sofield & Salmond, 2003). The study discussed the nurses' lack of skills to cope and handle verbal abuse as well as organizations not taking corrective action when the abuse occurs (Sofield & Salmond, 2003). The research did not focus solely on negative verbal interactions between nurses, but also included interactions between physicians, patients, and patient family members.

Many of the studies reviewed had commonality in that communication and interpersonal conflicts with medical staff and supervisors were the most distressing. Verbal abuse can be quite costly to the institution, the nurse and the patient (Rowe & Sherlock, 2005). Nurse to nurse verbal conflict has a notably debilitating impact on the new nurse and on his or her job satisfaction and sense of well-being in the workplace (McKenna, et. al., 2003; Rocker, 2008; Rowe & Sherlock, 2005).

Theoretical Framework

  The theoretical framework for the educational program for new and experienced nurses on identification and strategies for elimination of horizontal violence is the empowerment theory. Three central levels of the empowerment theory are involvement and control for the individual, organization, and community (Zimmerman & Warschausky, 1998). According to Zimmerman and Warschausky (1998), the empowerment theory incorporates "perceptions of control, a proactive approach to life, and a critical understanding of the sociopolitical environment" in order to attain goal achievement (Zimmerman and Warschausky, 1998, p. 4). Successful mastery and control over situations that are of concern can begin at the individual level and can affect the organizational and community level; however, Zimmerman and Warschausky (1998) mentioned that organizational and community empowerment is not simply accomplished by having an assembly of empowered individuals, but through levels of analysis. Each level of empowerment has 3 main components: values, processes, and outcomes. With each level- individual, organization, and community- there are three components within– values, processes, and outcomes- that influence how professionals work determine the culture of the organization and the effect it has on the community (Zimmerman & Warschausky, 1998). At the individual level of analysis, Zimmerman and Warschausky (1998) elaborate further upon psychological empowerment and empowerment that an individual has to motivate them to participate and make changes.

  Empowerment values can provide a belief of thought for an individual, a culture for an organization or even be influential for a community (Zimmerman & Warschausky, 1998). The empowerment values can command in either direction of a spectrum- great health versus poor health, capability versus insufficiency and how behaviors are conducted (Zimmerman &

Warschausky, 1998). It is also noted that values can provide development of skills to foster change or a condition, and work with others to overcome obstacles that are causing limitations in their organizations and communities.

The empowerment processes are levels in which individuals, organizations and communities are achieving control over concerning issues, cultivating a sense of awareness about their settings and contributing in decision-making developments that affect their lives (Zimmerman and Warschausky, 1998). During the empowerment processes, Zimmerman and Warschausky (1998) further explained that it was in this involvement that a person was able to explore and acquire resources and learn skills needed to intervene and purge the external forces that are hindering progress towards common goals. Interventions incorporated in the empowerment processes help people come together to integrate shared knowledge and learn from one another which can provide support, create improved skills at the organization level and impact the social and community environment in the way the collective group would want it to be (Zimmerman & Warschausky, 1998).

Opportunities to contribute through participation and collaboration will be a consistent theme for the duration of the empowerment process at all levels- individual, organizational, community (Zimmerman & Warschausky, 1998). Zimmerman and Warschausky (1998) provided examples of empowerment processes at the three varying levels for analysis (See Table 1).

Empowerment outcomes are considered to be the results of how effective the empowerment processes were. Zimmerman and Warschausky (1998) mentioned that in order to know if someone has been empowered, the outcomes must be analyzed. In research, the

empowerment outcomes refer to the variables that are consequences from the interventions learned or gained from all three levels: individual, organizational, and community.   According to Zimmerman and Warschausky (1998), empowerment outcomes "refer to control, awareness, and participation, these may also be operationalized differently across levels of analysis" (p.6). Empowerment outcomes at the individual level of analysis are considered to be the groundwork for empowerment for the other levels (Zimmerman & Warschausky, 1998).

The theory of empowerment with the emphasis at the empowered individual level was further explored by Zimmerman and Warschausky (1998) through Psychological Empowerment (PE). The individual was driven to control, understand or gain skills necessary to guide and create a lasting impact on the environment depending on the circumstance and people. According to Zimmerman and Warschausky (1998), PE has been theorized into a three-part section- *intrapersonal*, *interactional* and *behavioral*.

At the individual level of the empowerment theory, the intrapersonal section refers to a person's perception about themselves, the control they have over situations- self-efficacy, and capability they possess to handle the situation (Zimmerman & Warschausky, 1998). Zimmerman and Warschausky (1998) mentioned that perceived control was referred to *domain-specific* in reference to the control a person may think they have in a various array of situations that may be personal, interpersonal or sociopolitical. Zimmerman and Warschausky (1998) also noted that self- efficacy was only one aspect of PE and that the perception of an individual can vary- positive and negative. A poor outlook on one's self can foster low PE and can be correlated to negative outcomes.

In the *interactional* segment of PE, Zimmerman and Warschausky (1998) refered to how individuals think and relate to their environment. The interaction and involvement of individuals with one another facilitate the outcomes of their social and community successes or dissatisfactions (Zimmerman & Warschausky, 1998). At this level, change occurred to create a more positive result if desired. In this component of PE, an individual's capacity to have critical awareness, decision-making, and problem-solving skills are essential to actively empower others to change the environment in the direction that they choose (Zimmerman & Warschausky, 1998). Critical awareness in PE is defined as the individual's understanding of the resources available, information of how to attain the resources and abilities to manage to resources to achieve a desired objective (Zimmerman and Warschausky, 1998). The crucial element of the interactional section of PE is the individual's ability to influence others to utilize resources or exercise learned skills through leadership, decision-making, and problem-solving (Zimmerman & Warschausky, 1998). Individuals who have the capacity to disseminate resources make evident that there was social or environmental mastery (Zimmerman and Warschausky, 1998).

Lastly, the *behavioral* component of PE refers to the actions the individual initiates to influence others in the social environment through participation in organization and community activities as well as the ability for the individual to cope and adapt to stress and change (Zimmerman and Warschausky, 1998). Zimmerman and Warschausky (1998) stated that an individual's participation in community activities was essential to influencing others because they lead by example.

The intrapersonal, interactional, and behavioral framework of PE can be utilized to assess specific conditions. According to Zimmerman and Warschausky (1998), all three sections of PE framework must be measured in order to completely acquire PE. The authors (Zimmerman and

Warschausky, 1998) noted that capturing PE is complex and may be difficult to identify in single trait, suggesting a Likert-type measure may need to be incorporated when assessing and evaluating intrapersonal, interactional and behavioral components of PE. Furthermore, Zimmerman and Warschausky (1998), stated that individuals who scored high in all three components are considered highly empowered. Individuals who scored high in the intrapersonal component, but low in the interactional and behavioral components are considered to have limited PE (Zimmerman and Warschausky, 1998).

In summary, empowerment theory advocates that participation and control are the core components at the *individual*, *organizational*, and *community* level. With these three levels, correlation and understanding of *values*, *processes,* and *outcomes* are essential in an effort further conceptualize empowerment at the individual level (Table 2). The *values* are the beliefs that direct the way professionals or clients interact together. The *processes* are the implementations made through awareness, development and training of skills for their environment and community. The *outcomes* are the consequences of the empowerment processes. The *intrapersonal*, *interactional* and *behavioral* framework of PE is helpful in understanding the way the individual will perceive themselves, their external surroundings, and how they will react. Overall, outcomes at the individual, organizational, and community level can be applied to recognize and address future factors that inhibit an individual's or community's effectiveness for goal achievement and promote empowerment.

Chapter Three

Program Description

Motivation to developing this educational program was to explore the familiarity nurses have with horizontal violence and provide teaching strategies to put an end to verbal abuse among nurses in the acute care setting. It was mandated by the Joint Commission for healthcare institutions looking forward to accreditation and for accredited healthcare organizations to maintain elite standards of care to develop programs to manage horizontal violence and to provide a culture of safety (Joint Commission, 2008). In order to improve nurse retention and eliminate horizontal violence behavior, involvement of all disciplines of healthcare workers should be incorporated in the educational program (Thomas, 2010). Additionally, this educational program will empower nurses to come forth with incidences as well as acknowledge the behavior as it occurs (Thomas, 2010).

The new nurse is more likely to be subjected to horizontal violence within the first year of their professional nursing practice (Thomas, 2010). For this reason, it is imperative to invest in and empower our new nurses by educating them about horizontal violence and providing strategies in managing this disruptive behavior. Removing horizontal violence in the healthcare setting is a progressive process and can be done (Thomas, 2010). Referring back to the Empowerment Theory, the participation in this educational program and the information learned from the new nurse would allow them to have critical awareness of horizontally violent situations and gain control leading to behavioral components that can influence the culture of the acute care setting (Zimmerman and Warschausky, 1998).

Teaching and Learning Strategies

Knowledge and education about horizontal violence is crucial when promoting a healthy

work environment. The learning in this type of program is unique in that the students in this

setting are professional Registered Nurses. The Adult Learning Theory (ALT) will be the

underlying principle framework of how the program will be conducted.

The Adult Learning Theory, conceptualized by Knowles, Holton & Swanson (1998)

indicates that andragogy puts an emphasis of the teaching method to reflect on the adult learner

and not the instructor. Adult learners, in this case, Registered Nurses, are autonomous and self-

directed making the creation of a syllabus unique in that the student is more responsible, mature

and experienced (Beckman & Lee, 2009; Knowles, et. al., 1998). Incorporating clinical and

personal experience to the program will enhance the learning session. Not only will it include

didactic material, facilitated discussions will enhance the learning opportunity. Derived from the

Adult Learning Theory, a Collaborative Approach was developed by Beckman and Lee (2009) to

be applied to clinical teaching. The Collaborative Approach has four essential components: 1.)

establish relationship with the learner, 2.) diagnose the learner, 3.) use teaching frameworks that

engage learners, 4.) develop teaching scripts and a personal philosophy.

Establish Relationship with the Learner

According to Beckman and Lee (2009), establishing a relationship with the learner begins

with the environment of teaching and is influenced by the learner's motivation to be present,

which they call the learning climate. Creating a positive learning climate was dependent on

surroundings, the teacher, and the learner, but the behavior that the teacher demonstrates is the

most important role. Beckman and Lee (2009) acknowledged that providing a positive learning

climate was essential, but does not determinate learning. Meaning that, excellent teachers cannot facilitate good learning without great learning climates and creating positive learning climates are not enough for teachers who lack proficiency (Beckman & Lee, 2009). Furthermore, research has supported that teacher-learner relationships are influential in motivation and learning (Beckman and Lee, 2009).

Another implication Beckman and Lee (2009) address in order to establish a relationship with the learner is to *ask questions*. The skill of asking questions effectively by exhibiting the capability to listen, recognize facial expressions and adjust questions to the learner's level of understanding can aid the teacher-learner relationship to head in a positive direction (Beckman and Lee, 2009). Beckman and Lee (2009), further suggest the use of Bloom's taxonomy of educational objectives to build questions for learners. Bloom's taxonomy is a system of categories that elicit questions from a range of complexities: knowledge, comprehension, application, analysis, synthesis, and evaluation (Beckman & Lee, 2009). The sequence of questions can begin from recall (lower order –knowledge) and can be developed into more complex questions (higher order –evaluation) to implore clarification of information, confirm evidence learned or facilitate agreement among learners (Beckman & Lee, 2009). In order to solidify a teacher-learner relationship, Beckman and Lee also state that swapping between simple and complex questions can lead to confusion and should be avoided (2009). Henceforth, questions should be built upon and probing-type questions encouraged to assess the learner's clinical understanding and decision-making (Beckman and Lee, 2009).

Correspondingly, Beckman and Lee (2009) mentioned that teachers need to give feedback. Feedback is explained as the return of information that when processed backward from the performance is reformed while maintaining pattern and methodology. Beckman and

Lee further state that feedback is considered formative and constructive whereas evaluation implicates judgment (2009).

Diagnose the Learner

The second segment of the Collaborative Approach is diagnosing the learner. According to Beckman and Lee (2009), diagnosing the learner was a crucial process where the teacher was able to assess the knowledge and skills of the student in order to improve the learner's clinical growth and reasoning capacities.

Diagnosing the learner can be done in two ways –analytic or synthetic (Beckman and Lee, 2009). As an analytic learner, the student learns concepts and ideas by breaking them into individual phases and will demonstrate competency in previous phases before proceeding to the next concept (Beckman and Lee, 2009). A synthetic learner builds from concept to concept and ultimately compiles the knowledge and apply it. Furthermore, Beckman and Lee (2009) mentioned that there is a spectrum of synthetic learners from weak to strong depending on their basis of understanding the teachings.

Use Teaching Frameworks That Engage Learners

The tertiary step in a collaborative approach to clinical teaching is using a teaching framework that will engage the learner. Beckman and Lee (2009) recommend the teaching model S.N.A.P.P.S. S.N.A.P.P.S is short for summarizing, narrowing, analyzing, probing, planning, and selecting (Table 3). The collaboration is considered a progressive model because learners are encouraged to probe their teachers with inquiry and at the same time, teachers are able to recognize their own learning limitations (Beckman & Lee, 2009). Reciprocation between teacher and learner was important when using this method of teaching, it may seem that learners

are the ones who have control on the direction of the course, but teachers are guiding the student through the complexities of the course.

Develop Teaching Scripts and a Personal Philosophy

The last segment of the collaborative approach to teaching focuses on the teacher and suggestions to develop and use teaching scripts (Beckman & Lee). Beckman and Lee (2009) acknowledge that it was challenging to teach multifarious information to novices and that individuals who use teaching scripts are considered effective teachers. Teaching scripts are instructional knowledge concepts representative of the teacher's accrued experiences on topics (Beckman and Lee, 2009). Developing and using teaching scripts are recommended as follows: (1) Slow down; (2) Practice; and, (3) Keep a running list. Beckman and Lee (2009) stated that by slowing down during teaching connections and reflecting can create an opportunity for the teacher to explain and share their experiences more effectively. The authors mentioned that novice teachers can struggle with means to communicate their pearls of wisdom to students, but slowing down allows the teacher to be more precise. Secondly, Beckman and Lee (2009) indicated that whenever an opportunity arises to practice your scripts –practice them. Utilizing other resources (i.e. handouts, PowerPoints, diagrams) to help practice your scripts help build self-assurance and allow you to cater to varying learning levels. Lastly, keeping a current running list of preferred teaching scripts can support the teacher to become more comfortable with the information taught that the list becomes second-nature and will no longer be needed (Beckman and Lee, 2009).

Last but not least, developing a personal philosophy of teaching as a collaborative approach is mentioned by Beckman and Lee (2009). Having a personal philosophy to teaching

can create a customized approach to educating students. Teaching can reveal strengths and weakness that educators may have; resulting in teachers following a rigid path that removes from the focus of what a teacher *should* be (Beckman & Lee, 2009). Meditating and through reflection teachers will be reminded of why they invest in teaching and can polish their teaching styles and provide motivation.

Using the collaborative approach will enhance the teacher-student relationship. Students who are medical professionals are adults who learn best when the teacher-learner relationship is that of colleagues (Beckman & Lee, 2009).

Learning Outcomes

Registered Nurses (RN) are responsible in providing safe and efficient patient care. Behaviors associated with horizontal violence can yield nurses to feel disparaged and can lead to poor patient outcomes (Joint Commission, 2008; Walrafrn, Brewer & Mulvenon, 2012). RNs are entitled to work in an environment where they feel safe and are able to deliver patient care without the additional stress of horizontal violence (Joint Commission, 2008). With awareness, education and implementation of strategies to abolish horizontal violence, RNs can change the direction of culture and values within the nursing profession, so no one experiences horizontal violence.   The Collaborative Approach emerged from the ALT will be utilized when creating the course outline and learning outcomes. The RNs attending the course consist of bed-side nurses, administrative nurses, and nurses in a supervisory and management role. Tables 4 and 5 illustrate the breakdown of course competency, objectives and learning outcomes.

Program Content

Course content will be disseminated using the collaborative approach to teaching as well as incorporating various methods to reach different learning styles. In accordance with the Collaborative Approach to teaching, the course will begin with getting to know the learners (Beckman and Lee, 2009). Establishing rapport and trust with the learners is key so that they may open up and share sensitive experiences within the group. The course will be offered to registered nurses currently working in the hospital as well as new-hire Registered Nurses. Registered Nurses in administration or supervisory roles will be offered the course in a different group from staff nurses. The sessions will be in groups of 15-20 Registered Nurses and the course will be an hour long. Delivery of content in a smaller group provides for a more intimate setting for such a vulnerable topic.

In order to provide a safe place to discuss horizontal violence, RNs will be notified via email of confidentiality and required to sign a consent (Appendix A) prior to attending the course. During the course of an hour, time will be sectioned into ten minutes. The first ten minutes of the course will be allotted to creating a relationship and assessing the learners through a written survey about horizontal violence and discussing the importance of confidentiality of content discussed in the course. Additionally, the placement of the chairs in the course will be in a U-shape so that all participants can actively listen and engage in each discussion. Introduction of self by each person will occur at this time.

Parallel to Beckman and Lee (2009), the learner attending will create a reference point. With the intention of continuously tracking learning progress and provide timely feedback on staff learning, a written survey that will include multiple choice and Likert scales will be

conducted to get a baseline assessment of the registered nurses' understanding of horizontal

violence as well as strategies they are aware of. The same survey will be distributed again in 3

months to assess progress and knowledge gained about horizontal violence. To further engage

learners, a ten minute power point presentation about course objectives and introduction to what

horizontal violence is will be presented after the survey. After the presentation, Registered

Nurses will divide into groups of five to discuss their own personal experiences of horizontal

violence and how they dealt with the situation. Groups will decide which scenario to share with

the class via role-playing. Another power point presentation will be presented to explain

strategies and interventions of horizontal violence, including policies and procedures of the

hospital regarding horizontal violence. Collective discussion will then take place again once

knowledge on strategies have been disseminated. At this time, learners will have been able to

develop or modify scripts and strategies of their own (Beckman and Lee, 2009). The remaining

ten minutes of the course will be dedicated to further questions learners may have, feedback of

the course and resources for RNs regarding horizontal violence. At this time, learners will also

be presented with a Code of Conduct Contract (Appendix B) to sign to help eliminate horizontal

violence in the work place. The contract will be placed in their professional file.

Program Evaluation

Evaluation of the course will be appraised in two different techniques. According to

Teaching Strategies for Nurse Educators (DeYoung, 2009), there are various ways to evaluate

learning. Due to the nature of the course, time limitation and support of the hospital

organization, evaluation will consist of Classroom Assessment Techniques (DeYoung, 2009).

By utilizing Classroom Assessment Techniques (CAT), feedback is provided for both the teacher

and the learner of the effectiveness of the teaching and student learning (DeYoung, 2009). A

comparison of the written survey at the beginning of the course and 3 months later will be

conducted to evaluate the effectiveness of the course. The Self-Confidence Survey technique

will be used to gauge confidence the learner possesses in dealing with horizontal violence before

and after (Appendix C) in form of multiple choice and Likert scales. The technique of role-

playing will be utilized to create empathy and evaluate learners in a subjective manner. The

evidence of effectiveness of role-playing will be reflected in the Self-Confidence Survey at the

three month survey mark.

Chapter Four

Project Evaluation

Design

The Horizontal Violence course will use a pre- and post-survey to evaluate the success of the program. The tests provided prior to the educational class and 3 months after will determine the progress and awareness of horizontal violence in the hospital setting. The educational project presented will be broken up into 3 sessions per week per month for two months to ensure as many nurses can attend given their busy work schedules and to accommodate various shifts. In alignment with the expectations of nurse conduct mentioned by The Joint Commission (2008), attendance by all RNs will be strongly advised. The course will be a combination of lecture presentations, discussion, and role-playing.

The introductory segment of the course will go over course objectives. The initial presentation will contain an overview of horizontal violence terminology, what it is, and expectations of the hospital (via policy and procedure) as well as The Joint Commission. The second portion of the course will consist of discussion and breaking into groups. Discussion will primarily be learner driven and experiences they may have had with horizontal violence. Groups of 4 to 5 will then be formed to deliberate strategies that can be utilized to avert or deter horizontal violence in situations discussed. A second presentation will be shared containing sound strategies mentioned in scholarly journals that have positive outcomes to eliminate horizontal violence. Subsequently, another break into groups will be made to promote further discussion about strategies that may be adopted and create skits to share with class on how to deal with horizontal violent situations. Lastly, the final segment will provide time for questions,

signing of the Code of Conduct Contract, and course feedback and evaluation. A notice of a post survey will be mentioned at the end of the course and will be emailed to the learners in three months to determine if course information was effective. Throughout the course statistics, types of interventions and implementations on horizontal violence will be presented.

Setting and Sample

The setting will be at a community based hospital in San Diego, California. All registered nurses employed at the hospital will be invited to participate in the course and attendance will be strongly recommended. The inclusion criteria includes: (a) registered nurses regardless of sex, level of degree attained; (b) full- or part-time employment; (c) management, leadership role, or staff RN; (d) new grad RNs. Exclusion criteria will include: (a) registered nurses who are from the float pool, (b) external RNs from same healthcare system, but different hospital; (c) student RNs.

Instruments

Self-Confidence Survey. The 20-item question survey will consist of questions that will gauge the awareness of the learner on the subject of horizontal violence. Additionally, the same survey will be emailed to the learner after three months to determine effectiveness of strategies. The questions will be in a multiple choice format or Likert scale. The questions will derive from a compilation of scholarly journals about horizontal violence and strategies to eliminate the behavior. Determining the score will be done by calculating the overall percentage of the survey and dividing it by 20. The Likert scale portion of the survey will be tallied to determine the impact the course has made for the learner. The initial survey questionnaire will be compared to the three month questionnaire to evaluate improvement on disruptive behavior –if any.

Role-playing. Role-playing is a teaching strategy that enables the learners to gain skill in interpersonal conflicts (DeYoung, 2009). Horizontal violence is an unwanted behavior and provided time to create skits and role-play, learners can develop empathy (DeYoung, 2009). The groups will enact a three minute scenario and two minutes afterwards will be allotted to discussion of role-playing scene. No concrete evidence of learning will be assessed, but can later be revealed in the three month follow up survey.

Code of Conduct Contract. A Code of Conduct Contract will be an instrument utilized to promote accountability for the participant's actions. A clear and concise contract will be devised to state the behavior expectations and policy of the healthcare organization. It will also remind participants of the consequences of undesirable behavior. The Code of Conduct Contract prompts adherence to the policy of the hospital as well as prevents deviation of unprofessional behavior (Dimarino, 2011).

Data Collection Procedures

In order to evaluate the value of the course, the survey done at the first time of presentation and at the three month mark will be compared. Due to the sensitive nature of the course, the consent will ensure the protection of the information collected will be kept in a secure place and only available to the instructor. The consent will also state that participation of the course, as well as the surveys collected, will not affect their employment status.

Within each nursing unit or department, random code numbers will be assigned to each survey and will have a corresponding survey to follow with the same numbers. Numbers will then be paired with the email of the individual who filled out the survey. This information will

only be known to the instructor. Nursing units and departments will be separated to assess the different perceptions of horizontal violence before and after the course.

First thing during the 1-hour educational course on horizontal violence, the participants will answer the Self-Confidence Survey. Once the time frame has lapsed for the course to be disseminated, a baseline gathering of all the information will be created. In three months the same survey will be sent out via email with a one-week time frame to complete. The information collected from the second survey will be compared to the baseline data.

The effectiveness of the horizontal violence course will be assessed each year, beginning with the initial rollout of the first educational course (baseline). The data will be monitored and compared to ensure that nurses are gaining confidence in confronting horizontal violence and eventually eliminating the behavior. Regular evaluation of the data will be crucial to maintain an environment of professional behavior because of the continual hiring of new nurses. Ensuring we continue to foster a professional workplace and that unprofessional behavior is unsatisfactory.

Data Analysis

Descriptive statistics will be applied in order to compute the means, medians, deviations, variances, and percentages of data collected. Measures of tendencies and spread will be analyzed using the Statistical Package for Social Sciences (SPSS) version 18.0 computer program. The significance level for the intention of this educational project will be set at $p < 0.05$.

Chapter Five

Discussion

Awareness in the topic of horizontal violence amongst nurses has increased steadily in

recent years. Nursing as a profession should make every effort to eliminate the behavior.

Successful implementation of horizontal prevention strategies and policies in hospital settings

should begin with education (Coursey, Rodriguez, Dieckmann, & Austin, 2013). Education

surrounding horizontal violence as well as strategies to prevent it are not consistent. Awareness

through education on horizontal violence can provide clarity to misperceptions of behavior in

nursing culture –whether the behavior is acceptable or not (Walrafen, Brewer, & Mulvenon,

2012). However, each hospital and even within each unit have workplace cultures unique to

them. Therefore, measures to eliminate horizontal violence will vary. Zero tolerance policies

are used to implement a conducive workplace and deter horizontal violence, yet, evidence

reveals that that method was ineffective for some healthcare facilities (Coursey, et. al., 2013).

After implementing an educational program that included codes of conduct, continuing education

on the topic, and support from leadership, one surgical center no longer had nurse turnovers,

nurses were satisfied with their employer and nurses felt safe in their work environment

(Dimarino, 2011).   Moreover, with horizontal violence education, evidence for retention rates

for newly registered nurses was 91% and for experienced nurses 95% at an acute care hospital in

Boston compared to a national retention rate of 40% -60% (Griffin, 2004). There were methods

that worked in other facilities, but were ineffective in others (Coursey, et. al., 2013).

Support from leadership team members and administration as well as policy changes can

certainly direct the transformation of the hospital to prevent horizontal violence and improve

work contentment (Coursey, et, al., 2013). Educational programs on horizontal violence are being designed to help nursing professionals end disreputable behaviors at the workplace. Education presented will bring forth accountability, commitment, and respect to the healthcare organization, delivery of safety to all and build a place of work for nurses to provide excellent care to patients (Dimarino, 2011).

Implications for Nursing

Efforts to eliminate horizontal violence is important. According to Thomas (2010), removing horizontal violence from the nursing profession is a process that will need to incorporate a cluster of many different strategies and takes time. Despite the varying strategies and implementations to eradicate horizontal violence, leadership development and support has been a unified theme amongst all research done (MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2011; Walrafen, et. al., 2012; Hastie, 2009).

Implications for nurse administrations are to assess and determine the needs of the acute care units. Support from nursing management is imperative in order for nurses to continue to recognize, educate, monitor and evaluate effectiveness of educational programs about horizontal violence and cultivate a workplace where horizontal violence does not take place (Thomas, 2010; Walrafen, et. al., 2012). Staff nurses need to feel they are in an environment where administration is committed to eliminating horizontal violence and therefore feel safe and supported enough to report defiance and that there will be a follow-up to the matter (Longo, 2010).

Implications to nursing education is that learning styles and personal experience differ with each nurse and so with it, the courses about horizontal violence will have to be adjusted

according to the culture and needs of the hospital (DeYoung, 2009). Similarly, nursing school programs should include the topic of horizontal violence, strategies and prevention (Griffin, 2004; Thomas, 2010). Education in the academic setting can empower and provide tools for the future licensed nurses on how to deal with such behaviors (Griffin, 2004).

Implications for nursing staff are to take an active part in eliminating horizontal violence. Staff nurses need to be cognizant of their own actions. Continuing education on the subject and cultural awareness can bring forth accountability, understanding, professionalism (Walrafen, et. al., 2012; Longo, 2010). Nursing staff have an obligation to creating and maintaining a workplace where there is no tolerance for horizontal violence. Staff nurses need to continue to develop skills to counter horizontal violence and their willingness to report the unwanted behavior (Long, 2010). Collaboration amongst nurses can also be powerful in eliminating horizontal violence. When nurses stick together in situations where there is an individual causing horizontal violence, there becomes a power shift, because it is no longer a nurse to nurse issue, but a nurse to nurse-with-her-colleague's issue (Longo, 2010). This scenario can support empowerment for the group to stop horizontal violence and interference from patient care (Longo, 2010).

Limitations to the Project

There are several limitations to this project. The number of nurses participating in the educational program may be the first limitation. The sample size will be taken from a suburban 343-bed community hospital, therefore, the impact of the results may not be substantial for research at a national level. Secondly, the education and implementation of strategies shared in the project is not generalized, meaning, strategies that worked in this healthcare setting may not

be applicable for another as well as between different units within the hospital. Another limitation would be that the validity and reliability of the course and Self Confidence Survey used in the educational program may not accurately portray the growth and awareness the nurses have about horizontal violence if used in another healthcare setting. Because the classroom size is more intimate and the topic is considered a sensitive one, the nurses may not be entirely truthful when answering or participating. Lastly, the limitations to the inclusion and exclusion criteria is specific to one profession in one hospital setting, obtaining a fair evaluation of the project may not be clear-cut.

Future Studies

Initiating an educational program about horizontal violence is a good starting point to bring awareness and arm nurses with skills to combat the disruptive behavior. Currently, there is not enough sufficient research that provides effectiveness of evidence-based implementations of interventions (Coursey, et. al., 2013). Minimal evidence-based information is available which can assist hospital leaders adopt best practice methods to deal with horizontal violence and prevent destructive work environments (Coursey, et. al., 2013). The challenge for future studies is to investigate what interventions have been consistently effective in various hospital settings and create a unified program that can be reliably effective.

Conclusion

Horizontal violence is a disruptive behavior that can hinder a nurse from performing his or her best in the profession. The consequences of unresolved horizontal violence can cause dissatisfaction at work, which then results in turnover at the organizational level and causes new nurses distress and some to quit the profession (King-Jones, 2011; Rowe & Sherlock, 2005;

Simons & Mawn, 2010). In summary, application of an education program about horizontal

violence for new and experienced nurses can improve the work environment and in turn, have

safer outcomes for patients. Awareness, education, and strategies about horizontal violence can

increase job satisfaction, create great professional relationships, and effective communication.

The notion of abolishing horizontal violence in the hospital setting seems incredible; however,

with commitment, clear expectations, and consistency it can be done and is not impossible.

References

Beckman, T.J., & Lee, M.C. (2009). Proposal for a collaborative approach to clinical teaching. *Mayo Clinic Proceedings, 84*(4), 339-344.

Cheryl, Y. W., & Ruth, M. (2007). Nurse on nurse. *Nursing Forum, 42*(3), 123.

Coursey, J.H., Rodriguez, R.E., Dieckmann, L.S., & Austin, P.N. (2013). Successful implementation of policies addressing lateral violence. *Association of PeriOperative Registered Nurses Journal, 97*(1), 101-109.

Cox, H. C. (1987). Verbal abuse in nursing: Report of a study. *Nursing Management, 18*(11), 47-50.

DeFrino, D. M. R. (2009). A theory of the relational work of nurses. *Research and Theory for Nursing Practice, 23*(4), 294.

DeYoung, S. (2009). *Teaching Strategies for Nurse Educators* (2nd ed.). Upper Saddle River, N.J.: Prentice Hall.

Dimarino, T. J. (2011). Eliminating lateral violence in the Ambulatory setting: One center's strategies. *Association of PeriOperative Registered Nurses Journal, 93*(5), 583-588. doi:10.1016/j.aorn.2010.10.019

Embree, J., & White, A. (2010). Concept Analysis: Nurse-to-Nurse Lateral Violence. *Nursing Forum, 45*(3), 166.

Farrell, G. A. (1999). Aggression in clinical settings: nurses' views -- a follow-up study. *Journal of Advanced Nursing, 29*(3), 532-541.

Griffin, C. (2011). Healthy work environments: Empowerment strategies for Medical-Surgical nurses dealing with lateral violence. *Med-Surg Matters, 20*(5), 4-5.

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

Hastie, C. (2009). Horizontal Violence in the workplace. *Birth International.* Retrieved from https://www.birthinternational.com/articles/midwifery/69-horizontal-violence-in-the-workplace.

Joint Commision. (2008). Sentinal event alert: Behaviors that undermine a culture of safety. Retrieved from http://www.jointcommission.org/assets/1/18/SEA_40.PDF

Knowles, M.S., Holton, E. F., & Swanson, R. A. (1998). *The Adult Learner: The Definitive Classic in Adult Education and Human Resource Development* (5th ed.). Houston, TX: Gulf.

MacPhee, M., Skelton-Green, J., Bouthillette, F., & Suryaprakash, N. (2011). An empowerment framework for nursing leadership development: supporting evidence. *Journal of Advanced Nursing, 68*(1), 159-169. doi: 10.1111/j.1365-2648.2011.05746.x

Manderino, M. A., & Berkey, N. (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing, 13*(1), 48-55.

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96.

Rocker, C. F. (2008). Addressing nurse-to-nurse bullying to promote nurse retention. *Online Journal of Issues in Nursing, 13*(3), 11p.

Rowe, M. M., & Sherlock, H. (2005). Stress and verbal abuse in nursing: do burned out nurses eat their young? *Journal of Nursing Management, 13*(3), 242-248.

Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing, 12*(3), 399-403.

Simons, S. P., & Mawn, B. P. (2010). Bullying in the workplace- A qualitative study of newly licensed registered nurses. *American Association of Occupational Health Nurses Journal, 58*(7), 305.

Sofield, L., & Salmond, S. W. (2003). Workplace violence: a focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing, 22*(4), 274-283.

Thomas, C. (2010). Teaching nursing students and newly registered nurses strategies to deal with violent behaviors in the professional practice environment. *The Journal of Continuing Education in Nursing, 41*(7), 299-308.

Walrafen, N., Brewer, M.K., & Mulvenon, C. (2012). Sadly caught up in the moment: An exploration of horizontal violence. *Nursing Economic$, 30*(1), 6-12.

Zimmerman, M. A. & Warschausky, S. (1998). Empowerment theory for rehabilitation research: Conceptual and methodological issues. *Rehabilitation Psychology, 43*(1), 3-16.

Appendix A

Consent Form to Participate in Horizontal Violence Course

Introduction- I understand that I am being invited to participate in an informational research course by my leadership team. My participation is voluntary and I have the option to withdraw prior to the start of the course without penalty. It is important that I read through the following information and ask questions as necessary to be sure that I understand what I am being asked to participate in. I can obtain a copy of this consent form from the course instructor. The purpose of this course is to understand better aspects of horizontal violence and learn strategies to eliminate the behavior in the workplace.

Purpose of this course- This course is designed to identify disruptive behavior in the workplace among Registered Nurses defined as Horizontal Violence. The course will include strategies to improve work relationships by providing interventions to deter Horizontal Violence.

Procedures- I understand that the proposed length of my participation in this course consists of one session. The entire session will last approximately 1 hour. During this time I will respond to a questionnaire, as well as participate in skits and discussions pertaining to horizontal violence. Another questionnaire will be issued at a designated email provided within 3 months to determine if the course was effective in my workplace.

Risks- Although no risks are currently known in relation to this study, I understand that there may be a potential for minimum risk. The nature of the topic is sensitive and during the course absolute confidentiality must be made by each participant prior to the course beginning. During the course of the session, I may experience some feelings of discomfort related to the nature of the topic or scenarios presented. I have the option to discontinue my participation in the study at any time once the session has begun.

Benefits- The learner will be aware of what nursing horizontal violence is, have a better understanding of the detrimental effects of it, learn strategies to manage horizontal violence, and eliminate the disruptive behavior.

Confidentiality- I understand that my records will be held confidential to the extent permitted by law and that I will never be identified in any publication. Furthermore, I understand that I must do my part in keeping details of the course confidential and not share information with individuals that were not part of the course I participated in. I understand that my participation is voluntary and that I may refuse participation prior to the start of the course. Only signatures are required for proof of consent and they will be kept separate from the other materials.

<u>Debriefing-</u> I understand that I have the right to have all questions about the study answered in sufficient detail for me to clearly understand the level of my participation as well as the significance of the course. I understand that at the completion of this course, I will have an opportunity to ask and have answered all questions pertaining to my involvement in this course.

<u>Receipt of informed consent-</u> I acknowledge having received two copies of the consent form- One to be returned to the researchers and one for me to keep for my reference. I may call the instructor involved in the study, or the supervising professor, Dr. Jeanne Maiden, in order to discuss confidentially and any questions about participation in the study.

Name: _____   Specialty Unit: _____

Age: _____   Email: _____

Signature: _____   Date: _____

Instructor/ Investigator:

Lead Instructor: Maria Fe R. Stotts, RN

Cellphone: (619) 962-4644

Supervising Professor: Dr. Jeanne Maiden, PhD, RN, CNS-BC, Chair

Office: (619) 849-2420

Appendix B

<u>Code of Conduct/ Statement of Commitment to Co-Worker Contract</u>

Our Healthcare center is dedicated in providing patients and team members a safe and healthy environment in which to receive care and practice medicine. All staff members will adhere to this Code of Conduct at all times.

- ➢ Know that Managers, Nurse Leaders, and staff members are held accountable for their behaviors and actions.
- ➢ Treat colleagues with respect and courtesy.
- ➢ We will work together to achieve shared goals that support our healthcare facility.
- ➢ Disruptive and negative behaviors will not be tolerated in the workplace –negative conduct will result in disciplinary action.
- ➢ All team members are expected to identify and inform misconduct to administration and may do so without fear or reprisal.

I have reviewed the Healthcare Policy and attended the course on Horizontal Violence. I will adhere to the Code of Conduct.

_____   _____

Employee Signature   Date

Adapted by:

Dimarino, T. J. (2011). Eliminating lateral violence in the Ambulatory setting: One center's strategies. *Association of PeriOperative Registered Nurses Journal, 93*(5), 583-588. doi:10.1016/j.aorn.2010.10.019

Hastie, C. (2009). Horizontal Violence in the workplace. Birth International. Retrieved from https://www.birthinternational.com/articles/midwifery/69-horizontal-violence-in-the-workplace.

Appendix C

Self Confidence Survey

Please circle the appropriate answer.

1.)   What is your gender?

Male (1)
Female (2)

2.)   What is your present position?
Nursing Administrator (1)
Clinical Specialist (2)
Consultant (3)
Nurse Manager (4)
Staff Nurse (5)
Supervisor (6)
Other (7) Specify _____

3.)   Which of the following shifts do you MOST COMMONLY work?
7am -3pm (1)
3pm -11pm (2)
11pm -7am (3)
7am -7pm (4)
7pm -7am (5)
Other (6) _____

4.)   What is your primary practice unit?
Telemetry (1)
Emergency Room (2)
Critical Care (3)
Medical-Surgical (4)
Obstetrics (5)
Oncology (6)
Operating Room (7)
Pediatrics (8)
Recovery Room (9)
Other (10) Specify _____

5.)   What is your level of educational preparation?
Associates Degree in Nursing (1)
Baccalaureate Degree in Nursing (2)
Diploma in Nursing (3)
Master Degree in Nursing (4)
Doctorate Degree in Nursing (5)

6.)   I am familiar with the term Horizontal Violence or Lateral Violence?
Yes (1)
No (2)

7.)   In your work experience as a Registered Nurse, have you ever had an experience where you had been a victim of verbal abuse from another nurse?

Yes (1)
No (2)

8.)   How would you rate your handling of abusive situations from another nurse?
Poor   Very Good
1   2   3   4   5   6   7   8   9   10

9.)   Did the abuse occur after a high-stress situation for either you or the abuser?

Yes (1)
No (2)

10.)   Over a month's time, approximately how many abusive occurrences were you the recipient?
0-5 (1)
6-10 (2)
11-15 (3)
16-20 (4)
Over 20 (5)

11.)   I have the skills and knowledge to handle horizontal violent situations.

Yes (1)
No (2)

12.)   The amount of self-esteem I believe I have is:

Low   High
1   2   3   4   5

13.)   Have you ever left a nursing position due to the amount of abuse from that setting?
Yes (1)
No (2)

14.)   I know how to deal with nursing peers who are considered disruptive at my workplace?
Yes (1)
No (2)
I don't know (3)

15.)   I know my resources when it comes to being a victim of horizontal violence.
Yes (1)
No (2)
I don't know (3)

16.)   Horizontal abuse is part of the job.

True (1)
False (2)

17.)   Based on my experience with horizontal abuse, I believe incidences contribute to increased nursing shortage

Yes (1)
No (2)

18.)   Based on my experience with horizontal abuse, I believe incidences contribute to increase errors in patient care.

Yes (1)
No (2)

19.)   I feel confident in confronting horizontal abuse with my peers.

True (1)
False (2)

20.)   I have the support of leadership and feel comfortable going to them if faced with a horizontal violent situation

True (1)
False (2)

Appendix D

Table 1. Examples of Empowerment Processes at Each Level

LEVEL OF ANALYSIS	EMPOWERMENT PROCESS
Individual	• Provide assistance to other individuals • Receive assistance
Organizational	• Programs encouraging involving decision-making • Councils and Partnerships • Skill development
Community	• Equal access to resources i.e. protective services, recreational facilities • Media coverage

Zimmerman & Warschausky, 1998.

Table 2. A Comparison of Empowering Processes and Empowered Outcomes Across Levels of Analysis

LEVELS OF ANALYSIS	PROCESS	OUTCOMES
Individual	• Helping others gain control of their lives • Receiving help from others to gain control • Mutual help	• Sense of control • Critical awareness • Participatory behaviors
Organizational	• Providing opportunities for members to develop and practice skills • Erecting participatory decision-making structures • Sharing responsibilities an leadership	• Effective resource management • Linkages with other organizations • Influence in policy decisions or creation of alternative service
Community	• Providing equal access to resources • Allowing expression of diverse opinions • Building participatory structures in community institutions	• Organizations working together to exert control over policy decisions • Collective efforts to maintain or improve quality of life • Residents' participatory skills

Zimmerman & Warschausky (1998).

Table 3. Acronym for Teaching Method S.N.A.P.P.S

Acronym for S.N.A.P.P.S.	
Summarizing	History and examination
Narrowing	Differential diagnosis and other possibilities
Analyzing	Comparing and contrasting options
Probing	Asking about challenges, different approaches, and ambiguities
Planning	Management
Selecting	A case-specific topic to self-direct learning

Beckman and Lee (2009).

Table 4. Breakdown of Competency and Learning Objectives.

Course Competency: Upon completion of Horizontal Violence in Nursing: Strategies to Eliminate the Behavior, the learner will be empowered to address horizontal violence with the nursing population in a hospital setting.	
Learning Objectives:	1.) Define the term horizontal violence. 2.) Describe various ways horizontal violence is presented in the nursing field. 3.) Examine past and present scenarios of horizontal violence relevant to the nursing practice. 4.) Identify and review tactics utilized in the past to overcome horizontal violence. 5.) Formulate various effective approaches to impede horizontal violence. 6.) Demonstrate strategies learned to deter horizontal violence. 7.) Evaluate the effectiveness of strategies through mock-situations where horizontal violence occurred.

Table 5. Learning Objectives and Learning Outcomes.

Learning Objectives	Learning Outcomes
Define the term horizontal violence.	Verbalization of definition of horizontal violence: • Horizontal violence is a term used to describe inter-group hostility. It is adverse behavior and treatment between individuals or group members. The term is interchangeable with lateral violence.
Describe various ways horizontal violence is presented in the nursing field.	• Horizontal violence is described as harassment that can be psychologically damaging and includes verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendos, exclusion, denial of access to opportunities, disinterest, discouragement, and withholding of information amongst groups of people or individuals.
Examine past and present scenarios of horizontal violence relevant to the nursing practice.	Verbalization of subjective and objective occurrences (if any) during discussion. Provide re-enactments of situations. Use Likert scale to assess knowledge nurse has on horizontal violence and comfort level on confronting issue.
Identify and review tactics utilized in the past to overcome horizontal violence.	Discussion of recollections of actions taken in the past of situations that may have been horizontal violence. Provide role-play and skits. Breakout sessions (5 minutes) to assess scenario and discuss effectiveness of tactics.
Formulate various effective approaches to impede horizontal violence.	Signing of Hospital Code of Conduct Contract. Create a "trial" policy and procedure (P&P) on Code of Conduct Contract to be potentially adopted by the hospital or review existing P&P.
Demonstrate strategies learned to deter horizontal violence.	Replay skits during earlier session and utilize key words or scripts to deter horizontal violence.
Evaluate the effectiveness of strategies through mock-situations where horizontal violence occurred.	Feedback on skits, hand-outs and discussion of course. 3 months later-Use same Likert scale to follow up on comfort level on confronting and understanding horizontal violence.