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Defining and Identifying Negative Behavior: A Defense against Lateral Violence

DNP Scholarly Project Paper

submitted in partial satisfaction of the requirements

for the degree of

DOCTOR OF NURSING PRACTICE

in Nursing Science

by

Chiara Marella Cardoza

DNP Project Team:

Associate Professor Michelle A. Fortier, Chair

Associate Clinical Professor Nicole Martinez

2022



## **DEDICATION**

To all my fellow nurses, who not only choose a life of service every day but also rose to great heights with bravery from the frontlines in the battle between the pandemic and humanity, I dedicate this scholarly project to you. I chose this phenomenon of lateral violence because the dynamic nature of our profession leaves us subject to many levels and variations of harm and hostility, especially amidst conflict and crisis. Know that your vulnerabilities to becoming a recipient or perpetrator of lateral violence, either knowingly or obliviously, are realized. While the public recognizes the strength and resilience represented by the scrubs or white coats you wear, I recognize the infallible and benevolent person underneath that armor and wish to empower you to stand to lateral violence. I see you. The effort behind this project was intended to offer a hopeful solution to help diffuse the self-feeding conflict that perpetually threatens to weaken our solidarity. My work here thrives to help rid of barriers that get in the way of your altruistic acts of caring for the sick and the vulnerable. I chose to advocate for your emotional and psychological wellness while you advocate for the sick and the vulnerable in our community. Together, let us lead our community with empathy, kindness, and compassion - starting with our own nursing family.

This DNP scholarly project is dedicated to the loving memory of my uncles, Roman Carlos and Rommel Paras, whose earthly journeys ended last year with dignity and respect. Thank you for modeling strength in character and for calibrating our moral compass towards always choosing kindness to humanity above all else. Because you have lived your life fully and portrayed your roles authentically, I was nurtured in healthy environments devoid of this incivility that I chose to help rid of.

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Thank you, Colin Jacob and Autumn Grace, my little loves and biggest supporters, for being so forgiving and understanding. You are the reasons for the resilience and tenacity behind all this work. I am strong because you believed in me, always without a shadow of a doubt. I can never repay you both for your sacrifices in allowing mom to explore great heights for our family. I promise to never stop working towards building a better and more caring world for you.

To my mom and dad who have instilled in me the value of hard work and the belief that with it, anything and everything can be within my reach, thank you! To my siblings and their families, especially in moments of isolation, your every kind word and deed reminds me that I am never alone because I have the love of my family. Thank you for the outpouring of love and encouragement to my husband and kids in my absence during this program. Thanks for cheering me on!

To my friends and colleagues, I am blessed to share the same village with you. I write this for you with a promise to uphold ethical standards in my advocacy for health and in helping to build well communities founded on a culture of caring.

Finally, I would like to express my most sincere gratitude to Dr. Michelle Fortier, my lead chairperson. Undertaking this endeavor amidst a pandemic while working as a nurse and mother seemed like an impossible feat. You have guided me through this project with such grace and empathy, steering me steadily and kindly towards my goals. Your leadership and encouragement helped to make this a possibility for me. Rest assured, your mentorship and counsel will live on through me.

## **VITA**

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- |      |   |
|------|---|
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## **FIELD OF STUDY**

Doctor of Nursing Practice, Family Nurse Practitioner in Nursing

## **ABSTRACT OF THE DNP SCHOLARLY PROJECT PAPER**

Defining And Identifying Negative Behavior: A Defense against Lateral Violence

by

Chiara Marella Cardoza

Doctor of Nursing Practice, Family Nurse Practitioner in Nursing Science

University of California, Irvine, 2022

Associate Professor Michelle Fortier, Chair

**Background:** The nursing profession is dynamic, encompassing various roles and diverse skill sets. The intense and stressful demands in healthcare make for a challenging environment susceptible to high-pressure situations, a breeding ground for incivility. For decades, nurses have worked amidst a culture of lateral violence, commonly known as nurse bullying.

**Objective:** The purpose of this study is to review contributing factors that predispose novice nurses to lateral violence to educate nurses about their risks and their vital role in ameliorating this negative culture. Novice nurses will be empowered through the provision of communication strategies against incivility.

**PICOT:** This study was aimed to address the question: Would lateral violence awareness education with integration of communication promotion strategies to novice nurses improve their understanding of the issue, perception of workplace safety, and likelihood of addressing the problem?

**Research Design:** This study used both qualitative and quantitative methods to survey nine new graduates from nurses hired at the University of California Irvine Medical Center using the Negative Behaviors in Healthcare survey. Data were collected using a survey through Qualtrics, a secure web-based data management software.

**Ethical considerations:** The project was determined to be a Non-Human-Subject study and did not require approval by the Institutional Review Board (IRB). Participants were made aware that the study was voluntary. Consents were obtained from all respondents.

**Discussions:** Lateral violence manifests as negative behaviors in healthcare systems that affect the workplace climate and nurses' ability to deliver quality care that has been overlooked over time. The prevalence of this issue was discussed, and behaviors were defined and identified in this study.

**Conclusions:** This study reviewed the proneness of the nurses, especially new graduate nurses or novice nurses with up to three years of employment, to this type of violence through collective literature. Necessary components were included in the education material and survey for this project. This offered the opportunity for new nurses to exercise professional scripts when incivility is encountered. The results suggest a systemwide approach of combining educational intervention with cognitive behavior training as a potential defense against lateral violence.

## **CHAPTER I: INTRODUCTION**

### **Defining And Identifying Negative Behavior: A Defense against Lateral Violence**

Bullying is a widely known phenomenon that creates many repercussions regardless of the setting. Nurses, professionals who are traditionally often found amidst a care provider's role, are ironically not exempt from the susceptibility of this phenomenon. The bullying that happens between nurse-to-nurse is officially termed lateral violence (LV) or incivility. Unlike other apparent forms of violence, lateral violence manifests covertly as it involves emotional and psychological attacks. In rare and unguarded moments, verbal attacks are witnessed as well. The results from previously conducted surveys reflect a demand for more intervention program strategies to address the lateral violence that plagues the nursing profession and turns our young nurses away.

Any nurse at one point or another in her career presumably has heard the ominous saying that “nurses eat their young.” This phrase originated from Professor Judith Meissner and has been used over 30 years ago to bring to light the lateral violence that happens among nurses (Gillespie et al., 2017). In today's reality, one may wonder if lateral violence still exists after all these years. The affirmation of its current existence lies in casual nursing conversations when the term “nurse bullying” or “incivility” triggers a spectrum of reactions from dismay to anger, but not denial.

The presence of lateral violence, which is a form of bullying, falls under the general umbrella of workplace violence. It threatens the unity and solidarity among the nursing workforce, which is essential in rendering healthcare services. Consequently, lateral violence compromises the stability of work environments, which can negatively affect patient care. Although healthcare environments serve as a respite to many, certain environments can create breeding grounds for this lateral violence because healthcare institutions are intensely stress-provoking, highly regulated by numerous levels of bureaucracy, enforce strict norms of behavior, and characterized by challenging and sizeable workloads (Rainford LMSW, Ph.D. et al., 2015). In addressing this incivility, it is important to be cognizant of the fact nursing is the nation's largest healthcare profession comprising up to 3.8 million nurses in the United States alone (American Association of Colleges of Nursing [AACN], 2019). Nurses' position at the initial point of patient contact and the intersection of multidisciplinary teams in healthcare systems holds much potential for impacting healthcare for all, both positively and negatively. A positive impact requires

having a safe, nurturing, empowering, and satisfying workplace for nurses to perform/operate within. Literature has revealed common themes for reasons why nurses leave their workplace, primarily they are a negative work environment, nursing shortage, and unsatisfied individual expectations (Cameron et al., 2020). As the demand for healthcare services increases and the nursing shortage persists, we must shed light on this lurking issue and regain momentum in addressing this destructive phenomenon to conserve and preserve our nursing resources, which are at the frontlines of advancing individuals' and community's health and healthcare systems.

### **Background of the Problem**

Lateral violence is defined as “a pattern of workplace conflict in which confrontational behavior is targeted at one person by another who is employed at the same level of responsibility across time in repeated instances of emotional, psychological, physical, or sexual abuse” (Rainford et al., 2015, p. 158). This is more commonly recognized as nurse bullying, nurse-to-nurse, horizontal violence, incivility, and workplace bullying. Expressions of lateral violence are categorized as physical, verbal, and psychological. These manifest as negative behaviors, such as direct or indirect rude comments, verbal attacks, condescension, sexual misconduct, lack of collaboration, attack on a person's integrity or professional reputation, blaming, lacking empathy, engaging in nonverbal innuendos, or breaking confidence. Of these three categories, the psychological harassment resulting in hostility, rather than aggression, is the most common manifestation and is most difficult to address due to the subtlety with which this is enacted (Blair, 2013).

The damaging effects of this nurse-to-nurse violence are harmful on many levels and are far-reaching. It silently affects nurses on a personal level, which negatively manifests in their role and performance in the clinical setting. This triggers a domino effect with the insidious disintegration of authenticity and character of care delivery in the nursing culture starting from a personal level and leading to an institutional level in both local and global settings.

#### **Personal Consequence**

Nurses and co-workers victimized by this incivility reportedly experience stress, fatigue or insomnia, depression, shame or guilt, isolation, post-traumatic stress disorder, substance abuse, or even suicidal behavior (Rainford et al., 2015). These experiences also create moral distress in nurses, an emotional and psychological

disequilibrium that hinders nurses from carrying out morally appropriate actions. The experiences of incivility place them in a disempowered and uncertain position; for example, nurses may act out of obedience to preceptors instead of exercising their critical thinking skills. Such circumstances where certain practices are normalized may place them in conflict with their moral values. These pivotal moments are the frustrating experiences that consequently perpetuate a vicious cycle of lateral violence (Blair, 2013). Cumulatively, these factors contribute to an increase in nurse absenteeism, which triggers another cascade of problems affecting the workflow in patient care areas.

### Professional Consequence

The incivility that thrives causes a divide among nurses; it contributes to communication breakdown that can result in compromised delivery of care and potentially even medical errors. Communication is vital in healthcare systems where multidisciplinary and interprofessional interactions are required in collaborative efforts to deliver patient care. Patients' safety becomes compromised when health care provision comes from a destabilized condition as evidenced by a Joint Commission review on sentinel events. According to a review, up to 70% of the cases were rooted in poor communication, not technical or system failure (Blair, 2013)

### Institutional Consequence

This negative yet normalized culture of lateral violence breeds dissatisfaction among nurses, which significantly contributes to a high staff turnover rate with new nurses leaving their employers in the first six months and up to three to five years of employment (Rainford et al., 2015). A conservative estimate of the annual cost of nursing workplace violence is \$4.3 billion or nearly \$250,000 per incident (Embree et al., 2013). This indicates a fiscal loss for institutions and reflects an increase in workload for remaining nurses that in turn exacerbates occupational stress with psychological, physical, and organizational consequences (Embree et al., 2013). In addition to financial costs associated with turnover rates, high attrition rates of newly licensed nurses critically affect the nursing shortage, exacerbating the already daunting challenge of maintaining a sustainable nursing workforce (Sanner-Stiehr & Ward-Smith, 2017).

## **Project Statement**

The nursing profession upholds a remarkable reputation of having the most trustworthy and caring individuals in the eyes of the public. Nurses are respected and held to high standards based on their noble profession and being in a position to deliver care and compassion through the promotion of health and preservation of wellness. Given the profession's caring nature, it is quite ironic that this lateral violence exists wherein nurses inflict offensive behavior upon one another and threaten safety in their workplace. The prevalence of this type of workplace violence has persisted, both locally and globally, and has been well-documented in professional and scholarly works of literature for over three decades. It is an institutionalized problem that does more than stain the profession's noble reputation; it discredits the public's common belief that individuals are treated under the care of healthcare providers who work amidst a culture of care in a safe workplace. Lateral violence is the term awarded to the pre-existing infamous notion that "nurses eat their young." Such behavior imposes negative impacts on personal, professional, and institutional levels in the nursing profession, all of which inevitably contribute to a diminished quality of healthcare. It creates rifts between professional relationships that compromise the cohesiveness in a medical care team that is a necessary component of an effective healthcare system. Consequently, patients fall victims to a destabilized environment of care made ineffective because of distrust, fear of errors, and inability to seek help from workplace violence (Ebrahimi, Hassankhani, Negarandeh, Jeffrey, & Azizi, 2017). Neglecting to identify the permissive behaviors of lateral violence and not attempting to rectify the problem can lead to silencing the struggles of nurses. Lack of awareness and knowledge of the phenomenon is the fundamental barrier that can hinder the compliance, and ultimately the success, of any previously attempted intervention against lateral violence. One cannot fix a problem without acknowledging that a problem exists.

To improve the issue of lateral violence, the PICOT question in need of addressing is as follows: In nurse-to-nurse encounters, would lateral violence awareness education with integration of communication promotion strategies to novice nurses improve their understanding of the issue, perception of workplace safety, and likelihood of addressing the problem?

## **CHAPTER II: BODY OF EVIDENCE**

### **Search Process**

A review of literature on lateral violence was performed in search of relevant data that supports the need to currently address the prevalence of lateral violence amongst nurses. Most of the searches were done in the Grunigen Library database under CINAHL, PubMed, and Medline, as well as Google Scholar. Since lateral violence falls under a much wider umbrella of workplace violence, and the nursing profession represents multiple roles and positions, the search required many key terms used in combination with Boolean terms to create targeted phrases that help narrow down the results to the specifications of the PICOT question. The interchangeable search terms used include “lateral violence”, “horizontal violence”, “nurse bullying”, “incivility”, and “communication”. The second set of search terms was used in the same database with the inclusion of the terms “nurse”, “preceptors”, “harass”, and “eat young”. The only limiter applied was to articles in the English Language. The search generated 111 articles, 12 were erroneous and irrelevant to the search topics and thus were omitted. Twenty-seven were duplicates. Forty-two articles were removed because they were irrelevant to the population or method of intervention. Other articles with search terms embedded out of context were also omitted. After categorizing articles into inclusion criteria for this topic, 15 articles were generated and used in this review of literature on lateral violence, three of which are descriptive articles that discuss the multidimensional and multifaceted factors that comprise this phenomenon.

### **Appraisal of Evidence**

The literature search generated both quantitative and qualitative articles on nurse-to-nurse lateral violence (NNLV). Most of the articles were qualitative rather than quantitative research that utilized surveys and statistical methods to measure the perceived presence of incivility in the workplace. The literature review yielded studies that involved nursing students and nurses from different roles and specialties with varying educational backgrounds, training, and work experience. The sample population that was commonly cited were nursing

students, staff nurses, nurse educators, and nurse administrators wherein nursing students and staff nurses are depicted as victims of lateral violence while nurse educators and administrators were perceived as perpetrators. This statement serves solely to identify the contextual placement of these roles and does not aim to consider nor imply the perceived victimization and intention of each role on this subject matter. New graduate nurses and novice nurses who are new to a workplace environment were commonly identified as a population with more substantial susceptibility for lateral violence as compared to others (Sanner-Stiehr & Ward-Smith, 2017).

The sample settings specified in the articles were found to serve as testimony to the extensive infiltration of lateral violence in healthcare systems across the globe. Studies that evaluate the prevalence of incivility among nurses were conducted both in the United States, from the western states through the northeast, and expands to international settings. Sample sizes obtained varied from local, small convenience groups in local community clinics and expand to wider interdepartmental and multi-specialty systems in larger institutions. International institutions that have engaged in lateral violence studies include Korea, Jordan, Iran, Turkey, Australia, and Canada.

Measuring tools used to provide evidence of the existence of lateral violence were the Nursing Incivility Scale (NIS), Nurse Workplace Scale and the Silencing the Self-Work Scale (NWS-STSS), and The Copenhagen Psychosocial Questionnaire II, and the Lateral Violence in Nursing Survey (LVNS). The findings of this study depict the pervasiveness of lateral and hierarchical violence among nurses across various nursing populations and in various clinical settings. These take into consideration the psychological, verbal, and physical sources of violence. The results of these surveys showed statistical significance to the positive effects of incivility programs as a defense against incivility. There is inarguable data provided that although no nurse is immune to lateral violence, workplace violence is experienced by a high percentage of newly licensed nurses and is associated with their job outcomes (Chang & Cho, 2016). In the examination of the relationship between lateral violence and job outcomes, the Copenhagen Psychosocial Questionnaire II emphasizes verbal abuse being the most prevalent form of workplace violence. This tool highlighted the significant relationship of bullying with four job outcomes: job satisfaction, burnout, commitment to the workplace, and intent to leave. The Lateral Violence in Nursing Survey

was designed to measure the perceived incidence and severity of the issue (Stanley et al., 2007, para. 1). This survey was further developed later to include specific aspects of this phenomenon and converted to the Negative Behaviors in Healthcare (NBHC) survey.

Upon reviewing the contributing factors that precipitate acts of lateral violence, most of the articles reviewed had discussed in detail the complex nature of nursing as a profession. Many theories were considered in an attempt to both dissect the causes of lateral violence as well as an attempt to construct possible solutions for it. Nurses are exposed to many stressors that come with life-and-death decision-making, frenetic pace, and often crippling workloads in significantly diverse complex settings, particularly in hospital settings (Croft & Cash, 2014). In a work setting as dynamic as this, certain factors that compromise the caring culture that defines the nursing profession commonly surface in literature. Mainly, organizational structures with sub-optimal work environments are all too often the breeding ground for lateral violence. Holding nurses up to less than their standard value in an organization leads to diminished morale and internal stress that consequently results in external expressions of lateral violence. Untenable workloads, nursing shortages, budget retrenchments, constant change, and time-sensitive multitasking in critical roles implicate preceptors and fellow nurses as perpetrators of lateral violence. In addition, nursing management and leadership's hold on a rigid hierarchical power creates an unsafe workspace wherein lateral violence victims are deterred from reporting issues (Rainford LMSW, PhD et al., 2015). In numerous articles, The Oppression Theory and The Theory of the Wounded Healer were considered and have influenced the reasoning for the hostility in nurses' response to their less desirable working conditions to understand the nature of lateral violence.

Lateral violence, as analyzed in the literature review, rests on the premise that nurses are structurally an oppressed group (Duffy, 1995). Thus, the oppression theory will serve as the framework for the development of the educational intervention for activity. Three mechanisms arguably maintain this theory: (1) education of the oppressed is controlled by the oppressor, (2) the dominant group rewards the oppressed with behavior that they deem appropriate, and (3) the oppressor makes gestures of appeasement when change or revolt becomes

inevitable (Roberts, 1983). These mechanisms explain some of the behavioral responses that nurses have when faced with incivilities such as the self-silencing practice and lack of reporting.

The theory of the wounded healer touches upon the impact of previous trauma on nurses, or healthcare providers in general, on their desire and ability to alleviate someone else's pain. This concept fundamentally explores how the provider's effectiveness in coping from their lived experiences, or lack thereof, may pre-determine their path towards becoming a "walking wounded" or a "wounded healer". The premise of this theory describes that becoming a wounded healer involves undergoing these three conceptual steps: *recognition* of pain to allow for close examination of the trauma, *transformation* of experience to a manageable understanding, and *transcendence* from the woundedness to allow for insight and learning. According to theorist Marion Conti-O'Hare, on the contrary, the care provider with ineffective coping who remains incognizant of the pain caused by previous hurts is incapable of transforming the experience to transcend towards therapeutic processes and relationships. In their neglect to recognize their harm, these individuals then become ineffective care givers themselves as they project their woundedness to patients and colleagues and function as the "walking wounded" (Christie & Jone, 2014, para. 4). Ultimately, this theory stands on the claim that completion of the three-step process guides the walking wounded towards the path to becoming the wounded healer through gain of increased ability to understand other's suffering and empathize with their pain (Conti-O'Hare, 2002). (See Figure 1. Theory of Nurse as a Wounded Healer)

Many efforts have been attempted to ameliorate this toxic culture that plagues the nursing workplace including nurse empowerment programs, cognitive rehearsal training, resiliency training, communication strategy training, curriculum adjustments to include incivility education, and strategies in pre-licensure programs (Razzi & Bianchi, 2019). The most common technique cited was cognitive rehearsal training, an effective strategy used in behavioral science involving a skilled facilitator in preparing an individual to recognize and respond to incivility. An example of resiliency training is a tool called HeartMath which promoted self-regulation and composure when faced with challenging situations in the workplace and daily living (Clark & Gorton, 2019b). Another significant

communication strategy is an evidence-based response extracted from a TeamSTEPPS approach developed by the Agency of Healthcare Research and Quality called the CUS (Concerned Uncomfortable Safety) model. This model is a script response that is effectively used as an optimal response to address uncivil encounters. (Agency for Healthcare Research and Quality [AHRQ], 2017). These interventions rendered positive results in providing nurses and nursing students with evidence-based tools to build resilience to address incivility in patient care environments.

Implementation of preceptor role enhancement programs was attempted to address the roles of nurse educators and managers, who in some cases are implicated in this context, and review their significance in either diffusing or exacerbating lateral violence (Croft & Cash, 2014). Also found in one of the works of literature was an initiative to provide a safe learning place by creating a Delegated Education Unit (DOU) for the onboarding of new nurses (Glynn et al., 2017). Of these interventions, the latter highlights a significant component emphasized in the literature review: the new graduate nurses are the most common and most at-risk victims of nurse-to-nurse bullying. More so, pieces of literature reveal the studies that included education intervention strategies and cognitive rehearsal training which provided helpful tools to new graduate nurses to identify uncivil behavior, to react proactively and professionally to increase workplace safety (Stanley et al., 2007). They also help to build resiliency towards incivility (Clark & Gorton, 2019b).

### **Comprehensive Synthesis of Evidence**

Unlike other forms of violence, lateral violence hides in the open. It is rarely physical. Rather, it resembles acts of bullying that covertly inflicts psychological, emotional and mental suffering on nurses. It appears to be both intentional and unintentional that arise from the complex nursing workloads in toxic work environments. In the literature review on the topic of lateral violence, three themes have emerged from the data analyzed. The first theme yields this recognition that nurses portray both roles of victim and offender as they are oblivious to what constitutes acts of lateral violence. Many articles, although without proof of causality, have expressed possibilities that aspects of the Oppression Theory apply to nursing and manifest as acts of lateral violence among nurses. The

Oppression Theory speaks of the powerlessness in nursing in the presence of a dominant person or group that eventually leads to the submissive-aggressive syndrome. This behavior consequently leads to incivility because of the self-destructive release of pent-up anger towards the dominant group (Matheson & Bobay, 2007). The Theory of the Wounded Healer explains how the effect of nurses' exposure to previous trauma and the resolution or lack of thereafter affects their coping mechanism. Based on the theory, this can affect and determine the nurses' effectiveness as healthcare providers because in professions in which healing is provided, essentially "the walking wounded needs to first heal themselves in order to survive" (Christie & Jone, 2014). According to the AACN, more than 200,000 new registered nurse positions will be created each year from 2016 to 2026 as projected by the federal government projects (AACN, 2019). Articles upon articles have repeatedly noted that this population of novice professionals are among "the young" that are susceptible to incivility and needs to be protected from this phenomenon (Sanner-Stiehr & Ward-Smith, 2017). However, the risk of exposure to this incivility is not only limited to them; it also expands to every single nurse in the workforce and various positions. It is an insidious problem that has pre-existed for over three decades and remains to be unaddressed. With each new set of newly licensed nurses or experienced nurses hired in new and different settings, the lack of awareness and recognition of this subliminal phenomenon keeps re-igniting this problem of incivility. The lack of awareness and open discussion about the issue places nurses at equal risk of being both victims and contributors to lateral violence as depicted in the Oppression Therapy (Roberts, 2015).

The second theme to emerge was that nurses result in self-silencing practice as a strategy to avoid conflict and to maintain the status quo in the workplace and their private lives (Embree et al., 2013). This was made evident through the results from the surveys used to measure the prevalence of lateral violence in the workplace. Self-silencing becomes the coping mechanism for the insurmountable challenges and multi-factorial contributors to lateral violence brought on by the dynamic reality and diverse roles of nurses. These multiple contributing factors and perceived behavioral expressions of incivility, such as personality differences, cultural differences, and varied professional practice delivery methods, are often conveniently excused as the pre-existing workplace culture and departmental norm. In some cases, careless language and unprofessional demeanor are permitted based on the

pace and the level of acuity in each clinical situation or a unit's caseload, like in an emergency department for example. Although these factors explain the susceptibility of the profession to incivility, these should not validate the normalization of this negative culture that infiltrates the nursing collaboration in practice. It is caustic to nurses' personal and professional health. Consequently, nurses are kept from performing their responsibility when neglecting to address the incivility that plagues the nursing culture. This compromise in professionalism negatively affects patient care. Thus, self-silencing practice deprives care team members of the opportunity for dialogue and a chance to discuss and reduce the incidents of lateral violence.

The third theme that emerged showed that programs designed to ameliorate the issue of incivility in the workplace showed positive outcomes in creating awareness and building resilience to the negative behaviors in healthcare settings. The common sub-theme of these programs is the promotion of communication as a method used to speak up to raise awareness and counter acts of lateral violence. As accurately stated by Rainford et al., "Nurses are often confronted by untenable patient loads and burdened by time-sensitive multitasking critical roles and responsibilities that may likely leave them frustrated and susceptible to interpersonal conflict and, ultimately, lateral violence" (2015). Organizational structures predetermine the level of toxicity in various nursing conditions, fast-paced environments of specialty units like the emergency department, undervalued staff, lack of leadership, and unsupportive management. In data analysis of literature on the topic of lateral violence, it is incumbent to consider the promotion of professional and effective communication that is accessible, contextual, and concise as a defense strategy in contentious situations.

### *Gaps in Knowledge*

In the review of literature on the issue in discussion, there presents to be a significant number of qualitative articles across the globe that accurately identify and measure lateral violence. However, very few strategies were found in correcting or creating actions to correct this phenomenon. Of the few strategies brought up, the focus of interventions was on the defensive strategies to help nurses overcome lateral violence in the workplace. There is much to be improved with the development of programs or interventions toward ameliorating this issue by uprooting the source. There lacks intervention that helps to identify susceptibilities to enacting lateral violence

that can implicate nurses in mentorship roles and be perceived as offenders of lateral violence. There is hardly any literature found that focuses on the remediation of perceived perpetrators of this phenomenon. Due to the knowledge that leadership has been identified as a possible source of incivility, the accuracy in measuring these incidences is not ensured.

The biggest gap is the inconsistency in research methods and the lack of longitudinal data that limits the body of knowledge. Some studies used instruments that measured various aspects of lateral violence and did not focus specifically on nurse-to-nurse behavior. The qualitative methodologies are not always replicable in larger settings (Stanley et al., 2007). For a better assessment of the source, nature, and extent of lateral violence in each nursing workplace, a more user-friendly tool is required for nurse administrators to use efficiently to allow for a more proactive response.

### **Summary of Evidence**

The phrase “nurses eat their young” emerged from observed destructive behaviors of more experienced nurses towards the onboarding of newer nurses. The prevalence of this negative culture has been noted in articles as far back as 2016 in a literature review. It has been noted, however, that this reality is what prompted Professor Judith Meissner to coin this phrase in 1986. Her mention of this phenomenon serves as evidence that this negative culture has plagued the nursing practice for over three decades (College by the People, 2017). Its pervasiveness over an indefinite amount of time has earned its official term lateral violence, a subset of workplace violence.

Due to the major consequences on the professional and private lives of nurses, and on workplace and patient safety overall, incivility among nurses is well recognized and documented in scientific literature. As stated, lateral violence has a prevalence of up to 87% with a physical and mental sequela that can affect up to 75% of the victims (Bambi et al., 2018, para. 1). According to a Joint Commission Survey, 77% of physicians and 65% of nurses had witnessed disruptive workplace behavior (Blair, 2013, para. 1). Although lateral violence falls under the worker-on-worker category of workplace violence, which essentially includes three categories (physical,

verbal, and psychological), this type of violence manifests covertly, which makes it very hard to detect. Lateral violence essentially leads to conflict and lack of co-worker support; thus, cited as the major reason for nurses leaving the nursing profession (Blair, 2013). The stealthy pervasiveness of this issue is realized to be a cause of nurse attrition leading to high turnover rates in the nursing profession, with up to 60% of nurses leaving their jobs within the first six months of employment (Embree et al., 2013). Interventions cited in the literature focus on resilience training, awareness programs, education on defensive communication and cognitive strategies against incivility, and enhancement of orientation and preceptorship programs. However, most articles focus attention on interventions for nurses as the oppressed population, and very few were focused on the significance of self-awareness to understand susceptibilities to act as an oppressor. The outcomes showed a positive impact on the implementation of these programs early on as preventive measures against nurse-to-nurse bullying. Acknowledgment, or lack thereof, has shown to be the common barrier to decreasing the prevalence of incivility among nurses. One cannot resolve a problem that is not acknowledged.

### **Clinical Practice Guidelines Appraisal**

The Occupational Safety and Health Administration of the United States Department of Labor put forth a guidance document for preventing workplace violence for healthcare and social service workers. The guideline in this document includes risk assessments of three main domains: workplace violence hazards, setting-related factors (patients/client-related), and organizational risk factors. Under these three main domains, prevention programs, hazard identification, worksite analysis, safety training, and evaluation process are established and recommended to promote workplace safety and decrease workplace violence and injuries (Occupational Safety and Health Administration [OSHA], 2014). While not mandated, healthcare institutions have integrated Workplace Violence modules into their annual employee competency training. The content of these violence prevention programs in the workplace includes (1) management commitment and employee participation, (2) worksite analysis, (3) hazard prevention and control, (4) safety and health training, and (5) recordkeeping and program evaluation. It is unfortunate, however, to realize that there is no mention of lateral violence in these

programs. The absence of clinical guidelines for addressing incivility in the workplace serves as testimony to the lack of acknowledgment of the prevalence of lateral violence among nurses.

Currently, the Nursing Code of Ethics serves as the guide for nurses to cultivate a culture of dignity, respect, and inherent in every person in the workplace, inclusive of patients and nursing peers alike. Honoring these ethical codes in practice will serve to recalibrate the profession's moral compass and re-assign the power back to nurses as moral agents by providing excellent patient-focused and culturally sensitive patient care (Falletta, 2017). Nonetheless, the lack of systematic and practical guidelines for compliance with this code makes adherence a subjective matter.

### **Evidence-Based Recommendation for the Project**

The negative behavior in health care along with the negative consequences on nurses and healthcare organizations have been well captured in countless articles. These data were captured in studies and surveys. There is disproportionately less literature that speaks of preventive interventions and management of the issue and regrettably, only a handful of validated tools are available to measure the multi-factorial components that make up this issue of lateral violence. In a performed narrative literature review by Bambi et. al, the summary of international studies has reported that the implementation of zero-tolerance policies and passive dissemination of information about these phenomena showed to be ineffective (Bambi et al., 2017). Educational interventions were less effective than those with team-building programs and assertive communication. Articles that presented a mixed methodology in their intervention showed positive outcomes in their study. Based on these findings, the evidence-based recommendation is to provide an educational module on lateral violence with the utilization of these communication tools. This communication tool will include the CUS method supported by the Agency for Healthcare Research and Quality (AHRQ) that will serve as a scripted form of communication when addressing uncivil behavior between nurses. The C-U-S (Concerned, Uncomfortable, Safe) tool was extracted from an evidence-based teamwork system developed by the AHRQ to improve communication and teamwork skills among health care professionals called TeamSteps. With intervention strategies proposed in various literature,

emphasis on communication enhancement may be the fundamental tool worth utilizing to shed light on the prevalence of this phenomenon and can break the silence from which incivility thrives in the healthcare arena. Communication is an essential element that can overcome intimidation and silence resulting from bullying and renders a nurse an ineffective patient advocate

### **CHAPTER III: PROJECT FRAMEWORK**

#### **Logic Model**

The Logic Model was chosen because of its simplistic design which is a visual representation of the relationship between the program's activities and their intended effects. It is a graphic depiction that serves as a roadmap to navigate through shared relationships among the resources, activities, output, short and long-term outcomes, and overall impact of the project (Centers for Disease Control and Prevention [CDC], 2018). Many variations of this model exist due to modifications of formats to accommodate the varying level of details required with each project or program for which it is intended.

This model was chosen as the conceptual framework for this project based on the clear schematic approach that would serve this project well. The organization of resources and essential details required for this capstone project helped with the step-by-step execution of the activity that allows for careful observation of each process and led to attaining the outcomes desired. Essentially, the main objective of this project is to shed light on the acts of lateral violence that lurk in the open by creating awareness for the nurses, particularly the novice nurses. Additionally, this model serves to provide simple communication strategies to novice nurses to help empower them to confidently speak up against acts of incivility. In meeting these two objectives, the hope is to consequently break the cycle of acceptance and normalization of this negative behavior as part of the nursing culture in the long run.

This project with its time constraint only sought to achieve the short-term goals in the model. These goals include effective nurse-to-nurse communication, improved understanding of perceived lateral violence, improved

perception of safety, and increased awareness of behaviors of lateral violence in the workplace. Although, the simplistic and straightforward approach of this project allowed for the development of sustainable systems and processes that aspire towards the long-term goals that advocate for safety among nurses from a local to an institutional level. (See Logic Model Chart Appendix E)

## **CHAPTER IV: METHODS**

This DNP capstone project was intended to create, recreate, and reinforce awareness of the phenomenon of lateral violence to recognize and identify acts of lateral violence among nurses, especially towards novice nurses. Thus, recognition and acknowledgment of the problem's presence in the workplace was the first objective of this project. The education on this lateral aggression that was provided after served to shed light on the actual pervasiveness of the problem in the current workplace. The education content included proper identification and comprehension of incivility in the workplace and its concrete behavioral manifestations. The awareness alone was deemed a very significant part of the solution in creating an optimal working environment that is free of incivility. Finally, communication strategies were provided to empower novice nurses to confidently address and uproot incivility as it occurred. This strategy was shared through the provision of in-service education sessions on lateral violence and communication tools that can help in professionally addressing conflict.

Ultimately, the principal purpose of this project was to ameliorate the issue of lateral violence in nurse-to-nurse encounters through education on lateral violence awareness and the promotion of communication strategies that speak against acts of incivility.

### **Project Goals**

Despite the previous implementation of various preventive strategies shown in many pieces of literature, efforts to diminish or eradicate lateral violence will remain futile without proper identification and comprehension of incivility in the workplace to start. Hence, the intended goal outcome of this project was to emphasize increasing awareness by identifying subliminal acts of incivility through education. Additionally, improvement of nurse-to-nurse communication that is professional and devoid of hints of lateral violence paves the way towards fostering professional growth. Upon completion of this project, these were the short-term goals achieved:

- Nurses will know the definition of lateral violence and all other terms used to define this phenomenon.
- Nurses will be informed and knowledgeable of behaviors that constitute acts of lateral violence.
- New graduate nurses will be notified of their risks for exposure to incivility and contributing factors that predispose them to this phenomenon.
- Participants will verbalize the understanding and purpose of the communication cue cards provided.
- Nurses will use language that is constructive and professional.
- Develop a confidential reporting process for nurse protection

Meeting these goals helps to pave the way towards the attainment of sustainable and more long-term goals:

- Include incivility awareness modules in the orientation of new hires and preceptorship programs
- Have programs in place that promote nurse advocacy in the workplace
- Decrease staff turnover rate

To attain these goals, the project required collaboration with nurse leaders, particularly unit managers/directors, effective recruitment of nurses, and engagement of novice nurses. It was also important to practice vigilance in the selection of a validated and suitable survey as a measuring tool and in choosing an effective Incivility Training material to preserve a culture of safety throughout the implementation process.

### **Project Description**

This

project required the combined effort and commitment of a nurse manager who was willing and open to assessing the prevalence of incivility in the workplace. This collaboration involved the recruitment and participation of new graduate and new hire nurses (with up to three years of employment). The plan included conducting an initial confidential survey, The Negative Behavior in Health Care Survey (NBHC), to measure the perception and prevalence of lateral violence in the delegated workplace. An invitation to perform the survey was sent electronically through the institutional email, upon approval of nursing leadership. A weekly reminder was sent until the assigned deadline or the completion of the survey. After which, an informative in-service was conducted on the topic of lateral violence, which included its prevalence, verbal, and nonverbal manifestations. This was followed by the provision of professional scripted responses that served as communication strategies that included

the CUS Tool (Concerned-Uncomfortable-Safety) as recommended by the Agency for Healthcare Research and Quality (AHRQ). These two topics served to deliver the intended objective of creating awareness and providing communication strategies aimed to decrease perceived incidences of lateral violence. The participants were provided with a cue card to guide them with the use of the CUS tool and in identifying uncivil behaviors. The participants were then observed for four to five weeks as they were encouraged to observe their workplace and practice the information and tools provided should a conflict arise. The same survey was re-sent at the end of the observation period to measure any changes in the participants' perception of lateral violence in the workplace.

The outcomes from this survey measured how many novice nurses have identified and acknowledged the problem of lateral violence. The pre-and post-survey was used to reflect the level of effectiveness, or lack thereof, of the incivility teaching in diminishing the incidence of lateral violence by verbally self-advocating professionally. The post-surveys served to measure how many of the new nurses have "broken the silence" and used communication tools provided after the in-service was conducted.

### **Project Type and Design**

This was an evidence-based project because the foundation of this study was built upon evidence extracted from multiple works of literature regarding the existence and reality of lateral violence as far back as three decades. The literature review conducted bore evidence of the causes, contributing factors, and barriers. This evidence-based project has also been previously attempted and yielded significant and measurable outcomes with its systematic approach and integration of review and appraisal of scientific evidence (Moran et al., 2019). The simplicity in the implementation plan offered a potential success with the recruitment and engagement of participants. This project design was a pre-and post-assessment of new graduate nurses as it involved obtaining measures of the outcome of interest before conducting the educational in-service, followed by a post-test on the same measure after the teaching occurred. (Salkind, 2010).

### **Project Setting/Population**

This project took place in a Magnet-designated facility recognized by the American Nurse Credentialing Center (ANCC) for nursing excellence and innovations in professional nursing practice. University of California Irvine Medical Center comprises a nationally regarded team of healthcare professionals who are devoted to improving the

lives in their community. This multi-faceted organization is the only academic health system in Orange County dedicated to teaching future healers and to the discovery of new medical frontiers. As such, UCI Health has a New Graduate Nurse program designed to help transition newly certified nurses from novice to expert nurses. This population comprises approximately 18 newly graduated nurses who are currently undergoing clinical and didactic orientation for their onboarding to various clinical units as staff nurses.

### **Participants/Recruitment**

There is sufficient evidence that supports the notion that lateral violence is prevalent across the nursing profession regardless of the roles portrayed. New graduate nurses are particularly regarded as a high-risk population for exposure to incivility in the workplace. New graduate and newly licensed status were the main inclusion criteria considered for this project, regardless of age, gender, religion, and ethnic background. In light of an ongoing COVID-19 pandemic, consideration was placed on possible restrictions placed upon institutions in the past and thus, a plan was placed to extend the inclusion criteria for participants to include new-hire nurses with up to three years of employment. This detail has been validated in literature as an appropriate criterion to be considered a novice in nursing.

### **Stakeholders**

The main stakeholders considered in this project were the nurses themselves who are directly affected by lateral violence. New graduate nurses and even experienced new hire nurses particularly need advocates for workplace safety to be efficient in their practice. A supportive work environment is essential in fostering professional growth. Other stakeholders included nurse educators, nurse managers, organizational leaders, and the community. The clinical nurse educators' main responsibility is in facilitating the clinical and professional development of the staff as part of a wider multi-disciplinary healthcare system. The nurse managers have a stake in how nurses perform in their role as it directly affects patient care delivery as well as the professionalism among

the staff. The unfortunate implication of nurse managers in literature as one of the perpetrators of lateral violence, whether intentionally or not, is one of the reasons why lateral violence has been underreported (Rainford et al., 2015). Furthermore, their inaction on this matter when reported has discouraged others to do so and thus contributes to the prevalence of the problem. The response of management to lateral violence drives the outcomes it may have on an organizational scale as this unsafe culture consequently results in low retention rates that in turn accrues high turnover rates impacting the organizational budget (Tripp, 2018). The need for leadership to be more proactive in emphasizing teamwork as a promoter of safety in nursing practice is evident and essential in rectifying this problem. In case reviews performed by The Joint Commission, communication breakdown from lateral violence was identified as a root cause for preventable medical errors. This detail increased the susceptibility of patients to the ill effects of lateral violence. Therefore, members of the community also have a stake in this because the quality of care may be compromised when delivered from unsafe environments.

### **Description of Intervention**

The intervention consisted of a two-part in-service education. The first part included information on the identification, prevalence, and significant effects of lateral violence in the nursing profession and how it is concretely presented in practice. It also included strategies to manage a situation when faced with lateral violence. The education module was developed and published by another DNP student for the same intended purpose of increasing awareness and identifying subliminal acts of incivility through education (Tripp, 2018). The teaching module touched upon the concepts of cognitive rehearsal, conflict resolution, and emotional intelligence. All of which have shown increased knowledge of what constitutes lateral violence and positive impact to increasing awareness of the issue.

The second part provided a communication tool and cue cards with the inclusion of CUS tool to utilize in speaking against lateral violence when confronted with these acts. Influenced by the constructs under the Oppression Theory, empowerment was the intended force behind the inclusion of the second part of the in-service teaching.

The completion of the education in-service and explanation of the communication was followed by four to five weeks for the participants to observe their work environment and to trial the communication tool provided if an opportunity to do so arose. The effectiveness of the in-service was measured thereafter with a post-survey, utilizing the same initial survey. The results and data from the two surveys were gathered and compared against each other. The findings were organized using Microsoft Excel which was then converted into statistical data for analysis and measurement of significant outcomes. To aid with the convenience and accuracy of the data gathering involved in this project, Qualtrics was used as a technical resource essential in data collection, obtaining consent, recruiting participants, and analysis of survey results from nurses. Additionally, this online data management program helped in assuring confidentiality for the participants.

In summary, the main components of this project comprised of three items: a validated survey that measured the prevalence, severity, and causes of LV, an education module about incivility, and communication strategies provided in the form of badge-size cue cards for accessibility.

### **Measures/Instruments**

There are a select few available instruments for measuring negative behaviors among interprofessional workers, and even fewer that directly measure lateral violence specifically (Layne et al., 2019). The Negative Behaviors in Healthcare Survey is an updated version of the Lateral Violence in Nursing Survey that was validated, bearing internal consistency reliability and construct validity as an instrument to assess negative behaviors among interprofessional healthcare team members (Layne et al., 2019). Although this survey extended the invitation to additional healthcare teams and professionals who directly support direct patient care, the modifications to this instrument included further definition of lateral violence from vertical aggression; one that occurs from colleague-on-colleague on the same power level. The development of this survey involved a systemic review of 22 instruments measuring nine behaviors with only a few that measured behaviors across interprofessional teams. Two instruments measured both negative behaviors and acceptable psychometric properties. This instrument was previously administered on two separate occasions using Qualtrics following IRB

approval for approximately 2,000 nurses and 750 physicians at both times. The survey consisted of 28 items addressing aggression, 10 items measuring contributing factors to negative behaviors in the workplace, and three items measuring fear of retaliation using a Likert-type response scale. Additionally, the survey included demographic questions. The post-survey included open-ended questions to collect significant qualitative data all the while offering the participants an opportunity to provide feedback and recommendations for future studies. The overall results from previous studies suggest that the NBHC instrument is a reliable and valid measurement of the negative behaviors within the healthcare team (Layne et al., 2019).

### **Data Collection Procedure**

Qualtrics was the chosen secure web-based software used to create surveys and used in managing data. This conveniently generates reports of survey data that can be viewed in reports. It is geared to support surveys, feedback, and polls using a variety of distribution means. This application offers accuracy and convenience when collecting information from this survey. Recruitment of participants started during the first week of January. The data collection started during the first week of February after conducting the Negative Behaviors in Health Care (NBHC) pre-survey.

The results from this survey served as the initial measure of the current perception of the presence of lateral violence in their workplace. After the delivery of in-service about lateral violence and communication tools, the participants were given 4-5 weeks to observe and apply the teaching received into practice. The same survey was conducted as a post-survey at the end of that period. Two weeks were allotted to complete the post-survey during the second week of March. The last weeks of March were assigned and used for data collection and synthesis to help develop the final manuscript. The results from the second survey were used to measure the impact that teaching intervention may or may not have made on the nurses in comparison to the pre-survey. During the observation period, cue cards were given as visual reminders of the professional script proposed.

Qualtrics conveniently generated a report of all responses received for both pre-and post-survey. The results were then transcribed to an Excel sheet and converted into numeric data in preparation for data analysis using a statistical analysis program.

## **Data Analysis**

The data analysis entails a statistical comparison of the results obtained from the pre-and post-survey. The survey was divided into four major components of Lateral Violence: contributing factors (CF), frequency of aggression (FA), seriousness of aggression (SA), and fear of retaliation (FR). Results obtained from the first three categories help to measure the significance of the informational teaching to the PICOT question with regards to increasing the awareness of the problem. The results from the last component, fear of retaliation, directly measure the effect of the communication strategies provided as an intervention on the nurses' level of confidence in speaking to the issue. To examine change in knowledge from baseline to post-in service, a paired samples t-test was conducted for each of the four survey subscales. In addition, Cohen's d effect sizes were calculated for the mean difference for each of the subscales to determine magnitude of effect.

## **Ethical Considerations**

The University of California, Irvine (UCI) is required to comply with all review requirements defined by the Institutional Review Board (IRB) for all project/research submissions. The Request for Determination-Non-Human-Subjects was completed prior to the start of this project. The activities involved in this study did not constitute human subject research or a clinical investigation as verified on December 13, 2021. Therefore, UCI IRB review was not required nor was it provided. Permission was obtained from Dr. Janice White, Director of Nursing, to conduct the study at UCI Medical Center. A signed letter of cooperation was provided as proof of confirmation and agreement of the affiliation with the institution.

Signed consents were obtained before the commencement of each survey for participation. All participants were protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which, among other guarantees, protects the privacy of patients' health information (Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, 2013). All information collected as part of evaluating the impact of this project were aggregated data from the project participants and did not include any potential participant identifiers. The risk to participants participating in this project was explained. Participant confidentiality was

ensured by coding the participants using individual identification numbers. The list of participants and their identifying numbers were kept private, only accessible to the DNP student. All electronic files containing identifiable information were password-protected to prevent access by unauthorized users and only the DNP student will have access to the password.

### **Stakeholder Barriers**

Barriers encountered with engagement of stakeholder in the implementation of this project were in remote recruitment and the initial non-response of nurses with the first few invitations. This was overcome with persistent reminders and recruitment. From a leadership standpoint, full support was gained from the director of nursing who also agreed to be the Site Mentor. However, based on data from previous literature implicating the role and influence of leadership on lateral violence and the sensitive nature of the topic in review, the mentorship and oversight for this project were shifted to the clinical nurse educator who also provided full support.

### **Formative Process Evaluation**

As part of the formative evaluation, weekly informal in-hospital visits were planned to check in with participants and offer support as their confidant and advocate should the need arise. Restrictions were placed on in-person visits by UCI Medical Center due to the surge of the pandemic. In place of visits, weekly emails were sent to inquire about any encounters of negative behaviors from work each week, progress with the application of the proposed intervention and use of communication script and cue cards. Collaboration was also established with the clinical educator to follow up on participants' progress with more open communication. Although this project did not include a qualitative component, anecdotal testimonials were obtained through open-ended evaluative questions in the post-survey. Data collected from those responses may offer insight into the participants' level of engagement with the project and their increased awareness of the workplace climate.

## **Budget Plan**

The pandemic imposed a restriction on in-person access to the participants. Hence, this project was conducted remotely. This pressed upon a challenge with recruitment via emails. In addition, due to the nature of this project, some participants may have found this topic to be sensitive. All participants were offered remuneration in the form of a small gift card for their time and efforts with completing the surveys and participation with in-service. Gift cards were awarded at the end of each completed survey. A small fee was used as an allowance for the printing of project materials.

## **CHAPTER V: RESULTS AND CONCLUSION**

### **Results**

This chapter is a presentation of the data collected and analysis conducted to assess the impact of an informational in-service intervention to new graduate nurses on the level of awareness of lateral violence and the empowerment to speak up against it.

#### **Demographic and Descriptive Data**

The survey was sent out to 38 new graduate nurses. Thirteen individuals responded and completed the pre-survey, which is a 34% response rate. Only nine participants responded to the post-survey and were included in the analysis for this study. All participants who completed both surveys ( $n = 9$ ) were new graduate nurses with less than one year of experience who were hired for a full-time position. Of this group, only seven received workplace safety training, and five had undergone lateral violence training. The project revealed that five (55%) had received previous training regarding safety against lateral violence, two (22%) had not, and the remaining two (22%) were not aware of the existence of such a program. However, all nine participants were familiar with the phrase “nurses eat their young” (see Table 1).

For the analysis of results, a  $p$ -value of less than 0.05 indicates statistical significance of the results. In addition to quantitative analysis, themes from the qualitative data gathered from participants are presented from all 13 participants who completed the baseline survey.

## Quantitative Analysis

As expected, given the sample size, none of the paired sample  $t$ -test analyses were statistically significant. However, for three of the four subscales, the trend of scores was in the expected direction. Specifically, knowledge of contribution factors increased from baseline ( $M = 22.22$ ,  $SD = 5.61$ ) to post-in service ( $M = 24.00$ ,  $SD = 7.62$ );  $t(8) = -1.31$ ,  $p = 0.23$ . Similarly, awareness of aggression frequency increased from 11.33(3.20) to 12.67(4.15)  $t(8) = -1.13$ ,  $p = 0.29$ ) and understanding of the seriousness of aggression increased from 15.67(6.63) to 19.56(6.98)  $t(8) = -2.14$ ,  $p = 0.06$ ). There was no change in fear of retaliation from pre- ( $M = 7.33$ ,  $SD = 2.55$ ) to post-in service ( $M = 7.33$ ,  $SD = 2.18$ ). (see Table 2 and Table 3).

Given the small sample size, but trending results, a Cohen's  $d$  effect size was calculated for the first of the three subscales to reflect the potential magnitude of the effect of the difference in mean scores from pre- to post-in service. This measurement is independent of the sample size and denotes a practical significance, which shows whether the effect is large enough to be meaningful in the real world. (Bhandari, 2020). Cohen's  $d$  results correspond as such: 0.2 = small effect, 0.5 = medium effect, and 0.8 = large effect. The paired sample effects size showed a small impact effect for CF ( $d = 0.263$ ) and FA ( $d = 0.312$ ); whereas FR showed a medium effect size ( $d = 0.653$ ). (see Table 4)

Finally, descriptive statistics were used to find connections between data points and potential relationships between variables. A summation and average score were obtained from the data entry per participant. When calculating responses regarding CF in the pre-survey, the highest average score was reported for item four: *Inadequate staff/resources to handle the workload*, and item five: *Job stress leading to loss of control over behavior*. The lowest score was on item six: *Misunderstanding related to cultural differences*. For the post-

survey, the highest score shifted to item two: *Major personality clashes*. The lowest score for CF in the post-survey was on item nine: *Peers not willing to intervene*. In the subscale on FA, the highest score states “*I observe lateral aggression rarely*” with the score slightly shifting towards possibly experiencing it “*monthly*”. SA was perceived as very *serious toward healthcare professional peers* in the pre-survey. For the post-survey, *vertical aggression* rather than lateral aggression was deemed more serious compared to other job-related stressors. Regarding the subscale that discusses FR, there was a very slight decrease in score numerically.

## **Qualitative Results**

There were two optional and open-ended questions included in the pre-survey. The first question sought descriptions of negative behavior which occurred within the participants’ work environment. The recorded responses from five (55%) of the participants included negative and passive-aggressive behaviors such as eye-rolling, backbiting (describing their new graduate orientee as “lazy” to others), unfair workload distribution, and withdrawal of support under the pretense of reinforcing independence. The second question asked participants for their suggestions on how to decrease these episodes amidst the healthcare team within their work area. Recommendations that were suggested reflected the desire to open various lines of communication such as notification of management, teamwork promotion via team-building exercises, non-judgmental communication, and direct resolution of issues that precipitate negative behaviors in the workplace.

The post-survey included 12 open-ended questions that served to evaluate participants’ feedback on the project. The results showed that the in-service was well-delivered, well-received, and very helpful in the identification of specific behaviors that constitute lateral violence. All nine participants expressed openness to receiving the educational intervention and eight (88%) nurses indicated the likelihood of using the communication tool taught to them. The same participants believed that having the ability to identify concrete acts of lateral violence and realizing their negative effects empowered them to reject the normalization of this negative culture. In the four-week project period, six (67%) either witnessed or experienced acts of incivility and utilized the CUS tool effectively. The common response, when asked about possible barriers to speaking up, included lack of confidence in the method and uncertainty with gaining the support of management and other experienced nurses

when confronted with incivility. Overall, the participants believed that the inclusion of this education during orientation and annually would have a positive influence on the promotion of a healthy work environment for nurses. In addition to the promotion of open communication, the participants' recommendations included using self-assessment tools to evaluate and help realize their aggressor tendencies, improving staffing, increasing resources, and leadership support with open and blame-free communication.

## **Discussion**

This study offered the opportunity for new graduate nurses to observe and seek out the presence of lateral violence in health care as well as attempt to use the provided professional script against acts of incivility. The two main objectives for this evidence-based DNP scholarly project were: to increase awareness of lateral violence through education and promote professional communication tools as a defense. Thus, the new graduate nurses were given both formal and informal definitions of the problem, informed of concrete acts of these negative behaviors, notified of their risk for both exposures and aggressors tendencies, and were provided with professional communication verbiage as their defense tool. Although underpowered to find statistically significant results, the survey findings showed that after the in-service, nurses reported increased awareness in three of the subscales in the survey: contributing factors, frequency of aggression, and seriousness of aggression.

A closer look at the statistical analysis showed that the most notable change between the surveys was with the increased scores on the subscale on the seriousness of aggression. This is a significant finding because it suggests recognition of the severity of the problem and the harmful consequences in the short and long term. In the review of the contributing factors to lateral violence, the highest score shifted from organizational causes to that of personal causes. With regards to measuring factors that addressed the fear of retaliation, there was no change on this account. One can argue that this subscale may not accurately be reflected at this time as new nurses generally have less exposure to other experienced nurses while under close observation of a preceptor. In addition, the intensity and frequency of conflict exposures generally increase with years of experience. This subscale will likely bear more significant data when surveyed among experienced nurses. Although the study results were not

statistically significant, the effect size was more heavily considered as it denotes practical significance in this study despite its small population size. Based on the overwhelming evidence to the contrary as repeatedly noted in the literature and described previously, there is enough reason to believe that other confounding factors may have contributed to this lack of statistical significance.

Respondents were provided a chance to provide thoughts, suggestions, and feedback through open-ended questions in the evaluation portion of the post-survey. The remarkable yet not unexpected responses revealed that although all participants have heard the phrase “nurses eating their young”, only five (55%) of the participants have received previous training against lateral violence and most are not familiar with the term. Three common themes emerged from the responses received. First, participants expressed a yearning for open communication among nurses. This is a positive sign toward effectivity in the reinforcement of avoiding self-silence as a stopgap solution for incivility. It is an indicator of nurses choosing dialogue over risking divisiveness with the lack thereof. Second, nurses realized their susceptibility to lateral violence is not solely as victims, but as inadvertent perpetrators as well. This depicts an increased level of self-awareness that shows promising opportunities for new graduate nurses to take a proactive stance in slowing further destructive iterations of this self-perpetuating cycle. Lastly, this survey conveyed the desire for a supportive, blame-free, and non-retaliatory work environment led by an encouraging leader with a team mentality. Both qualitative and quantitative responses confirmed an increase in their knowledge about the issue of lateral violence in nursing. In fact, some of the participants expressed using the communication tools in the qualitative survey.

As made evident in many scholarly pieces of literature, lateral violence has been an ongoing problem for over three decades, thus addressing this problem and finding resolutions for the damage caused by this phenomenon will require time and effort. However, with knowledge comes the power to make a change. Promoting safety in work environments must include identifying the potential threats to safety and the level of risks they pose. Given adequate time, sincere and consistent effort, and dependable backing of leadership, there is much promise in the pursuit of eliminating incivility as part of the nursing culture. This study provided valuable information to aid in the development of plans to sustain this project such as the impetus to include lateral violence awareness training

in new graduate and/or new hire nurse orientation and in annual workplace safety competency training. Many literatures showed evidence that the exposure to lateral violence starts in academia among nursing students. Implementing this education is an acknowledgement of the confounding theories previously reviewed that drive nursing behavior. Influenced by the constructs in the Oppression Theory, early intervention through education could serve to urge nurses to self-redefine their roles from being oppressed to health advocates and safety agents. Creating awareness of the problem of lateral violence can be achieved by acting upon two main purposes: to continually acknowledge that incivility is an existing problem, and to make ceaseless efforts to speak of and to the issue. Hence visual effects, such as cue card distribution on the behavioral manifestation of lateral violence and poster reminders to speak against incivility in high yield areas such as break rooms and bathrooms, help maintain an optimal level of professionalism and awareness in the workplace. These recommendations are reinforced by the premises of the theory of the nurse as a wounded healer. Under this theory, Conti-O'Hare emphasized the importance of this realization of recognition and transformation process of previous hurtful experiences, whether causes were work-related or personal, in order to transcend and continue along the path to become a wounded healer. With that thought, nurse satisfaction and self-awareness surveys that include components of the NBHC survey should be conducted periodically by leadership as a surveillance tool to continually assess the workplace climate and promote sustainability of this project (Conti-O'Hare, 2002).

The Advanced Practitioner Registered Nurse (APRN) holds a vital role in the betterment of nursing work culture as a nurse advocate. With a wider perspective that comes with higher education and training, APRNs are uniquely suited to care for the nurses' psycho-emotional wellbeing in the workplace because they not only have the skills to provide care and compassion but also are equipped with the knowledge to analyze, synthesize, and implement evidence-based interventions. Having lived experiences as nurses themselves, they have the truest understanding of the challenges and pressures that nurses are faced with in their day-to-day operations. Hence, they can approach this phenomenon with a more empathetic viewpoint and a much wider and contextual perspective.

## **Limitations to the study**

Limitations of this study include restriction of in-person access to participants as imposed by the COVID-19 pandemic, small sample size, non-response to the second survey, project time implementation, years of experience, and nursing specialties.

## **Conclusion**

This study was intended to create, recreate, and reinforce awareness of lateral violence and serves as an extension to previous research on the negative impact of incivility on nurses, particularly the new graduate nurses. Outcomes from the intervention in this evidence-based project support the claim made by multiple articles that lack of awareness is a factor that increases nurses' susceptibility to lateral violence. The responses received from the surveys reflect the need and demand for education on characteristics of lateral violence and descriptive definition of lateral violence. This study suggests that although many defensive strategies have been attempted in the past, the very act of defining the problem and identifying concrete behaviors that constitute lateral violence through education is the essential first step that is often overlooked when searching for solutions to this problem in the nursing profession. Therefore, this project stands to support recommendations made by previous studies to combine educational interventions with cognitive behavior training as a defense against lateral violence. Results further recommend investing efforts towards addressing barriers to promoting communication at the forefront as likely furtherance of this cause. Recommendations proposed for further consideration are as follows: *Inclusion of lateral violence awareness in orientation.* Conducting this early on will prime the nurses' thought process when faced with conflict to shift from responding with fearful self-silencing thoughts or defensive and retaliatory reactions to one that is positive and serves to promote resolution. *Provide ongoing education on the prevalence of lateral violence and communication strategies.* This knowledge will serve to equip nurses to address incivility openly and confidently, putting the problem on display and open for discussion and problem-solving initiatives. *Develop confidential reporting processes.* This will serve as an adjunct resource that will offer open lines of communication for a nurse when uncertain of support from their leadership team. *Enhance preceptorship*

*training*. Training for preceptors should include emotional intelligence to help recognize tendencies in the manifestation of negative behaviors that constitute lateral violence within themselves and/or upon others.

Given the wide range of effects of lateral violence, clinical and institutional leaders must recognize that as care delivery transcends to the nurses from patient care delivery, recommendations are placed to suggest that the level of workplace safety is likely to increase

### **Project Links to DNP Essentials**

The constructs of this project were built upon a plethora of literature on the issue of lateral violence whereby the Oppression Theory and Theory of the Wounded Healer were used as the foundation for many studies. Clinical scholarship and analytical methods were applied in the synthesis of background literature, development of the intervention, and search for relationships between qualitative and quantitative data from the results obtained from this project. A review of previous advocacy and current policies was conducted to evaluate gaps in practice that permit the prevalence of this phenomenon in nursing culture. Consideration for organizational systems and interprofessional collaboration necessitated a systems-thinking approach in the development of evidence-based interventions and desired outcomes for the improvement of the overall health and wellness of the nursing population. The application of these elements shows mastery of the DNP essentials upon completion of this project.

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**APPENDIX A: Site approval/authorization letter**

**Letter of Cooperation with Outside Organization for UCI DNP Project**

Date: 11/22/2021

Dear: (name of DNP Student): Chiara Cardoza

This letter confirms that I, as an authorized representative of allow the above-named Doctor of Nursing Practice student access to conduct a leadership, policy, quality improvement, or evidence-based practice project activities at the listed site(s) as discussed with the DNP student and outlined below. These activities may commence after the DNP student has consulted with UCI IRB about the proposed project.

- **Project site(s):** (list specific site name and address for all sites within which the organization is providing student access to conduct the project)

University of California Irvine Medical Center  
101 The City Dr S.  
Orange, CA 92868

- **Project purpose:** (briefly summarize the project purpose, plan and expected outcomes)

The purpose of this project is to increase awareness by means of defining lateral violence and identifying the subliminal acts of incivility through education and provision of communication strategies that can be professionally used to speak to lateral violence.

- **Project activities:** (briefly summarize the activities that will commence at the site, including any baseline data collected, educational interventions, PDSA cycle proposed...)

An educational in-service on identification, prevalence, and significance of incivility is the main activity that will commence, supplemented with communication cue cards. This will include a pre- and a post-survey to measure significance of the education.

- **Target population:** (identify the population upon whom the project will focus)

The target population for this project will be focused on the new graduate nurses at UCI Medical Center based on evidence from literature that this population's susceptibility to the exposure of lateral violence in the nursing profession

- **Site(s) support:** (briefly describe the support the project site(s) agree to provide to support the project, such as space to conduct project activities, data retrieval from electronic records, facilitation of educational activities...)

The site agrees to allow for inclusion of education on lateral violence to this year's cohort of new graduate nurses during one of the scheduled didactic portion of their orientation in collaboration with the new graduate coordinator.



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268 Berk Hall  
Irvine, CA, 92697-3959  
(949) 824-3650  
www.nursing.uci.edu

- **Data management plan:** (briefly describe the plan for management of data such as what data will be collected, whether it will be identified/de-identified, what protections will be in place for data protection...)

Data to be collected will primarily consist of the validated pre- and post-survey on the negative behaviors in healthcare and a program evaluation at the end of the project with the use of REDCap. This system will honor anonymity in data collection with the use of participant identifiers.

- **Other agreements:** (briefly describe any additional agreements that have been made to support the project, if applicable)

Provision of communication tool and cue cards with the inclusion of CUS method, as recommended by the AHRQ, were approved to supplement the educational in-service as a tool to use when confronted with these negative acts.

- **Anticipated end date:** (indicate the anticipated date that the project will be concluded at the site)

The projected implementation timeline for this project is from the beginning of January 2022 up until data collection and analysis by the middle of March 2022.

It is understood that all DNP Scholarly Project related activities must cease if directed by UCI IRB. It is also understood that any activities that involve Personal Private Information or Protected Health Information must comply with HIPAA Laws and institutional policy.

Our organization agrees to the terms and conditions stated above. If there are any concerns related to this project, we will contact the DNP student named above and their DNP Scholarly Project Chair. For concerns regarding IRB policy or human subject welfare, we may also contact our own institutional IRB.

UCI IRB: <https://www.research.uci.edu/compliance/human-research-protections/researchers/irb-faqs.html>

With regards,

**Janice White**

Digitally signed by Janice White  
Date: 2021.11.29 10:21:27  
-08'00'

**Director of Nursing**

(Signature of Project site-authorized representative)

(Job title of authorized representative)

(Date signed)



**Sue & Bill Gross School of Nursing**  
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## APPENDIX B: KualI Approval Email

From: KualI Notifications <no-reply@kuali.co>  
Subject: Confirmation of Activities that DO NOT Constitute Human Subjects Research  
Date: December 13, 2021 at 3:38:44 PM PST  
To: cmcardoz@uci.edu

Dear Chiara Marella Cardoza,

The University of California, Irvine (UCI) Human Research Protections (HRP) Program complies with all review requirements defined in 45 CFR Part 46 and 21 CFR 50.3.

**Based on the responses provided in Non Human Subjects Research (NHSR): #660 - "Defining and Identifying Negative Behavior in Healthcare: A Defense Against Lateral Violence", and per the definitions cited below, the activities do not constitute human subject research or a clinical investigation, as applicable. Therefore, UCI IRB review is not required and will not be provided.**

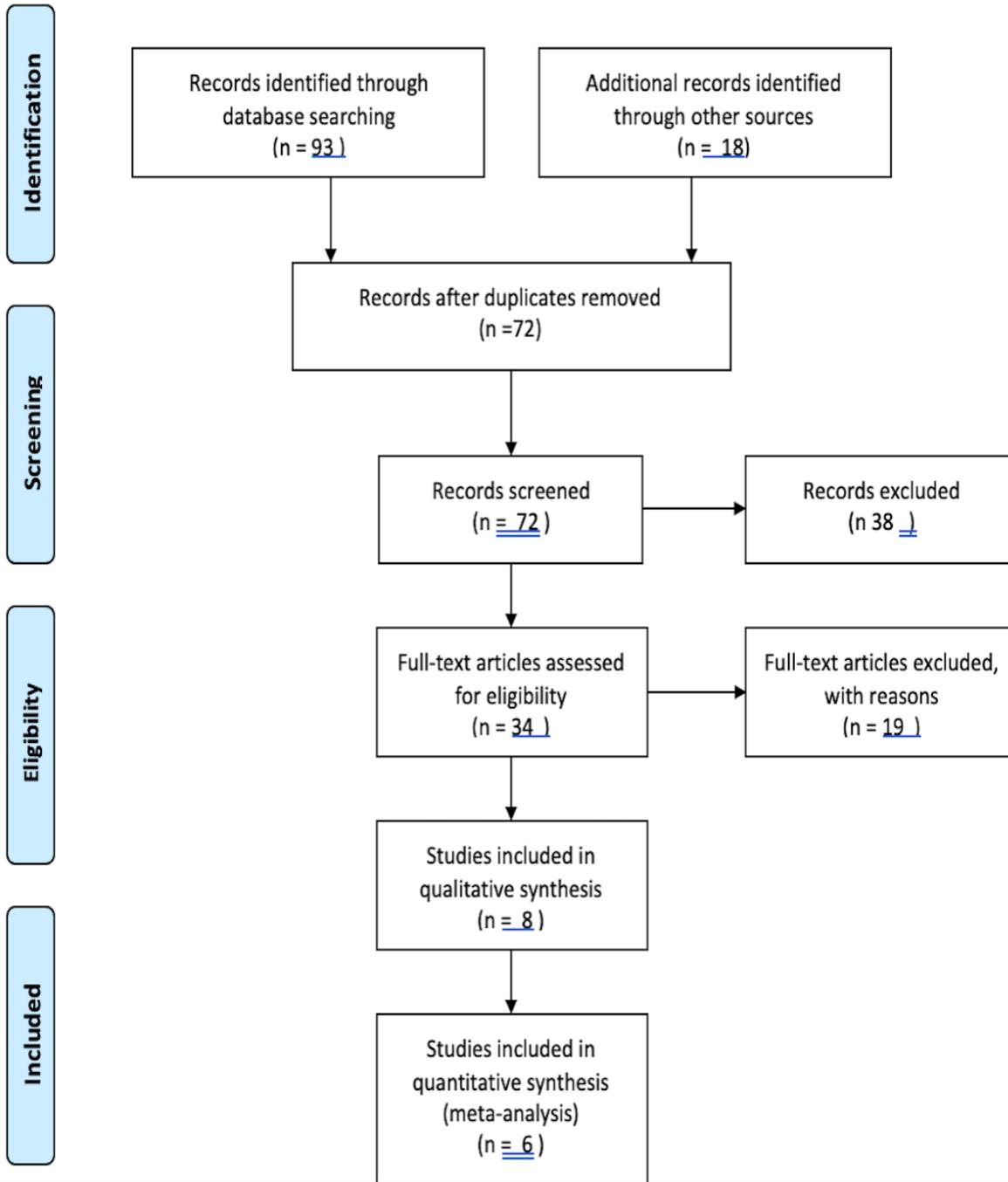
45 CFR 46.102(l) defines research as “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge; and 45 CFR 46.102(e)(1) defines a human subject as “a living individual about whom an investigator conducting research obtains (i) Obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or (ii) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens.”

21 CFR 50.3(c) defines a clinical investigation as “any experiment that involves a test article and one or more human subjects and that either is subject to requirements for prior submission to the Food and Drug Administration under section 505(i) or 520(g) of the act, or is not subject to requirements for prior submission to the Food and Drug Administration under these sections of the act, but the results of which are intended to be submitted later to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.”

To view the determination for your submission, click here:  
[uci.kuali.co/protocols/protocols/61a9cba46d35600037d00a81](https://uci.kuali.co/protocols/protocols/61a9cba46d35600037d00a81)

Please DO NOT REPLY to this email as this mailbox is unmonitored. If your project changes in ways that may affect this determination, please contact the HRP staff for additional guidance: [irb@uci.edu](mailto:irb@uci.edu).

APPENDIX C: PRISMA CHART



**APPENDIX D: Table of Evidence**

Articles	Source (Author, Date)	Conceptual Framework (Theoretical Basis)	Methods/ Design	Population & Sample Setting	Independent/ Dependent Variable (*Primary Outcome)	Measurements/ Data Analysis	Results/ Findings	Appraisal/ Relation to PICO	Limitations
<a href="#">SOURCE 1</a>	Cynthia M. Clark, PhD, RN, ANEF, FAAN, Karen L Gorton PhD, RN, FNP (2019)		Addressing incivility through implementation of Cognitive Rehearsal, <del>HeartMath</del> and CUS Method by <del>Team STEPPS</del> in new graduate orientation and senior nursing students.	Nursing Students and New Graduate Nurses.	IV: Mixed Methodology of EB tools to build resilience in addressing incivility. (Cognitive Rehearsal, <del>HeartMath</del> , CUS Method by Team STEPPS. DV: Resilience to incivility, awareness of consequences of incivility with patient care, decreased stress, increased practical application of new skill acquired.		This study shows that the EB education strategy provides nursing students and new graduate nurses helpful tools to build resilience towards incivility. However, further reinforcement of knowledge and practice is required for further effectivity. This model helps mitigate the potential negative effects of this to patient safety.	YES. The mixed methodology of EB tool is applicable to promote resilience in new graduate nurses who may encounter lateral violence. This article relates to the same population intended for my study.	Lack of generalizability to other academic settings and student population (conducted only in 1 school), Lack of external validation due to self-reporting of results, requires follow-up training/practice sessions to reinforce use of tool and application

SOURCE 2	Donna M. Glynn, PhD, APRN, Cecilia McVey MHA, BSN, RN, Judith Wendt, MSN, RN, Bonnie Russell MSN, RN. (March/April 2017)		This article introduces a Dedicated Educational Nursing Unit Model (DEU) in the student nurse orientation process. The goal in the incorporation of this model is to promote academic-practice relationships to increase effectiveness of nursing resources. This goal is geared towards improving learning outcomes for both student nurse and staff nurse in the role of a clinical instructor/preceptor.	Nursing Students, Staff RNs with >5-year experience.	IV: Appointment of a DEU (Dedicated Educational Nursing Unit). Utilization of an Academic Affiliate to foster academic-practice partnerships. DV: Identification of CI roles perceptions, Identify perceived education learning needs of CI and student nurse. Improved basic skill competency and critical thinking skills.		This study yielded positive learning outcomes from both clinical instructors (CI) and student nurses. To further meet learning goals and objectives successfully, the CIs did report that structured orientation to the role with development of clear clinical objectives would be very helpful.	YES. Understanding the framework of a successful orientation process helps understand the foundation from which learning is built upon as a new nurse. By identifying the roles and expectations of the key players in the study, one can hope to identify where the point of diversion to lateral violence occurred.	This study indicated biased support of Academic Affiliate towards the student nurse more than the staff nurse who is learning the clinical instructor's role. Limited support was noted for student's/orientees with a language barrier. The study was only conducted at one healthcare institution and thus lack generalizability to other academic settings. This study also reports need for staffing commitment to support the learning needs of staff RN and student nurse.
SOURCE 3	Ericka S. Stahler PhD, RN, Peggy Ward PhD, RN (Aug 21, 2016)		Emphasis is placed to the vital role of nurse educators in the deconstruction of the lateral violence cycle in this article. Faculty incivility is likened to that which is found between nurses in the clinical environment. This article also discusses other contributory factors that need ameliorating for the reduction of LV incidences.	Student nurses in clinical settings. Nurses in clinical settings are excluded in this study sample.	IV: Inclusion of counter strategies to LV and simulation to curriculum content, Code of Conduct reinforced with consequences, Faculty Accountability reinforced.		In this article, tolerance of lateral violence in nursing is attributed to response witnessed/experienced from a student nurse's clinical rotation. The responsibility to break this cycle of incivility is heavily placed upon nurse educators who are appointed as role models in behavior, practice and conduct.	NO. Wrong Population. This article helps me contemplate on what population will be more effective to focus on in the implementation of my DNP scholarly project. It inspires me to start thinking of an innovative response/implementation plan to this phenomenon.	This article excluded the nurse's experience in the clinical setting.

SOURCE 4	Berry, Peggy Ann, Gillespie, Gordon L., Fisher, Bonnie S., Gormley, Denise, Haynes, Jared [September 2016]		This article includes a mixed method study to assess the psychological distress resulting from workplace bullying (WPB) and the ill effects it poses to work environments in healthcare organizations.	Nurses of varied ages, backgrounds, and years of experience.	IV: Five-component survey, 10-item Perceived Stress Scale, State Trait Anxiety Inventory, Posttraumatic Stress Disorder Checklist, demographic surveyed: DV Perceived stress and anxiety level, nurses' retention and turnover rate		No nurse is immune to WPB. Leadership needs to be more proactive in resolving conflict and empowerment of staff. Teamwork is essential in facing this complex arena in healthcare.	YES. This article supports the need for intervention of my chosen phenomenon through statistical backing of the undue effects of workplace bullying to nurses and healthcare organizations.	The limitation of this study is in its small sample size. This study may also contain response biases due to the use of self-reports from respondents.
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<a href="#">SOURCE 5</a>									
<a href="#">SOURCE 6</a>									
<a href="#">SOURCE 7</a>	Catherine C. <del>Raza</del> DNP, RN, ACNS, Ann L. Bianchi PhD, RN		Quality Improvement program (Incivility Education & Cognitive Rehearsal Training)	Community hospital in NE, convenience sample of nurses		NIS-Nursing Incivility Scale. Showed <del>statistical</del> significant decrease in perceived incivility	Incivility Program helps ID uncivil behavior, react proactively professionally, +safety	YES	
<a href="#">SOURCE 8</a>	<del>Hyun Cho</del> RN, MPH1 Sung-Hyun Cho RN, PhD2		Online Survey to examine the prevalence of workplace violence toward newly licensed	Newly licensed RN, 5-12 month of employment in Korea	IV:	The Copenhagen Psychosocial Questionnaire II - measure violence and job outcomes. <b>Data Analysis:</b> The relationships between violence and job outcomes	Workplace violence is experienced by a high percentage of newly licensed nurses and is associated	YES	

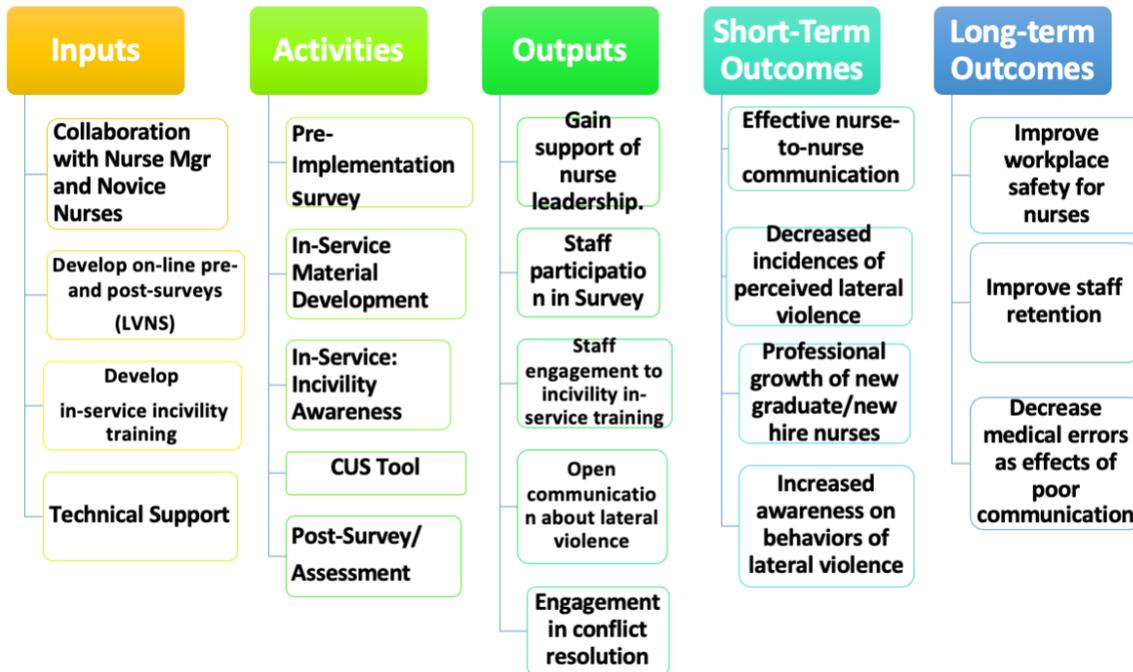
			nurses & the relationship between workplace violence and job outcomes.			were analyzed using multiple linear regression analysis for job satisfaction, burnout, and commitment to the workplace, and multiple logistic regression analysis for intent to leave.	with their job outcomes.		
<a href="#">SOURCE 9</a>	Jennifer L. <del>Eppoe</del> , Deborah A. Bruner, and Ann White	to determine perceived extent and increase awareness of NNLV through an educational project	Cognitive Rehearsal	Nurse-to-Nurse in Clinical access hospital.		Nurse Workplace Scale and the Silencing the Self-Work Scale. <b>Data Analysis:</b> Data analysis for pre- and post-survey data identified no statistical significance. However, when reviewing trends, the means of the NWS-Internal Sexism Scale and the STSS-W indicate a positive sense of empowerment and self-esteem	The project provided nursing dialogue for contentious situations in a CAH. Post-survey participants described recognizing their personal displays of NNLV and intervened when witnessing lateral violence in other nurses [33].	YES	small sample.
<a href="#">SOURCE 10</a>	Hossein Ebrahimi and <del>Hadi Hajianpour</del> <del>and</del> <del>Bozta</del> <del>Negarandeh</del> , Carol Jeffrey, Azim Azizi		qualitative method with conventional content analysis approach	New graduate nurses. The study setting included intensive care units, internal medicine, and surgical wards, and emergency wards in five general, governmental, and teaching hospitals		Subjective interpretation of the content of textual data by the systematic process of coding and identifying categories or themes. <b>Data Analysis:</b> Data were analyzed using conventional content analysis. This process comprised six steps: 1. Transcribing data, reading and re-reading documents, and perceiving initial ideas; 2. Creating original codes. Coding verbatim and line by line; 3. Searching for themes. Contracting the codes into potential themes; 4. Reviewing of themes. Relating themes with each other, with extracted codes and the entire data set; 5. Defining and naming themes. Ongoing	This study provided the context for identifying details of various types of workplace violence against new graduated nurses. The findings of this study depict lateral and hierarchical violence against new graduated nurses in clinical settings; these included psychological, verbal, physical, and source of violence.	YES	

						analysis, distillation of themes, creating apparent definitions and names for each theme;6. Producing the report. Final analysis, moving between transcripts and themes, selection of vivid stories for each theme, conducting the report.			
<a href="#">SOURCE 11</a>	Karen M. Stanley	The LVNS included three constructs for analysis (perceived seriousness, oppressors, mediators) derived from oppressed group theory ([Freire, 1971]; [Roberts, 2000]) and the Health Belief Model ([HBM; Becker, 1974]).	Instrument Development and Administration, Conceptual Framework	Approximately 1850 registered nurses (staff nurses, advanced practice nurses, educators, managers, administrators) and ancillary staff (licensed practical nurses, clinical associates, nursing and therapeutic assistants, patient care technicians, unit secretaries) were contacted via institutional e-mail and invited to participate in the survey. Single tertiary care medical center in the Southeast.		Lateral Violence in Nursing Survey (LVNS). This survey was designed to measure the perceived incidence and severity of LV in nursing. <b>Data Analysis:</b> Quantitative data were analyzed using the SPSS	Respondents noted that rude behavior is common in the work area and adopted by coworkers. Participants also believed that new nurses are tested to see if they can make it in the work area	YES	The non-random convenience sample used in this pilot study increases the possibility of sampling errors

SOURCE 12	Horton, Claudia		1-day workshops, preceptors participated in activities to increase their understanding of the preceptor role and to enhance their ability to assess the learning needs of preceptees, communicate effectively, provide constructive feedback, and resolve conflict successfully.	The 714 participants were RNs who attended the 8-hour NPA, NURSE PRECEPTOR ACADEMY		Descriptive statistics were used to describe the sample. An investigator-developed questionnaire was designed to elicit quantitative and qualitative data.	A Likert-scale format ranging from 1 (no), 2 (probably not), 3 (undecided), 4 (probably), to 5 (yes) was used to determine if the preceptor felt "better prepared to precept new nurses after having attended the NPA." The score of 4.56 clearly indicated that the purpose of the workshop had been achieved.	YES	Some surveys were sent more than 6 months after the preceptors had attended the <del>NPA</del> and recall of content may have been compromised as a result.
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<a href="#">SOURCE 13</a>	Rainford, William C.	Oppressed Group model	Systematic Review					YES	
<a href="#">SOURCE 14</a>	<del>Carpark</del> RN		Qualitative Descriptive Design	Young RN, employed between 4 mos-3 years			It was shown that the main and most important reason for the nurses' decision to leave their organization was their poor relationship with their managers and colleagues.	YES	
<a href="#">SOURCE 15</a>	<del>Meissner</del> <del>Judith E</del>	NURSES EAT THEIR YOUNG							

**APPENDIX E: Logic Model**



## APPENDIX F: Recruitment Material

### **ATTENTION ALL NEW GRADUATE NURSES!!!**

*Have you ever heard of the saying  
"nurses eat their young (and each other)"?*

My name is Chiara Cardoza, DNP-C, RN, and I am part of the inaugural DNP-FNP cohort at University California Irvine. I invite you to learn more about this long-standing phenomenon called **LATERAL VIOLENCE** and find ways to speak to the manifestations of **LATERAL VIOLENCE** in the workplace.

This nurse-to-nurse bullying is a problem that has persisted for far too long. Please join me in breaking this negative trend by participating in my scholarly project entitled:

#### **DEFINING AND IDENTIFYING NEGATIVE BEHAVIORS IN HEALTHCARE: A DEFENSE AGAINST LATERAL VIOLENCE**

**LATERAL VIOLENCE AFFECTS ALL NURSES AND CONTRIBUTES TO NURSE BURNOUT, COMPASSION FATIGUE, ANXIETY, DEPRESSION, AND OTHER HEALTH ISSUES. IT HURTS THE INSTITUTION AND CONTRIBUTE TO NURSE SHORTAGE.**

By signing up, you are agreeing to three simple tasks:

- 1** Pre-survey
- 2** Brief in-service session (15-20 minutes via Zoom)
- 3** Post-survey

 Sign-up and now **follow this link** to take the survey: **Take the Survey**

Or **copy and paste** the URL below in your internet browser:  
[https://uci.co1.qualtrics.com/jfe/form/SV\\_6KXVfbHWkZtVMRo?Q\\_DL=Cv8ljWYpj3NnXEB\\_6KXVfbHWkZtVMRo\\_MLRP\\_8jksBVNCPp3SJq6&Q\\_CHL=email](https://uci.co1.qualtrics.com/jfe/form/SV_6KXVfbHWkZtVMRo?Q_DL=Cv8ljWYpj3NnXEB_6KXVfbHWkZtVMRo_MLRP_8jksBVNCPp3SJq6&Q_CHL=email)

## APPENDIX G: Data Collection Instruments (NBHC Survey and Questionnaires)

*Confidential*

### **Negative Behaviors in Health Care Survey (NBHC)**

Page 1 of 3

**The following information is provided to assist you in completing the survey by increasing your understanding of lateral and vertical aggression in health care.**

Colleague: a fellow worker or member of a team, staff, department or profession

Lateral Aggression and Vertical Aggression are forms of colleague-on-colleague verbal and nonverbal behaviors that inflict psychological pain.

Lateral aggression occurs between colleagues at the same power level within healthcare (e.g., staff RN to staff RN; resident MD to resident MD).

Vertical aggression occurs between colleagues at different power levels within health care. It may be directed downwards (abuse of legitimate authority; e.g., manager to subordinate; attending MD to resident MD) or upwards (abuse of informal power; e.g., subordinate to manager)

#### **Examples of negative behaviors in health care:**

Disruptive or inappropriate behaviors such as eye rolling and other nonverbal messages, rude remarks, name-calling, condescending communication, infighting, deliberately not helping team members, not passing along important information, deliberately setting someone up to fail/get in trouble/look bad, talking behind a coworker's back, spreading rumors, scapegoating, breaking a confidence, excluding, silent treatment, not responding to questions/comments/pages, hanging up phone abruptly before problem is resolved, criticizing excessively, cyber abuse, making unfair assignments, withholding opportunities.

**Please choose the response that fits best for you:**

#### **CONTRIBUTING FACTORS**

**These factors contribute to lateral and/or vertical aggression in my work area:** Agree strongly Agree

Disagree Disagree strongly

1 Rude behavior

2

	Major personality clashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	Power and control issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	Inadequate staff/resources to handle the workload	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	Job stress leading to loss of control over behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	Misunderstandings related to cultural differences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	Targeted person not willing to stand up to perpetrator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	Leaders not willing to intervene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	Peers not willing to intervene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Frequency of aggression**

**Experience with LATERAL aggression (between peers at the same level in health care) in my work area:**

**Experience with VERTICAL aggression (between team members at different levels within health care) in my work area:**

	Daily	Weekly	Monthly	Rarely	Never
10	I observe lateral aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11	I am the recipient of lateral aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	I use lateral violence aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	I observe vertical aggression directed downward from healthcare professionals in leadership positions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14	I am the recipient of vertical aggression directed downward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15	I use vertical aggression directed downward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16	I use vertical aggression directed upwards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Seriousness of Aggression**  
**Degree of seriousness of LATERAL aggression (between colleagues at same level within health care) in my work area:**  
**Degree of seriousness of VERTICAL aggression (between colleagues at different levels within health care) in my work area:**

	Very serious	Serious	Somewhat serious	Not serious
17 Lateral aggression toward health care professional peers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18 Lateral aggression toward new health care professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 Compared to other job-related stressors, lateral aggression is	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 Vertical aggression directed downward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21 Vertical aggression directed upward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22 Compared to other job-related stressors, vertical aggression is	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**FEAR OF RETALIATION**

	Agree strongly	Agree	Disagree	Disagree strongly
23 I feel safe from retaliation when reporting an episode of lateral aggression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24 I feel safe from retaliation when reporting an episode of vertical aggression directed downward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25 I feel safe from retaliation when reporting an episode of vertical aggression directed upward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**EXPERIENCE AND OPINIONS (Optional)**

**Please provide information about your experience and opinions regarding lateral and vertical aggression among health care professionals.**

26 Please describe example(s) of negative behavior which occurred recently within your work environment which you observed or experienced and are willing to share?

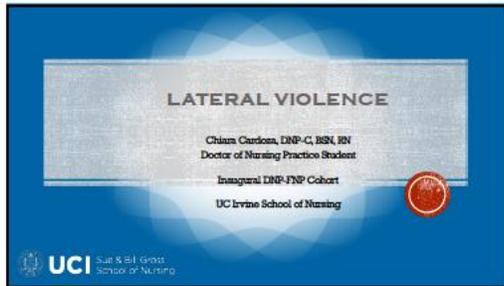
27 Please provide suggestions to decrease episodes of negative behaviors among members of the healthcare team within your work area?

## APPENDIX H: Post-Survey Questionnaire

### POST-SURVEY QUESTIONNAIRES

1. Please provide suggestions to decrease episodes of negative behaviors among members of the healthcare team within your work area?
2. Please share your thoughts about this in-service or the topic of lateral violence.
3. Please share your thoughts about the delivery of this project.
4. How could we improve this project?
5. How do you feel this project would influence the nurse culture/workforce if provided during onboarding orientation?
6. How likely are you to use the professional language proposed as a defense against lateral violence?
7. What would **promote** the use of this proposed professional communication tool?
8. What would **deter/hinder** the use of this proposed professional communication tool?
9. What type of support do you hope to receive from management/mentors with the use of the proposed approach?
10. What barriers do you foresee from management/mentors that can discourage you from using this proposed approach?
11. Have you witnessed/encountered any of negative behaviors in healthcare after the delivery of this informational in-service? If yes, please describe the situation.

## APPENDIX I: Intervention Material (Educational Power point)



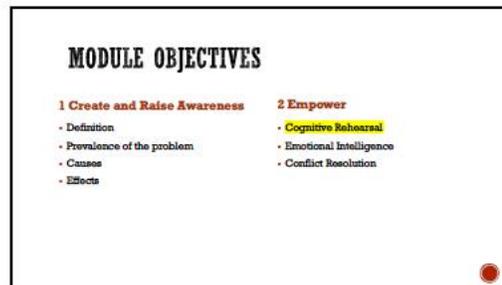
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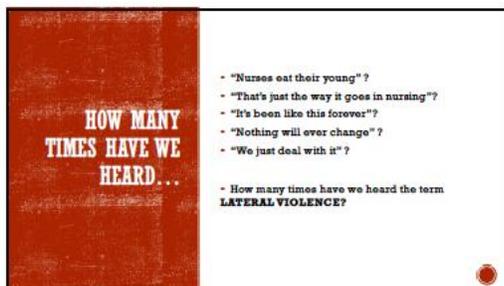
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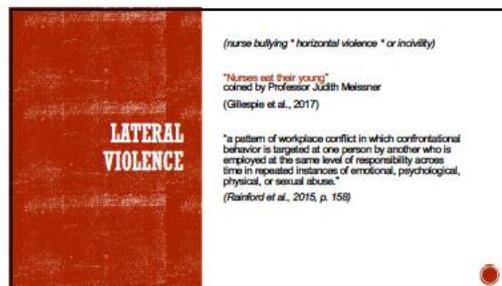
3



4



5



6



- Studies have estimated that up to 85% of all nurses have experienced lateral violence at some point in their career (JONA, 2011; Christie & Jones, 2013; JGIM, 2016).
- 80-90% of new nurses will leave their first nursing job within the first 6 months of employment (Christie & White, 2012; Oregon Nurses Association, n.d.).
- LV is a contributing factor to the nursing shortage, which is estimated to be over 1 million by 2028 (Chalchisvan, 2014).
- Contributes to increased absenteeism (Blair, 2012).
- LV is a contributing factor to burnout and compassion fatigue (Sharon, 2010).
- Compared to nurses outside the nursing profession, female nurses are 23% more likely to report suicide (American Society of Registered Nurses, 2008).
- The cost of turnover and collecting a new nurse ranges from \$22,000 to \$145,000 per nurse (Rogney, et al, 2009; Christie & Jones, 2012; Fayson, 2016).
- Contributes to medical errors (Blair, 2012).

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### Literature Review

WHO are most affected by this phenomenon?



## LITERATURE REVIEW

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### BEHAVIORS ASSOCIATED WITH LATERAL VIOLENCE

Non-verbal Insults (Conroy, 2012)

Behaviors (Walters et al., 2012)

Rehabiling (Conroy, 2012)

Degrading / Undermining (Cheek & Vianovsky, 2012)

Eye-rolling (Cheek & Vianovsky, 2012)

Lack of respect for privacy (Conroy, 2012)

Abuse of confidence (Sharon & White, 2012)

Humiliation (Edlin & Bader, 2012)

Blaming (Cheek & Vianovsky, 2012)

Refusing to assist (Cheek & Vianovsky, 2012)

Intimidation (Cheek & Vianovsky, 2012)

Impatience (O'Brien, 2004)



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### CAUSATIVE FACTOR

<h4>ORGANIZATIONAL</h4> <ul style="list-style-type: none"> <li>• undervalued staff</li> <li>• fear of retaliation – self-silencing</li> <li>• underreporting of incidents</li> <li>• socio-cultural norms</li> <li>• lack of effective leadership</li> <li>• unsupportive nursing management</li> </ul>	<h4>ENVIRONMENTAL</h4> <ul style="list-style-type: none"> <li>• untenable workloads</li> <li>• stress-provoking work environment and work pace (ED/ICU)</li> <li>• nursing shortages</li> <li>• budget retrenchments</li> <li>• time-sensitive multi-tasking</li> <li>• constant change</li> <li>• diverse complex settings</li> </ul>
---	--

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### DAMAGING EFFECTS OF LATERAL VIOLENCE

<h4>Personal</h4> <ul style="list-style-type: none"> <li>• Stress/Physical Distress</li> <li>• Fatigue or Insomnia</li> <li>• Anxiety/Depression</li> <li>• Shame or guilt</li> <li>• Isolation</li> <li>• Post-traumatic stress disorder</li> <li>• Substance abuse</li> <li>• Suicidal behavior</li> <li>• Moral distress</li> </ul>	<h4>Professional/Institutional</h4> <ul style="list-style-type: none"> <li>• Causes a divide among nurses</li> <li>• Contributes to communication breakdown</li> <li>• Increases absenteeism</li> <li>• Compromised delivery of care and patient safety</li> <li>• Potential medical errors \$4.3 billion annually / ~\$250,000 per incident</li> </ul>
--	---

Up to 70% of cases were rooted in poor communication, not technical or system failure. (Blair, 2013)

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### SOLUTIONS:

- **Cognitive Behavioral**
  - is learning to not immediately react to verbal abuse, but rather step away from the situation, processing the information, quietly releasing appropriate responses that diffuse tension and anger in order to maintain civility and open communication.
- **Conflict Resolution**
  - is a set of skills that manage conflict in a healthy and respectful manner that allows for successful communication and growth between 2 individuals.
- **Emotional Intelligence (EI)**
  - is the ability to recognize one's own emotions, how it personally affects one and others, and how one's emotions influence one's behaviors.

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## SOLUTIONS: COGNITIVE REHEARSAL

**Cognitive Rehearsal** is learning to not immediately react to verbal affront, but rather step away from the situation, processing the information, quietly rehearsing appropriate responses that diffuse tensions and anger in order to maintain civility and open communication.

(Griffin, 2004; Longo, 2017)

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### Cognitive Rehearsals

- Non-Verbal Intuents**
  - Sense that something is up or that someone is looking at you
- Verbal Affront (side remarks, abruptness)**
  - How best to respond? Get the direct feedback and clear direction. Is there a way we can structure the type of abuse or?
- Infighting (bickering with peers)**
  - This is not the time or the place. Please stop (Physically walk away)
- Backstabbing (complaining about an individual to others without confronting the individual directly)**
  - How best to respond about this?
  - How do I know or do I know the facts?
  - How do I support the team?
- Broken confidences**
  - How best to respond?
  - This is not the time or the place. Please stop
  - How do I know or do I know the facts?
  - How do I support the team?

**Healthy Responses to Conflict**

- Ask questions
- Clarify the situation
- Make a plan
- Seek compromise and support
- Stay calm and focused

**Emotional Intelligence**

- Self-Awareness
- Self-Regulation
- Social Skills
- Empathy
- Motivation

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### Verbal Alarm

## CUS

- I AM **C** **CONCERNED**  
with my patient's condition
- I AM **U** **UNCOMFORTABLE**  
with my patient's condition
- THIS IS A **S** **SAFETY ISSUE**  
that puts my patient at risk for...

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## WHAT CAN YOU DO?

Keep your eyes and ears peeled for these negative behaviors in the workplace.

Use the tactics mentioned to prevent knee-jerk reactions that inflame situations.

**BE ASSURED that...**

- It is ok to confront your aggressor.
- It is ok to confront someone else's aggressor.

Be the change you wish to see!!!

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## PERSONAL TESTIMONY

17

### AFTER COMPLETION OF THIS MODULE:

- You will receive a badge card
- Post-survey in 4-5 weeks




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18

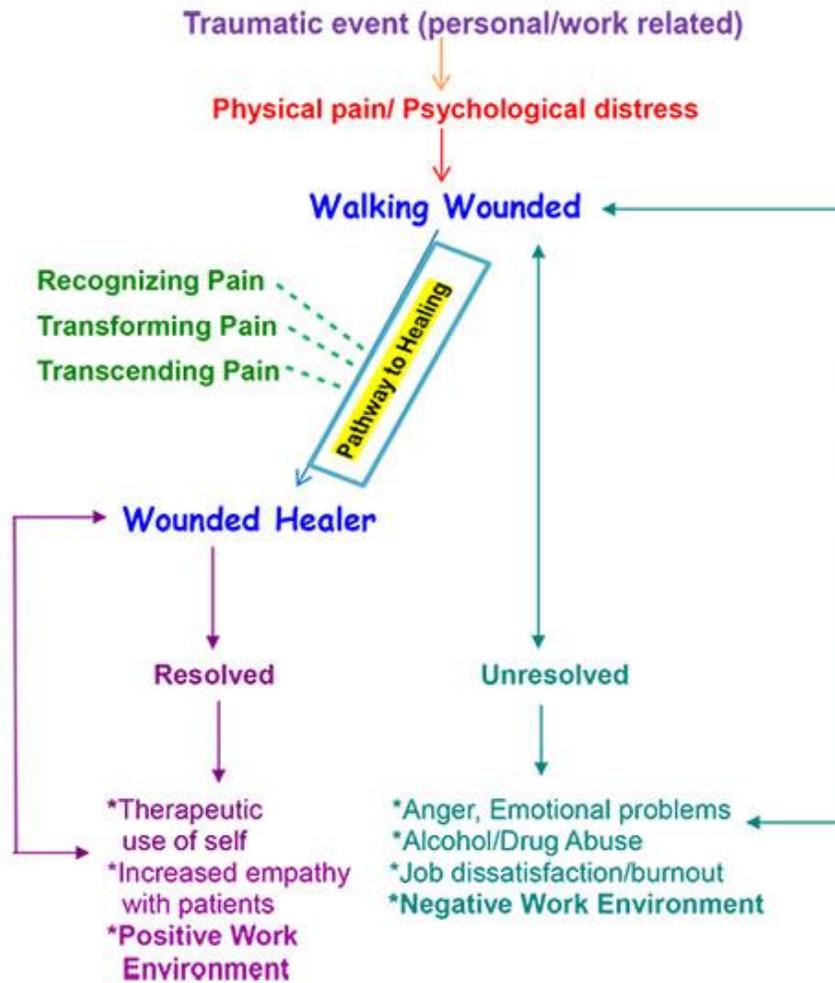


**APPENDIX J: Interventional Material (Badge Cue Card)**

FRONT CARD	BACK CARD
<p><b>Cognitive Rehearsals</b></p> <p><b>Non-Verbal Innuendo</b></p> <ul style="list-style-type: none"> <li>I sense that there is something you would like to say to me. It's ok to speak directly to me.</li> </ul> <p><b>Verbal Affront (snide remarks, abruptness)</b></p> <ul style="list-style-type: none"> <li>I learn better from those that give me direct feedback and clear directions. Is there a way we can structure this type of situation?</li> </ul> <p><b>Infighting (bickering with peers)</b></p> <ul style="list-style-type: none"> <li>This is not the time or the place. Please stop. (Physically walk away).</li> </ul> <p><b>Backstabbing (complaining about an individual to others without confronting the individual directly)</b></p> <ul style="list-style-type: none"> <li>I don't feel right speaking about him/her.</li> <li>I was not there and/or don't know the facts.</li> <li>Have you spoken to him/her?</li> </ul> <p><b>Broken confidences</b></p> <ul style="list-style-type: none"> <li>Wasn't that said in confidence?</li> <li>That sounds like it should remain private.</li> <li>He/she asked me to keep that confidential</li> </ul> <p><i>Adapted from David (2014), Griffin (2004), Segal &amp; Smith (2017)</i></p> <div data-bbox="516 527 699 684" style="background-color: #e0f2f1; padding: 5px;"> <p><b>Healthy Responses to Conflict</b></p> <ul style="list-style-type: none"> <li>Able to emphasize</li> <li>Calm, non-defensive reactions</li> <li>Ready to forgive and forget</li> <li>Seek compromise, avoid punishing</li> <li>Facing conflict is best for all</li> </ul> </div> <div data-bbox="516 701 699 884" style="background-color: #e8eaf6; padding: 5px;"> <p><b>Emotional Intelligence Requires:</b></p> <ul style="list-style-type: none"> <li>Self-Awareness</li> <li>Self-regulation</li> <li>Social Skill</li> <li>Empathy</li> <li>Motivation</li> </ul> </div>	<div data-bbox="753 373 1372 449" style="background-color: #393b79; color: white; padding: 10px; text-align: center;"> <h1>Verbal Alarm</h1> </div> <div data-bbox="836 453 1105 552" style="background-color: #00838f; color: white; padding: 10px; text-align: center; margin: 10px 0;"> <h2>C U S</h2> </div> <div data-bbox="868 569 1364 657" style="margin-bottom: 10px;"> <p><b>I AM C CONCERNED</b> with my patient's condition</p> </div> <div data-bbox="868 674 1364 762" style="margin-bottom: 10px;"> <p><b>I AM U UNCOMFORTABLE</b> with my patient's condition</p> </div> <div data-bbox="813 772 1404 856" style="margin-bottom: 10px;"> <p><b>THIS IS A S SAFETY ISSUE</b> that puts my patient at risk for...</p> </div> <div data-bbox="1133 863 1398 894" style="background-color: #e8eaf6; padding: 5px; text-align: right;"> <p><i>By Agency of Health Research &amp; Quality</i></p> </div>

## LIST OF FIGURES

Figure 1. Theory of Nurse as a Wounded Healer



## LIST OF TABLES

**Table 1. Participants Demographic Table**

CHARACTERISTICS	FREQUENCY	PERCENTAGE
<b>AGE</b>		
18-24 y.o	2	22%
25-34 y.o	5	56%
35-44 y.o	2	22%
<b>YEARS OF EXPERIENCE</b>		
< 6 months	7	78%
6-12 months	1	11%
> 1 year	1	11%
<b>EMPLOYMENT STATUS</b>		
Fulltime	8	89%
Per Diem	1	11%
<b>EDUCATIONAL LEVEL</b>		
BSN	8	89%
Entry Level Masters	1	11.0%
<b>RECEIVED WORKPLACE SAFETY TRAINING?</b>		
Yes	7	78%
No	2	22%
<b>RECEIVED LATERAL VIOLENCE TRAINING?</b>		
Yes	5	56%
No	2	22%
I do not know what that is.	2	22%
<b>HAVE YOU HEARD THE PHRASE “NURSES EAT THEIR YOUNG?”</b>		
Yes	9	100%
No	0	0%

**Table 2. Paired Samples Statistics Results**

### **Paired Samples Statistics**

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	CFPre	22.2222	9	5.60753	1.86918
	CFPost	24.0000	9	7.61577	2.53859
Pair 2	FAPre	11.3333	9	3.20156	1.06719
	FAPost	12.6667	9	4.15331	1.38444
Pair 3	SAPre	15.6667	9	6.63325	2.21108
	SAPost	19.5556	9	6.98411	2.32804
Pair 4	FRPre	7.3333	9	2.54951	.84984
	FRPost	7.3333	9	2.17945	.72648

**Table 3. Paired Samples Test Results**

		Paired Samples Test							
		Paired Differences							
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	CFPre - CFPost	-1.77778	4.08588	1.36196	-4.91847	1.36291	-1.305	8	.228
Pair 2	FAPre - FAPost	-1.33333	3.53553	1.17851	-4.05099	1.38432	-1.131	8	.291
Pair 3	SAPre - SAPost	-3.88889	5.44161	1.81387	-8.07168	.29390	-2.144	8	.064
Pair 4	FRPre - FRPost	.00000	2.50000	.83333	-1.92167	1.92167	.000	8	1.000

**Table 4. Paired Samples Effect Sizes**

**Paired Samples Effect Sizes**

			Standardizer <sup>a</sup>	Point Estimate	95% Confidence Interval	
					Lower	Upper
Pair 1	CFPre - CFPost	Cohen's d	4.08588	-.435	-1.109	.263
		Hedges' correction	4.29075	-.414	-1.056	.251
Pair 2	FAPre - FAPost	Cohen's d	3.53553	-.377	-1.045	.312
		Hedges' correction	3.71281	-.359	-.995	.297
Pair 3	SAPre - SAPost	Cohen's d	5.44161	-.715	-1.436	.041
		Hedges' correction	5.71445	-.681	-1.368	.039
Pair 4	FRPre - FRPost	Cohen's d	2.50000	.000	-.653	.653
		Hedges' correction	2.62535	.000	-.622	.622

a. The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation of the mean difference.

Hedges' correction uses the sample standard deviation of the mean difference, plus a correction factor.