LATERAL WORKPLACE VIOLENCE IN NURSING:

BEST PRACTICE GUIDELINES FOR CREATING A CULTURE OF CIVILITY

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Abstract

This best-practice paper explores research on the phenomenon of lateral violence in the nursing workplace. The research articles reviewed in this paper will discuss factors contributing to workplace violence and possible strategies for mitigating incivility. Articles will focus on student nurses and newly-licensed nurses who are often the primary recipients of bullying behavior. The literature review will discuss the implications of lateral workplace violence including high new nurse turnover, early burnout, inadequate patient care, and increased hospital costs. Beyond the analysis of the current literature, this paper will identify evidence-informed recommendations for best-practice protocols. A proposed implementation plan and evaluation will be applied using the innovation-decision process theory. A five-stage process will be outlined in the final chapter including the knowledge, persuasion, decision, implementation, and confirmation of the proposed innovation.

Executive Summary

Background and Significance to Nursing

According to the American Nursing Association, statistics show a significant decline in retention rates among newly licensed nurses (2017). The U.S. Bureau of Labor Statistics projects the need to "produce 1.1 million new RNs for expansion and replacement of retirees, and avoid a nursing shortage" (2017). Lateral workplace violence (LWV) is defined as "disruptive and inappropriate behavior demonstrated in the workplace by one employee to another who is in either an equal or lesser position" (see Table 1). LWV in nursing is widely acknowledged yet continues to disrupt a profession that the public has voted number #1 in trust and integrity for the past 15 years (Gallup Poll, 2016). Although there is not a single, agreed-upon definition of turnover, LWV plays a significant role. Organizations that fail to address these issues are indirectly promoting incivility, workplace violence, and a "culture of silence" ultimately perpetuating the problem (ANA, 2015).

Key Findings

A review of the literature was conducted to explore the prevalence and patterns of LWV in nursing among student nurses and newly-licensed nurses. Student nurses were surveyed about their experiences with bullying during clinical rotations. Nearly 60% indicated that they had experienced some form of LWV and 90% of those students states it would impact their career or employment choices (Curtis, Bowen, and Reid, 2007). A study by Kovner et al. found that over a quarter of newly-licensed registered nurses leave nursing within the first year and one-third leave within two years (2014). Dr. Renee Thompson, a leader in nursing professional development and anti-bullying programs, states that 73% of all nurses report being a target for incivility in the workplace and 60% of all new nurses leave the profession within six-months due

to bullying behaviors from their co-workers (2015). A 10-year, multi-state, longitudinal study was conducted focusing on new nurses' turnover rates, intentions, and attitudes. This study, known as The RN Work Project, found that it can cost a large acute care hospital up to 6.4 million due to registered nurse turnovers as well as an increase in pressure ulcers, patient falls, and the use of physical restraints (Kovner et al., 2014).

A prevalent theme among these two populations were feelings of being ignored and treated as if invisible followed by humiliation in front of other staff, gossiping behind their back, verbal put-downs and being made to feel incompetent and inferior (Smith, Gillespie, Brown, and Grubb, 2016). The research indicates that nurse preceptors have a direct effect on the mentality of student nurses and new graduates. There are currently no standard guidelines for what is expected of a preceptor as well as no mandatory training before becoming a preceptor (Longo, 2007). Finally, nurse managers and clinical leaders have been shown to have a resounding impact on the culture of their unit. Their leadership style and can, directly and indirectly, perpetuating incivility among their staff due to lack of action when complaints are filed, dismissive behaviors, and even threats of retaliation (Ceravolo, Schwartz, Foltz-Ramos, and Castner, 2012).

Recommendations

To address the harmful effects of LWV at all levels, proposals are aimed towards both academic institutes and healthcare organizations. Nursing programs should incorporate modules into the nursing curriculum that raises awareness among nursing students through education and training to identify patterns of LWV (Magnavita & Heponiemi, 2011). Universities should provide nurse educators with resources to partner with appropriate clinical sites as well as resources to support nursing students regarding LWV (Smith et al., 2016).

Hospital units that utilize preceptors should establish required qualifications and training of nurse preceptors including communication, teaching techniques, and understanding of the unit's stance on bullying (Longo, 2007). It is recommended that hospitals adopt or develop strategies for recognizing and coping with experienced or witnessed LWV for newly-licensed nurses during their orientation period (Embree, Bruner, & White, 2013). This should also include training newly licensed nurses how to handle situations regarding LWV including real-time strategies and procedures for reporting (Ebrahimi et al., 2016).

Healthcare organizations must educate nurse managers on the impact of an unhealthy culture and the effects on the unit by providing workshops for training nurse leaders and nurse managers how to deal with LWV occurrences within their unit (EEOC, 2017). Finally, there should be the development of clear and direct policies and programs which address zero-tolerance and promote a culture of civility among hospitals and healthcare organizations (AONE & ENA, 2015).

Chapter One

Background

According to Embree & White (2010), up to 90% of nurses have experienced some form of lateral workplace violence[3] (see Table 1). This is a global phenomenon that has been underreported for the past two decades. As new nurse turnover continues to increase the average lifespan of the nursing career declines, investigations into the root of these trends are required. Many of the studies included in this paper address student nurses and their experiences during clinical rotations. Longo (2010) identified that the negative behaviors associated with lateral workplace violence gives rise to poor morale, staff attrition, disrupted communication and collaboration, adverse patient outcomes, and decreased staff retention.

Purpose

The purpose of this paper is to identify some of the common behaviors associated with lateral workplace violence (LWV), as well as risks for experiencing bullying or becoming a bully[1] (see Table 1). Additionally, how lateral workplace violence affects job performance, average work lifespan, patient outcomes, and costs to hospitals each year will be discussed. This paper will also examine the attitude of incivility[5] (see Table 1) directed toward student nurses and some practices that can be implemented to either prevent or prepare students for what has become a widespread, devastating mark on the profession of nursing. After reviewing the contributing factors in LWV and its role in the nursing field, some proposed best practices will be outlined with the intended purpose of prevention of lateral workplace violence.

Significance to Nursing

This topic is of the utmost importance to the future of nursing. A nurse begins training in school during a vulnerable time. The poor treatment they receive or observe may have a lasting

effect on their perception of the profession or possibly the behavior they display after graduation. The bullying and harassment[4] (see Table 1) of this population has been linked to lower self-esteem and confidence, higher student and nurse attrition, and higher new nurse turnover (Curtis, Bowen, & Reid, 2007). Student nurses, as well as new grad nurses, often lack the confidence and social connectivity to ward off interpersonal conflict.

According to the American Nurses Association (ANA), "more than 500,000 seasoned RNs are anticipated to retire by 2022" (Workforce section, 2017, para. 1). The U.S. Bureau of Labor Statistics projects the need to "produce 1.1 million new RNs for expansion and replacement of retirees, and avoid a nursing shortage" (2017). The average age of nurses in the United States is increasing. The data from the American Association of Nursing (ANA), 2014 nursing workforce states the average age of a nurse as 80 years old. The number of nurses under 40 years old has decreased significantly from 54% in 1980 to 29.5% in 2008 (ANA, 2014). These statistics show a declining rate of retention among young nurses.

A study by Kovner et al. (2014), indicated that 17.5% of newly licensed registered nurses leave the profession within the first year and that figure increases to 33.5% leaving within two years. The American Nurses Association Health Risk Appraisal (HRA), surveyed 3765 nurses and nursing students and found that "up to half had been bullied in some manner in the workplace" (2013). According to Thompson, nearly three-quarters of all nurses indicate being the target of some form of workplace violence, and sixty percent of new nurses quit their job within the first six months due to the bullying behavior of their co-workers (2015).

High turnover rates are significant to nursing as well as to the hospitals which pay approximately $82,000 to replace one nurse (*Journal of Nursing Administration [JNA]*, 2015).

That cost includes "vacancy, orientation and training, the lowered productivity of a newly hired nurse, and advertising and recruiting" (*JNA*, 2015).

Current Guidelines

The American Association of Nursing: Code of Ethics for Nurses with Interpretive Statements states that nurses are required to “create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect” (ANA, 2015). Included in this statement is the idea that recognition and acknowledgment are the first steps to eliminating workplace violence[2] (see Table 1). Organizations that fail to address these issues are indirectly promoting workplace violence, and the "culture of silence," fear of retaliation, and defeated mentality is only perpetuating the problem (ANA, 2015).

The U.S. Equal Employment Opportunity Commission (EEOC) investigates employment discrimination cases and enforces federal laws that prohibit discrimination against a job applicant or employee. The EEOC also uses outreach, education, and technical assistance programs to prevent discrimination. Prevention is the best tool to eliminate harassment in the workplace. Employers are encouraged to create an environment that promotes open communication, freedom from fear of retribution, and trust that concerns will be addressed appropriately. On October 4, 2017, the EEOC published a press release unveiling the launch of a new training program on a respectful workplace. Two new pieces of training for employers: Leading for Respect (for supervisors) and Respect in the Workplace (for all employees). The training program focuses on respect, acceptable workplace conduct, and the types of behaviors that contribute to a respectful and inclusive, and therefore ultimately more profitable, workplace. The

program is customizable for different types of workplaces and includes a section for reviewing employers' harassment prevention policies and procedures (EEOC, 2017).

The American Organization of Nurse Executives (AONE) and the Emergency Nurses Association (ENA) has jointly developed a toolkit for mitigating violence in the workplace. This toolkit addresses many forms of workplace violence including LWV. The AONE and ENA state "these principles provide a framework to systematically reduce lateral, and patient and family violence in hospital settings" (2015). The toolkit includes five focus areas of prevention including necessary foundational behaviors, zero-tolerance policy, ownership and accountability, training and education, and outcome metrics. It also provides resources for nurse leaders to identify, implement, and evaluate interventions to decrease LWV on their unit (AONE & ENA, 2015).

Important Terms Defined

There are several interchangeable words used to describe bullying and workplace violence. Below (Table 1) are important definitions with the various interchangeable terms.

Table 1

Definitions of commonly used terms to describe workplace violence

Term	Definition	Reference
Bullying[1]	Repeated, unwanted harmful actions intended to humiliate, offend and cause distress to the recipient.	(ANA, 2015)
Workplace Violence[2]	Physically and/or psychologically damaging actions that occur in the workplace or while on duty.	(National Institute of Occupational Safety and Health, 2015)
Lateral Violence or Worker-on-Worker Violence[3]	Disruptive and inappropriate behavior demonstrated in the workplace by one employee to another who is in either an equal or lesser position	(Coursey, Rodriguez, Dieckmann, & Austin, 2013)
Harassment[4]	Unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information	(EEOC, 2017)
Incivility[5]	One or more rude, discourteous, or disrespectful actions that may or may not have a negative intent behind them	(ANA, 2015)
External Violence[6]	Assault or harassment by colleagues, staff, and others, including teachers, doctors, and supervisors	(Magnavita & Heponiemi, 2011)
Internal Violence[7]	Assault or harassment by a patient, their relative or their friend.	(Magnavita & Heponiemi, 2011)

Summary

The nursing profession has been ranked the number one most trusted profession, with the highest honesty and ethical standards, for the 15th year in a row according to a Gallup poll (Gallup, 2016). However, according to Jacobs & Kyzer, nursing is also the primary occupation at risk for lateral workplace violence (2010). Nursing students and newly licensed nurses are experiencing emotional, psychological, and sometimes even physical violence from their co-workers. This act of bullying can lead to lower job satisfaction, high job turnover, decreased nurse retention, and additional costs to hospitals to replace the losses.

Although several states have enacted legislation or regulations aimed at preventing workplace violence, there is currently no federal standard that requires workplace violence protection (ANA, 2016). It is currently projected that there will be a nursing shortage of nearly one million nurses by 2020. These numbers can be addressed and reduced by adopting and utilizing evidence-based solutions to improve nurse-to-nurse interactions and enhance nursing retention.

Chapter Two

In reviewing the literature on lateral workplace violence, this section will address the patterns and prevalence of LWV for both the nursing student and newly licensed nurse population. It will also explore the effects of LWV on the organizational culture among nurses. Search engines included PubMed, OvidSP, CINAHL, and Google Scholar to find research articles. Keyword search was utilized to narrow the field of relevant articles. Keywords used included: "nursing workplace violence," "nurse on nurse violence," and "lateral violence nursing." Twelve articles were reviewed, one published in 2002 and the remaining articles published between 2007 and 2016. Studies included: one retrospective study, one interventional study, two qualitative studies, four descriptive survey studies, one quality improvement project, and one best practice guideline.

Prevalence and Patterns of Incivility

Magnavita and Heponiemi (2011) conducted a retrospective survey in three separate Italian nursing schools during the 2009-2010 school year. Participants were self-selected at the end of the lecture to fill out a questionnaire addressing workplace violence, justice, mental health, and job stress. The answers to these questionnaires were then compared to 275 nurses from general hospitals in the area. The purpose of this study was to examine the extent of mistreatment of nursing students and what effects transpire from these experiences. Forty-three percent of nurses and thirty-four percent of nursing students reported at least one upsetting episode of physical or verbal violence. Nurses reported more physical assaults and sexual harassment during the previous 12 months than students. Nurses reported more external violence[6] (see Table 1) whereas students reported more verbal and physical internal violence[7] (see Table 1). The types of issues associated with verbal violence included high levels of

psychological problems and job strain as well as low social support and organizational justice, but only among nursing students. This study also found that internal violence caused more severe detrimental effects than external violence, especially among nursing students. The results of this study indicate that nursing students, as well as nurses, would benefit from programs of violence prevention.

A descriptive study by Longo (2007), was conducted to survey senior baccalaureate nursing students' experiences of horizontal violence in the practice setting. Forty-seven (60%) surveys were returned. Thirty-three participants (70%) were 18–25 years old, 11 (23%) were 26–35 years old, 2 (4%) were 36–45 years old, and 1 (2%) was N 46 years old. Nine of the respondents (19%) were men, and 38 (81%) were women. Two respondents (4%) had experience as licensed practical nurses, and 11 (23%) had experience working as patient care associates. None of the participants reported being physically or verbally threatened, and only one student (2%) reported being pushed or shoved.

The behavior that was most frequently reported was being put down by a staff nurse. Twenty-five respondents (53%) reported this behavior. This was followed by being humiliated (n = 19; 40%), having a sarcastic remark made about them (n = 15; 32%), and being talked about behind their back (n = 12; 26%). Student nurses identified experiences of horizontal violence that included verbal or emotional abuse, with one student reporting physical violence. Staff nurses involved with students directly through preceptorships or mentoring opportunities need to be cognizant of their behaviors toward the students and how these behaviors impact the student's present and future practice. Most students (72%) in this study believed the statement that nurses eat their young.

A literature review conducted by Seibel (2013) examined 31 peer-reviewed articles and dissertations to investigate the perceptions of faculty bullying of nursing students and what factors influence this behavior. Although LWV in nursing is a widely acknowledged concern, this phenomenon continues to escalate (Roche, Diers, Duffield & Catling-Paull, 2010). The origins of bully behaviors are complex and multifaceted, but it is suggested that bullying that begins in undergraduate nursing can often carry over into the nursing profession (Pope, 2011).

Students are typically on the bottom of the totem pole and therefore highly susceptible targets for bullying. As some nursing faculty members promote the belief that bullying behaviors are to be expected, this mentality influences the normalization of incivility and may explain some of the passive and resigned mannerisms that have been adopted in this profession. Some factors that may influence faculty behaviors are lack of knowledge, teaching experience, bias and favoritism, and trying to balance the needs of the students while appeasing the clinical staff (Seibel, 2013).

Student's perceptions must also be considered when evaluating the faculty culture. Sometimes certain circumstances or personalities are associated with incivility but may not be explicitly bullying behavior. Students who feel that standards and expectations are impossibly high may become discouraged or angry towards that faculty member. Students may use ego-defense mechanisms to respond to negative feedback; students can avoid examining his/her performance through denial or deflection. Students that apply these maladaptive strategies of coping may become further frustrated or disengaged.

Simons and Mawn (2010), studied one hundred eighty-four nurses who shared their stories of bullying in their workplaces. A qualitative method was used to provide data for this article. The sample included newly licensed nurses in the United States. Surveys were mailed

out to 511 registered nurses. One hundred thirty-nine participants returned the open-ended surveys and reported being bullied at work. Fourteen others reported witnessing other nurses being bullied. Seventeen participants reported consistently being given an unmanageable workload. Nurses reported leaving their jobs as a result of being targets of bullying behaviors. Some talked of leaving their jobs, and others wrote of leaving the profession.

Several nurses wrote of their negative experiences as student nurses. One commented, "When I was in nursing school, we spent most of our time doing clinical work in a small community hospital. I found so much negativity in this environment that I considered quitting nursing school" (p. 308). Another wrote, "Nursing school was a very different experience. I witnessed many registered nurses who treated my classmates horribly, and that almost prevented me from practicing" (p. 308).

Vessey, Demarco, Gaffney, and Budin (2009) used a descriptive survey design to evaluate the perceptions of frequency and patterns of bullying behavior experienced by registered nurses (RNs) across the United States. The sample size included 303 self-selected, registered nurse volunteers nationwide. An electronic survey was used to identify the frequency, type, perpetrators, and personal and professional consequences of bullying. The Internet Web link was open for participant responses over a 3-month period.

Results indicated that 70% of the bullying was reported by a predominant group of staff RNs (n = 212). Of this group, bullying occurred most frequently in medical-surgical (23%), critical care (18%), emergency (12%), operating room/Post Anesthesia Care Unit (9%), and obstetrical (7%) areas of care as well as within 5 years or less of employment on a unit (57%). Perpetrators included senior nurses (24%), charge nurses (17%), nurse managers (14%), and

physicians (8%). Common themes that emerged were feelings of humiliation, isolation, exclusion, or feeling excessively criticized by the staff nurses.

Two organizational channels were used by RNs to report bullying: human resource department (23%) and the union or professional organization representative (12%). More than half (65%) did not use formal channels at all. However, some participants reported that employee assistance programs (61%), written harassment policies (58%), and collective bargaining (26%) were available to them. Almost all RNs reported being unaware of any written policy about bullying (96%) or in-service education addressing the problem (97%). Participants reported moderate or severe stress levels as a result of being bullied and reported family, friends, and colleagues as their primary source of support; not an organizational infrastructure. Many left the workplace entirely with or without jobs awaiting them.

A qualitative study was done by Ebrahimi, Hassankhani, Negarandeh, Jeffrey, and Azizi, (2016), set out to understand the experience of Iranian experienced nurses' use of lateral and horizontal violence against newly graduated nurses. A conventional content analysis approach was conducted with 18 experienced nurses and 30-60 minute interviews were conducted with each nurse. Four categories were described: "Psychological violence," "Verbal violence," "Physical violence," and "Source of violence" were four categories extracted through data analysis. The experienced nurses attributed labels to newly graduated nurses such as awkward, clumsy, lightheaded, cumbersome, soldier, and burden. Verbal harassment was the frequent form of violence experienced by the participants. This type of violence could occur in one or more of the following situations: bawling out, harsh criticism in front of others, insults, spreading gossip, lying about their performance, attributing unbecoming things committed by others to them, and sarcastic and humiliating remarks.

Participants asserted that some of the experienced nurses delegated their duties to newly graduated nurses because they were unfamiliar with their job description. They looked upon them as the ward runner and left practical tasks to them while they did administrative tasks, slept in shifts or even left work to do personal chores. Those nurses that help newly graduated nurses behave as if the recently graduated nurses were indebted to them, and that they should continuously do their jobs in return for the help they had given. It must be approached as a health system priority that needs specific multi-dimensional interventions consisting of identification, strategic planning, policymaking, education, and research. Newly graduated nurses also must be prepared to identify and manage the negative behaviors.

Significance to Student Nurses and Newly-Licensed Nurses

Curtis, Bowen, and Reid (2007) investigated experiences, both directly or indirectly, of horizontal violence among second year (n= 88) and third year (n= 64) nursing students. Students were recruited from the University of Wollongong. This descriptive research study utilized surveys, which were completed and submitted during class time, to gather data. Students were given a general description of HV before taking the survey which consisted of five, open-ended questions. Eighty-six students (57%) indicated that they had experienced or witnessed HV.

The analysis produced five major themes that were associated with such experiences: humiliation and lack of respect; powerlessness and becoming invisible; the hierarchical nature of HV; coping strategies; and future employment choices. The students described feelings of humiliation that often occurred during their first clinical placement. These students felt that they were not respected, not valued and that they were treated differently than the Registered Nurses (RN). A prevalent theme was that students were ignored and at times treated as if they were invisible. Students spoke of a ‘pecking’ order that occurred in the clinical area and a trickle-

down effect where registered nurses and staff treated enrolled nurses and assistants in nursing poorly (p. 160). Ninety percent of the respondents who had experienced or witnessed HV said that it would impact on their career and/or employment choices.

Second-year students often appeared to be overwhelmed by their experiences of HV and were not able to find a way through the situation. They were able to identify that it was occurring but struggled to understand why. Seventy-seven (90%) of the respondents who had experienced or witnessed HV said that it would impact on their career and/or employment choices. It is therefore imperative that the nursing profession identifies ways to equip nursing students and new graduates with strategies to recognize, manage, cope with and ultimately decrease the incidents of HV within nursing.

An interventional study by Embree, Bruner, and White (2013) evaluated a period of six to nine months after education, all nurses (= 143) were surveyed to determine their perception of the extent of Nurse-to-Nurse lateral violence (NNLV) among nurses in the organization. Nurses were paid by the organization for the time they participated in activities associated with the project. The purpose of this study was to determine the perceived extent and increase awareness of NNVL through an educational project about NNLV and cognitive rehearsal (CR). Evidence supports using education and cognitive rehearsal to raise the level of awareness of NNLV and shield the harmful effects of the disruptive behavior on learning and socialization. Education is one mechanism that can be utilized to improve communication and increase awareness with the practice of cognitive rehearsal.

Two-hour educational sessions were provided to nurses and included handouts for dealing with conflict and confrontation, cue cards for NNLV responses, and expected behavior of professionals. During the sessions, nurses were able to identify which strategies worked well

form them and offered suggestions to other participants. These nurses agreed to report any future episodes of NNLV to their nursing project managers. Post-survey participants described recognizing their personal displays of NNLV and intervened when witnessing lateral violence in other nurses.

Significance to Healthcare Organizations

Smith, Gillespie, Brown, and Grubb (2016) used a descriptive qualitative approach to gain insight into how nursing students experienced bullying in the clinical setting and how these behaviors impacted them. The study included 56 nursing students aged 20 to 53 with a median age of 24 years. A total of 56 undergraduate BSN students from four separate colleges in the Midwest United States were divided into eight focus groups. Each focus group was held at the participant's respective college and was led by one or two researchers. An interview script was used to assure consistency. Sessions lasted for approximately 26 to 58 minutes and were voice-recorded and transcribed verbatim.

Four categories of themes were identified: bullying behaviors, the rationale for bullying, response to bullying, and recommendations to address bullying. Behaviors identified included: being ignored, avoided, or isolated, witnessing non-verbal behavior, experiencing negative interactions, being denied an opportunity to learn, and being hazed. Rationales included: the rite of Passage, bullying is unpreventable, students are not welcome, other stressors, and the nurse is just not a nice person. Responses included: physical, emotional, psychological, avoidance, productivity, performance, learning, and finally, the overall view of nursing and healthcare. Recommendations include: education and prepare students, student response strategies, support of students, response strategies for faculty members as well as the facility/organization, the

qualifications of the preceptor, how student/patient assignments are made, and clarifying the student nurse's role and scope of practice.

The primary objective of a clinical practicum is for students to gain real-world experiences with patients. When bullying behaviors occur, it interferes with students meeting these objectives. Thus, students should be instructed to inform clinical instructors immediately if the nurse preceptor will not let them take care of their assigned patient. Nurse educators are integral in the identification and acquisition of clinical sites. Therefore, it is imperative for faculty to identify clinical sites where clinical nursing staff will be supportive and welcoming of students as to provide an enriching environment for learning to occur

Ceravolo, Schwartz, Foltz-Ramos, and Castner (2012) developed a quality improvement project to address lateral violence among a five-hospital integrated health-care delivery system from 2008 to 2011 in the northeastern United States. This project aimed to reduce nurse-to-nurse lateral violence and create a more respectful workplace culture through a series of workshops. During this three-year project, 203 educational workshops, approximately 60 to 90 minutes long were delivered to over 4000 registered nurses. Workshops were designed to enhance assertive communication skills and raise awareness of the impact of lateral workplace violence. The primary emphasis across all workshops involved healthy conflict resolution and eliminating a culture of silence. Another workshop was created to help nurse mentors and nurse preceptors train new nurses.

Post-workshop, online surveys were used to collect data. After the workshop series, nurses who reported experiencing verbal abuse fell from 90 to 76%. A higher percentage of nurses perceived a workplace that was respectful to others and in which it was safe to express opinions. After the workshop series, a more significant percentage of nurses felt like they could

address the problem after an incident of lateral violence, while a smaller percentage felt powerless. Nursing turnover and vacancy rates dropped from 8.9% to 6% and 3% respectively. The author suggested that nurse-managers must raise awareness of lateral violence with individual and organizational consequences. They also state that leadership can affect organizational change to decrease lateral violence and enhance a healthy workplace culture by replicating our intervention or components of our workshops.

A best practice guideline was developed by Fink-Samnick (2016) using a four-part series addressing the various levels of workplace violence. This article is part two of the series and discusses the new regulations and professional guidance addressing bullying and workplace violence. These guidelines include "addressing recent organizational initiatives to support the healthcare workforce; reviewing how professional education has historically contributed to a culture of bullying across health care; and exploring how academia is shifting the culture of professional practice through innovative education programming" (Fink-Samnick, 2016). This article places a specific emphasis on the role traditional education program models play in the promotion of workplace violence, directly and indirectly.

Dellasega (2009) identified five triggers or situations, that can precipitate or make a nurse vulnerable to bullying: "being a new graduate or new hire, receiving a promotion or honor that others feel is undeserved, having difficulty working well with others, receiving particular attention from physicians, or operating under conditions of severe understaffing" (p. 56). Also noted are six types of nurses in the context of bully behaviors: the super nurse, the resentful nurse, the put-down, gossip, and rumors nurse, the backstabbing nurse, the green with envy nurse, and the cliquish nurse (Dellasega, 2009).

Fink-Samnick (2016) concludes this article by bringing attention to some current federal guidelines as well as actions taken by professional associations and organizational institutes. The Quality and Safety Education in Nursing (QSEN) project has ensured that nursing professionals are provided the knowledge and tools needed to deliver high quality, safe, effective, and patient-centered care (AACN, 2015). In April 2015, Occupational Safety & Health Administration (OSHA) developed Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (OSHA, 2015). Also in April 2015, The U.S. Department of Veterans Affairs rolled out the Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement (U.S. Department of Veterans Affairs, 2015). In July 2015, the American Nurses Association (ANA): Professional Issues Panel on Incivility, Bullying and Workplace Violence developed a new position statement.

The American Organization of Nurse Executives (AONE) and the Emergency Nurses Association (ENA) united to publish Guiding Principles for Mitigating Workplace Violence in response to the negative impact of workplace violence on workforce safety and retention and attrition of nurses (AONE & ENA, 2015). There continues to be no federal law directly addressing bullying; The United States is the last of the western democracies do not have a law forbidding bullying-like conduct in the workplace (Healthy Workplace Bill, 2015). However, according to the ANA, with respect to nursing, 21 states have enacted and/or adopted laws addressing workplace violence (2015).

Summary of Literature Review

Current research is beginning to expand the understanding of lateral workplace violence. However, much research is still needed to guide evidence-based interventions that could elicit a

resounding change. This longstanding, global phenomenon has grown into a normative attitude that should not be tolerated. Evidence has shown that leadership is essential and nurse leaders and nurse managers can play a very impactful role in preventing or dealing with workplace violence appropriately and giving the future nurses the confidence and compassion they need to provide the best care possible and provide better patient outcomes.

Chapter Three

The purpose of this paper is to develop best practice guidelines for the mitigation of lateral workplace violence among nursing students and newly licensed nurses. Although there have been several qualitative studies identifying and evaluating the adverse effects of LWV, more research is needed to study the efficacy of specific interventions. Thus, the evidence-informed recommendations proposed in chapter three will come from expert opinions, federal (EEOC) and professional (ANA, AONE, & ENA) position statements as well as the articles presented in chapter two.

Chapter one discussed some of the current practices and purposed interventions that apply to a spectrum of nursing populations. The overview of relevant literature addressed in chapter two indicates that incivility, bullying, and violence in the workplace are serious issues in nursing with prevalence in all settings. The preceding articles explored the prevalence and patterns of LWV among the nursing population as a whole and specifically regarding the impact on nursing students and newly licensed nurses. Results of these studies recognize how this culture of incivility has led many nurses to leave the profession entirely (Vessey et al., 2009). Recognition and rationales of bully behavior were also explored and discussed (Dellasega, 2009).

Chapter three will take the findings and outcomes presented in the literature review to develop best practice guidelines for lateral workplace violence (see Table 2). The best practice guidelines presented below will include how nursing students and newly licensed nurses can prepare themselves for possible encounters of LWV during clinical rotation and orientation. It will also include strategies for dealing with LWV in real time as well as after the encounter(s).

Qualifying criteria and subsequent training for nurse preceptors will be proposed. Incivility and bullying occur in academic settings affecting students and faculty members.

Recommendations for training and education on LWV will include nurse educators and clinical instructors. Nurse leaders and nurse managers have a monumental impact on the culture of a unit and therefore higher standards, and more substantial responsibilities should be acknowledged, accepted, and practiced. Finally, hospitals and other healthcare organizations must take a stance against LWV by developing, implementing, and enforcing programs that assist in the mitigation of incivility and bullying in the workplace.

Prevention-Based Strategies for Nursing Students

Internal violence has shown to cause more severe detrimental effects than external violence, especially among nursing students (Magnavita & Heponiemi, 2011). Nursing school is a challenging and humbling experience for many individuals. Students should be supported and encouraged in their efforts with proper leadership that will guide their learning and clinical practice. However, with popular culture and the influx of medical dramas such as *Grey's Anatomy*, *Scrubs*, and *ER*, nursing students often enter a program with fictional idolizations of nurse's and doctor's roles and experiences. It is essential to prepare students beginning clinical rotations that LWV is a possibility, maybe even a probability. This can be done by teaching nursing students strategies on how to recognize, manage, and cope with incivility (Curtis et al., 2007). Another critical component to address in educating students on this topic is to explain the various reasons why this behavior occurs and how to develop healthy coping strategies. By giving students perspective, they may better identify patterns and thus protect themselves.

Prevention and Outcome-Based Strategies for Newly Licensed Nurses

Evidence supports using education and cognitive rehearsal to raise awareness of LWV as well as shield the harmful effects of the disruptive behavior on learning and socialization (Embree, Bruner, & White, 2013). New nurses must be prepared to identify and manage the negative responses of senior nurses including the use of assertive communication techniques and understanding the proper reporting chain of command. A new graduate nurse program aimed at training and providing resources would be beneficial to the new nurse and hospital unit alike. This support helps increase new nurse job satisfaction, patient care, and quality performance (Ebrahimi et al., 2016).

Roles and Expectations of Nurse Educators and Preceptors

Nurse educators play a significant role in the identification and acquisition of clinical sites. Therefore, they need to be able to identify and choose sites that will welcome and support students as well as recognize unhealthy workplaces (Smith et al., 2016). Nurse educators can utilize innovation education programming to adequately prepare students to enter the workforce and equip them with the tools they need to face the challenges of LWV (Fink-Samnick, 2016). Staff nurses and potential preceptors need to be cognizant of their behavior towards student nurses and how it impacts the students present and future practice. Preceptors often establish harmful behaviors that are passed along to student nurses in their practice, perpetuating a cycle of incivility (Longo, 2007). Developing a preceptor training program or adopting an existing program can assist preceptors to be better communicators and mentors.

Roles and Expectations of Clinical Leaders and Nurse Managers

Educational resources need to be provided to help managers identify, implement, and evaluate interventions to decrease LWV on their unit (AONE & ENA, 2015). Nurse managers must establish efficient complaint/grievance processes, anti-harassment training, and take

immediate action when presented with a complaint to improve the culture and support of their unit, reduce turnover and transfer requests, and improve patient care (EEOC, 2007). A zero-tolerance policy includes addressing concerns immediately and taking the appropriate action to mitigate incivility and workplace violence. These measures can help eliminate the current "culture of silence" (ANA, 2015). Many nurses who left the workplace or profession completely stated they were unaware of any written policy of bullying or in-service education. Nurses indicated feeling unsupported and adopted a defeated mentality (Vessey et al., 2009). The use of educational workshops that focus on creating a healthy workplace, eliminating fear or retribution, and promoting assertive communication and conflict resolution can reduce turnover and vacancy rates (Ceravolo et al., 2012)

Table 2

Best Practice Guidelines: Decreasing the incidence of lateral workplace violence among nurses

Evidence-informed recommendations	Rationales	References	Level of Evidence
Incorporating curriculum that raises awareness among nursing students through education and training to identify patterns of LWV	Increasing the awareness LWV among nursing students will help prepare them emotionally and psychologically through clinical rotations and into practice.	(Magnavita & Heponiemi, 2011)	III
	Nursing students who experience LWV during clinicals are more likely to consider a different path or quit the program entirely.	(Simons & Mawn, 2010)	V
	Most student nurses who experienced or witnessed LWV had difficulty understanding the "why." Most all NS stated it would impact the career choice.	(Curtis, Bowen, & Reid, 2007)	V
Provide newly licensed nurses strategies for recognizing and coping with experienced or witnessed LWV	Evidence supports using education and cognitive rehearsal to raise awareness of LWV as well as shield the harmful effects of the disruptive behavior on learning and socialization.	(Embree, Bruner, & White, 2013)	V
Train newly licensed nurses how to handle situations regarding LWV including real-time strategies and procedures for reporting	New nurses must be prepared to identify and manage the negative behaviors of senior nurses including the use of assertive communication techniques and understanding the proper reporting chain of command. This support helps increase new nurse job satisfaction, patient care, and quality performance.	(Ebrahimi et al., 2016)	VI

Provide nurse educators with resources to partner with appropriate clinical sites as well as resources to support nursing students regarding LWV	Nurse educators play a significant role in the identification and acquisition of clinical sites. Therefore, they need to be able to identify and choose sites that will welcome and support students as well as recognize unhealthy workplaces.	(Smith et al., 2016)	VII
	Nurse educators can utilize innovation education programming to adequately prepare students to enter the workforce and equip them with the tools they need to face the challenges of LWV.	(Fink-Samnick, 2016)	VII
Establish required qualifications and training of nurse preceptors including communication, teaching techniques, and understanding of the unit's stance on bullying.	Staff nurses and potential preceptors need to be cognizant of their behavior towards student nurses and how it impacts the students present and future practice. Preceptors often establish harmful behaviors that are passed along to student nurses in their practice, perpetuating a cycle of incivility.	(Longo, 2007)	VI
Educate nurse managers on the impact of an unhealthy culture and the effects on the unit	Nurse leaders and managers have a resounding impact on the health of their unit. Educational resources need to be provided to help managers identify, implement, and evaluate interventions to decrease LWV on their unit.	(AONE & ENA, 2015)	VII
Provide workshops to train nurse leaders and nurse managers how to deal with LWV occurrences on their unit	Nurse managers must establish efficient complaint/grievance processes, anti-harassment training, and take immediate action when presented with a complaint to improve the culture and support of their unit, reduce turnover and transfer requests, and improve patient care.	(EEOC, 2017)	VII

	A zero-tolerance policy includes addressing concerns immediately and taking the appropriate action to mitigate incivility and workplace violence. These steps can help eliminate the current "culture of silence."	(ANA, 2015)	VII
Establish a zero-tolerance policy along with mandatory workshops designed to promote a culture of civility among hospitals and healthcare organizations	Many nurses who left the workplace or profession completely stated they were unaware of any written policy of bullying or in-service education. Nurses reported feeling unsupported and adopted a defeated mentality.	(Vessey et al., 2009)	V
	The use of educational workshops that focus on creating a healthy workplace, eliminating fear or retribution, and promoting assertive communication and conflict resolution can reduce turnover and vacancy rates	(Ceravolo et al., 2012)	VII

Summary of Evidence-Informed Recommendations

Incivility and lateral workplace violence among nurses is a complex and challenging issue to address. As stated in several of the studies from chapter two, the bully behavior is prevalent in every area and on every level in healthcare. Prevention is the best strategy to combat this disruptive and toxic condition effectively. Every member of the healthcare team has an important role to play and must recognize and evaluate their behavior as well as their colleagues. Nursing students and newly licensed nurses have received the brunt of abuse for a variety of reasons, none of which are acceptable (ANA, 2015). The continuation of this incivility will breed a new generation of bullies. Providing nursing students and new grads educational resources to promote awareness and present coping strategies will significantly reduce the negative impact of LWV on this population.

Nurse educators and nurse preceptors are a direct link to students during this critical time in their training. These roles must have their support and access to resources to promote a healthy workplace and educational setting. Preceptors should meet specific criteria regarding qualifications and receive training focused on encouraging and supporting the growth of student nurses. This will not only instill positive behaviors that students will take with them in their practice but also bridge the gap between new and experienced nurse's attitudes toward one another.

Finally, clinical leaders and nurse managers have an opportunity as well as the responsibility to develop a healthy, supportive unit culture that promotes teamwork and quality patient-centered care. The implementation of workshops addressing issues of incivility; how to recognize, address, communicate, and report (if needed), can assist nurse managers in establishing safe and productive units that encourage feedback and maintain fidelity.

Chapter Four

This section will discuss the proposed theoretical implementation and evaluation of the recommendations mentioned in chapter three. Lateral workplace violence occurs in all settings and at all levels. Although primary prevention is a crucial element of mitigating incivility, LWV must be addressed and customized at each level and within each population. A diffusion of innovation framework will be used, specifically the innovation-decision process theory. This theory, developed by Rogers, is based on time and utilizes five distinct stages: knowledge, persuasion, decision, implementation, and confirmation (1995, p. 169).

To successfully implement best practice guidelines throughout the nursing profession, this framework will be applied both to the academic (student nurses, nurse educators, preceptors) and professional (newly licensed nurses, preceptors, clinical leaders/nurse managers) organizations. Rogers defines innovation as "an idea, practice, or project that is perceived as new by an individual or other units of adoption" (2003, p. 12). The innovation to be diffused has three general elements: incorporating LWV-focused education and training into nursing school curriculum, establishing unit-specific criteria and computer-based training requirements for potential nurse preceptors, and providing resources (in-service training and/or workshops) for clinical leaders and nurse managers with emphasis of creating a culture of civility in the workplace and LWV mitigation.

Innovation-Decision Process Theory: Implementation

Knowledge. The review of literature in chapter two establishes the wide acknowledgment of lateral workplace violence in nursing. However, according to Rogers, individuals may consciously or unconsciously avoid exposing themselves to messages or communications that are not in accordance with their own beliefs. This selective exposure

influences what individuals will and will not attend to based on existing predispositions. At the same time, selective perception influences the way these messages or communications are interpreted if they are received (Rogers, 1995, p. 172). Therefore, while LWV is demonstrated in many areas of nursing, individuals may choose to ignore the behaviors or deny they exist. This response could be explained by a variety of factors including ego-defensive mechanisms, fear of retribution, or the attempt to protect a school/unit/hospital reputation.

A complete collaboration between the college of nursing and the teaching hospital is crucial to the success of this best practice model. The faculty and curriculum committee could conduct a program-wide anonymous student survey that addresses the prevalence and patterns of incivility in the classroom as well as in the clinical setting. The survey would also include questions about experiences with nurse preceptors. A similar survey could be designed for newly registered nurses who have been with the unit for less than one year; this survey would also include questions about experiences with nurse preceptors.

Finally, a questionnaire could be administered to the clinical leaders/nurse managers as well as the nursing staff of a unit to evaluate their perception of the workplace culture and the current level of knowledge pertaining to LWV protocols if any. These surveys and questionaries' provide raw data to better tailor the existing curriculum, training, and workshops as well as a baseline to compare to later.

Persuasion. During the persuasion phase, individuals such as the faculty members and clinical leaders will look at the information provided by the surveys and questionnaires to determine what information is credible and how to interpret the data (Rogers, 1995). Information regarding LWV and the results of the survey would be shared in a faculty meeting to enhance knowledge and persuade faculty that changes are needed. Forward planning and the

ability to think hypothetically is crucial to this stage. These individuals will then assess the advantages and disadvantages of the innovation. Incorporating new information into a curriculum takes time and planning, training the educators to field questions, and may require other material to be minimized to make room. However, education is a well-established and relatively inexpensive form of prevention.

Preceptors would be required to meet stricter standards and be required to complete training about LWV thus incentivizing may be needed. Workshops and in-service training take time away from other duties or employees free time. However, the expense of the training, salary, and time allocated elsewhere should be measured against the cost of replacing new nurses, poor patient outcomes due to an unhealthy workplace culture, and possibly legal action against the employer and/or unit regarding neglected workplace violence.

The American Association of Critical Care Nurses (AACN) offers various levels of online training modules. A single-site, one year license costs $2200. This includes employee access to the preceptor challenge; an online course worth 3.5 contact hours for $90 per individual. This module addresses preceptor roles and responsibilities, communication techniques, rationales for best practice techniques, and how to give constructive feedback and evaluation to the preceptee. The AACN also offers an "essentials of nurse managers" module which counts for 40 contact hours and was developed in partnership with AONE to promote leadership, boost nurse retention, and improve the health of the unit. These would be some of the factors to consider which assessing the innovation costs and benefits.

Decision. In the decision stage, individuals will either adopt or reject the innovation. Many times, a small-scale trial is utilized during a probationary period. Innovations that can be divided up are generally adopted more rapidly (Rogers, 1995). As the proposed intervention is

already divided, it could potentially be trialed in one area first before moving on to the next phase (i.e., start with the college and trial the new curriculum). However, as the concerns of LWV have no boundaries and are interconnected at all levels, it would be best to implement a trial in each area for a set period. For example, a new LWV-focused module could be added to the first semester nursing course, online training and requirements for preceptors could be implemented in one area of the hospital, i.e., the intensive care units, and the clinical leaders and nurse manager from that same area could receive a certain number of hours of training and education as well as have resources made available to them. The trial period could last one year after which an evaluation would be made to determine whether to continue or discontinue the adoption.

Implementation. If the innovation has been adopted based on the outcomes of the trial period, it now becomes fully adopted and implemented. Reinvention typically occurs at this stage as the innovation may need to be adjusted or modified to meet the program-specific or unit-specific needs. As there is still a degree of uncertainty at this stage, it is critical to plan for the alternative outcomes as best as possible (Rogers, 2003).

The implementation of the LWV-focused module should be fully adopted into the first semester fundamentals of nursing course and may need to be reinforced during the final semester as students are preparing to graduate and enter the professional workplace. Possible suggestions to incorporate into the LWV topic could include self-administered personality tests to help students identify their strengths and weaknesses, communication exercises, and/or role-modeling/rehearsal. Staff nurses who wish to become preceptors should be required to meet the necessary criteria set by the unit as well as completed the mandatory hours of the online preceptor challenge program. Possible criteria for preceptors could include a minimum amount

of work experience, a minimum amount of time spent on that particular unit, no prior grievances filed against them, approval from the nurse manager, and show that they are current of the evidence-based practice techniques.

Finally, the clinical leaders and nurse managers are expected to attend mandatory leadership workshops, demonstrate knowledge of what resources have been provided for them to attend to incivility complaints, demonstrate an understanding of the proper chain of command and their legal responsibilities, and possibly develop and implement a zero-tolerance policy on bullying behavior. The leadership role should also incorporate training and education into the new nurse residency program such as establishing an ombudsperson within the healthcare organization to whom nurses can complain without fear of backlash. Also, involving nurses in policy development gives them the opportunity to take ownership and responsibility for the environment in which they work (Field, 2005).

Innovation-Decision Process Theory: Evaluation

Confirmation. The evaluation of the innovation is a crucial step in the continuance or discontinuance of the innovation. The information collected during the evaluation is also an essential element in determining how best to tailor the curriculum/program. Course-evaluations given at the end of the semester as well as a follow-up survey regarding students experiences with bullying during their clinical rotations could be used to evaluate the effectiveness of the curriculum. Open feedback should be encouraged to understand better the needs of the students and how the nurse educators can facilitate this support. Anonymous preceptor evaluations should be completed by students and given to both the teacher and unit manager. When evaluations are expected to be handed back to the preceptor, students may fear retaliation, especially if they intend on applying to that unit in the future, and may not be as honest in their

feedback. A short best-practice quiz could also be administered to preceptors after their training to determine their post-challenge knowledge.

Clinical leaders and nurse managers can utilize a variety of sources to evaluate the training, workshops, and policy innovation. Nurse retention rates would ultimately be one of the best indicators; however, it may take several years of data to identify a positive trend. Anonymous surveys could be completed by the nursing staff as well as the new nurses on a quarterly or semiannual basis. Lastly, a formal evaluation of the program(s) could be conducted by a third-party organization, not directly responsible for the innovation, who can provide objective evidence of the validity and effectiveness of the programs (Canadian Centre for Occupational Health and Safety, 2007).

Conclusion

Lateral workplace violence, bullying, and general incivility is a significant, under-reported, and under-recognized occupational safety and health problem that is directly impacting the health and culture of nursing. Bullying behavior is a learned process with nursing students and newly employed nurses who observe and then embrace the bullying behaviors of other nurses just to fit in, thus contributing to the continuation of bullying behavior (Lewis, 2006). Incivility in the workplace has a myriad of detriments for both the individual and the organization. The individual may have a decrease in job satisfaction, work ethic, productivity, self-esteem, depression, and motivation to continue in the profession; the organization may experience high turnover rates, attrition rates, poor patient outcomes due to nursing errors, loss of funding due to complaints, and a negative reputation making it more difficult for recruitment.

Prevention is a necessary element to mitigating incivility in the workplace and must be addressed with a multilevel and multidimensional approach. This should start in the nursing

education programs when future nurses are first exposed to the clinical setting. A curriculum that is focused on raising awareness and providing students with strategies to recognize and handle LWV can help decrease the incidence of LWV for future nurses (Longo, 2007). Preceptors have a significant impact on student nurses and newly licensed nurses. The requirement of preceptors to meet specific qualifications, attain proper training about workplace civility, and demonstrate current evidence-based practice can help empower new nurses with positive feedback and ensure that all training is up to date.

Clinical leaders and nurse managers have a direct impact on the culture of their unit and need to be cognizant of their leadership style and behavior towards staff members. Providing workshops, training, education, and resources to help guide and encourage managers can help create a culture of civility through their healthy practices. Bullying must not be tolerated in any capacity, in any setting, or for any reason; the benefits of a healthy workplace environment infinite and the consequences of LWV are immeasurable.

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Appendix

Levels of Evidence Defined

Levels of evidence (sometimes called hierarchy of evidence) are assigned to studies based on the methodological quality of their design, validity, and applicability to patient care. These decisions give the "grade (or strength) of recommendation."

Level of evidence (LOE)	Description
Level I	Evidence from a systematic review or meta-analysis of all relevant RCTs (randomized controlled trial) or evidence-based clinical practice guidelines based on systematic reviews of RCTs or three or more RCTs of good quality that have similar results.
Level II	Evidence obtained from at least one well-designed RCT (e.g., large multi-site RCT).
Level III	Evidence obtained from well-designed controlled trials without randomization (i.e., quasi-experimental).
Level IV	Evidence from well-designed case-control or cohort studies.
Level V	Evidence from systematic reviews of descriptive and qualitative studies (meta-synthesis).
Level VI	Evidence from a single descriptive or qualitative study.
Level VII	Evidence from the opinion of authorities and/or reports of expert committees.

This level of effectiveness rating scheme is based on the following: Ackley, B. J., Swan, B. A., Ladwig, G., & Tucker, S. (2008). *Evidence-based nursing care guidelines: Medical-surgical interventions.* (p. 7). St. Louis, MO: Mosby Elsevier.