NURSES’ PERCEPTIONS OF HORIZONTAL VIOLENCE

A Dissertation Presented

by

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Acknowledgements and Dedication

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Abstract

Horizontal violence contributes to an unsafe work environment and adversely affects patient outcomes. It affects nurses’ health, morale, and sense of worth, and is a factor in recruitment and retention. Despite increased awareness and Joint Commission mandates requiring healthcare institutions take action to eliminate disruptive behaviors, the problem remains unresolved.

The majority of nursing studies to date have focused on describing associated behaviors, measuring prevalence, and identifying antecedents and consequences. Most are based on survey data, relying on self-report. Because horizontal violence is poorly defined and studies indicate that nurses minimize its associated behaviors, self-report alone may not adequately reveal the complexities of the phenomenon. The purpose of this study was to explore individual nurses’ perceptions of horizontal violence within the context of their work environment to inform the development of future interventions to improve recognition of the phenomenon.

This descriptive study utilized elements of ethnography and phenomenology. Policies and codes of conduct were analyzed. Observation (370 hours) was used to develop an understanding of the context and culture of two inpatient hospital units. In addition, 35 members of staff shared their perceptions of horizontal violence, broadly defined as “any physical or emotional, non-caring or non-supportive behavior between nurse colleagues,” factors they believe contribute to the perpetuation of these behaviors, and their own experiences of the phenomenon. Data was coded and analyzed thematically.
Results indicate that horizontal violence is perpetuated by lack of recognition and causal attributions. Reporting is inhibited by fear of reprisal, isolation, and labeling. Systems problems are also identified as contributing to the phenomenon. The majority of behaviors identified would not meet criteria for workplace violence as defined under existing policies, but would be prohibited under codes of conduct, which were not enforced. Addressing horizontal violence was not a priority on either unit.

Finding support existing theories of horizontal violence. The phenomenon is revealed as multifactorial; indicating that interventions focused on a single cause may not be effective. Future interventions must address the complexity of phenomenon. The results of this study illustrate some of this complexity and may be used to inform the design of future interventions.
Chapter 1: Phenomena of Concern

Introduction

The term horizontal violence was first introduced into the nursing literature by Dr. Susan Jo Roberts in her 1983 article, “Oppressed Group Behavior: Implications for Nursing.” Horizontal violence refers to “a variety of unkind, discourteous, antagonistic interactions that occur between persons at the same organizational hierarchy level” (Alspach, 2007, p.10). It has been defined as a non-physical intra/inter-group conflict manifested in overt and covert hostile behaviors (Freire, 1970), although some definitions encompass physical violence as well (Duffy, 1995). Specific to nursing, Thobaben (2007, p.83) defines horizontal violence as “hostile, aggressive, and harmful behavior by a nurse or a group of nurses toward a coworker or group of nurses via attitudes, actions, words, and/or other behaviors.” It is a phenomenon that has been described interchangeably with a number of other terms in the literature, including bullying, disruptive behavior, and incivility.

Bullying is an umbrella term used both in the literature and by nurses themselves to describe aggression between members of staff (Gilmour & Hamlin, 2003). A number of studies distinguish between bullying and other types of workplace aggression, such as horizontal violence, based on a power differential between the aggressor and the “victim” (Vessey, DeMarco, & DiFazio, 2010, for example). Despite this qualifier, not all studies limit potential sources of bullying to those in supervisory or higher ranked positions. In a study by Anjum, Yasmeen, and Yasmeen (2011), “boss”, “coworker”, and “subordinate” were listed as potential sources of bullying in the study questionnaire. The results of the study demonstrated that 20% of bullying was by a coworker, someone in a similar
position within the hierarchy. In one study of bullying in nursing (Vessey, DeMarco, Gaffney, & Budin, 2009), researchers state, “when bullying is intraprofessional, it is closely related to horizontal violence” (p. 300). Despite attempts to create distinction between the terms bullying and horizontal violence, they share overlapping characteristics, are often used interchangeably, and there is no universally accepted definition of either.

The Joint Commission defines disruptive behavior as “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities” (Joint Commission, 2008). For Walrath, Dang, and Nyberg (2010), disruptive behavior is an overarching term applied to a wide range of “bad behaviors” that are reported in the healthcare literature, many of which have been cited as examples of bullying or horizontal violence in other studies.

Incivility has been broadly defined as “employees’ lack of regard for one another” (Pearson & Porath, 2005). A recently developed scale demonstrates a continuum of behaviors associated with incivility (Clark, Olender, Cardoni, & Kenski, 2011) (Figure 1). This scale ranks these behaviors, beginning with eye rolling and progressing to sarcastic comments, bullying, taunting, racial/ethnic slurs, intimidation, and ultimately to potential physical violence. Bullying is included as a behavior in the Continuum of Incivility. Per Clark’s definition, bullying is not a term used interchangeably with incivility, but instead is defined as a form of incivility.

Despite continued efforts to clearly define and differentiate the range of terms used interchangeably within the literature to describe the phenomenon, consensus has not
yet been reached. In fact, in a recently published article in *The Annual Review of Nursing Research* (Vessey, et al., 2010), researchers combine bullying, harassment, and horizontal violence into a new term, BHHV, which they define as “repeated, offensive, abusive, intimidating, or insulting behavior, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence” (p.36). The absence of consistent, well-defined terminology and shared language to describe the phenomenon not only inhibits reporting, but also inhibits collaboration between researchers and their ability to incorporate and build upon previous research (Bartholomew, 2006; Crawshaw, 2009; McKenna, Smith, Poole, & Coverdale, 2003).

It was not the intent of this study to explore existing definitions within the literature, however. The intent was to investigate individual nurses’ perceptions of horizontal violence within the context of their work environment, the meaning they give to the phenomenon and its associated behaviors, as well as the language used to describe the phenomenon, to inform the development of future interventions to improve recognition. The term horizontal violence was chosen over other possible descriptors as it was the first term used in the nursing literature to describe the phenomenon. The inclusion of the qualifier “horizontal” emphasizes the study’s focus on behavior between nurse colleagues.

Although it was my intent to have nurses make sense of the phenomenon without leading them with or to existing definitions, a description of the phenomenon was required as a starting place for discussion. For the purposes of this study, horizontal violence was broadly defined as “any physical or emotional, non-caring or non-
supportive behavior between nurse colleagues.” This definition was used in conversations, interviews and other inquiries rather than the term horizontal violence. The wide range of behaviors that have been associated with horizontal violence in the nursing literature, from eye rolling to physical assault, two extremes of Clark’s proposed continuum (Figure 1), were subject to review and investigation under the proposed definition.

Statement of the Problem

Horizontal violence is a recognized problem in business, in industry, and in education (Anjum et al., 2011; Jennifer, Cowie, & Ananiadou, 2003; Lutgen-Sandvik, Tracy, & Alberts, 2007; Parker-Pope, 2008; Pearson & Porath, 2004, 2005; Terasahjo & Salmivalli, 2003). Its appearance in nursing is therefore not surprising. What is surprising is its prevalence, as well as the documented extent of its impact on individual nurses, health care, and patient safety. My interest in these behaviors is their perpetuation in a profession that identifies caring as a core value (American Nurses’ Association, 2004). Despite this, horizontal violence is prevalent and perpetuated by and upon nurses by nurse colleagues.

Horizontal violence affects nurses’ morale, sense of worth, as well as physical and mental health (Daiski 2004; Kivimaki, Elovainio, & Vahtera, 2000; McKenna, et al., 2003; Quine, 2001; Woelfle & McCaffery, 2007). It has been implicated as a factor adversely affecting recruitment and retention (Simons 2006, 2008). In addition, behaviors associated with horizontal violence contribute to an unsafe work environment and adversely affect patient safety (Joint Commission, 2008). Despite increased awareness,
studies of the behaviors, and development of instruments and interventions, the problem remains unresolved.

Nursing Populations at Risk

Nurses in all work environments, from midwifery practices (Leap, 1997) to the operating room (Dunn, 2003), are affected by behaviors that can be identified as horizontal violence (Walrath et al., 2010). Based on the responses of 303 nurses to an internet survey advertised in print and on the website for the publication *Nursing Spectrum*, “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, and is most often directed to nurses with 5 years or less of employment on a unit (57%) (Vessey et al., 2009). New graduate nurses are understood to be particularly at risk (McKenna et al., 2003; Pellico, Brewer, & Kovner, 2009). Student nurses in classroom and clinical sites are also subject to horizontal violence by instructors and classmates (Clark, 2008; Clark & Springer, 2007; Curtis, Bowen, & Reid, 2007; Ferns & Meerabeau, 2007; Jackson, et al., 2011; Longo, 2011; Thomas & Burk, 2009). Members of faculty are not immune. Just as there are reports of faculty abuse of students, there are reports of student nurse aggression toward classroom and clinical instructors (Clark, 2008; Clark & Spinger, 2007). Work by Nel Glass (2003a, 2003b) and Yildirim, Yildirim and Timucin (2007) demonstrates these behaviors occur between colleagues in nursing education as well.

Prevalence of Horizontal Violence

Studies of horizontally violent behaviors in nursing have been conducted in many countries: the United States (Griffin, 2004; Stanley, Martin, Michel, Welton, & Nemeth,
2007), Canada (Daiski, 2004), the United Kingdom (Farrell, 1997, 1999, 2001; Randle 2003), Australia (Glass, 2003a, 2003b; Hutchinson, Jackson, Vickers, & Wilkes, 2006; Hutchinson, Jackson, Wilkes, & Vickers, 2008), New Zealand (McKenna et al., 2003), and Turkey (Yildirim & Yildirim 2007; Yildirim, Yildirim, & Timucin, 2007). Despite increasing numbers of studies internationally, there is no accurate measure of prevalence. The number of terms that are used interchangeably and the lack of consistent, agreed upon definitions of these terms inhibit accurate measurement (Crawshaw, 2009). For example, two studies completed in the United Kingdom using different definitions for the term “bullying” found different rates of prevalence. The first study listed twenty types of bullying behavior identified from the literature and asked staff if they had been subject to any of these behaviors in the last twelve months. The results demonstrated that more than one third (38%) of staff had experienced some type of bullying behavior within the last year (Quine, 1999). The results of second study, a survey by The Royal College of Nursing, which defined bullying as “the misuse of power or position” (Royal College of Nursing, 2001), indicated that one in six British nurses (16.6%) had been bullied by a colleague during the previous year (Royal College of Nursing, 2002).

Labeling of behavior as bullying, aggressive behavior, or horizontal violence differs from study to study and appears to be arbitrary (Zapf & Einarsen, 2001). Although many studies have been conducted, most researchers develop their own definitions, instruments and methodology, producing conflicting reports of prevalence. Further complicating the problem, many studies use the terms that include the word “violence” (lateral violence or horizontal violence, for example). Many nurses associate violent
behavior with physical violence and so do not perceive the behaviors they witness or experience as violent (Hockley, 2000).

Reporting is affected by perception. If the problem does not meet an individual's understanding of a reportable event, it will not be reported. In one of the few studies involving observation, a study of aggressive behaviors directed toward nurses, only 7 out of 686 observed occasions of violence or aggression were reported (Jackson, Clare, & Mannix, 2002, p. 14). Other factors identified in the literature as affecting reporting include fear of retribution and resignation to the problem (Stanley et al., 2007). Minimizing of the behaviors also contributes to underreporting (Hockley, 2000).

In a 2006 study of workplace injuries, managers and nurses expressed a common view that injuries are an expected part of the job. This was associated with inconsistent reporting of injuries and a discrepancy in the perception for the need for ongoing, mandatory health and safety prevention programs (Hoff, Koren, Mawn, Melillo, Pearce, & Sperrazza, 2006). If nurses also understand horizontal violence as “part of the job”, as the literature suggests, they may not perceive it as a problem needing resolution. In a study of horizontal violence between nurses in NY State (Sellers, Millanbach, Kovach, & Yingling, 2009-2010), the researchers conclude that horizontal violence is so deeply ingrained in nursing culture that nurses do not perceive it to be a problem. Current interventions and conflict resolution strategies will not be effective if nurses themselves do not recognize the phenomenon when they witness or experience it or if they minimize the associated behaviors. As the researchers conclude, “until a phenomenon is recognized and named little can be done to alter it” (Sellers, et al., 2009-2010, p.20). A goal of this research was to improve recognition of horizontal violence among nurses by
investigating how they make sense of associated behaviors within the context of their work environment.

Purpose of the Study/Relevance to Nursing

The purpose of this study was to investigate individual nurses’ perceptions of horizontal violence within the context of their work environment, the meaning they give to the phenomenon and its associated behaviors, and the language used to describe it to improve recognition of the phenomenon. As the phenomenon is under recognized and underreported, a descriptive exploratory approach incorporating ethnography and phenomenology was used to capture what studies based on self-report might miss.

I proposed that investigating nurses’ perceptions of horizontal violence, paying particular attention to language used to describe the phenomenon, as well as the meanings ascribed to the phenomenon, would aid in efforts to improve recognition. Results of this study can be used to inform modification of existing interventions and may contribute to the design of new interventions to improve recognition and reporting of the problem and reduce horizontal violence in the nursing workplace.

Qualitative Research Methods and Justification

Qualitative inquiry has been identified as a valid approach to developing an understanding of a multifaceted phenomenon within a context-bound setting (Patton, 2002). Since the purpose of this study was to investigate and further understand nurses’ perceptions of horizontal violence within the context of their inpatient hospital units, a descriptive exploratory approach with both ethnographic and phenomenological elements was used.
Ethnography is a generalized approach to developing concepts to understand human behaviors from the emic point of view (Field & Morse, 1985). It is “the study of socio-cultural contexts, processes, and meanings within cultural systems” (Whitehead, 2005, p. 4) and differs from other research methods in its focus on fieldwork as a mode of inquiry (Walcott, 2001). Ethnography has been identified as suitable approach for providing an insider perspective on the work of health professionals (Thomson, 2011) and has been used to investigate nurse-doctor interactions during rounds (Manias & Street, 2001), nurse stress (McGibbon, Peter, & Gallop, 2010), experiences of patients and staff within a trauma unit (Tutton, Seers, & Langstaff, 2008), and systems issues affecting screening for intimate partner violence (D’Alvio, 2010). Although not a nursing study, but closely related to the objectives of this project, a Finnish study used ethnographic methods to explore how students interpret and construct bullying (Terasahjo & Salmivalli, 2003).

The intent of ethnography is to produce an “in-depth understanding of real-world social processes,” which makes it an appropriate approach for investigating the complexities of nursing interactions within the unit environment (Forsythe, 1999, p.129). Ethnography focuses on the cultural aspects of social groups and seeks to illuminate both explicit aspects of a culture (what all members are aware of and take for granted), and tacit elements (outside of awareness).

Although observation is a primary mode of data collection in many ethnographic studies, observation alone may not be adequate for studying subtle and discrete forms of horizontal violence. Combining observation with phenomenological interviews provided
some additional insights for understanding the phenomenon that may not have been revealed in studies based entirely on self-reported data.

The aim of phenomenology is to describe the different ways in which people understand a phenomenon, focusing on understanding lived experience (Maggs-Rapport, 2000). In this study, interviews focused on participants’ experience and sense making of horizontal violence to better understand the phenomenon in context, in relationship to “things, people, events, and situations” (Richards & Morse, 2007, p. 50).

**Perspective**

This study was conducted using a constructivist perspective, focusing on the meaning nurses and unit staff ascribe to behaviors, actions and experiences between colleagues within the context of their own workplaces. In this perspective, meaning and sense making are studied because meaning and sense making shape action (Guba & Lincoln, 2008). This approach allowed me, as the researcher, to develop an understanding of how individual nurses’ understanding of horizontal violence might shape their behavior, as well as the role of work environment and workplace culture in shaping that understanding. The constructivist approach allows multiple interpretation of realities and alternative interpretations of data to be presented (Fetterman, 1989). This approach does not seek to uncover a single truth, but to develop an understanding of the multiple, situational realities experienced by individuals in their daily lives, an aim of this study.

**Definitions**

**Culture:** Culture is a social order that exists explicitly or implicitly and includes assumptions, rules, beliefs, values, norms, and behavioral expectations for individuals who join a specific group (Schein, 2010). It is the learned, shared knowledge that people
use to generate behavior and interpret experience (Spradley & McCurdy, 1990, p.4)

Culture “exists in the space between people, rather than residing in any one individual” (Neyfakh, 2012).

**Horizontal violence:** For the purpose of this study, horizontal violence is defined as “any physical or emotional, non-caring or non-supportive behavior between nurse colleagues.” There is no requirement that behaviors be repeated over time or involve a power differential. (Table 2 - Manifestations of Horizontal Violence)

**Perception:** A person’s description, a form of interpretation (Richards & Morse, 2007, p. 51)

**Unit culture:** Culture within a hospital unit. It has been proposed that every unit has a culture and behavior within a unit is influenced by its culture (Hawkins & Kratsch, 2004).

**Work environment:** The term work environment is often used interchangeably with unit culture. In this study, work environment is defined as the physical space in which people work, the physical attributes and resources within a space defined as a single hospital unit.

**Assumptions Identified Prior to Data Collection**

Human behavior and interaction are complex and self-report alone may not provide a complete picture of behavioral phenomenon. Examining behavior and meaning in the context in which they occur may improve understanding.

If a barrier to reporting and effective intervention involves a lack of recognition of the phenomenon, understanding how nurses’ make sense of the phenomenon and the language nurses use to describe the phenomenon may provide framing and
language that can be used in interventions to improve recognition of the
phenomenon and improve outcomes.

My presence as a researcher on the unit will be accepted over a prolonged engagement
with the site and staff.

I will be able to negotiate my role as an observer and maintain the required level of
distance, discipline, and objectivity. I will keep a journal throughout the process
to aid in continued awareness of my personal beliefs and biases. In addition, I will
meet with committee members throughout the process to review data collection
and analysis to aid in maintaining objectivity.

Research Questions

The purpose of this study was to investigate individual nurses’ perceptions of
horizontal violence within the context of their work environment, the meaning they give
to the phenomenon and its associated behaviors, as well as the language they use to
describe it, in order to improve recognition.

Initial research questions included:

- Is the phenomenon of horizontal violence present and can it be observed?
- If so, what does it look like?
- What factors contributing to horizontal violence can be identified through
  observation?
- How do nurses and other staff describe their experiences of horizontal violence?
- What are their perceptions of the phenomena?
Overview of the Dissertation

The following chapter, Chapter Two, is a review of the literature focusing on the terms used to describe the phenomenon, as well as the range of behaviors associated with horizontal violence. The historical context and existing theories are also described, as well as the effects of horizontal violence. Chapter Three describes the methodological approach, setting, sampling, data collection and analysis. Chapter Four further describes the setting and presents findings based on document review, observations, and informal and formal interviews. Chapter Five will discuss the significance of the findings, as well as implications for nursing research, practice, education, policy, and hospital management.
Chapter 2: Review of the Literature

Terms and Behaviors

The phrase “nurses eat their young” is familiar to many nurses. It is uncertain how long this term has been used to describe horizontally violent behaviors between nurses, but behaviors related to the phenomena known as “eating our young” have been visible within the context of nursing practice for several decades (Wolf, 1988). Messnier’s use of the phrase in her article, “Nurses: Are We Eating Our Young?” (1986), written to raise awareness about behaviors she referred to as “insidious cannibalism,” created controversy. In a follow up article published over a decade later, she saw little change in the way nurses treat one another despite increased awareness (Messnier, 1999). Recent literature suggests that these behaviors are actually increasing (Embree & White, 2010).

Exposure to these behaviors has been described as a rite of passage, initiation into the profession, and part of the culture of nursing (Griffin, 2004). This embeddedness contributes to difficulties studying and addressing the problem. Farrell (2001) suggested that nurses themselves act as “insidious gatekeepers” to the status quo of horizontal violence.

It is uncertain how widespread the problem of horizontal violence is in nursing. One barrier to accurately measuring its prevalence is the wide variety of terms to describe the phenomenon, often used interchangeably (see Table 1). Research has been compromised by a lack of consistent definitions. As described previously, even the most commonly used term in the workplace violence literature, bullying, remains contested.

There is also a wide range of behaviors associated with horizontal violence described throughout the literature, from verbal slights to physical violence, indirect or
relational aggression to direct aggression. Clark and colleagues (2011) proposed a scale of incivility, placing the behaviors on a continuum from eye rolling to physical violence (see Figure 1).

This scale, illustrating a ranking of behaviors associated with incivility, involves eye rolling, sarcastic comments, bullying, taunting, racial/ethnic slurs, intimidation, and physical violence. Some of the behaviors described in the literature that are not included in this continuum include rudeness, lack of regard, engaging in gossip, disrespectful behavior, passive aggressive behavior, refusal to do one’s job, verbal aggression, power plays, condescending language, dressing down, professional disregard, backstabbing, backbiting, scapegoating, elitism, isolating, unfair or inequitable assignments, unwarranted criticism, non-verbal innuendo, withholding information, sabotaging, infighting, failure to respect privacy, and verbal abuse. (Duffy, 1995; Dunn, 2003; Farrell, 1997; Griffin, 2004; Joint Commission, 2008; McKenna et al., 2003, Walrath et al., 2010).

Theories and Historical Context

Many theories have been used to explore and explain these behaviors in nursing. Some of most widely recognized theories include oppressed group behavior (Dunn, 2003; Roberts, 1983; Roberts, Demarco, & Griffin, 2009; Simons, 2006; 2008), “toxic” practice environments (Alspach, 2007; Rowell, 2005), organizational characteristics (Hutchinson et al., 2008), relational aggression (Dellasega, 2009), and generational differences (Hahn, 2011; Kupperschmidt, 2006). Of these, the most frequently cited theory is oppressed group behavior.
Roberts’ application (1983) of Freire’s theory (1970) explains that nurses are members of an oppressed group who are unable to confront the oppressive system and so take out their frustrations laterally, on others in their oppressed group (DeMarco & Roberts, 2003). This oppression stems from the nursing profession’s place in the dominant medical hierarchy (Carter, 1994; Farrell, 1997). As a female-dominated profession involving caring, a “natural” role for women, nursing is not afforded the same status as the historically male-dominated profession of medicine (Huppatz, 2009).

Nursing has been historically situated in a non-privileged position in health care. The dominance of the medical model and the continued structural subordination of nursing work in the current health care system contribute to the nursing profession being identified as an oppressed group (Holmes & Gastaldo, 2002).

According to oppressed group theory, members of oppressed groups display characteristics such as low self-esteem and self-hatred (Roberts, 1983). As members of an oppressed group, it is theorized that nurses react to a sense of powerlessness by overpowering others and becoming aggressive (Bartholomew, 2006). The theory of oppressed group behavior has been validated and is an important theory in explaining horizontal violence and oppression within the profession of nursing (Matheson & Bobay, 2007). However, Farrell (2001) and other researchers believe the origins of intragroup conflict in nursing are more complex, and that while oppression is a useful lens, focusing on it too closely may obscure other, equally valid, ways of understanding the phenomenon.

Other proposed origins of horizontal violence include environmental and organizational factors (Rocker, 2008). Environmental factors include emotionally,
spiritually, and psychologically toxic practice environments, where nurses are under pressure to provide care in the face of downsizing, aggressive management styles, and increased competition (Alspach, 2007; Rowell, 2005). Within many practice environments, nurses have little private space and spend most of their work hours “on stage”, in view of patients and their families, accessible at all times by physicians and coworkers. This increases stress without opportunities for release (Halford & Leonard, 2003).

Organizational factors contributing to horizontal violence include implicit managerial acceptance of the behavior. Behaviors associated with horizontal violence are more prevalent in organizations where individuals perceive the behaviors are tolerated (Lewis, 2006). Hutchinson and colleagues (2006) suggest that organizations may even promote these behaviors as a means of maintaining power and control.

Relational aggression is identified in the nursing literature as a form of bullying. There is a gender component, however, as it often refers specifically to female bullying behaviors (Dellasega, 2009). Associated behaviors are primarily non-physical and include backstabbing, gossiping, eye rolling, and withholding assistance, all behaviors which are understood to be expressions of horizontal violence. Dellasega suggests that this form of violence originates in childhood in the ways girls are taught to manage aggression and anger (Dellasega & Nixon, 2003).

Generational differences are also identified as a potential source of nurse conflict (Kupperschmidt, 2006; Zemke, Raines, Flipczak, 2000). Researchers describe four distinct generations in the current nursing workforce: the Veterans (born 1922-1943), the Baby Boomers (born 1943-1960), Generation X (1960-1980), and the Nexters (born
1980-2000) (Zemke et al, 2000). The term “nurses eat their young” generally refers to the lack of support of or aggression directed toward nursing students and new graduate nurses by more senior nurses (Daiski, 2004), but the conflict and lack of respect go both ways, as each generation of nurses has different attitudes, beliefs, work habits and expectations (Zemke et al, 2000). If not addressed, it is theorized that multigenerational conflict may result in behaviors associated with horizontal violence (Kupperschmidt, 2006).

**Effects of Horizontal Violence on the Profession of Nursing**

*Socialization*

Recent literature reveals that nursing students are exposed to horizontal violence during their education in the classroom, lab, and clinical sites. This early exposure is believed to normalize the behavior even before these students enter the workforce as nurses (Clark & Springer, 2007; Ferns & Meerabeau, 2007). Acceptance of horizontally violent behavior is learned and then reinforced within the work environment (Lewis, 2006). Research suggests that nursing management may lack the skills and resources to identify and deal with horizontally violent behaviors and in some cases, seek to perpetuate the behaviors (Hutchinson et al., 2006). As behaviors are not addressed, nurses come to accept these behaviors as expected and are socialized into the phenomena (Felblinger, 2008; Randle, 2003). Individuals may cope with these behaviors by avoiding or accommodating those who enact the behavior, and ultimately accept it as part of their job (Farrell, 2001; Walrath et al., 2010).
Image of the profession

Horizontally violent behaviors have the potential to undermine what nursing has long held as its primary contribution to health care: caring. The word caring is often used by the public in talking about nurses and by nurses themselves in describing their work. (Gordon, 2005). Many nursing theorists base their models on the concept of caring. Madeleine Leininger, for example, holds caring as a central tenet to nursing. In her Theory of Cultural Care, care “is the essence of nursing” and a “unifying focus of nursing” (Leininger, 1991). Jean Watson’s Theory of Human Caring includes ten carative factors as the core processes involved in the professional practice of caring. These core factors are: faith and hope, humanistic system of values, sensitivity towards others, trust, expression of positivity and negativity, problem solving, promotion of learning relationship, provision of support, fulfillment of human needs and promotion of transpersonal caring and love (McCance, McKenna, & Boore, 1999). Theorist Kristen Swanson defines nursing as “informed caring for the well-being of others” (Swanson, 1991, 1993). In her middle-range theory of caring she specifically identifies nurse colleagues as a “cared for other”, asking nurses to consider caring for their colleagues as they would their patients. Because of their understanding of care as fundamental to nursing, Leininger, Watson, and Swanson, would find their theories of nursing as caring incommensurate with the perpetuation of horizontal violence.

Caring is also identified as central to nursing practice. The American Nurses Association’s (2004) Scope and Standards of Practice states, “The art of nursing is based on a framework of caring and respect for human dignity” (pp. 11-12). Allowing horizontally violent behaviors to be perpetuated violates nurses’ professional oath to
respect one another and to work together to keep patients safe (American Nurses Association, 2001).

**Effects of Horizontal Violence on Individual Nurses**

*Physical and emotional health*

Relationships with nurse colleagues strongly affect nurses’ experience of stress on the job (Isenalumhe, 2000). While social support among hospital nurses has been shown to enhance performance and decrease stress (AbuAlRub, 2004), aggression from colleagues is a significant source of workplace distress. In one study, nurses described aggression from nurse colleagues as more distressing than that from physicians, patients and patient family members (Farrell, 1999). According to a 2002 study by the Royal College of Nursing, of all the workplace factors, being bullied or harassed by members of staff has the worst impact on psychological health, followed by work-related injury or illness (Royal College of Nursing, 2002).

Nurses who experience horizontal violence have been diagnosed with psychological disorders including depression, acute anxiety and post-traumatic stress disorder (Rowell, 2005). In addition, incivility and bullying have been found to elicit shame responses in nurses (Felblinger, 2008). When shame is triggered, those affected may respond by withdrawing from or avoiding persons or situations that evoke the response, acting out and attacking others, or attacking themselves and questioning their abilities and self worth (Nathanson, 1992). Nurses who are exposed to horizontal violence use more sick time than nurses who have not experienced horizontal violence (Kivimaki et al., 2000; Woelfle & McCaffery, 2007). Physical complaints
associated with experiences of horizontal violence include weight changes, hypertension, palpitations, and irritable bowel syndrome (Rowell, 2005).

Effects of Horizontal Violence on Health Care Costs

Retention and lost days at work

As a supportive work environment has been identified as an important factor in job satisfaction (Kangas, Kee, & McKee-Waddle, 1999), it is not surprising that nurses who are victims of horizontal violence have a higher rate of absenteeism and are more likely to leave their current positions or to leave the profession than other nurses (Daiski 2004; Kivimaki et al., 2000; McKenna et al. 2003; Quine, 2001; Simons 2006, 2008; Woelfle & McCaffery, 2007). A large number of new nurses leave their first place of employment within the first 6 months because of horizontal violence (McKenna et al., 2003; Winter-Collins & McDaniel, 2000). Nurses who witness horizontal violence are also affected. They are more likely to be dissatisfied with their job and more likely to leave their current positions or leave the profession than nurses who have not witnessed horizontal violence (Daiski 2004; McKenna et al., 2003; Quine, 2001; Simons 2006, 2008).

Financial costs of nurse turnover are considerable. It is estimated that nurse turnover costs the employing institution between $22,000 and $64,000 per nurse (Jones, 2008).

Effects of Horizontal Violence on Patient Health and Safety

Errors

Medical errors are the fifth leading cause of death in the United States despite efforts to establish a culture of safety in healthcare (Institute of Medicine, 2000). According to the Agency for Healthcare Quality Research (AHQR), communication and teamwork are crucial for safe patient care (Baker, Gustafson, Beaubien, Salas, & Barach,
2005). Any behavior that breaks down team effectiveness and impairs communication can contribute to adverse outcomes. Infighting between nurse colleagues adversely affects teamwork and unit cohesion and nurses’ ability to do their job safely (Droppleman, Smith, & Thomas, 1996). In a study of nurses who were verbally abused, 13% of the respondents reported this abuse caused them to make an error at work (Rowe & Sherlock, 2005). The performance of nurses who witness abuse are also affected. The ability to complete routine and creative tasks is diminished in witnesses to abusive behaviors, increasing the risk of error (Porath & Erez, 2009).

*Joint Commission Sentinel Event Alert*

In July 2008, The Joint Commission issued a Sentinel Event Alert, stating that intimidating and disruptive behaviors contribute to medical errors, poor patient outcomes, increased costs of caring, and attrition (Joint Commission, 2008). The Joint Commission currently requires that all hospitals surveyed by the Commission establish a process to identify problem behaviors and implement procedures to lessen them, as well as develop a code of conduct for acceptable and unacceptable behaviors. The Commission requires education, holding staff accountable for modeling behavior, enforcing the code of conduct, and developing zero-tolerance policies (Joint Commission, 2008). Although the effectiveness of these interventions has yet to be evaluated, based on the results of the NY State study (Sellers et al., 2009-2010), the lack of recognition of the phenomenon is a possible barrier to success.

*Summary*

Given the number of terms used interchangeably with horizontal violence, the range of behaviors associated with horizontal violence, and the wide scope of theories
used to explain horizontal violence, it is clear that horizontal violence is a complex phenomenon. The literature demonstrates an urgency to resolve the problem, yet there is no indication that existing interventions have been effective over time.

There are few exploratory qualitative research studies investigating how individual nurses understand and describe the phenomenon within the context of their work environment. In my review of the literature, I did not find any studies of horizontal violence that incorporated observation to explore the phenomenon or the role of context in contributing to horizontal violence within the work environment. If horizontally violent behaviors are embedded in nursing culture, solutions must be presented in language nurses themselves use and incorporate nurses’ perception of phenomenon. If it is true that nurses do not recognize horizontal violence or see it as a problem requiring intervention, interventions will not be effective. This study focused on two hospital-based inpatient units and their staff to examine how individual nurses’ perceptions of horizontal violence and the language used to describe it within the context of the nursing unit might differ from that in the literature. The role of the context and culture of the units was also explored. Data collected in this study may lead to improved recognition of the problem and be used to improve existing and future interventions.

Chapter Three describes the methodological approach, setting, sampling, data collection, and analysis.
Chapter 3: Methods

The Methodological Approach

This descriptive exploratory study incorporated elements of both ethnography and phenomenology to investigate horizontal violence. Observation, document review, and phenomenological interviews were used to develop an understanding of horizontal violence within the context of two hospital-based nursing units.

Study Setting

The host facility was a large not-for-profit hospital in an urban center, part of a health care system in Central Massachusetts that includes a number of smaller community hospitals. The hospital itself had approximately 400 beds and served over 112,000 patients per year. Both of the units participating in the study, Unit A* and Unit B*, had 28 patient beds and were located on the same floor of the facility. The two units shared a medication room, storage rooms, a conference room, and a kitchen. Unit A* was a general medical/surgical unit and Unit B* was a specialty surgical unit providing care to a specific surgical population. This study focused on these two hospital-based inpatient-nursing units and their staff as units of analysis.

Site Selection and Sampling

Sites and participants for this study were identified using purposive sampling. Purposive sampling of participants involves identifying potential informants who are likely to know or have something to say about a phenomenon. With regard to location, purposive sampling looks to identify sites where the phenomenon under study is likely to occur (Fetterman 1998). Although horizontal violence can and does occur in all nursing care settings, it is believed that some units are more at risk for the phenomenon than
others (Hawkins & Kratsch, 2004). For example, units with high turnover rates and frequent reports of interpersonal conflict may support more aggressive, non-caring or non-supportive behaviors. Although neither unit participating in the study reported a high level of staff turnover, the two nurse managers offering to host the study on their units believed their staff was affected by horizontal violence and were open to inquiry. Nurses and other staff on these two units who were willing to reflect on nurse-to-nurse interaction, had the time, and were willing to participate were included in the study (Spradley, 1979).

**Participants**

There were approximately 120 participants across the two units including 80 nurses (RNs), 22 patient care assistants (PCAs), 14 unit secretaries, 2 nurse educators, and 2 nurse managers (staff on the individual unit’s payrolls). Physicians rounding on the units with medical and surgical teams were also observed, as well as respiratory therapists, phlebotomists, IV therapists, float nurses, STAT nurses (nurses who are available by pager to assist in patient care, most often in critical situations), nursing students, and other staff not on the individual unit payrolls but coming to the units to provide patient care. Every health care provider who was observed on the unit was made aware of the study.

**Entering the Field and Negotiating the Field Experience**

Potential research sites were identified using personal and professional connections to establish contact with Chief Nursing Officers who might consider supporting this research at their institution. The study proposal was presented to contacts at one site, supported, and then passed on to the hospital’s Nurse Executive Committee.
The Executive Committee at the participating facility expressed interest in the study and three units self-identified as appropriate and open to research. These inpatient units included Unit A*, a medical/surgical unit, Unit B* a specialty surgical unit, and Unit C*, an intensive care unit (ICU). Before data collection was commenced, the ICU site was dropped from the study when the unit’s Nurse Manager position was eliminated in a planned lay off.

Prior to data collection, a short description of the study (Appendix A) was delivered to the two managers of the participating units. This description and a copy of the informed consent form (Appendix B) were posted in the break rooms and charting areas so that unit staff would be aware of the objectives of the study, how data collection would take place, and how they could participate or decline participation. I undertook this study as a single researcher and identified myself as such in all interactions with staff, first in staff meetings that had been scheduled prior to study approval, and then individually to staff who were unable to attend the scheduled meetings or who visited the units to provide patient care.

To minimize the effects of observation, engagement with the site and staff was prolonged. Over the course of five months, a total of approximately 370 hours were spent observing, interacting with, and interviewing staff. Observations took place across all shifts in order to obtain a variety of perspectives and viewpoints. Observations began by attending, with permission, formal group activities such as staff meetings and morning rounds where I could become familiar with and to staff and where my presence might be less obtrusive. During the first two months I focused my observations on the layout and the workflow on both units to develop an understanding how things worked. More
focused observation and informal one-on-one interviews began during the third month of observation once I felt my presence on the unit was recognized and accepted (as described in Becker, 1991).

I had hoped that my qualifications as a nurse would allow me access and help me to gain acceptance. Although I had not worked directly with staff on either participating unit, I had worked as a nurse within the host facility for 10 years, but was no longer an employee. The fact that I was a former employee was shared with all participants as part of disclosure. It is not clear if this relationship biased the participants’ responses in any way. It may have aided in my acceptance, as well as raised suspicions about my motives.

The shared experienced of nursing and shared knowledge of the institution appeared to have been, for the most part, useful. Throughout the study I kept a reflective journal and met with a dissertation committee member to review data collection and analysis in order to maintain self-awareness of my role of researcher versus that of nurse and to develop and maintain objectivity.

Because of a realization during early reflections, I had to rethink the terminology I used to describe the type of observation I was engaging in. During the proposal stage of the study and for a short while on the units, I referred to myself as a participant observer and to the observations as participant observations. Although many staff members, referred to me to as “one of us”, my role was as a researcher. I did not participate in activities on either unit as a nurse, providing direct patient care, and soon realized I was not a participant in any meaningful way. Although a nurse, I chose not dress as a nurse, not wear scrubs, as not to blur the boundaries of my role with staff and, more importantly, patients and their families. I revisited the literature and found my experience
mirrored that of another researcher (Kite, 1999). After reading this researcher’s account of her experiences as a nurse observing nurses in practice, I recognized myself in her terms, as a “peripheral observer” or “apart-icipant observer.” From that moment, I referred to myself simply as an observer conducting observations.

Observation was overt and I dressed simply, in plain, solid-colored trousers and plain shirts or sweaters. My photo id badge identified me as a nursing researcher and as a student. At least six members of staff: nurses, patient care assistants, and managers, commented that my presence was quite obvious. I was told that I stood out. Much like the hand hygiene observers from Infection Control who patrol hospital patient care areas monitoring staff “foaming in” and “forming out”, everyone seemed to know when I was on the unit. A few members of staff expressed their concern that everyone would be on their best behavior when observations were taking place and that I would have nothing to report.

Measures and Indicators

The focus of observation, policy and document review, and interviews was to elicit perspectives on horizontal violence and language used to describe this phenomenon, as well as understand what the phenomenon might look like. Observation included taking note of appearance, verbal behavior and interactions, physical behavior and gestures, use of personal space, traffic patterns, and actions/interactions between staff. In creating an objective account of events and informal conversations, particular attention was paid to people’s body language and other information that may indicate conflict, for example, avoidance, tone of voice, gestures and posture, and content of conversations (Mack, Woodsong, MacQueen, Guest, & Namey, 2005).
Prior to the study, I created a table listing possible manifestations of behaviors associated with horizontal violence (Table 2). This table was used to categorize witnessed and reported behaviors during data collection.

*Ethics, Consent, Confidentiality and Human Subject Considerations*

Institutional Review Board approval for this study was obtained from Northeastern University. The institution hosting the study did not require IRB approval because I was not a currently member of staff, a student at the facility, or working with a researcher at the facility. A letter to this effect from the facility’s Institutional Review Board Office was obtained, as was a letter from the Nursing Director overseeing the units hosting the study, indicating I had permission to conduct research within the hospital. These letters were submitted as part of the IRB at Northeastern University.

The Guidelines for the Protection of Human Subjects were strictly followed. The purpose of the study, and risks and benefits of participation was explained to all potential participants, all staff on the units involved in the study as I encountered them in small groups or individually. Although general permission to observe was granted by the institution and by representatives of the units involved, individual members of staff were fully informed of my objectives within the unit and were notified in posted notices in the break rooms and charting areas and individually by me when I introduced myself, of the right to opt out of participation beyond observation by declining opportunities to engage with me. The consent process was ongoing. Participation in informal and formal interviews was voluntary and I notified participants that they had the right to withdraw at any time without penalty. Some staff that had been hesitant about talking with me during the first months of the study did consent to be interviewed. Only one person stated to me
directly that she was not interested in participating in any way. One nurse who had agreed to be interviewed later declined the opportunity. Consent was verbal, as suggested by Northeastern University’s Institutional Review Board, to better protect anonymity.

Confidentiality was of paramount concern and measures were taken to protect the identity of all participants. These measures include securing all materials and removing all identifying information. Pseudonyms were used in final notes and transcripts and have been used in this document and identified with asterisks (*). All notes, recordings and transcripts were stored under lock and key at a secure location away from the field site. All recording and notes taken on-site remained in my possession during the period of data collection. No materials were ever left at the research site.

Prior to data collection, it was acknowledged that exploring and recounting experiences of the phenomenon of horizontal violence might be distressing for some participants. All participants were notified in the description of the study and in the consent form that referrals to Employee Assistance Programs could be made as necessary. No participants felt the need for referral.

**Limits to Confidentiality**

Participants were notified that as a licensed nurse, I would, even if my role on the units was as a researcher, be legally mandated to report unsafe conditions or practices, suspected abuse of patients, and any suicidal or homicidal ideation uncovered in the course of data collection. These were identified as limits to confidentiality in the posted consent form and when the study was introduced verbally to members of staff. No reports were required.
Data Collection Methods

Prior to and during the first weeks of observation, data was collected to describe the unit. These measures included layout of the unit, number of beds, profile of patients cared for, staffing plans and patterns, and information about turnover, as well as information about the administrative hierarchy. This data allowed me to develop a picture of the site characteristics and resources. Originally I had intended to distribute a demographic questionnaire to all member staff to create a composite. Instead, demographic profiles of the two units were created using work schedules, seniority lists, credentialing information, and date of hire information provided by the nurse managers.

Initial observations focused on Spradley’s Nine Dimensions of Descriptive Observation (1980), including space (layout of the physical setting), actors (the names and relevant details of people involved), activities (the various activities of the staff), objects (physical elements: furniture and equipment), acts (specific individual actions), events (meetings, rounding), time (the sequence of events), goals (what individuals are attempting to accomplish), and feelings (emotions displayed in particular contexts). These dimensions served as a guide for initial observations. Nurses and other staff on the unit were observed in their normal day-to-day activities. Observations included informal interviews/conversations with staff to develop an understanding of the daily routine, use of language, workflow, and the role of the physical environment in potentially aiding or inhibiting horizontally violent behaviors. Observation and informal interviews during periods of observation were also used to identify relationships between staff, existing hierarchies, and rules and expectations of behavior, both explicit and implicit.
Observation and informal interviews occurred across all shifts. Documentation consisted of field notes (recordings of observations and conversations) and my subjective responses to data collected. Initial periods of observation were scheduled for approximately four hours and focused on periods during the day where staff was likely to interact. These periods include hand-over, rounds, medication administration periods, and any scheduled meeting or learning opportunity. The length of time of periods of observation and scheduling of these periods varied. A total of 75 periods of observation were conducted, lasting from one hour to nine hours, with the average period of observation lasting 5 hours.

Review and analysis of policies, distributed educational material, posters, assignment rosters, whiteboards, hospital forms, and other artifacts was part of the study. The intent of the purposeful sampling of existing documents, such as written policies, was to identify any behavioral expectations in order to compare and contrast that with what was actually occurring within the unit settings (Lincoln & Guba, 1985).

Once initial observations and document review were completed, phenomenological semi-structured interviews were scheduled with staff. Participants were asked to describe their experience and understanding of horizontal violence. Open-ended questions were used to better allow participants to elaborate on what was important to them. The majority of the formal interviews began with the question, “Why did you become a nurse?” I started with this question to help put the participant at ease and to build rapport. I then asked, “Is nursing different than you thought it would be before you went to nursing school or before you started working as a nurse?” and, “How?” This provided information about any disconnect between their nursing education and first
experiences in the nursing workplace, which allowed me to investigate their experiences as a student and new graduate nurse, two recognized targets of horizontal violence. Participants were then asked to describe “a good day at work” and “a bad day at work”. This allowed me to inquire about the work environment and relationships with colleagues. If participants mentioned any behaviors by colleagues that contributed to “a bad day”, they were asked to describe the types, characteristics, and diverse experiences that had in negative interactions with colleagues; to identify the triggers that may precipitate related behaviors; to identify how they responded to experiencing or witnessing these behaviors; and to describe how they thought these behaviors might impact nursing, their patients, and the unit. I derived some of these questions from a study of disruptive behavior by Walrath and colleagues (Walrath et al., 2010).

The majority of the interviews were digitally recorded with consent and transcribed verbatim. Notes were taken during these interviews (with consent) capturing participants’ reaction to questions and summarizing the responses in case of recording failure. The participants who did not consent to digital recording allowed me to take notes during their interviews. Transcripts summarizing those interviews were created from my notes. Interviews ranged in length from 15 minutes to 2 hours.

Overlapping of Data Collection Strategies

Data collection strategies were modified throughout the data collection process. Using observation, document analysis, and formal and informal interviews together allowed me to contextualize what participants reported in relation to their everyday practice and to cross-check information and compare actual behavior and views to
reported behavior and views, as well as those prescribed or implied in policies and other documents.

Qualitative data collection and analysis are recognized as dynamic, interrelated processes where the researcher analyzes existing data before narrowing the focus of the research and exploring emerging concepts by collecting additional data (Spradley 1980). As such, data collection and analysis informed the adaptation of interview questions, as well as any alteration in approaches to additional data collection and analysis, such as the recording of field notes.

Managing Data

Field notes were recorded during or shortly following every period of observation and informal interview. These notes included descriptions of what was observed and details of any interactions, as well as any questions, thoughts, and reactions I had about what was observed. These notes were expanded upon in memo form after the period of observation was completed to include further detail and to allow for reflection. During the first few months of data collection, notes were shared bi-weekly with a member of the dissertation committee who is experienced in qualitative methods to aid in the reflexive process and as a chance to debrief and make changes and improvements to the approach, identify possible researcher bias, and to assist in identification of emerging issues or problems.

I had originally designed a field note form to standardize my observations and note taking. This form was 8½” x 11” and kept on clipboard which I carried. After a few days on the units I began to taking notes on index card sized pieces of paper that I kept
out of view in my pocket, as some staff complained that they didn’t like seeing me with a clipboard or writing things down.

Recorded interviews were transcribed verbatim. Summaries of non-recorded interviews were created from notes taken during the interview. In transcribing and summarizing these interviews, identifying information was removed. Pseudonyms were used to further assure confidentiality.

*Analysis and Coding*

All field notes, notes from the analysis of documents, memos, and interview data were transcribed into a computerized format. Field notes, results of document analysis, and interview transcripts were coded and analyzed from the first moment of data collection on index cards then, as coding became more concise, the information was transferred to the QDA Miner 4 software (Provalis Research). Ultimately, however, the majority of coding was done using index cards, manually sorting and resorting until categories of data were identified and refined.

Analysis and coding focused on themes. Thematic analysis involves the systematic examination of data that allows for the recognition of potential themes and common elements within collected data (Boyatzis, 1998). It is described as being more flexible than content analysis, which relies on the repetition of words in transcripts (Scherl & Smithson, 1987). Both inductive (from the data) and deductive (from theory) theme development and coding were utilized in this study, as described by Fereday and Muir-Cochrane (2006).
Validity and Reliability

Validity and reliability are terms not generally viewed as relevant in qualitative studies. Lincoln and Guba (1985) use the term trustworthiness as a corollary to validity and reliability. Criteria for trustworthiness include credibility, transferability, dependability and confirmability. These require that the research findings represent the realities of the participants truthfully and consistently. This is determined by the researcher’s ability to capture and share the truth and universality of the setting and the experiences of people within that setting.

Extended time in the field assisted me in establishing trust and rapport, so that participants were willing to share experiences and perceptions openly. This allowed me to develop a more accurate understanding of how things worked on the units. The use of multiple data collection methods helped to create an accurate depiction of the unit, staff and their experiences. Truthfulness and credibility was achieved through accurate depictions of the unit and staff that were confirmed as accurate with participants, and through the use of thick description. This was furthered through sharing the findings with participants whenever possible either during or following the interviews to assess whether or not these represent the reality of the unit (Miles & Huberman, 1994).

Study Limitations

This study involved observation of behaviors that are often identified as difficult to capture, often happening behind closed doors, and inquiry into behaviors that are often not recognized and are often minimized (Forest, Eatough, & Shevlin, 2005). I hoped that by committing to close observation and engaging with staff over a prolonged period of time, these behaviors could be observed and explored further. While I was able to witness
behaviors between members of staff that met many of the definitions of horizontal violence described in the literature, I am aware that my presence may have inhibited behavior or moved it to areas away from the Unit Secretaries’ desks, medication room, and charting areas, where most of my observations took place. On a number of occasions, I was made aware that I had missed an event when someone would tell me, “Oh, you should have been here yesterday. You missed it” (PCA), “You know, when you aren’t here ‘lateral violence things’ happen right out in the open [in front of the desk]” (Per Diem RN), and, “You’re just here on the wrong days ” (RN).

I was the sole researcher, increasing the possibility of error and bias. In addition, this study focused on two nursing units sharing a floor within a single hospital in Central Massachusetts and their staff as units of analysis and investigation, limiting generalizability. The study was conducted during a time when the nurses at this unionized facility were working without a contract (the contract was ratified approximately 6 months after data collection ended) and during a period of recent layoffs. The fear of potential job loss in this climate may have contributed to increased horizontal violence and other negative behaviors (Sidle, 2009), despite participants’ identifying conflict between coworkers and systems problems as ongoing issues.

Findings may not be readily transferable to other nursing units and their staff. However, presenting these nurses’ perceptions of horizontal violence may resonate with other nurses and their experiences of the phenomenon. Results of this study may be used to modify existing interventions and to contribute to the design of new interventions to improve recognition and reporting of the problem and reduce horizontal violence in the nursing workplace.
Chapter Four begins with a summary of the data collection process and followed by a description of the setting. Findings based on document review, observations, and informal and formal interviews are presented, followed by descriptions of themes emerging from the data collection and data collection experience.
Chapter 4: Findings

Summary of Data Collection Process

Data collection for this study began in June 2012 and was completed in November 2012. Prior to commencing observations on the two units involved in the study, policies related to behavior and behavioral expectations were obtained from the facility’s intranet, Human Resources Department, and Health and Safety Department. Initial document review focused primarily on the hospital’s Workplace Violence Prevention Policy (Appendix H) and the section “Respecting One Another” in the facility’s Code of Ethics and Business Conduct (Appendix I), two documents that were accessible to any employee of the facility.

Nurses and other staff were aware of a number of initiatives that had been trialed on the units over the years, as artifacts of these initiatives (posters) remained hanging on Unit B*. These included “Commitment to My Co-workers” (Creative Health Care Management, 2010), the Proclamation for Patient-Centered Care (Planetree, 2007), and Palomar Pamerado Health’s Nursing Model for Relationship-Based Care (Palomar Health, n.d.). Hospital and unit mission and vision statements were also reviewed (Appendices E, F, &G),

Approximately 370 hours of observation took place across the two units. Initial observations focused on developing an understanding of the unit. Subsequent observations focused on behavior between staff.

Thirty-five interviews with staff and members of administration were completed. These included interviews with two nurse managers, two nurse educators, two patient care assistants, two unit secretaries, twenty-two nurses, and five administrators from
Human Resources, Quality and Safety, Patient Experience, and Risk Management.

Seventeen interviews were digitally recorded with permission and transcribed verbatim.

Eighteen interviews were not digitally recorded, per participant request. Transcripts summarizing interviews that were not digitally recorded were created from notes taken (with permission) during the interview or shortly after.

*Document Review and Analysis*

Documents were analyzed using a data analysis worksheet adapted from worksheets developed by the education staff at the National Archives and Records Administration, Washington, DC.

The Work Place Violence Prevention Policy was developed by Human Resources and available to all employees via the hospital intranet. The policy defined workplace violence as “any physical assault, threatening behavior or verbally abusive remark that is made in the workplace and/or affects the workplace behavior of an employee” and listed a range of reportable behaviors, ranging from “verbal threats, intimidation, or coercion” to “any unauthorized use or possession of firearms.” The policy emphasized the importance of reporting behaviors that posed imminent threats to safety.

Four sections of the facility’s Code of Ethics and Business Conduct relevant to behavioral expectations were reviewed. A Joint Commission leadership standard effective January 1, 2009, requires all hospitals adopt and implement a code of conduct that defines and manages disruptive or inappropriate behavior. This hospital’s Code of Ethics and Business Conduct identified that intimidating and disruptive could be verbal or physical. Examples include “verbal outbursts and foul language; sexual harassment in any form; physical roughness; threats; refusing to perform assigned tasks; quietly
exhibiting uncooperative attitudes during routine activities; reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions” (Appendix I). A Human Resource representative reported little success in pursuing behavioral complaints unless the complaint of harassment was actionable under Equal Employment Opportunity law, based on allegations of discrimination based on race, color, sex, national origin, religion, age, disability, sexual orientation, or related to reprisal.

Other documents reviewed during the course of data collection included posters left from initiatives trialed at the facility. These included “Commitment to My Co-Workers” (Creative Health Care Management, 2010), posted on the door to the Nurse Educators’ office on Unit B*, the Proclamation for Patient-Centered Care (Planetree, 2007), and Palomar Pamerado Health’s Nursing Model for Relationship-Based Care (Palomar Health, n.d.), both hanging at the Unit Secretaries’ desk on Unit B*. Although none of these initiatives were currently funded, the Relationship-Based Care model lived on in RBC Committees on each unit that focused on the addressing related issues. As part of the Planetree initiative, nurses were given control over some resources to improve their patients’ experience. That funding was no longer available. As one nurse on put it, “Planetree was about caring. Now that we don’t have it, we obviously don’t give a shit.” The lasting impact of “Commitment to My Co-Workers” was staff trying to recount the “3 Bs” (Bickering, Back-biting, and Blaming). The first line of the pledge reads, “I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you [my co-worker] and every member of this team.” One member of staff suggested, “Things like that should be taken down because it’s just not true.”
The hospital Mission, Vision and Values Statement was downloaded from the hospital webpage. The Unit A* Vision Statement and the Unit B* Mission Statement were transcribed verbatim from postings in each unit’s break room. Each of these statements mentioned either respect and/or collaboration as part of their mission or vision. None of these documents was mentioned to me in any interaction with staff.

The Two Units

As part of my orientation to the units, I drew a map of each and labeled the function of each room (Appendix J). Both units were located on the same hospital floor and were essentially mirror images of one another with some variation in use of space. Staff and visitors would enter each unit through sets of double doors on opposite sides of a bank of elevators. On Unit A*, the Unit Secretaries’ desk area was on the right as you entered the unit. On Unit B*, it was on the left. Patient charts were kept at the entrance to the desk area, which often resulted in congestion at change of shift or during rounding. The Unit Secretaries’ desk was the heart of the unit and the center of activity. This is where the majority of my observations took place.

Supply closets, the medication room, a kitchen, and a conference room were shared between the two units. Each unit had their own break room and charting areas. Charting areas on Unit A* included a small office with a door behind the Unit Secretaries’ desk, which had two stationary computers on the desk area on the left wall and usually accommodated an additional portable computer cart in the corner. There was an open alcove to the left of that office with two computer stations, a space that was utilized by both physicians and nurses. Between the two Unit Secretaries’ desks were additional stationary computers.
Unit B* mirrored Unit A*, except the office with a door behind the Unit Secretaries’ desk was the Nurse Manager’s office. The alcove to the right had additional two stationary computer stations. Additional charting areas on Unit B* included another alcove to the right of the entrance to Unit B*. On Unit A*, this area was used for storage, stretchers and wheelchairs below and shelves with patient care supplies above. There was a small room just past the entrance to Unit B* with a small sign reading “Family Room”. It was often occupied by three or four nurses and their portable computer carts. A few of the day shift nurses referred to this room as their “office”. Both units had additional portable computer carts and computers in drop down desks along the hallways between patient rooms.

The medication room, which doubled as a storage area, was shared. During medication administration times, the nurses formed lines behind each of two Pyxis machines, computerized medication dispensers. Behind the medication room was the Nursing Conference Room, which again was a space shared by both units. It was used daily by staff on Unit A* at 11 am and intermittently as a meeting room for any nursing students and the instructors. On nights, it often was used as a break room by Unit A* nursing staff, allowing them to stay closer to the central desk area. The bulletin boards displayed results of recent initiatives, as well as Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) scores for each unit, reporting each unit’s results in the standardized, publically reported survey of patients’ perspectives of the hospital care they received.

During initial observations, in conversation with staff, both Unit A* and Unit B* were identified as two of the better units to work on within the facility. Float staff
referred to both units as “safe units”, units where patient assignments would be fair and that help would be available if needed. A few nurses and patient care assistants shared that they had chosen to take part or full-time positions on one of these two units because the environment was more supportive than other care environments within the hospital.

Mood of the Units

Staff often described the mood on the unit as “palpable”, especially on day and evening shifts. The mood was described as “chaotic, but controlled”. Sometimes staff described the units as “thick with stress”. When there was anxiety, nurses described it as “contagious”. Most nurses reported that the chaotic environment didn’t bother them, however. When patients were acutely ill, especially if they “crashed” (experienced a rapid decline in health status requiring immediate intervention), the nurses felt confident that they could manage the situation, especially with the resources that were often available in those situations, such as the STAT Nurse. What nurses described as distressing was trying to plan a course of action for the day and experiencing disruptions, when meds were not available or communications were missed.

Workflow

Most physician teams rounded on the day shift. The majority of off-unit tests and treatments were done during the day. Two meals were served during the day shift and the majority of daily medications were administered in the morning. Most personal care also occurred in the morning.

The majority of admissions and discharges happened after 3 pm. Evening shift nurses juggled discharge teaching and new admissions. On any given day, upwards of ten
patients, approximately one-third of the patients on either unit, were discharged. The evening shift also provided an evening meal, as well as evening and bedtime medications.

There were few discharges on nights, although some admissions arrived on the night shift, usually earlier in the shift, sometimes at shift’s end. There were no teams of physicians rounding and fewer off-unit tests. There was no unit secretary on nights. Night shifts were generally quieter.

Nurses filled the area behind the unit secretaries’ desks around change of shift. Handover, which used to be face-to-face, now consisted of the oncoming nurse reading the previous nurse’s note, and the nurse who was headed out asking if there were any additional questions. Some nurses were relieved when handover essentially became computerized. Others reported missing the interaction.

Medical teams were geographically assigned on Unit A*. There were ten internal medicine teams that rotated coverage on that unit. Each team consists of one Resident and two Interns. At 8:15 am, the case manager and resource nurse reviewed the patients and identified potential discharges. At 11 am, the case manager, nurses, social worker, and members of the medical teams, including attending physicians, met in the Nursing Conference Room to confirm discharges and potential discharges. There was another period of rounding at 4:15 pm.

One specialty surgery team covered the majority of the patients on Unit B*. This team rounded at 6 am. The case manager met with nurses in the Unit B* break room to discuss discharges and patient statuses at 11 am.

Staffing ratios across the shifts were similar: Day shift – 6 or 7 Nurses (RNs), 4 Patient Care Assistants (PCAs), 1 Unit Secretary (US) until 11 am, then 2 USs 11am-3pm.
Model of Care and Patient Assignments

The model of care at this facility was primary nursing. Efforts were made to assign the same nurse to the same patients whenever possible to promote continuity of care. Patient acuity was also a factor in determining assignments, which were generally made by the Resource Nurse on the previous shift. Nurses on both units were assigned to care for three to six patients, some at opposite ends of two long hallways in order to preserve primary nursing and share the burden of higher acuity patients.

Despite recognition that this practice resulted in wasted time and energy, contrary to “lean” initiatives that had recently been introduced to the facility, and that nurses felt the practice was unsafe, I observed that at least one nurse on each shift on both units had an assignment that was geographically challenging. I wasn’t the only one to notice it. During my observations, I helped a doctor look for a nurse who had such an assignment. She had been assigned patients at the ends of the two halls. I took one hall to look for her, as he took the other. Later he asked me, “Her patients are so far away. Are they trying to screw her? (Surgical Staff)”

Unit Similarities and Differences

Unit A* had a higher percentage of younger and newly graduated nurses than Unit B*. This was expected as working on a medical/surgical unit is often seen as a “stepping stone” to other positions. As a specialty unit, Unit B* had a higher percentage of more senior nurses. Unit B* nurses with greater than 5 years of experience were more likely to have their Bachelor’s or higher level degree than those on Unit A* (9 out of 21
versus 2 out of 18). On both units, about half of the nurses with 5 years of experience or less were Baccalaureate prepared. Approximately 60% of the nurses on each unit worked 32 hours per week or more, and 40% were per diem or worked 24 hours or fewer.

As a general medical/surgical unit, Unit A* cared for patients presenting with a wide variety of medical diagnoses, a number of whom also had underlying psychiatric and/or addictions issues. The staff on Unit B* served a specific population of complex surgical patients, but also took general medical surgical patients. The use of sitters, staff assigned to sit with patients at risk for self-injury, was high on both units. Security was called to both units a number of during periods of observation.

The managers on both units had approximately three to five years experience managing the units. Both described inheriting many of the problems in their work environment and described some of the remaining conflicts between members of staff as resulting from lack of management or mismanagement under the previous managers. Both nurse managers addressed conflicts with the individuals involved, when identified, and both felt their unit culture was “improving”.

Although the units shared a floor and there was an open wall between them, for the most part, staff did not interact, except occasionally to talk in the medication room. Unit A* did provide back up in a multiple code situation I witnessed on Unit B* that occurred just before morning handover, but that was not the norm.

They were different units. Members of staff on each unit identified strongly as belonging to the unit on which they worked, with allegiance to their coworkers, despite reporting difficulties with some of them. Staff on either unit identified the other unit as
“them” or “that side, over there.” Staff also verbalized strong allegiance to their unit’s Nurse Manager.

Observation Focused on Behavior

Once a sense of how things worked was established, observation focused on behaviors and addressing the following research questions: “Is the phenomenon present and can it be observed?” “If so, what does it look like?” and “What factors contributing to horizontal violence can be identified through observation?”

I observed both helping and non-helping behaviors. Nurses, especially in the role of Resource Nurse, offered assistance to other nurses, as this was an expected part of their job. Patient Care Assistants often worked together, especially when assigned to the same hallway of patient rooms. Nurses and other staff answered call lights and alarms for one another, stepped in and offered help, started admission paperwork, or gave medications for a nurse who was busy with other patients. Postings in the break rooms and charting areas indicated that staff supported one another in celebrations and in times of need: gift giving for new babies, get well cards in times of illness, sympathy cards when a staff member lost a family member, and collections and donation of time earned when someone had used all of their own sick and personal time.

Initial observations of non-helping behaviors focused on manifestations of behaviors associated with horizontal violence described in the nursing literature (Table 2), both overt and covert. These included non-verbal cues and innuendo, verbal remarks and verbal affront, actions and inactions, withholding information, sabotage, infighting/clique behaviors, scapegoating, passive aggressive, and broken confidences. Despite being told by nurses on both units that I would not see anything, as my presence
was overt and every employee was made aware of the purpose of my study, the phenomenon was present and observable.

I witnessed all of these behaviors except for sabotage and withholding information. Assessing intent in withholding assistance was difficult. It was impossible to know if someone was busy and unable to help or deciding not to help, except when they said aloud that they were not going to help a colleague because that colleague never helped them, which I overheard occasionally.

Many of the behaviors I observed at the desk area involved a general lack of courtesy or respect. Eye rolling and face making in response to questions or requests were common. Staff were often short with one another, especially during periods of high activity, at change of shift, or as patients were admitted or discharged. When I heard “please” or “thank you”, it was jarring because it was uncommon. There were daily episodes of verbal abuse, shouting or using a condescending tone of voice, between staff at all levels both in person and over the phone. Verbal abuse was the most commonly observed behavior, specifically rudeness, a finding shared with Farrell (1999). Among the many episodes, I witnessed physicians yelling at one another on the phone and in person, physicians yelling at nurses on the phone, physicians speaking to nurses in a condescending tone, nurses speaking about physicians in a condescending tone, nurses raising their voices to unit secretaries, and doctors yelling at and rolling their eyes at unit secretaries when charts couldn’t be immediately located. In general, nurses did not yell at one another at the desk, but used sarcastic and condescending tones of voice, often in describing conflict with a colleague to another colleague.
I was told that a nurse who reported a medication error was publicly called out for this error, which she had freely reported, in an abusive tone in front of other nurses in the medication room one day. A witness reporting the initial incident to me described, “Everyone felt uncomfortable, but no one wanted to report it because they were afraid of retaliation” (RN). Although I did not witness the episode in the medication room, I witnessed the continued harassment related to this error the next day, as one nurse followed the nurse who had made the error around for the better part of the morning, watching over her shoulder. At one point, the nurse who had made the error turned to the nurse who was now behind her at the desk and asked, “So are you going to yell at me again today? I am trying to keep up.”

The presence of cliques was subtle but visible. Subsets of nurses on different shifts worked together, took breaks together, and were known to socialize with one another outside of work. When a nurse not part of the “in” group was working a shift with such a group, he or she often sat away from them and worked alone. While being part of a clique provided support and encouraged teamwork between members, working on a shift as nurse who was not part of the clique was isolating.

Based on my observations, at least one nurse on each unit was scapegoated. These individual nurses were labeled and disproportionately blamed for creating the negative work environment. In conversation with the nurses from both units, one nurse on each unit was singled out as “a problem”. On one unit a few nurses identified a colleague as “a bully”, but that nurse reported to me that she was the one being harassed, both verbally and physically. Sharing that she had previously had personal issues that may have affected her work, she was working to reestablish herself and her reputation now without
support. She reported that her coworkers didn’t speak to her, wouldn’t help her, and that some would physically walk into her in the hall, setting her off balance, and keep walking. On the other unit, another nurse was labeled. In conversations with nurses on that unit, many off-handedly refer to her as “The Complainer” rather than by her name. This nurse described to me that a colleague anonymously reported her to the Nurse Manager as “passive aggressive” and that she was called into the manager’s office and told this. She was not provided with examples of her passive-aggressive behavior or provided with any suggestions to address the issue. She was thinking about looking for a position elsewhere.

Gossiping was an activity that I witnessed and that nurses on both units acknowledged as taking place. Although many took part in talk at the desk and in the break room, when asked about the behavior they often distanced themselves from the destructive aspects of gossiping, describing it as “a way to blow off steam” or “it’s what we do for fun”.

Another behavior I observed, that fit somewhere between verbal affront and backstabbing, was mimicking. One morning as I stood by the desk, a senior nurse asked the Resource Nurse if one of her more acutely ill patients could be assigned to someone else for the day. She stated that she had had the patient for a number of days in a row and “needed a break”. The Resource Nurse agreed to make the switch. When the nurse requesting the change was barely out of earshot, a nurse colleague who had been standing nearby mimicked her walking away and in whiny voice said, “I’m too busy”, then in her own voice said, “That’s what you’re here for. To work.” Later that day, the nurse who was mimicked told me she was sure the nurse who was now assigned her heavy patient
“must be talking about me now.” She sighed, “I just needed a break.” In another instance, as a nurse hung up the phone after taking a verbal report about a patient being transferred to the floor from another unit, she mimicked the accent of the nurse she had just taken report from at the Unit Secretaries’ desk for all to hear.

**Staff Experiences and Perceptions of the Phenomenon**

Nurses and other staff shared their perceptions and experiences of helping and non-helping behaviors in formal interviews, and informal interviews. The majority of staff that interacted with me felt morale on the units could be improved and that some of their colleagues demonstrated “unprofessional behavior.” Certainly the recent threat of layoffs and ongoing contract negotiations were a factor, but the most felt the issues affecting morale had been going on long before contract negotiations began.

Helping behaviors described included answering call lights and alarms for other nurses, offering assistance, and providing emotional support after a code situation or if a colleague had issues at home. Most nurses reported that they could anticipate what kind of a day they would have as soon as they arrived and found out with whom they would be working. “Coworkers affect your work.” “Your relationship with your PCA can make or break your day.” In one interview, a nurse described a good day at work as, “Teamwork. Communication. People being pleasant.”

Conversations about bad days at work led to discussions of horizontally violent behaviors. There was a variety of non-helping or horizontally violent behaviors described by staff. These included name-calling and labeling, gossiping, backstabbing, reporting or threatening to report, and refusing to assist when asked.
A number of nurses on one of the units reported an administrator had called them “fucking lazy nurses” when they each refused to go off unit to treat a patient in another care area, citing the complexity of their current patient load which they would have to hand over to already overstretched nurses. Six nurses, one who took the issue to the nurse’s union, reportedly witnessed this. The administrator denied using the expletive, but after time, reportedly admitted to calling the nurses “lazy”. One of the nurses pointed out to me that they didn’t usually take any breaks, even for lunch, on most days, and being called lazy indicated a lack of respect for the work they did with diminishing resources. They believed the administrator should have been reprimanded. She was not.

Nurses who reported problems with coworkers or even with inefficient systems voiced a fear of being labeled. If they reported a colleague, the might be labeled “a snitch” or somehow they would become “the problem” when blame would be focused on them. If they reported missing medications, delays in transport, or problems obtaining supplies, they stated they might be labeled “a complainer”.

In interviews, gossiping was acknowledged. One nurse described observing a coworker perpetuate a campaign of gossip. “I had an experience where someone said something out of context and it was talked around. Someone planted a seed and watched it grow. Our floor likes gossip. I don’t know why.” (RN)

Many of the nurses described themselves as conflict avoidant. Rather than confront another member of staff with a concern or complaint, they would voice that complaint to an audience of peers, resulting in backstabbing. Nurses on committees described that colleagues would act friendly and supportive of one another in meetings,
but undermine their peers behind closed doors. “They are polite to your face and talking about you as soon as you walk away.” (RN) The nurse summarized the result,

When a nurse says something about you to another nurse who doesn’t know you, it taints that other nurse’s view of you, poisons their mind. It makes you less effective, less respected. They heard something bad about you and they are building on that, and that may not be the truth.

Nurses on each unit identified that reporting or threatening to report could be a form of abuse of power. Some felt reporting was done out of spite. “Some people write you up as a hobby.” (RN) “Writing up can be a form of retaliation. They can be used by nurses to complain, or bitch”. (Representative from Patient Safety) One nurse noted and shared with me a pattern she had observed. When she was assigned to be the Resource Nurse, a colleague routinely wrote her up, claiming her assignments were unfair, a form of manipulation.

Lastly, most nurses felt they had trouble getting assistance when they needed it. It was difficult to know if someone was refusing to assist or was genuinely busy, as the workload was heavy and it appeared that there was always more to do than time to do it. However, a few nurses admitted to refusing to assist certain coworkers when asked, openly admitting to not helping colleagues who did not help them.

A few nurses shared more extreme examples of abuse. A float nurse described leaving a job in an Intensive Care Unit after reporting a coworker who had grabbed her by the stethoscope that she had been wearing around her shoulders and pulled it tight around her neck, saying, “I don’t like you.” I asked why she thought her colleague had done this and she replied, “I knew it wasn’t about me, I hadn’t done anything.” When she
reported it, the manager told her, “It’s a known fact that ‘nurses eat their young’. You just have to deal with it.” When she took her report to the union, she felt she was now seen as “the problem” and described a number of ways the manager attempted to intimidate her and tried to get her fired. Reporting to work nauseous everyday because of the stress, she ultimately left the unit. She insists that there were no sequelae, but states that she will never work in an ICU environment again.

Another nurse told me about an incident resulting from conflict with a coworker. She and a nurse colleague, whom she identified as a friend at the time, were having some sort of miscommunication and she wasn’t sure what exactly the problem was, so she set aside time at the end of the shift to inquire. “I approached her to make things better. I expected us to agree that it was a misunderstanding.” She planned to discuss this at the end of the shift and asked her friend if they could talk on the way out to their cars. She said as they were walking through a public area of the hospital, the colleague unexpectedly verbally assaulted her in “a barrage of name calling and blaming.” She described the event. “I felt like someone had died. My insides were ripped out. I had plans for after work, but instead I just went home and went to bed.”

In another case, a nurse who had been out on medical leave for a number of months was concerned about returning to work. She felt unsure about her practice after time away and was relieved to have one of the younger nurses offering to help. New equipment was in use and this young nurse volunteered to provide instruction. She described that she was thankful for the assistance until the day she walked in to hear this nurse mimicking her in front of group of nurses in the break room. “Turns out they would give me the help and then they run to somebody else that was a staff member and make
fun of me.” “I just felt very hurt. I didn’t realize… then I was wondering what other people were thinking of me. You know, instead of getting the support I thought I was gonna get when I came back, I was just having such a hard time and afraid to ask anybody questions.” Neither of the last two cases was reported. The two nurses who described being berated and publically humiliated by a coworker both described not thinking of those instances as horizontal violence or reportable.

What’s Reportable?

Most members of staff, other than the Managers and Nurse Educators, were not familiar with the Workplace Violence Policy or the Code of Ethics and Business Conduct. They did not have a clear sense of what behaviors were reportable. One evening, after an admission arrived from the Emergency Department (ED), the nurse receiving the patient asked aloud, “If the ED sends up a patient and the paperwork isn’t done, is that horizontal violence?” Under the definition of intimidating and disruptive behaviors used by the Joint Commission (2008) that includes “passive activities such as refusing to perform assigned tasks”, it may be.

The hospital Workplace Violence policy appeared to minimize the importance of reporting verbal aggression, focusing on imminent threats and more extreme forms of aggression. The policy did include “verbal threats, intimidation, or coercion” as reportable under the section further defining prohibited behaviors workplace violence as, “any behavior that could be construed as threatening, overly aggressive, confrontational, or violent”, but listed these behaviors with more extreme behaviors, such as carrying a firearm.
The Code of Ethics and Business Conduct, on the other hand, outlined workplace conduct expectations.

Intimidating and disruptive behaviors are unprofessional and not tolerated.

Behaviors that are considered intimidating and disruptive can verbal or physical. They include verbal outbursts and foul language; sexual harassment in any form; physical roughness; threats; refusing to perform assigned tasks; quietly exhibiting uncooperative attitudes during routine activities; reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.

The Code of Ethics and Business Conduct did not appear to be enforceable. Some nurses suggested that everyone should have to abide by some behavioral code as a condition of employment, sign an agreement and have it be binding, but there was no such requirement. The study findings indicate that intimidating and disruptive behaviors were tolerated on both units.

*Reporting*

Some reports of conflict between staff were brought to the nurse managers. However, both nurse managers expressed frustration with reporting because it was often related to something that had been ongoing or happened months ago, and was therefore difficult to assess and treat. In addition, staff were often unwilling to identify the person behind the problem by name.

The fear of retaliation is a barrier to reporting which is a major barrier to creating change. Everyone should be involved in creating the environment they want to
work in. If they want change, they have to act, speak up. How can I act if no one will give me names? (Nurse Manager)

In cases where parties were identified, the nurse managers worked to resolve the issue. Verbal warnings and reminders were the most common result. There were barriers to success, however.

The persons having the conflict are often unaware of their own behavior. Once they are brought in they are aware for a while, heightened awareness, and they are on good behavior for a while, but tend to fall back into their ways eventually. There are a couple employees I have to pull in every couple of months to remind them about perception. (Nurse Manager)

Anything that could not be resolved by the Manager, involved the Manager, or met criteria for sexual harassment or discrimination was passed on to Human Resources. The Human Resources representative reported that very few cases made it to their level. Nurses sometimes brought issues to the attention of representatives of the nurses’ union, if it involved two nurses. Some nurses described that bringing a complaint to the union was not usually satisfactory, as the union represented both nurses and disciplined neither.

Again, in bringing an issue to the manager or to the union, there was a fear that you would be labeled “the problem” or “a complainer”. There was also a sense that if you were involved in a conflict with a coworker and they reported you first, they would be believed and supported over you. It appeared to be a no win situation, especially if reporting did not bring change.
Attributions

In interviews and conversation, nurses attributed colleagues’ negative behaviors to a number of causes. Most focused on individual personalities and personal characteristics as being at the root of the problem; “It’s primarily a personality problem.” (STAT RN) “Personalities are the issue. People know who they are.” (RN) “We have a couple of bad eggs, but we won’t let it get us down.” (Unit Secretary)

Problem behavior was also tied to work ethic. “It’s all about working. Some people work hard, some don’t. It’s frustrating.” (RN) Related to work ethic, staff had issue with a real or perceived lack of accountability. “Bad nurses get to stay without repercussions.” (RN) “You can have a terrible work ethic and still work in this job, and that stinks for everybody.” (RN)

Some nurses suggested that burnout was a contributing factor. “There is cattiness in groups here. People talk crap and call it ‘venting’. They’re burned out.” (RN) Others felt it was about life outside of the hospital. “Sometimes people can be unpleasant. I can trace it to unpleasantness or discontent in their personal lives.” (RN).

Generational differences and expectations were also cited.

There is friction there, between the younger and older nurses. I think there is a tendency for the younger nurses to be high energy, to be efficient, to do everything, and to do everything right for the next shift. The older nurses are a bit more, and I am one of them, they have a tendency to be a bit more lazy when it comes to that (RN).

A number of female nurses felt the problem was a “woman thing”, noting the different ways men and women acted in conflict. “They [the male nurses] just sit back
and watch. They think it’s absurd how women interact.” (RN) “Females hold grudges a lot more than the males. Males have a tendency to let it go, blow it off, and move on.” (RN) “Women don’t like confrontation.” (RN) “We need more male RNs. They don’t overreact… If it’s not a big deal, it’s not a big deal.” (RN) “The male nurses don’t get involved in gossip. They just don’t get involved. They are more set back, more calm. They help keep the unit calm. They don’t get involved in bickering.” (RN) “Women are always comparing what they have. If I had two baked potatoes and I gave one to each woman, they would look at each others’ to see who got what.” (STAT RN) There were approximately four male nurses working between the two units. I asked one about his perception. He declined the opportunity to theorize and replied, “I’m not gonna go there.”

One nurse shared that her perception that the phenomenon was the result of being female and nurses’ place in the medical hierarchy.

It’s because I think nurses were stepped on all their life by doctors. But I also think that women are nasty to one another… And I think it’s because they were so beaten down. And nurses are so beaten down over the course of years. For example when you had to get up when a doctor came into a room so he could sit in your chair. Or over at the endoscopy clinic, the doctors have a fit when the nurses sit down. That’s an OSHA violation. And that’s still going on today… I think the behavioral stuff goes way back, and I think it’s a learned behavior from the way women were treated way back. (Float RN)

Nurses were aware that avoiding confrontation and conflict could exacerbate the problem. “Grudge holding is here all the time. People need to get over it. Confront that person. Be direct.” (RN) “Put on your big girl panties and say what you mean.” (RN)
Nevertheless, most of the staff reported avoidance was their most common reaction to difficulties with a coworker.

Other Stressors

Staff identified environmental factors and systems problems as stressful and as potential triggers contributing to negative behaviors. “When things gets busy, people get angry.” (RN) “Systems problems make people short with one another. It’s the systems problems that make someone appear to be having a bad day.” (RN) “In general, people are good, and then you put them into this stressful environment…” (RN) “Definitely the environment here. It’s extremely stressful here… You’ve seen it here. Just nuts at times. And the tension level and stress level of that, you can tell. You can feel it in the air.” (RN) “Everybody is like, ‘Don’t touch me ‘cause I am really busy right now’… The environment stress level [is a factor]…definitely.” (RN) “The stress on the unit. When there is stress you are going to see these behaviors. It’s a way to cope. People don’t know how stressful the job is.” (RN) “The biggest thing is the patient population. High-risk behaviors in the population. Drug seekers. Alcohol abuse. Difficult patients that burn the nurses out” (Nurse Manager).

Systems problems included medications and supplies not being available when needed, delays in transport, poorly managed discharges, and admissions arriving at change of shift. These problems were compounded by a sense that “nothing changes” and a perception of disconnect with administration.

In addition, lack of good communication was identified as a factor. Nurses described not being made aware of new orders, not being included in rounds, and missing
overhead pages. “Communication is awful in this institution and leads to hostility. Lots of excuses and blame.” (RN)

Abuse by patients and family members was also identified as a source of stress and distress. Staff felt there was no recourse for verbal abuse and threats by patients and family members. “The culture is to please the patient. If you get punched or piss thrown at you, no one comes to support you.” (RN) “The patient is always right. The patient rep always sides with the patient. They can say anything they want and you can't respond.” (RN) This is one area where staff on both units felt wholly unsupported by Nurse Managers. Despite evidence that verbal abuse by patients and family members adversely affects staff ability to perform their jobs, increases the risk of error, and can result in job dissatisfaction (Henderson, 2003), there was no policy at this facility specifically protecting staff from non-physical abuse by patients and their visitors.

Course of Action/Inaction

When data collection was completed, I drew a model demonstrating the possible courses of action after a negative interaction, or “event”, with a colleague (Figure 2). Possible actions, based on observations and interviews included: Inquire/Confront, Report, Minimize/Ignore/Avoid, or Retaliate.

Although many of the nurses felt that they should communicate more directly about conflict, inquire or confront, most did not. Mahon and Nicotera (2011) describe nursing’s professional culture as conflict avoidant. Many nurses in this study described themselves as conflict avoidant, yet there were limited resources for them to develop conflict management skills. All physicians at this facility were required to participate in a two-day course to work on communication skills and managing confrontation. While this
training was mandatory for all medical staff and physicians were paid to attend, the training was elective for nursing staff and would require manager approval to be paid for participation. While I was observing on the units, I was aware of only two members of staff attending the two-day workshop. A nurse and a PCA were sent to the workshop punitively when their working relationship became so strained that they could no longer be assigned to the same shift. A representative from Quality and Patient Safety was surprised to learn that the course was being used as a punitive measure and not required for nursing staff. “Everyone should take it.” (This representative worked primarily with physicians.)

Reporting was encouraged in rhetoric and in policy but not enacted by many members of staff. Lack of recognition of events as reportable appeared common, but a sense that reporting would not result in change and could result in some form of retaliation was pervasive.

The most common course of action was to minimize the behavior, ignore the behavior, or avoid the person enacting the behavior. Nurses minimized the behaviors when they attributed them to an individual’s personality, “That’s just how she is”, or “He’s just having a bad day”, or a one time behavior. A student nurse told me that an instructor (at another facility) had yelled at her in front of a patient, which “made me look stupid and made me cry.” She minimized the event saying, “It was ok, because I know she didn’t mean it.”

Many nurses reported being embarrassed by their colleagues’ unprofessional behavior at the desk. “Things happening at the desk. There is no filter. Everyone should have a filter, it’s called professionalism.” (RN) “Socializing at the desk can be annoying.
Loud. The kind of talk. Raunchy conversations. You have to think about patients and family members. It’s very unprofessional. It’s not appropriate.” (RN)

Some staff recognized their own participation in these behaviors. “Sometimes I feel like I’m at a bar. Sure I sometimes participate, up to a point, but sometimes it’s too much.” (RN) Many of the nurses reported that when people were unprofessional at the desk (talking about one another or patients, being loud, or joking around) they would simply walk away, suggesting that somehow their colleagues would “get the message” that they were being inappropriate.

One nurse described that she and her colleagues on one shift dealt with a coworker who “always had something negative to say” by excluding her from conversation and avoiding her rather than confront her about her negative focus. Eventually, isolated and without support, this “negative” nurse left the unit. In the extreme cases mentioned earlier, where one nurse was berated and another mimicked, their course of action was to avoid interacting with their coworker and anyone in alliance with that coworker.

Retaliation was demonstrated in tit-for-tat behaviors. Yelling in response to being yelled at. Name-calling in response to name-calling. Some nurses felt that reporting was also used as a form of retaliation, that coworkers would find something to write you up for if you wrote them up. The most damaging form of retaliation that I witnessed, in terms of teamwork and safety, was withholding assistance. Some nurses freely shared with me that they did not help certain colleagues because “they never help me”.
All of these events occurred within the greater context of the unit and hospital cultures (Figure 3). Nurses’ sensemaking of events and possible outcome of all actions were affected by unit and institutional contexts.

**Themes**

In reviewing field notes and transcripts, I coded five interrelated themes.

*Theme #1 - Behaviors associated with horizontal violence are not recognized, are minimized, and are not a priority.*

The nurses participating in this study rarely used terms from the literature to describe conflicts with coworkers. Occasionally the term bully would surface in conversation. In those cases, the term was used to describe someone who was demanding and expected others to do their work for them. In general, participants did not use specific terms to name the behavior, but described it and attributed it to something, most often to an individual’s personality.

The hospital Workplace Violence Policy did not clearly identify “lower risk” or “disruptive” conflicts (per Clark’s Continuum) between coworkers as reportable, with a specific focus on imminent threat. The policy listed “verbal threats” as reportable, just behind “use or possession of firearms”, a juxtaposition that had the potential to minimize any verbal threat. As the Workplace Violence policy appeared to minimize the importance of reporting of behaviors that did not pose imminent threat or that would not be actionable as discrimination, the importance of addressing these behaviors was minimized and reporting was infrequent.

Despite potential long-term consequences of unresolved conflict, other concerns, such as caring for patients, took precedent. Meeting patient needs was the nurses’ focus
and priority. “At the end of the day, it doesn’t matter how my peers treat me, I am here for my patients and I can go to sleep at night. I am here to make sure that the patient got the assistance they needed.” (RN) “I don’t care any more [about other nurse behavior]. What I care about is my patients.” (RN) Addressing interpersonal conflicts was not a priority.

Theme #2 - Fear inhibits all reporting.

Nurses and other members of staff in this study described fear of retaliation as a barrier to reporting. If one were to confront a colleague about their actions or behavior, there was concern that they would be next in line for abuse. “If I write someone up, I’ll be arch enemy #1 and I’ll never get help.” (RN) One of the managers described how she understood why nurses didn’t report one another.

‘I don’t want to risk people turning on me and the ramifications, so I’m not saying anything.’ Or, ‘I respect this nurse for her nursing care skills, even if she is totally rude, I might need her in the future, so I am not going to say anything.’

In another example, a member of staff reported that they had witnessed another member of staff breaking sterile technique. The witness did not intervene at the time and, although they reported the event, they would not identify the member of staff fearing, “You never know what they might do. They could come to my house.” (RN)

There was a fear of being labeled. If you “told”, you might be seen as a “snitch” or “complainer”. “Staff doesn’t want to get people in trouble.” (RN) “People don’t report it – don’t want to “tattle”. They are afraid and believe nothing will get done.” (Nurse Educator) “They fear that they will be seen as incompetent, ‘we can handle it’.” (Nurse Manager)
This hesitance to report also extended into reporting issues with medications or working conditions. “When you tell them that the Pyxis is out or there is something wrong with the system, they tell you ‘You have a bad attitude. Better work on your attitude’.” (RN) “If I file an unsafe staffing report, I will be labeled a complainer.” (RN)

Nurses often missed meals or stayed late to complete patient care or paperwork. This “working off the clock” was not allowed per hospital policies. Fear of being labeled was again an issue and prevented nurses from reporting the actual number of hours they worked. One nurse described, “If I put in for a missed break or stay late, I will be labeled a time waster or be told I have a problem with time management.” (RN) I witnessed three senior nurses on one unit explain to a new nurse who was thinking about putting in for a missed meal because of an extremely busy shift that “it’s not worth the aggravation”, that she’d be accused of time-wasting, having poor time management skills, or seen as complaining, thus socializing her into that aspect of unit culture.

Reporting was often equated with complaining. Administrators, managers, and nurses themselves frequently referred to other nurses as “complainers.” It is possible that nurses did not feel empowered to “complain.” As one PCA said, “now they treat everyone like a number and tell you there are ten people lined up for your job.”

However, nurses did risk abuse and question orders or report problems when they felt patient safety was at obvious risk, for example when they disagreed with a physician’s order or felt their patients required intervention or transfer to an ICU. While waiting for physicians to return pages at the desk, nurses discussed amongst themselves about how much trouble they would be in for “bothering the doctor”, calling for clarification, a new order, or re-evaluation of the patient’s status. The idea that calling for
clarification of an order or that advocating for safe care could be construed as “bothering a physician” or would result in backlash was disheartening, but I can confirm that this did happen. From my observation spot several feet away, I witnessed more than one nurse answering the phone and heard a physician yelling on the other end of the line.

Theme #3 - Nursing is not included as part of the team, is unrecognized, and has no control over workflow or resources.

Many of the posted initiatives espoused teamwork, but unit environments did not promote it. Nurses described not being included by physicians in rounds and often being unaware of plans of care for their patients. I witnessed a surgical resident explain to one nurse why he hadn’t sought her out before telling a patient his condition was inoperable and leaving the room, requiring that she page him and ask him to return to floor to provide more information to the now distraught patient and family. He told her he was not obligated to consult her, as she was “not part of the team”.

One morning, a medical team did not include a patient’s nurse in their plan to remove a surgical drain. Instead of seeking her out before the bedside procedure, they pulled the drain and when they could not control the bleeding, scrambled looking for her and for lidocaine and suture material.

Nurses described how this, not knowing the plan of care, made them “look stupid” and “unprofessional.” In addition, having to track down and page physicians to be updated about the plan took time away from other tasks; most importantly, patient care.

The staff I spoke with described a lack of respect and positive recognition for their role in patient care. “No one appreciates what we do. We do everything and no one cares. It makes you wonder, ‘Am I worth anything?’” (PCA)
Although some staff providing direct care (nurses and patient care assistants) were nominated for recognition in a hospital-wide initiative to recognize excellence, recognition was awarded primarily to administrators. People who won were at the systems level. People who saved the hospital money were recognized. No bedside nurses won. If a nurse was involved it was only recognized if they were part of a committee. It was a perfect forum to again recognize people at the bedside. That didn’t happen. That reflects their priorities.

(RN)

At an event planned to celebrate the diversity of the staff on one of the units, a senior administrator insisted in his speech to the attendees that staff “had to know how much their hard work was appreciated.” Especially during this time of recent layoffs, staff expressed to me they did not feel appreciated or heard.

There was also a feeling of disconnect between administration and front line patient care staff, a feeling that management had no understanding or concern for the front line carers.

Administration stays out of it. They don’t get involved. They don’t care… It doesn’t trickle down [support]. Administration has no idea what goes on on the front lines. Even the managers don’t know what goes on. They are in meetings, not out on the floor, not hands on. (RN)

Despite loyalty to the unit managers, who were the only bridge between administration and front line staff, a few nurses identified the managers as “administration” in their conversations with me. As managers were often in meetings throughout the day, the time they could spend on the units was limited and they did not get involved in direct patient
care, except for in an occasional code situation. As nursing contract negotiations were ongoing, some nurses described themselves as “us” and their own nurse managers, as “them”. Both managers were aware of this and expressed that being seen and referred to as “them” by their staff was hurtful.

Adding to the stress, nurses and managers essentially had no say in the managing the flow of patients into their own unit. Many members of staff felt that moving patients to different rooms multiple times within one admission was disrespectful to patients and resulted in patient dissatisfaction. A few minority patients had actually voiced to a manager that they felt targeted for this inconvenience. They felt it was related to who they were or to their insurance status. It was rare that a nurse could successfully stop bed management from moving patients around to create open beds for new admissions. Patients were sometimes successful in preventing a move if they complained, involved family, and called for a Patient Representative.

It was recognized that there were patients waiting to fill every bed, but many nurses felt administration put the profit motive to fill every bed before consideration for quality of the patient care. Nursing staff had little input into decisions to block rooms, even when safety was an issue. I witnessed a manager close a bed on one of the units because the patient in the other bed was extremely aggressive to staff and no single room was available. The bed was unblocked “from above” and another patient was put into that shared room despite concerns for staff and patient safety.

Nurse managers described their power as limited in trying to address systems problems. Nurse managers were called in from home to assist in discharges when the hospital was on alert because the number of admissions severely outweighed capacity,
even though their only power, as one nurse manager described it, “was to nag the doctors to write orders.” Nurses and nurse managers had no control in admissions or discharges. Only when a physician writes discharge orders can a patient go home. Orders for patients were often written in batches, when a doctor had or made time to sit down and write orders. When a batch of discharge paperwork was completed and those patients were sent home, admissions arrived to fill the empty beds, creating periods of high activity. Nurses and nurse managers both described long-standing issues related to how physicians managed discharges. Patients were dissatisfied with the process when they were told they would be discharged in the morning and then were not discharged until mid-afternoon.

Nurses on the evening shifts were overwhelmed with discharge teaching as new admissions arrived to fill the newly emptied beds. Despite evidence that this endangered patient safety, no improvement was seen in the months I was on the unit.

Nurses also had no power in controlling the flow of admissions to their own units. When one nurse asked if there could be a 15-minute delay in a transfer from the ICU while she settled her first admission, the nurse on the transferring unit called bed management, who then called the receiving nurse telling her that her patient was “being sent now.” A nurse involved in that exchange commented, “Bed control is the bully now.”

With regard to control of resources, nurses were not represented in the upper levels of administration and appeared to have little input into determining their allocation. During the time the study was taking place, the majority of Associate Chief Nursing Officers were laid off and the Chief Nursing Officer retired. By the time data collection was completed, there was very little nursing representation beyond a single Associate
Chief Nursing Officer who was filling in all the recently vacated roles. Nurse managers on both units were charged with managing their budgets, but had little influence or ability to advocate for additional resources. They had to work with what they were given.

Of particular relevance to the phenomenon of horizontal violence, the hospital did not provide training to nurses to enhance their interpersonal or conflict-management skills. Although these courses were mandatory for medical staff, they were not easily accessible to nursing staff. Educational resources for nurses were limited. The Associate Chief Nursing Officer in charge of nursing education was among those laid off. Nurses received little training in effective communication despite the need for high-level communication skills.

Theme #4 - There is no oversight, coordination or management of systems.

Temper flared when things didn’t work or didn’t happen. At change of shift, at handover, nurses going off shift complained that nurses coming on only focused on “what you didn’t get done.” The attribution that “no one else is doing their job” was pervasive. Real or perceived, many staff members felt that certain coworkers on the unit and elsewhere in the system were not doing their job. There was a widespread perception that no one was accountable and no one was held to task.

Many nurses cited systems problems as creating opportunities for hostility. In an already stressful environment where nurses were expected to do more with less, missing medication and supplies, as well as delays in transport, resulting in unnecessary workarounds. A number of systems were inefficient. As one of the nurse educators explained,
Phones are outsourced. Four months to get a new phone activation for a new employee. Four month of calling and calling and calling. Glucometer out for weeks. People start taking it from one another… Oxygen and suction canister wall mounts waiting to be put up for over a year. If things worked the nurses would have more time in the rooms. It would reduce falls. It’s so frustrating to have to look for all this stuff… There are systems failures and people are not accountable. It could make a huge difference in everyone’s day… Sometimes I feel, ‘Am I the only one that cares?’ There’s a direct correlation to how you feel about going to work.

Inefficient systems inhibited the delivery of care. Plans to complete care in a timely manner were affected by missing medications and supplies, delays in transport, and nurses not being able to find assistance for moving patient on and off stretchers before and after off-unit tests, as well as assistance to reposition and ambulate patients.

Additional barriers included frequent interruptions, unexpected changes in patient conditions, and poor transfer of information. Nurses addressed many of these problems through workarounds: borrowing equipment or supplies from another unit, making frequent calls to pharmacy to encourage prompter delivery of specific medication, and even transporting patients off unit themselves when transport was delayed. Workarounds were not infrequent and were accepted as part of the job.

This is part of being a nurse on this floor. This has become an expectation… part of the orientation process, maybe not on paper, but you are taught how to deal and how to mediate these problems that will happen on a consistent basis. It is expected you will deal with these problems. (RN)
A surprising finding was the adversarial relationship between units, especially between one of the two units and the Emergency Department. One night, I overheard a nurse tell another group of nurses at the desk, “They [the Emergency Department] did that last night. They’re holding patients because no body wants another patient.” A phlebotomist expressed her opinion of the situation, “They [the Emergency Department] get away with that because ‘I’m an ER [Emergency Room] nurse’. It shouldn’t be like that. People are burned out and don’t care anymore.” One of the evening nurses on informed me that the floor and the emergency department nurses “take turns writing each other up.” A senior night nurse told me, “These issues with the emergency room have gone on for over 20 years. Nothing changes.”

Nurses were not aware of any sustained effort to improve the discharge process, patient flow or communication between the ED and the units, to improve timely delivery of medication, availability of supplies, or patient transport issues. There was no identified process for reporting systems problems.

*Theme #5 - Avoidance and isolation*

The majority of nurses involved in this study identified themselves as conflict-avoidant. They avoided coworkers rather than confronting them, which meant conflicts went unresolved.

Nurses described avoiding coworkers who had bullied them or were demanding as self-protection. But they also described avoiding some colleagues and isolating others in response to their behavior. Nurses described avoiding and isolating colleagues who were identified as “bullies” or “complainers”, exhibited negative attitudes, and those they perceived as asking for help but not reciprocating. In avoiding and isolating “problem”
coworkers, these nurses themselves were enacting an identified form of horizontal violence. (Hutchinson, et al, 2008; Hutchinson, et al., 2010; Lewis & Orford, 2005).

Nurses in this study feared being labeled, whether the label was “the bully”, “the problem”, or “the complainer”, as it could result in being ostracized. Nurses who were labeled were sometimes scapegoated and nurses who were not labeled were careful not to engage in behaviors, including reporting, that might attract a label. This fear of labeling and isolation of those who were labeled diminished opportunities for teamwork, taking away from nurses’ collective ability to care for patients.

Another finding was that nurses isolated themselves from others physically as a way to protect themselves from exposure to conflict. Two nurses, one from each unit, reported to me that they geographically isolated themselves as far away from the desk area as physically possible, not just in response to prior abuse from colleagues, but to avoid being associated with behaviors at the desk or to avoid taking all the responsibility for answering the call lights or helping other nurses when they did not get help when they needed it.

Nurses on both units often worked independently. For the most part, nurses and PCAs focused on their own patient assignments. The focus on routines and the completion of tasks with decreased resources and increased time constraints appeared to further contribute to isolation. Outside of the nurse/PCA dyad, there was limited opportunity for teamwork with regard to patient care. One nurse described, “You know, you have your five patients and you take care of your five patients and that’s it. You don’t look outside the scope.” (Float RN) This made sense as the nurse is responsible for his or her assignment, as well as the work of the PCA they are working with. PCAs were
generally assigned to two, occasionally more, nurses. Some nurses felt certain PCAs were not reliable, and some PCAs felt nurses didn’t respect the work they did, wouldn’t assist them in any way, or failed to include them in the plan of care. So even when staff was technically working together, they weren’t. Perhaps this was exacerbated by of model of care (primary nursing), a focus on “my patients.” Poor relationships with other members of staff led to avoiding others and not seeking help. When people did ask for help and help was not readily available, many stopped asking and some stopped helping.

Summary

The Workplace Violence policy focused on reporting imminent threats to safety and behaviors that were actionable under Equal Employment and Opportunity law. A representative from Human Resources reported they could do little about complaints that did not involve imminent threat or discrimination. Definitions of reportable events were unclear and, in general, events were not reported. Behavioral expectations set in the Code of Ethics and Business Conduct were high but were not upheld or enforced.

Posters hanging in on the units described initiatives that empowered nurses and spoke to a supportive work environment, but these initiatives were no longer funded. Values and mission statements hanging in the break rooms described respect and collaboration. Staff shared with me they did not feel respected by the institution in general or by certain coworkers. Collaboration was sporadic and appeared dependent upon the presence of individuals who valued collaboration.

I first entered the field focusing on developing an understanding of each unit culture and context. The phenomenon was observable on both units. As an overt observer, I witnessed behaviors associated with horizontal violence happening right in
front of me. Rudeness, yelling, gossiping, and mimicking occurring at the unit
secretaries’ desk evidenced either a lack recognition of the problem or lack of concern for
the problem.

In conversations and interviews, I found nurses primarily attributed negative
behaviors to individuals, a finding supported in Farrell’s work (1997). Policies did not
provide a clear description of reportable behavior and nurses were not provided with the
skills to manage conflict. Many did not recognize the phenomenon as problematic. Those
who did indicated futility in attempts to address the behaviors. Reporting was affected by
a sense that “nothing changes” and fear of retaliation, labeling and blame.

Nurses and other staff described a disconnect between front line staff and
management. Systems to provide equipment, medication, and transport were inefficient
and there were no obvious processes for reporting systems problems. Although many
participants acknowledged these systems problems were triggers for negative behaviors,
they appeared resigned to working around problems rather than becoming involved in
resolving them.

Nurses were not included in decision-making and resource allocation, but were
affected by the results of budget cuts and layoffs. The stress of doing more with less may
have contributed to them concentrating on their own patient assignment, focusing on task
completion, and taking it upon themselves to make up for system failings. These actions
appeared to contribute to further breakdowns in teamwork and communication.

For the nurses, meeting patient needs in the face of shrinking resources was of
primary concern and superseded addressing all other issues in the environment. As time
was among the shrinking resources, little time was devoted to addressing conflicts with coworkers.

Many staff spoke about reaching the limit on stress and distractions. Nurses described they couldn’t get help when they needed it, couldn’t depend on certain coworkers for help and wouldn’t ask certain coworkers for help. Individual nurses often worked in silos. They described isolating negative and difficult colleagues rather than confronting them. In addition, some nurses described purposefully isolating themselves from colleagues to avoid abuse or escape the chaotic environment at the desk.

Chapter Five will discuss the significance of the findings, as well as their implications for nursing research, practice, education, policy, and hospital management.
Chapter 5: Significance and Implications

Significance

The study’s findings support each of the theories used to explain horizontal violence cited in the review of the literature in Chapter Two. Indications of factors contributing to horizontal violent behaviors related to oppressed group behavior, relational aggression, generational differences, “toxic” work environments, and organizational characteristics were identified on both units during the study.

Nurses took out their aggressions on other nurses, supporting oppressed group behavior (Dunn, 2003; Roberts, 1983; Roberts, Demarco, & Griffin, 2009; Simons, 2006) as a contributing factor. Many of the female nurses involved in interviews felt that horizontal violence was a “woman thing”, that their male colleagues did not engage in, supporting Dellasega’s (2009) research on relational aggression. There were generational differences (Hahn, 2011; Kupperschmidt, 2006) that resulted in conflict. Nurses working on both units identified a number of systems problems and stressors that contributed to and were “triggers” for behaviors associated with horizontal violence. My own experience on the units over time, witnessing nurses’ lack of control over resources and workflow, suggested that both units could be considered “toxic” (Alspach, 2007; Rowell, 2005). Nurses and other staff demonstrated a tolerance for the behaviors and felt reporting was not effective. They shared their perception that coworkers who enacted horizontally violent behaviors were not held accountable, indicating a tolerance of the behaviors by the organization and, therefore, tolerance of the behaviors as an organizational characteristic (Hutchinson et al., 2008). The presence of all of these
indicators suggests that any intervention on these unit or units like them would have to address all of these issues in order to be effective.

_The Hospital’s Framing of Horizontal Violence_

Recognizing and addressing horizontal violence did not appear a priority for the hospital or for the nurse participants themselves. Per Joint Commission requirements, there was a workplace violence policy and a code of conduct in place, but there were no clear definitions of reportable behavior, no clear processes for reporting, and no obvious enforcement.

This hospital’s policies focused on the individual. The policies attributed blame for the problem of negative behaviors and placed responsibility for the resolution of the problem on individuals. In focusing on the individual as “the problem” and requiring individuals to report or intervene, or nothing could be done, the institution positioned itself as blameless and unable to act. It has been suggested that the phenomenon of horizontal violence should be viewed as “not just as pathological (mis)behavior by the perpetrator, but as something located in relation to the character of the normalized cultural practices that go on in organizations, that is, as a form of both individual and systemic violence.” (Rhodes, Pullen, Vickers, Clegg, & Pitsis, 2010, p. 98)

This perspective would require organizations to create processes to monitor, address and minimize the presence of such acts and take note of the environments within which they occur, a form of organizational self-awareness or self-critique.

Based on my observations, the majority of hospital staff on both units were well intentioned. Some horizontally violent behaviors appeared to be in reaction to systemic pressures and conflict in an environment that tolerated these behaviors as acceptable and
even expected. Nurses were not provided with training to improve communication and conflict resolution. Lack of awareness of one’s own behavior was cited by a number of participants as contributing to perpetuation of horizontally violent behaviors, but the lack of consequence allowed individuals to take out their frustrations on coworkers unchecked. Over five months, I observed only one nurse who appeared to intentionally manipulate coworkers. She was very covert in her actions and no one identified her to me as a bully. I concluded that a bully could operate discreetly in an environment that condones incivility.

**Implications**

**Implications for nursing and nursing research**

Nurses participating in this study did not, for the most part, use terms found in the literature when talking about aggression between colleagues but could identify behaviors associated with horizontal violence. This finding is shared with other studies (Farrell, 1997; Nicotera & Mahon, 2013; Stanley, et al, 2007). As part of my observations, I had hoped to discover unique terms that nurses use to describe the phenomenon so that those terms might be incorporated into existing and future interventions. I did not discover any. The term bully was used occasionally, which is not surprising given recent media focus on school and cyber bullying. Some nurses spoke of coworkers’ “unprofessional behavior”. They attributed this and other negative behaviors to individual personality defects. Although many nurses were affected by horizontal violence, addressing the issue was not a priority. Further research should investigate the barriers to nurses recognizing horizontal violence as a problem worthy of attention and how nurses manage competing priorities in the care environment.
Although many reported instances of horizontal violence happen behind closed doors, I observed behaviors associated with horizontal violence occurring in public areas on both units, enacted in front of others, yet I did not witness any intervention by bystanders. Further research is needed to understand bystander non-intervention in tolerating and passively witnessing unacceptable behavior (Hutchinson, Jackson, Haigh, & Hayter, 2013). Bystander interventions have been proposed in the school bullying literature but their effectiveness has yet to be evaluated. The role of bystanders in the addressing horizontal violence in health care environments requires further investigation.

Horizontally violent behaviors were occasionally witnessed by patients and visitors and even reported in patient satisfaction surveys at this facility. There is a gap in the health care literature about the effect of witnessing horizontally violent behaviors on patients and visitors. The consumer research literature has investigated the effects of consumers witnessing employee-employee incivility, however. Results of one study indicate that consumers who witness incivility experience anger and make negative inferences about workers, the institution, and future encounters, “inferences that go well beyond the incivility incident” (Porath, C., MacInnis, D., & Folkes, V., 2010, p. 292). Further investigation into patient and visitor bystander experiences may help to shape future interventions, as nurses at this facility were concerned about their colleagues’ behavior at the desk and cited their patients as their top priority. Linking behaviors witnessed by patients and the effect on their perception of care may provide a way to illustrate to nurses and other health care staff how the phenomenon is perceived by others and is problematic in the health care environment.
In addition, as many female nurse participants in the study offered their opinion that these behaviors are enacted by female nurses but not by their male colleagues, continued investigation of horizontal violence as a gendered phenomenon should be undertaken. Recent nursing research about nurse aggression has focused on relational aggression, also known as female bullying (Dellasega, 2009; Dellasega & Nixon, 2003). When attributing aggressive behaviors only to female nurses, some nurses suggested that this is just how women are and interventions were futile. The recent media focus on female aggression has further reinforced this idea with concepts such as “mean girls” and “queen bee syndrome.” It is critical that research provide balanced accounts of both male-to-male conflict as well as female-female conflict to address the implications that female-to-female conflict is problematic while male-to-male conflict is not (Sheppard & Aquino, 2013). In addition, the exclusion of men from this behavior in some way furthers the notion of male nurses as different, as “other”. The literature suggests that men in nursing are frequently treated differently by their colleagues and by patients (Milligan, 2001; Stott, 2004). In fact, one nurse participant in this study shared that balancing the ratio of male to female nurses in nursing might help to resolve horizontal violence, but that it would create “other problems”, as she described men as “task oriented and less caring.” In order to present a clear picture of aggression in health care settings, male aggression and the perspectives of male nurses need to be included in future studies.

Lastly, isolating an individual has been identified as a form of bullying in the literature (Hutchinson, et al, 2008; Hutchinson, et al., 2010; Lewis & Orford, 2005). Nurses and other staff experiencing or witnessing horizontal violence and related behaviors often avoided interaction with other staff and, in some cases, isolated
themselves from others physically as a way to protect themselves from further exposure as well as potential involvement in conflict. This finding, of nurses literally creating their own silos, requires further investigation, as it is a barrier to teamwork and communication.

*Implications for practice*

Nurses are obligated to ensure patient safety. In not addressing issues affecting teamwork, including horizontal violence, patient care is endangered. Lack of teamwork can result in “missed care”, defined as “care not completed” (Kalisch & Lee, 2010, p.233). In their research, Kalisch and Lee, attributed 11% of missed care, including ambulation, turning, nutrition, medication administration, surveillance, and IV site care, to lack of teamwork. There are processes in place for reporting and investigating errors of commission, such as giving the wrong medication to the wrong patient. Errors of omission, care that didn’t happen, was unfinished, or was rationed, are not reported but nevertheless affect patient outcomes (Kalisch & Lee, 2010). Nurses on both units complained that nurses on the shift before them left tasks undone. Kalisch (2006) suggests that interventions to develop teamwork would result in a shared sense of the care of patients as “our” work, increase awareness of other team members’ workload, and encourage nurses to assist one another more readily. Future research should investigate the effectiveness of teamwork interventions to address horizontal violence, as well as the role of horizontal violence, specifically the intentional withholding of assistance, in missed care.

Nurses on both units worked around the system to get work done. A study of nursing care processes found that addressing process failures are an expected and routine
part of working on the front lines of health care delivery (Tucker & Edmondson, 2003).

A problem, defined as “a disruption in a worker’s ability to execute a prescribed task because something the worker needs is unavailable in the time, location, condition, or quantity desired” (Tucker & Edmondson, 2003, p.57), affects care delivery. Inefficient processes patient affect safety by reducing the amount of time nurses have for monitoring patients and providing therapeutic care (National Research Council, 2004). In their study of work system failures on the front lines of care delivery in nine hospitals, Tucker and Edmondson (2003) report that seventy percent of the nurses interviewed “believed their manager expected them to work through the daily disruptions on their own. Speaking up about a problem or asking for help was likely to be seen as a sign of incompetence.” This finding is supported in my study where nurses described that in reporting problems, they were often labeled “complainers” or found that their ability to do their job would be called into question. Unfortunately, although problems may be solved in the short term when nurses compensate for failures in the delivery of medications, supplies and services by taking it upon themselves and working around the system, they do solve the root cause of the problem, so the problem is likely to recur. Nurses need to be involved in identifying and solving systems processes. A process for reporting systems problems should be implemented in all facilities. Transparency in these processes would allow for a shared understanding of problems and improved solutions. Although some studies have investigated the phenomenon of the workaround in nursing (Tucker & Edmondson, 2003), further research is warranted.
Implications for education

Education about the phenomenon of horizontal violence and a focus on improving communication skills needs to begin during nurse training. Findings from Daiski’s study (2004), suggest that nurses are trained to be patient advocates but not taught how to advocate for themselves, their work environment, or their profession. It is an expectation of the International Council of Nurses (International Council of Nurses, 2012) that nurses not only advocate for patients but that they advocate for themselves and for healthy workplaces. Nursing education must widen their definition of advocacy beyond patient advocacy and provide nurses with skills to improve communication and manage conflict. With recent changes in the delivery of care, nursing education will also need to prepare new graduates to work in environments where they have responsibility for process improvement (Needleman & Hassmiller, 2009). In a facility such as this one, they may have to advocate for involvement in process improvement as well.

Nurses and nurse managers in all practice settings who have completed their training require on-going education to identify and find ways to resolve behavior and communication issues. Further research is needed to evaluate the effectiveness of current interventions and to develop new educational programs and interventions. Health care organizations must provide training in conflict management to all staff, not just a select few, to be effective. Educational opportunities and support have benefit beyond giving staff skills they can bring back to their units. Whether the skills learned are related to patient care directly or indirectly, educational opportunities have been identified as a vital factor for nurse satisfaction (Upenieks, 2003) and their long-term value should be considered in budgetary decisions.
Minimally, institutions need to provide ongoing education to all staff that increases awareness of horizontal violence, provides clear guidelines for addressing conflict, and encourages non-punitive reporting for behaviors affecting communication, teamwork, and patient safety to satisfy the Joint Commission mandate. Processes for reporting and addressing behavior need to be well defined and enforceable. Behavioral expectations have to be modeled by administration.

_Implications for policy_

This study demonstrates that existing policies related to staff behaviors at the host institution were ineffective in managing horizontal violence. The facility’s Workplace Violence policy focused on higher-level threats and behaviors that violated Equal Employment Opportunity laws. The Code of Conduct was not enforced. Simply having a policy does not result in change. As required by the Joint Commission, these policies have to be clarified, distributed, and upheld in order to have impact. In addition, there must be an organizational commitment to resolving behavioral issues including identifying models for interventions, supportive policies, surveillance tools, review processes, multilevel training, and a commitment of resources to promote professionalism and interdisciplinary respect (Hickson, Pichert, Webb, & Gabbe, 2007).

Like most institutional workplace violence policies in the United States, the Workplace Violence policy at this institution was written specifically to protect individuals whose mistreatment is related to as sex, race, or age, or is in retaliation for reporting or who are in imminent danger. Policies that take a proactive stance to address hostile work environments, not just workplace violence, and protect all employees from abusive mistreatment, would fill a huge gap in the law. Enforcement of policies with a
broader definition of abuse would allow Human Resource departments to better address problem behaviors that were not related to discrimination or retaliation. Twenty-four states since 2003 have introduced the Healthy Workplace bills to address hostile work environments rather than their outcomes, workplace violence. Unfortunately, no laws have been enacted at the federal level in the United States (Healthy Workplace Campaign, n.d.).

There are governments and private organizations have recognized the importance of a healthy work environment. The Quality Worklife Quality Healthcare Collaborative (QWQHC), a coalition of twelve national healthcare organizations in Canada, defines a healthy work environment as, “a work setting that takes a strategic and comprehensive approach to providing the physical, cultural, social, and job design conditions that maximize the health and well-being of health care providers” (Quality Worklife Quality Healthcare Collaborative, n.d.). This organization recognizes the link between quality of worklife and patient/client outcomes. Addressing problems in the work environment would demonstrate concern and respect for employees and might be a first step toward bridging the perceived divide between front line staff and administration.

Given the costs, in terms of recruitment and retention of staff, physical and mental health of staff, risk for errors, poor patient outcomes, and decreased patient satisfaction scores, hospitals need to develop preventative and corrective measures to address horizontal violence and to focus on efforts to promote a respectful and healthy work environment for all employees. Enacting new policies to address factors contributing to hostile work environments, before laws such as Healthy Workplace bills are enacted, as well as taking steps to improve systems and working conditions, should be considered.
Implications for hospital management

The nurses on both units involved in this study describe a sense of disconnect with administration. When budgets were cut at this institution, nursing, as the largest cost center for any health care facility, was disproportionately affected. By the time I concluded data collection at the facility in November 2012, all but one Associate Chief Nursing Officer position had been eliminated. A lack of nursing representation in administration is apparently not unique to this institution. As described in Keeping Patients Safe: Transforming the Work Environment of Nurses, a summary of a study completed by the Institution of Medicine’s Committee on the Work Environment for Nurses and Patient Safety, “Clinical nursing leadership has been reduced at multiple levels, and the voices of nurses in patient care has been diminished” (National Research Council, 2004, p. 4).

Nurses on both units felt disrespected by administration; that administrators had no idea what direct patient care involved or what it was like to be on the “front line”. Nurses felt they were being asked to do more with less. There was an environment of organizational chaos, described in the literature as “poor organization and coordination of the labour processes” (Roscigno, Hodson, & Lopez, 2009, p. 79). Analyses of other industries in the workplace literature reveals that all forms of incivility, including horizontal violence and excluding sexual harassment, are rooted in organizational chaos, as workers interfere with one another in a struggle to complete their own work (Roscigno, et al., 2009). The role of organizational chaos in horizontal violence in health care is yet uninvestigated, but a worthy of future research.
Research indicates that nurses cannot effectively practice without the right resources, including an appropriate amount and mix of caregivers, supplies, and supporting systems (Hess, 2004). It has been suggested that hospitals involve nurses and other frontline staff in initiatives to improve the quality and efficiency of care delivery, shifting the vision of nursing as simply a cost center to be a critical service line and involving nursing in key decision making roles. Nurses in my study did not feel heard or valued by the hospital entity. Listening and valuing input from staff at all levels may improve relations and provide opportunities for open dialogue and true problem solving (Needleman & Hassmiller, 2009). This requires a commitment not only of resources, but a commitment to cultural change by all, from staff on the front lines to those in the highest levels of administration.

This study uncovered systems problems that impeded delivery of care and required workarounds by nurses. Tucker, Singer, Hayes, & Falwell (2008) identified that “the two most frequent categories of operational failures, equipment/supplies and facility issues, posed safety risks and diminished staff efficiency, but have not been priorities in national initiatives.” Nurses had no control of patient flow on the unit and could not close beds, even when they believed patient safety was an issue. The Institute of Medicine suggests that nurses should regulate workflow and set criteria for unit closures to new admissions and transfers as nursing workload and staffing necessitate (National Research Council, 2004). Tucker and colleagues suggest involving front line staff in identifying and addressing problems in work systems. It is suggested that prioritizing improvement of work systems in general, can increase safety and efficiency of hospitals, and frontline staff should be involved in these efforts as well (Tucker, et al., 2008).
The work environments observed on the two units involved in the study did not appear to support or empower nurses. Nurses comprise the single largest group of healthcare professionals in the United States and need to be empowered to be able to care for their patients. Kanter (1977) defines an empowering work environment as one where employees have access to information, resources, support, and opportunities to learn and grow. These environments have been correlated to positive cultural change and reduction in horizontally violent behaviors (Laschinger, Wong, & Cummings, in press). Nurses who work in empowering work environments have a lower incidence of workplace incivility and emotional exhaustion, and improved health and well being (Laschinger, Finegan, & Wilk, 2009; Laschinger, Grau, Finegan, & Wilk, 2010). Structural empowerment initiatives should be further investigated as an intervention for horizontal violence.

Hospital management should also consider recent changes in Medicare reimbursement and recent research linking patient satisfaction to nurses’ work environments. Beginning in 2012, some costs incurred related to readmissions of patients treated for heart failure, acute myocardial infarction, and pneumonia within 30 days of discharge may not be reimbursed. In addition, starting in 2013, 30% of hospital Medicare reimbursement will be tied to Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, a survey to measure patients’ perceptions of their hospital experience, which is a public report (Center for Medicare & Medicaid Services, n.d. a, n.d. b). A study conducted by researchers at the University of Pennsylvania, indicates improving nurses’ work environments and staffing may be an effective intervention for preventing readmissions (McHugh & Ma, 2013). In addition, research
has found that nurses’ job satisfaction is linked to patient satisfaction (Molyneux, 2011). Investment in improving the nursing work environment would likely pay for itself in the end not only in patient satisfaction and fewer readmissions, but also in improved retention of nursing staff.

Conclusions

The urgency to address the problem of horizontal violence is evidenced in the nursing literature, but in the face of competing priorities on the two units I observed, horizontal violence was minimized. The hospital’s policies focused on reporting imminent threats over “lesser” behaviors and solutions were reactive. There were no resources providing staff with the skills to improve communication and conflict resolution to reduce instances of horizontal violence. Verbal abuse was widespread and tolerated. More serious offenses were not recognized as reportable.

In order to address horizontal violence in the workplace, staff and administration need to recognize its affect on patient care, as well as the work environment, be proactive in addressing the phenomenon through education to create awareness and improve communication and conflict resolutions skills. Codes of Conduct should define expectations and processes should be in place to address behavioral deviations from expected norms, which must be modeled by all employees, from the top down.

Horizontal violence is a complex, entrenched phenomenon whose affects are detrimental to healthy work environments and patient care. Institutions cannot simply create policy and expect results. Nor can employees accept horizontal violence as the status quo. Solutions must by implemented systemically and systematically and address the many facets of the problem in order to be effective.
References


[www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No1Jan04/FromBedsidetoBoardroom.aspx](www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No1Jan04/FromBedsidetoBoardroom.aspx)


[http://apha.confex.com/apha/134am/techprogram/paper_135060.htm](http://apha.confex.com/apha/134am/techprogram/paper_135060.htm)


McHugh, M.D., & Ma, C. (2013). Hospital nursing and 30-day readmissions among Medicare patients with heart failure, acute myocardial infarction, and pneumonia. *Medical Care, (51)*1, 52-59.


Table 1

Terms Used in the Nursing Literature

<table>
<thead>
<tr>
<th>Term</th>
<th>Study or studies used in</th>
</tr>
</thead>
<tbody>
<tr>
<td>bullying</td>
<td>Lewis, 2006; Hutchinson et al., 2006; Hutchinson et al., 2008; Stevens, 2002</td>
</tr>
<tr>
<td>conflict/intra-group conflict</td>
<td>Almost, 2006; Almost, Doran, McGillis Hall, &amp; Spence Laschinger, 2010</td>
</tr>
<tr>
<td>disruptive behavior</td>
<td>Joint Commission, 2008</td>
</tr>
<tr>
<td>hazing</td>
<td>Brown &amp; Middaugh, 2009</td>
</tr>
<tr>
<td>horizontal hostility</td>
<td>Thomas, 2003</td>
</tr>
<tr>
<td>horizontal violence</td>
<td>Dunn, 2003; Roberts, 1983; Skillings, 1992; Leap, 1997</td>
</tr>
<tr>
<td>incivility</td>
<td>Clark, 2008; Walrath et al., 2010</td>
</tr>
<tr>
<td>interpersonal conflict</td>
<td>Farrell, 1997, 2001; McKenna et al., 2003</td>
</tr>
<tr>
<td>intimidation or intimidating behavior</td>
<td>Lamotagne, 2010; Joint Commission, 2008</td>
</tr>
<tr>
<td>intrastaff aggression</td>
<td>Farrell, 2001</td>
</tr>
<tr>
<td>lateral hostility</td>
<td>Alspach, 2007</td>
</tr>
<tr>
<td>lateral violence</td>
<td>Griffin, 2004</td>
</tr>
<tr>
<td>mobbing</td>
<td>Yildirim &amp; Yidirim, 2007; Dragana, Bela, Vesna, &amp; Danka, 2009</td>
</tr>
<tr>
<td>negative workplace behaviors</td>
<td>DeMarco, Roberts, &amp; Chandler, 2005</td>
</tr>
<tr>
<td>nurse-on-nurse violence</td>
<td>Woelfle &amp; McCaffrey, 2007</td>
</tr>
<tr>
<td>psychological aggression</td>
<td>Walrath et al., 2010</td>
</tr>
<tr>
<td>relational aggression</td>
<td>Delsasega, 2009</td>
</tr>
<tr>
<td>sabotage</td>
<td>Dunn, 2003</td>
</tr>
<tr>
<td>vertical violence</td>
<td>Alspach, 2007</td>
</tr>
<tr>
<td>workplace aggression</td>
<td>Farrell, Bobrowski, &amp; Bobrowski, 2006</td>
</tr>
<tr>
<td>workplace bullying</td>
<td>Stagg &amp; Sheridan, 2010</td>
</tr>
</tbody>
</table>
Table 2

Manifestations of Horizontal Violence

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Overt or Covert</th>
<th>Possible manifestations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonverbal cues, Nonverbal innuendo</td>
<td>Overt and covert</td>
<td>Eye rolling, making faces in response to questions</td>
</tr>
<tr>
<td>Verbal remarks, Verbal affront</td>
<td>Overt</td>
<td>Snide, rude, demeaning comments, shouting, using a condescending or patronizing tone of voice</td>
</tr>
<tr>
<td>Actions/Inactions</td>
<td>Overt</td>
<td>Refusing assistance, allocating unrealistic workloads, hoarding or hiding supplies</td>
</tr>
<tr>
<td>Withholding information</td>
<td>Overt and covert</td>
<td>Deliberately withholding information</td>
</tr>
<tr>
<td>Sabotage</td>
<td>Overt</td>
<td>Deliberately setting up another nurse for failure,</td>
</tr>
<tr>
<td>Infighting</td>
<td>Overt</td>
<td>Excluding members of staff from communication</td>
</tr>
<tr>
<td>Scapegoating</td>
<td>Overt</td>
<td>Blaming negative outcomes on one identified nurse without regard to his or her actual responsibility for those outcomes</td>
</tr>
<tr>
<td>Passive Aggressive Behavior</td>
<td>Overt</td>
<td>Backstabbing, complaining to others about a person but not speaking to that person directly</td>
</tr>
<tr>
<td>Broken Confidences</td>
<td>Covert</td>
<td>Gossiping, sharing information that is meant to be private</td>
</tr>
</tbody>
</table>

(From Sheridan-Leos, 2008, p.401, based on Freshwater, 2000; Griffin, 2004)
Figure 1

Clark’s Continuum of Incivility

Continuum of Incivility

Distracting, annoying, irritating behaviors

Low Risk

Disruptive Behaviors

High Risk

Threatening Behaviors

Bullying, aggressive, potentially violent behaviors

Behaviors range from:

eye-rolling  sarcastic comments  taunting  racial/ethnic slurs  intimidation  physical violence

(Clark et al., 2011)
Figure 2

Model of Action/Inaction

Processing/Sensemaking by “target” & bystanders (other staff, patients & family)

Action

Inquire/Confront

Outcome

+ understanding/learning
+ awareness, + apology
- exacerbation, - retaliation

Report

Remediation/Investigation

No action or perception of no action taken

- perpetuates and/or exacerbates problem behavior, - contributes to a permissive environment, - may strengthen aggressor, - affects interpersonal relationships, - reduces helping behaviors, teamwork, job satisfaction and patient experience/safety

Minimize/Ignore/Avoid

Retaliate

processing and sensemaking affect action

environment (context) and prior experiences affect framing, processing and sensemaking

outcomes affect future framing, processing and sensemaking
Figure 3

Model of Action/Inaction in Context
Appendix A

Letter of Introduction to Unit Staff

To: [participating unit]
From: Rosemary Taylor
Subject: Research Study

My name is Rosemary Taylor. I am a nurse and a doctoral candidate at Northeastern University School of Nursing. I have been invited to conduct my research here at [UMass Memorial Medical Center – University Campus]. My research focus is nurses’ perceptions of “non-caring or non-supportive behaviors between nurse colleagues”, a phenomenon often referred to as horizontal or lateral violence in the nursing literature. This study aims to provide a clearer understanding of how horizontal violence is understood and explained from the perspective of nurses themselves and how it is perceived by unit staff within the context of the workplace.

The methodology I will use is ethnography. In an ethnographic study, researchers position themselves in the environment of interest and collect data via observation, formal and informal interviews and other modalities. Over the course of the next three to six months, I will be on the unit during all shifts and all days of the week, observing routines and interactions. I will also be attending meetings and speaking to staff to develop an understanding of the unit and how things work here. I will conduct my research as unobtrusively as possible as not to interfere with your work. At times I may have questions about my observations and may ask you individually for clarification. I will review the purpose of study and the verbal consent process with you at that time.

Formal interviews with staff will also be conducted as part of the research process. If you agree to participate in these interviews, verbal consent will be required and the purpose of the study and verbal consent process will be reviewed prior to each interview. You have the right to opt out of participation by declining opportunities to engage with me. Involvement is completely voluntary. There is no obligation to participate. Participating or declining to participate will not affect your employment in any way. If you have consented to participate, you may withdraw from participation at any time. You may also ask questions concerning the research or research procedures at any time.

Identifying information will be removed from all notes and transcripts so that your part in the study will remain confidential. Your name and identity will not be used in any reports on this study; pseudonyms will be used in all writings, publications or presentations.

I would like to create a composite of nursing staff demographics. It would be extremely helpful if nursing and other staff could complete the demographic questionnaire that will be made available throughout the study. Completion of this form is also voluntary.

Copies of the final report will be available. I will present the findings in person to the unit staff upon completion and your feedback will be included as part of the report. I look forward to meeting each of you and spending time on your unit.

Sincerely,

Rosemary Taylor, BSN, RN
Appendix B

Consent Form

Northeastern University School of Nursing
Principal Investigator: Susan Roberts, DNSc, ANP
Student Researcher: Rosemary Taylor, BSN, RN
Project title: Nurses’ Perceptions of Horizontal Violence

Informed Consent Form

You are being asked to participate in a dissertation research project being conducted by Rosemary Taylor, a doctoral candidate at Northeastern University. The purpose of this research is to learn more about staff experiences and perceptions of a phenomenon known in the nursing literature as “horizontal violence” and defined in this study as “any non-supportive or non-caring behavior between nurse colleagues”.

The researcher will be on the unit for extended periods of time (4-6 hours) during different times of day and days of the week. She will observe day-to-day activities and interactions on the unit as part of her study. Informal interviews, where the researcher may inquire in the moment about a situation or activity, may be conducted during observations. The researcher will review the purpose of study and the verbal consent process with you at that time. In the later phases of the study, formal interviews will be scheduled with participants who are willing to share their insights and experience with the researcher. These interviews will be scheduled at the participant’s convenience. The purpose of the study and the verbal consent process will be reviewed before each interview. These interviews will last approximately one hour and will be digitally recorded with permission. The researcher will transcribe each interview and remove identifying information so that your part in the study will remain confidential. If you would like to participate in the interview phase of the study but do not wish the interview to be digitally recorded, the interview will not be digitally recorded.

You have the right to opt out of participation by declining opportunities to engage with the researcher during observations and in formal or informal interviews. Involvement is completely voluntary. There is no obligation to participate. Participating or declining to participate will not affect your employment in any way. If you have consented to participate, you may withdraw from participation at any time. You may also ask questions concerning the research or research procedures at any time.

The researcher will remove all identifying information from any notes or transcripts so that your part in the study will remain confidential. Your name and identity will not be used in any reports on this study; pseudonyms will be used in all writings, publications or presentations. Notes may be taken during periods of observation and during interviews to assist the researcher to recall details accurately. Identifying information will be removed from these as well. All written notes will be stored in a locked cabinet in the researcher’s office. Digital recordings and transcripts will be stored in a password-protected computer file. Confidentiality will be maintained throughout the study. Participants will be deidentified in the final report and this report will be shared with the units participating prior to publication. There are limits to confidentiality, however. As a nurse, the researcher is legally mandated to report unsafe conditions or practices, suspected abuse of patients, and any suicidal or homicidal ideation uncovered in the course of data collection.

The study will not benefit you personally. There is no monetary compensation for participation. If you agree to participate, you will be adding to the body of knowledge about staff perceptions of this phenomenon that may help to improve existing interventions. Recalling and sharing experiences of non-supportive or non-caring behaviors at work may be distressing. You should consider this potential risk in deciding whether or not to participate in this study. Counselors at the Employee Assistance Program here at UMass are on-call 24 hours a day, 7 days per week at 1-800-322-5327. Participants who experience distress will be referred to this service.

If you have any questions about this research study, you may contact the researcher, Rosemary Taylor at taylor.ro@husky.neu.edu or her faculty advisor, Dr. Susan Jo Roberts at s.roberts@husky.neu.edu. If you have any questions about your rights as a participant, you may also contact Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115 tel. 617-373-7570. You may call anonymously if you wish.
Appendix C

Written Document Analysis Worksheet

1. Type of document (policy statement, report form)

2. Physical characteristics of the document (printed, on-line, on letterhead)

3. Date of document

4. Author/creator of the document (position or title, if provided)

5. Audience (intended or excluded)

6. Purpose of the document

7. Message (explicit message of document, potential implicit message of document)

Other observations

Adapted from the Written Document Analysis Worksheet from The National Archives. Developed by the Education Staff, National Archives and Records Administration, Washington, DC 20408 (National Archives, n.d.)
http://www.archives.gov/education/lessons/worksheets/
Appendix D

Semi-structured Interview Guide

The interview will begin with questions about the participant’s interest in nursing:
How and when did you decide you wanted to become a nurse?
Is nursing different from what you thought nursing would be like?
Tell me about a good day at work. What does a good day at work look like?
Tell me about a bad day at work. What does a bad day at work look like?

Interviewees will be asked to describe the types, characteristics, and diverse experiences that they have had of horizontal violence; to identify the triggers that believe may precipitate behaviors they feel are related to horizontal violence; to identify how they have responded to experiencing or witnessing horizontal violence; and to describe the impact of horizontal violence on nursing, their patients, and the unit. (Adapted from Walrath et al., 2010)

Have you seen or experienced any behaviors, physical or emotional, between nurse colleagues that could be described as non-caring or non-supportive?
If so, please share a story of your experience.
How did you respond to witnessing or experiencing those behaviors?
What contextual factors do you believe trigger and/or facilitate these behaviors?
What could have been done to prevent it or to better alleviate the consequences?
How did you make sense of the experience at the time?
In reflection, how do you make sense of the experience now?
How do these behaviors impact nursing? The unit? The patients?
Appendix E

Facility Mission, Vision, and Values Statement

Mission, Vision, and Values

Our Mission - A Statement about Our Present and Why Our Organization Exists

[UMass Memorial Health Care] is committed to improving the health of the people of our diverse communities of Central New England through culturally sensitive excellence in clinical care, service, teaching and research.

Our Vision - A Statement about Our Future and What We Want to Be

As one of the nation's most distinguished academic health care systems, [UMass Memorial Health Care] will provide leadership and innovation in seamless health care delivery, education and research, all of which are designed to provide exceptional value to our patients.

Our Values - A Guide to Our Decision-making as We Move to Our Future

Consistently excelling at patient-centered care
Acting with personal integrity and accountability
Respecting one another
Effecting change through teamwork and system thinking
Supporting our diverse communities

(downloaded from facility website 2/26/13)
Appendix F

Unit A* Vision Statement

Vision Statement
Our 6 East Team is empowered and committed to working in unity to maximize a positive experience for our patients and families. The 6E Team continues to create a supportive environment by enhancing professional and personal growth through collaboration, communication and accountability.
Appendix G

Unit B* Vision Statement

General Surgical Services Mission
It is our mission on 6 West to utilize effective communication, evidence based practice, continuity of care, teamwork and accountability to exceed the expectations of those patients and families for whom we care. We will provide compassionate, holistic and quality services. We support an environment that promotes professional nursing practice with emphasis on creativity, new ideas and continuing education. As a unit, we are dedicated to collaborating with, supporting and respecting our peers to succeed with our mission.
(Nursing Practice Council, August 2010)
Appendix H

Facility Workplace Violence Policy

Workplace Violence Prevention Effective Date: 6/7/2011

I. Policy

[Redacted] is committed to providing a safe and secure workplace and an environment free from physical violence, threats, harassment, aggression, and intimidation for patients, visitors, and staff. This policy will outline the procedures to be followed when inappropriate behavior such as acts or threats of violence occur at [Redacted]. All reports of potential violations of this policy by any individual at [Redacted] will be investigated appropriately and may lead to disciplinary action up to and including discharge, and/or legal action, including contacting law enforcement authorities, as appropriate.

II. Definitions

Workplace Violence (WPV): Any physical assault, threatening behavior or verbally abusive remark that is made in the workplace and/or affects the workplace behavior of an employee, which includes but is not limited to:

- Verbal threats, intimidation, or coercion;
- Physical assaults of attempted physical assaults;
- Sexually inappropriate behavior;
- Any unauthorized use or possession of firearms, explosives, knives, or other devices, machinery, or material(s) that could be used, and/or could be threatened, as weapon in the workplace.
- Abusive, obscene, and/or coercive language or conduct;
- Grossly negligent or reckless conduct that a reasonable person would foresee as resulting in injury to persons or property.

Risk Assessment Team: Includes representative(s) from but is not limited to Hospital Leadership; Human Resources, Risk Management, Campus Police and the Employee Assistance Program (EAP). This team will assess risk and make recommendations pertaining to acts of alleged violence in the workplace.

III. General Procedure:

REPORTING A THREAT/INCIDENT

It is each individual’s responsibility to immediately report any situation that could result in harm to anyone in the workplace. Security emergencies can be communicated via the telephone system by dialing 12345 at the [Redacted] Campus and 911 at the [Redacted] Campus. A report of imminent danger shall be acted upon in a timely manner by the Campus Police.

DOMESTIC VIOLENCE/PERSONAL SITUATIONS
Employees sometimes experience personal issues that may adversely affect the safety and security of the workplace. Employees who are aware of any situation that could adversely affect the workplace should report it to their manager, Human Resources and Campus Police. Employees who possess a restraining order or stay away order that includes the workplace in its provisions are strongly encouraged to notify Campus Police and to cooperate fully in analyzing the risk and establishing protective measures in the workplace. Such information will be treated in a confidential manner to the extent practicable, with considerations to the safety of the general employee population.

PROHIBITED BEHAVIORS

- The carrying or concealment of weapons within Medical Center facilities, or on its premises, including parking areas and grounds. No person may enter a facility or company vehicle, or come onto any premises with any type of weapon including firearms. This includes visible and concealed weapons, even those for which the owner has obtained necessary permits. For the purpose of this policy any device which is considered a weapon may not be brought onto the premises. This policy excludes Law Enforcement Agencies & Campus Police currently on duty.
- Any behavior that could be construed as threatening, overly aggressive, confrontational, or violent. Prohibited activities include any threatening behavior or acts of violence including, but not limited to, conduct that is harassing, intimidating, presents a challenge to fight, constitutes veiled or direct threats, assaults, or attempts to assault or sabotage, or the use of obscene, abusive or threatening language or gestures.
- Retaliation against any person who brings a complaint of hostility or violence in good faith, or serves as a witness in the investigation of a complaint.

LEADERSHIP IS RESPONSIBLE FOR THE FOLLOWING:

- Collaborating with Campus Police to develop guidelines and coordinate training programs regarding workplace violence and prevention; Keeping abreast of workplace violence trends and considering these factors during budgeting and planning activities.

CAMPUS POLICE AT THEIR RESPECTIVE CAMPUSES ARE RESPONSIBLE FOR THE FOLLOWING:

- Management, planning, monitoring, and implementation of this policy;
- Investigation of all incidents and/or perceived threats and notification of Law Enforcement and Emergency Services as appropriate;
- Overseeing the preventative measures outlined in this policy;
- Reviewing incidents and insuring that procedures have been implemented as appropriate;
- Development of security reports for the Safety Committee, Quality Council and Board as well as an annual report to the Hospital Leadership on the effectiveness of the plan;
Initiation of the preventative measures listed in this plan related to reports by staff, patients and/or visitors of stalking, domestic violence or threats of violence which occur on hospital property;
Notifying the Administrator on Call (AOC) of incidents, as appropriate;
Collaborating with Leadership to develop guidelines and coordinate training programs related to workplace violence and prevention.

DEPARTMENT MANAGERS ARE RESPONSIBLE FOR THE FOLLOWING:
Reported imminent danger immediately to Campus Police and Human Resources Business Partners;
Reporting incidents or any perception of threat in a concise and timely manner to Campus Police and Human Resources Business Partners;
Completion of an Occurrence Report;
Providing department specific education regarding security and workplace violence prevention issues/procedures to staff;
Development and maintenance of department specific security procedures as appropriate;
Ensuring staff adheres to policies and procedures;
Completion of employee corrective plans and documentation;
Participate in Leadership and Campus Police developed programs regarding workplace violence and prevention.

HUMAN RESOURCES DEPARTMENT IS RESPONSIBLE FOR THE FOLLOWING:
Ensuring that appropriate resources are involved in response to an incident including but not limited to: Employee Health, Employee Assistance Program (EAP), Legal and Labor Relations;
Conducts investigation in coordination with other Risk Assessment Team members;
Overall responsibility to ensure an action plan is developed and implemented;
Interpretation and adherence to this policy;
Maintaining a detailed file on the incident;
Recommending, in conjunction with operational leadership, the appropriateness of discipline or other remedies as an outcome of any investigation.

THE EMPLOYEE ASSISTANCE PROGRAM IS RESPONSIBLE FOR THE FOLLOWING:
Mental health consultation to the WPV Risk Assessment Team as well as evaluation of referred employees. EPA also provides support to assist employees with issues related to possible workplace violence and hostility.
INDIVIDUAL EMPLOYEES ARE RESPONSIBLE FOR THE FOLLOWING:

- Observing and reporting to the Campus Police and his/her manager any irregularities, suspicious activities throughout the facility or unknown individuals in restricted or questionable areas;
- Wearing required Medical Center issued photo identification badge at all times while on duty as outlined in Policy # 6056 Photo Identification Badge.

Security incident reports should be used to provide information for analysis, risk assessment, evaluation of methods of control, severity determinations, identifying training needs and overall program evaluations.

A review will be conducted on all security incidents that meet the definition of a sentinel event as outlined in the Serious Event Reporting Guidelines (Policy #1090 Root Cause Analysis 1090 Review Process and Regulatory Reporting Guidelines.)

IV. Clinical/Departmental Procedure: N/A

V. Supplemental Material: N/A

VI. References:

- Policy #1409 – Reporting and Investigation of Events, Allegations, and Complaints
- Policy #6202 – Prisoner/Patient Management
- Policy # 6056 – Photo Identification Badges
- On-line occurrence reporting, guidance and tips
Appendix I

Facility Code of Ethics and Business Conduct
Workplace Conduct, Diversity and Equal Opportunity, Discrimination and Harassment, Workplace Violence
p.11-12 Code of Ethics and Business Conduct

Workplace Conduct
UMass Memorial strives to provide a working environment based on respect, fairness, honesty and integrity, and has developed workplace policies and practices to support this goal. Safety and quality of patient care are fostered by a collaborative environment of courtesy and mutual respect. Intimidating and disruptive behaviors are unprofessional and not tolerated. Behaviors that are considered intimidating and disruptive can verbal or physical. They include verbal outbursts and foul language; sexual harassment in any form; physical roughness; threats; refusing to perform assigned tasks; quietly exhibiting uncooperative attitudes during routine activities; reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. Covered individuals should conduct themselves in a responsible manner that protects the interests of UMass Memorial.

Diversity and Equal Opportunity
UMass Memorial is committed to enhancing diversity in the workplace and a positive work environment. UMass Memorial is an equal opportunity/affirmative action employer and complies with all federal and state laws in this area. Employee hiring, personnel actions, and social and recreational programs sponsored by UMass Memorial are designed and administered without discrimination with respect to race, color, religion, gender, age sexual orientation, national origin, veteran status, disability or any other category protected by law. UMass Memorial workforce members strive to celebrate our diversity, and to build on each other’s differences and expertise.

Discrimination and Harassment
The policies at UMass Memorial prohibit discrimination or harassment. Retaliation against any person seeking to report concerns in good faith regarding our compliance with applicable laws or UMass Memorial policies is not tolerated. Employees should bring concerns to their manager, Human Resources Department or the Equal Opportunity Office. The manager, in consultation with the Human Resources Department and/or Equal Opportunity Office, will promptly follow up to address the particular behavior and ensure that all parties understand that UMass Memorial policies prohibit discrimination or harassment, and that retaliation against any individual for reporting concerns is not tolerated.
If you have any questions or wish to report suspected discrimination or harassment, call your Human Resources Department or Equal Employment Opportunity Office.

Workplace Violence
prohibits workplace violence, including behavior that is threatening, overly aggressive, confrontational or violent (e.g., verbal threats, stalking, terrorism, hate crimes, or similar conduct).

Workplace violence should be reported immediately to your Security Office.
Appendix J

Map of Units A* and B*

[Diagram showing floor plan of units A and B with labeled areas such as Patient Rooms, Staff, Break Room, etc.]
**Appendix N – Codebook**

<table>
<thead>
<tr>
<th>Code</th>
<th>Working definition/inclusion &amp; exclusion criteria</th>
<th>Examples</th>
<th>Notes</th>
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<tbody>
<tr>
<td>HV OBSERVED</td>
<td>Events or behaviors related to horizontal violence witnessed by the researcher during observations. Examples of any behavior listed in Manifestations or horizontal violence (nonverbal cues/verbal innuendo, verbal remarks/verbal affront, actions/inactions, withholding information, sabotage, infighting, scapegoating, passive aggressive behavior, and broken confidences). Inclusion criteria - The event or behavior related to horizontal violence must have been directly witnessed by the researcher. The event or behavior must be between employees of the facility. Exclusion criteria - Events or behaviors reported to the researcher, not directly observed, are excluded. Events or behaviors between employees and non-employees (for example, patients and family members) are excluded.</td>
<td>Gossiping, mimicking, labeling, evidence of cliques, scapegoating, public calling out for medical error. Yelling on the phone MD to MD, MD to RN, bloodbank RN to RN. Yelling RN to US. Eye rolling MD to US</td>
<td>Researcher witnessed all of the behaviors except sabotage and withholding information. Assessing intent in inactions (not helping) was difficult.</td>
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<td>HELP OBSERVED</td>
<td>Helping behaviors witnessed by the researcher during observations. Examples of any behavior that involves assisting or helping another member of staff with a task or duty. Inclusion criteria - Any behavior performed by a member of staff to assist or support another in any way that is not explicitly part of their job description. Exclusion criteria - The task or duty cannot be an assigned duty of the person assisting. For example, a transport team member arriving to transport a patient as assigned would not be included.</td>
<td>Answering call lights and alarms for other nurses, stepping in and offering help, starting admission paperwork. Providing emotional support after a code situation. Mentoring. Teaching.</td>
<td>Postings in break rooms indicate gift giving for new babies, get well cards in times of illness, sympathy cards when a staff member loses a family member, and donation of time earned when someone is out for a long period of time.</td>
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<td>HV REPORTED</td>
<td>Events or behaviors related to horizontal violence reported by members of staff during conversations, informal and formal interviews. Examples of any behavior listed in Table 2 - Manifestations of horizontal violence (nonverbal cues/verbal innuendo, verbal remarks/verbal affront, actions/inactions, withholding information, sabotage, infighting, scapegoating, passive aggressive behavior, and broken confidences, or identified as non-caring or non-helping by staff) reported by participants. Inclusion criteria - The event or behavior related to horizontal violence must reported by a member of staff. It does not have to have been witnessed by that member of staff. Events or behaviors that are rumored to have occurred can be included but must be identified as second hand information. The event or behavior must be between employees of the facility. Exclusion criteria - Reported events or behaviors between employees and non-employees (for example, patients and family members) are not included.</td>
<td>Gossiping, mimicking, labeling, cliques, scapegoating, name-calling, threat to report, and backstabbing. New grad nurse reported being laughed at by her clinical instructor.</td>
<td>Participants reported all of the behaviors except sabotage and withholding information. Assessing the intent in inactions (not helping) was difficult but some nurses reported that they made decisions not to help others who did not help them.</td>
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<td>HELP</td>
<td>Examples of any behavior that involves assisting or helping another member of staff with a task or duty reported to the researcher by a participant. Inclusion criteria - Any example of a behavior performed by a member of staff to assist or support another in any way reported to the researcher by a participant can be included. The event or behavior must be between employees of the facility. Exclusion criteria - The task or duty cannot be an assigned duty of the person assisting. For example, a transport team member arriving to transport a patient as assigned would not be included. Events or behaviors between employees and non-employees (for example, patients and family members) are not included.</td>
<td>Answering call lights and alarms for other nurses, stepping in and offering help, and starting admission paperwork. Providing emotional support after a code situation. Mentoring. Teaching.</td>
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<td>REPORTED</td>
<td>Helping behaviors reported by members of staff during conversations, informal and formal interviews.</td>
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<td>ATTRIBUTION / PERSONS</td>
<td>Participant attribution/ sensemaking of horizontal violent behaviors/non-caring/non-helping behaviors between staff that is related to a person's personality, work ethic, or values. Any description by participants about how they understand, make sense of behaviors between colleagues that is related to personality or individual characteristics. Inclusion criteria - Any mention/examples of the role of personality or personal attributes as contributing to negative behaviors between members of staff. Exclusion criteria - Any examples of personal characteristics or attributes that participants mention by do not connect directly to contributing to negative behaviors. Factors contributing to negative behavior that are not tied to personality or personal attributes are not included. For example, &quot;It was busy&quot; would not be included in this code, but &quot;She gets angry when it's busy&quot; would be.</td>
<td>Individual personalities, work ethic, burnout, generational differences, personal lack of accountability, life outside of work/personal lives, gender. Includes recognition of conflict avoidance.</td>
<td>Attributions for most behaviors were primarily directed at individuals</td>
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<td>ATTRIBUTION / ENVIRONMENT</td>
<td>Environmental factors/systems problems identified by participants as triggers/contributing to negative behaviors. Any environmental factor or systems problem that participants identify as contributing in any way to making the work environment more stressful, decreasing the threshold for additional stressors. Inclusion criteria - Any mention of environmental factors contributing to stressors that result in negative behaviors. Exclusion criteria - Any examples of environmental factors that may be stressful but that the participant does not connect directly to contributing to negative behaviors.</td>
<td>High stakes environment with multiple distractions. Nurses have no control of patient flow or allocation of resources. Medications and/or supplies not available. Transport not reliable. Discharges are poorly managed. Admissions occur at change of shift. Unprofessional behavior at the desk. A sense that &quot;nothing changes&quot;. Sense of disconnect between front line staff and administration. Verbal abuse and threats by patients and family members.</td>
<td>Bartholomew (2006: 74) points out that nurses, situated at the bottom of the hierarchical ladder, feel “the total weight of all of the pressures from above”.</td>
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<td>OTHER CONTRIBUTING FACTORS</td>
<td>Factors identified by the researcher, not by participants, as contributing to or perpetuating negative behaviors. Includes systems problems. Inclusion criteria - Includes any conditions contributing to minimizing, not recognizing, not reporting behaviors associated with horizontal violence, as well as any factors contributing to non-caring, non-helping behaviors between staff not explicitly mentioned by staff but observed by researcher or extrapolated from the data. Exclusion criteria - Conditions and/or contributing factors identified by staff participants are excluded.</td>
<td>General lack of civility. No norm of mutual respect or courtesy. Human Resource policies are difficult to enforce/focus on legal definitions of harassment, not on reducing hostility in the work environment by supporting staff with initiatives, and education and other resources / not focused on prevention. Care is delivered in silos/model of care delivery contributes to isolation of individual workers and adversely affects teamwork. Communication is unreliable/no system to assure that messages are received. Nurse Managers and Floor Nurses have no say in patient flow. Admits and discharges appear to be batched. Self-sacrificing behavior by nurses enables system to function with limited resources. Nurses who point out problems on the unit are labeled as &quot;the problem&quot;</td>
<td>Policies must create clear expectations of acceptable behavior/no tolerance for non-professional behavior. There is a lack of conceptual clarity in hospital policies.</td>
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