

HORIZONTAL VIOLENCE IN NURSING: POLICY IMPLICATIONS

by

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DEDICATION

This effort is dedicated to my dear family who patiently supported me during the sunny weekends and powder days that were dedicated towards pursuing this Masters in Nursing degree. We have many more adventures to come!!

There is also a very special appreciation that I need to send to my parents. They have tirelessly supported my goal of becoming a Nurse Practitioner and have been my staunchest advocates for pursuing this program through the years. Thank you!!

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ABSTRACT

The problem of horizontal violence (HV) in nursing remains a prevalent problem despite recommendations of zero tolerance from national organizations such as the American Nursing Association and the Joint Commission. Horizontal violence is defined as “hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words and/or behaviors”(Thobaben, 2007, p. 82). A study conducted in 2003 and repeated in 2013 by the Institute of Safe Medication Practices (ISMP) found a persistent culture of HV tolerance and indifference in healthcare settings. Horizontal violence is closely related to retention of both seasoned and new graduate nurses, a serious concern in the current and looming nursing shortage. This project investigated possible policy implications related to horizontal violence in nursing by increasing an understanding of the supportive role of hospital policies. Procedures for this project included (a) a review of current HV literature, (b) a request for policies on HV, workplace violence, harassment, bullying and/or codes of conduct/ethics from 10 hospitals (both critical access and non-critical access) in Montana, and (c) analysis of the policies using an evidence-based grid. Out of the ten hospitals of various sizes contacted, there was a 50% response/participation rate. Of the five hospitals that responded, none had policies specific to horizontal violence. Three hospitals had workplace violence policies and two hospitals had no policies on HV or any related key words. Findings indicate a clear need for further study with a larger hospital sample and an improved policy retrieval process to better understand the presence or absence HV healthcare policies. Use of the evidence-based grid developed for this project could serve as a useful tool for hospitals interested in creating a policy directly related to HV in nursing and a mechanism for consciously developing and enforcing cultures of respect in the workplace.

CHAPTER 1

INTRODUCTION

Healthcare organizations share common goals that include excellent patient care and workplace safety. The unique environment of healthcare organizations, in particular hospitals, presents challenges including pressures to increase productivity demands, cost containment initiatives, historical power structures, and fear of litigation (Institute for Safe Medication Practices [ISMP], 2013). To achieve optimal performance, team members within a hospital must work together and feel safe within their workplace. The healthcare team includes, but is not limited to, physicians, mid-level providers (APRN), nurses (RN, LPN), certified nursing assistants (CNA), laboratory and radiology technologists, nurse managers, hospital administrators, pharmacists, environmental/ nutrition/equipment services, and patients and their families.

The work within healthcare organizations is often difficult, emotional, and occasionally burdened with historical paradigms of internal and external oppression specifically related to nurses. “To achieve high-quality care, professional teamwork among nursing staff is imperative. Teamwork is a critical element for achievement of positive patient outcomes” (Joint Commission, 2008). A culture of safety, both emotional and physical, is critical in the attainment of these goals.

A safe workplace environment is a vital cornerstone to the effective functioning of any organization. A number of factors contribute to providing employees and employers with a safe workplace environment. According to the Institute of Medicine, a healthy

work culture incorporates most or all of the following components of a “healthy culture molecule”: humanity, shared purpose, principles of dialogue, healthy relationships, safe infrastructures, service, competency, networking, and client resources (Wesorick, 2001, p. 1). These tenets cover the physical safety factors of infrastructure, i.e. stable walls and dry floors, as well as the more intangible psychological safety factors or healthy relationships and dialogue, i.e. recognizing each person’s contribution to a project or feeling like one has a voice within an organization. The following “healthy culture molecule” summarizes the fundamental elements necessary to support the creation of healthy, healing work cultures (Wesorick, 2002, p. 30):

- Quality exists when shared purpose, vision, values, and partnerships are lived.
- Each person has the right to health care, which promotes wholeness in body, mind, and spirit. Each person is accountable to communicate and integrate his or her contribution to health care.
- Partnerships are essential to plan, coordinate, integrate, and deliver health care across the continuum.
- A healthy culture begins with each person and is enhanced through self-work, partnerships, and systems support (Wesorick, 2000, p.3).

One of the goals of the American Organization of Nurse Executives 2010 and 2012 Strategic Plan is to improve and create healthy work practice environments that will improve patient safety and quality of care (Lewis & Malecha, 2011, p. 41). Integral to this initiative is the necessity of effective work relationships in creation of a healthy workplace. “The relationship between the nurse and the nurse’s manager and peer relationships are critical to healthy work environments” (Lewis & Malecha, 2011, p. 41-42). In working with others in a stressful environment, it is essential that each player is

able to safely ask questions, offer opinions, make suggestions, and elicit appropriate change without fear of punishment, shame, or belittling remarks.

“Hostility exhibited in the workplace leads to decreased staff morale, employee dissatisfaction, decreased staff retention, decreased feelings of empowerment, and, ultimately, loss of professional obligation and commitment toward patients” (Hickson, 2013, p. 293). Although an initial insult or incident may be viewed as an isolated event, it is when a pattern of hostility emerges that the new nurse feels trapped in the cycle of abuse and cannot draw on experience or confidence to guide him or her through the tough time. Hickson states “Tolerance for NH [nurse hostility] has been viewed as a rite of passage, whereas new nurses often endure an underground hazing process” (2013, p. 293). This process is difficult to combat and requires each nurse to assume accountability for his or her own behaviors and attitudes, as well as one’s responses toward negative nurse influences that may be in leadership roles or peer roles within the department or unit.

Evidence-based practice is defined as “an integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families, and communities who are served” (DiCenso et al, 2004, p. 69). In developing an evidence-based policy for nurse bullying, the impact on patient safety and patient outcomes must play a strong role. The literature supports the idea that nurse bullying has the potential to impact patient safety due to a number of factors.

In nursing we continually strive to positively impact patient outcomes. Therefore, it is important to determine what factors impact patient outcomes; then, we as a profession can take steps to minimize factors that may have a negative impact, support

actions that have a positive impact, and accept practices that do not have an impact (Dorwart, 2009, p. 2).

Based on a review of current literature, in developing or analyzing an anti-nurse bullying policy, evidence-based practice leads one to address: the impact of nurse bullying on nurse retention, job satisfaction, nurse health, and patient safety; the prevalence of nurse bullying across nursing; and patient outcomes related to the issue of nurse bullying.

Problem Statement

“The challenge of bullying is not new to nursing but has been long ignored as an issue critical to the profession. As a result, the behaviors have been allowed to contaminate the work environment” (Longo, 2013, p. 951). The presence of horizontal violence within nursing has long been identified by the familiar adage, “nurses eat their young.” The issue of horizontal hostility in nursing had reached such epidemic proportions with significant impacts to retention and the nursing shortage in 2004 that the AACN, American Association of Critical Care Nurses, issued a ‘Zero Tolerance for Abuse’ position statement during that year. It has been almost a decade since this statement was issued and the problem of horizontal violence is still prevalent in the headlines.

“Effective processes to prevent, report and deal with abuse are not universally in place in organizations” (AACN, 2004, p. 1). Due to the lack of accountability to hostile behaviors, the perpetrators, who may not be aware of how their covert body language and side remarks affect others, continue to act as they always have acted. It is essential to

explore the organizational culture and leadership style. “Pointing blame at individual personality differences or assuming that it is because of a personality conflict may result in the organization missing the bigger picture - it is the culture that could be the cause of the bullying, not the individual” (Fanning & Hennessy, 2014, p. 10).

According to the American Nurses Association’s Position Statement titled, “Zero Tolerance for Abuse” (2011, p.1), the following bulleted points are key impacts of horizontal violence and bullying in nursing:

- Intimidating colleagues contributed to up to 40 % of medication errors due to intimidation.
- Health problems of hypertension, coronary artery disease, depression, psychological problems can stem from increased stress.
- Standards of patient care can suffer due to low staff morale, increased absenteeism, and lack of retention of experienced nurses.
- Nurses may choose to leave the profession due to lateral violence and bullying, contributing to the nursing shortage.

Due to the continuing presence and discussion of HV in the healthcare workplace, as well as the impact that it has on nurse retention and patient safety, it is essential to understand more fully the concept of HV and to determine the evidence-based policy steps hospitals can take to address this issue. Current literature and data suggest that HV will continue unless zero tolerance policies are instituted and education programs for skill development are utilized to prevent and respond to verbal abuse (Sofield & Salmond, 2003, p. 14).

Purpose Statement

The purposes of this project are to (a) examine established policies regarding bullying in the healthcare environment and (b) identify available evidence to support the policy across various sizes and types of hospitals in Northwest Montana including Critical Access Hospitals and non-Critical Access Hospitals.

Significance

The need for this project is clearly based on the close relationship between HV and retention of nurses, in particular new graduate nurses, and the continuing epidemic of nurse bullying despite zero tolerance statements issued by national organizations and greater awareness campaigns during the past decade. For this paper, the term horizontal violence (HV) will be used synonymously with nurse bullying, nurse hostility, lateral violence, workplace violence, and horizontal hostility. “One in three nurses leave their position in nursing due to horizontal hostility. Approximately 60% of graduates leave their position within the first six months due to some form of lateral violence” (Bartholomew, 2006, p. 9). The negative impact that horizontal violence currently has on the profession of nursing, as well as its historical significance and potential for adverse future effects, creates a determination that this issue must be adequately addressed by nursing, administration, and the entire medical community.

According to the Institute for Safe Medical Practice (2013) in a national survey that was conducted in 2003 and again in 2013, a number of key points are made (p.3):

- Fewer respondents in 2013 were satisfied with organizational efforts to address disrespectful behaviors than in 2003.
- Only 50% of respondents in 2013 felt that their organization had a clear, effective process for processing disagreements regarding the safety of an order, down from 60% in 2003.
- Only 25% of respondents in 2013 thought that their organization dealt effectively with disrespectful behavior, down from 39% in 2003.

Due to the lack of improvement in these categories, despite the 2004 zero tolerance policy recommendations made by the AACN and ANA, we must closely examine the content of current policy against the evidence and determine if there may be room for improvement.

Operational Definitions of Terms used in this Paper

Horizontal Violence

[This definition will also to apply to a number of terms used interchangeably within this paper. The other terms are: Bullying, Horizontal hostility, Lateral violence, and Relational aggression.]

Horizontal or lateral violence has been explained across contexts as any unwanted abuse or hostility within the workplace (Becher & Visovsky, 2012, p. 210). Thobaben (2007) defines horizontal violence as “hostile, aggressive, and harmful behavior by a nurse or group of nurses toward a coworker or group of nurses via attitudes, actions, words and/or behaviors” (p. 82). The definition of bullying takes an individual act of

violence, either emotional or physical, and translates it into a repeated encounter that the victim must face more than a single time in a certain setting. Bullying is not usually a physical act, but instead can be any of a list of the following most commonly determined behaviors (Griffin, 2004, p. 259):

- Non-verbal innuendo (raising of eyebrows, face-making)
- Verbal affront (covert or overt, snide remarks, lack of openness, abrupt responses)
- Undermining activities (turning away, not being available)
- Withholding information (about practice or patient)
- Sabotage (deliberately setting up a negative situation)
- Infighting (bickering with peers)
- Scapegoating (attributing all that goes wrong to one individual)
- Backstabbing (complaining to others about an individual and not speaking directly to that individual)
- Failure to respect privacy
- Broken confidences

The following is a table from Rocker's Canadian research into horizontal violence in nursing with specific attention to nurse retention (2008, p. 7-8) (Table 1).

Table 1. Examples of Nurse-to-Nurse Bullying.

Communication	Description
Interactions	<ul style="list-style-type: none"> ● Withholding information. ● Posting documentation errors on bulletin boards for all disciplines to view and others to critique. ● Intimidating others by threats of disciplinary procedures. ● Writing critical and abusive letters or notes to co-workers. ● Verbalizing harsh innuendos and criticism. ● Using hand gestures to ward off conversation. ● Rolling eyes in disgust. ● Having personal values and beliefs undermined.
Power Disparities	<ul style="list-style-type: none"> ● Using shift/weekend charge positions to direct/control staff assignments/breaks. ● Controlling co-workers' behavior by reporting them to their supervisors for perceived lack of productivity and assistances. ● Placing others under pressure to produce work and meet impossible deadlines. ● Withholding knowledge of policies and procedures to get co-workers in trouble.
Actions	<ul style="list-style-type: none"> ● Yelling at co-workers. ● Demanding co-workers answer the telephone, NOW! ● Refusing to mentor and guide new staff in their practice. ● Refusing to help those who struggle with the unknown and uncertainty. ● Refusing to help others in need of assistance. ● Giving public reminders of incomplete/missed documentation or work.

Abuse

This term encompasses all behaviors, physical, emotional, and verbal, that produce angst, harm, and/or doubt in another individual. These behaviors are most-often intentional behaviors, done with the goal of power or control over another, but are occasionally spontaneous.

Nurse

This includes all educational levels of nursing: RN (Registered Nurse), LPN (Licensed Practical Nurse), and the CNA (Certified Nurse Assistant).

Magnet Status

“The Magnet Recognition Program recognizes health care organizations for quality patient care, nursing excellence and innovations in professional nursing practice” (Drenkard, 2010, p. 1). It is generally accepted as the highest standard of successful nursing practices and nurse satisfaction through means of empowering nurses to make changes and improvements in their workplace. Recent literature supports the statement that nurses in Magnet organizations are more satisfied with their jobs by utilizing a path of transformational leadership and higher levels of engagement. Higher levels of engagement correlates to better outcomes and higher retention rates. “Gallup estimates that Magnet hospitals, on average, experience 7.1% fewer safety-related incidents and accidents than the industry norm” (Drenkard, 2010, p. 1).

Overt Behaviors

Intentional behaviors that can be noticed by others, i.e. gossiping at the nurses station, shouting or yelling at a co-worker, slamming items onto the counter and stomping away, etc. “Overt behaviors are more blatant and include sabotaging another nurse, scapegoating, taking actions that prevent another nurse from doing his or her job (such as hiding items needed for patient care), forming cliques, and exhibiting passive-aggressive behavior toward a particular nurse” (Flateau-Lux & Gravel, 2013, p. 24).

Covert Behaviors

Secretive behaviors that are often not noticed by others directly. “Examples of covert behaviors include nonverbal cues, deliberately withholding information, gossiping, and sharing private information that wasn’t intended for others to know”(Flateau-Lux, & Gravel, 2013, p. 24).

Critical Access Hospital

According to the Centers for Medicare and Medicaid Services (2014) a Critical Access Hospital (CAH) must meet the following criteria: be located in a State with a rural health plan; be located in a designated rural area; comply with specific regulations; provide 24-hour Emergency Services 7 days a week, with on- site or on-call staff (with specific response times); maintain less than 26 inpatient beds; maintain an annual average length of stay of < 96 hours; and, be > 35 mile drive from any other hospital/CAH or > 15 mile drive from any other hospital/CAH with mountainous terrain or only secondary roads, or have been certified as a CAH prior to 1/1/2006 with a State designation of being a necessary provider of health services to local residents. For the purpose of this paper,

the use of CAH will help to compare hospitals of different sizes in Montana while maintaining their anonymity.

Non-Critical Access Hospital

The purpose of this definition for this study is to help maintain anonymity of participating Montana hospitals based solely on size. For this study, a non-CAH hospital is a hospital that is larger than a CAH hospital and does not meet the above-mentioned CAH criteria. Some of these hospitals may be trauma centers, Magnet or aspiring-Magnet hospitals, or have other specialty services. None of these identifying features will be used in this paper other than non-CAH.

Organization of the Remainder of the Project

In Chapter 2, the literature on horizontal violence and bullying within nursing and policy development will be reviewed. Chapter 3 will cover the methodology to be used for discovering and analyzing policies for a select number of hospitals in Northwest Montana. Chapter 4 will present the findings of the projects and a report of the data. It will also include discussion of the findings within the conceptual framework and recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

Key words used for the review of literature included: bullying, nurse, nursing, horizontal violence, oppression, policy, and workplace violence. The Montana State University library system was used to access the CINAHL, Medline, and EBSCOhost databases. By varying the combinations of the key words during the search process, as well as limiting each category to 'nursing', the references for this project were discovered. The reference lists of certain articles were used as sources for additional references. All sources were limited to peer-reviewed, published titles. All references used in this paper were available in full text by either MSU-library database or Kalispell Regional Healthcare medical library. The chosen articles include peer-reviewed studies and comprehensive review articles. The articles found on bullying were further analyzed to only include horizontal violence, and to purposely exclude physician-nurse bullying studies.

The remainder of the literature review explores horizontal violence (HV) in nursing from multiple perspectives. The topics to be investigated in relation to HV in nursing include: retention and job satisfaction, health and wellbeing of the nurse, prevalence of HV, relationship of HV to patient safety, and the role of policy in nursing professionalism. This comprehensive literature review seeks to provide a thorough examination of the problem of HV in nursing as it relates to the stated topics in order to

fully understand the breadth and impact of nurse bullying in the current climate of healthcare.

Prevalence

“Verbal abuse of nurses by their colleagues in health care settings is an ongoing and well-documented problem” (Robert Wood Johnson Foundation [RWJF], 2013, p. 1).

The study that was conducted by the RWJF looked at verbal abuse of nurses by nurses, with the most common forms of abuse being condescension or being ignored. More specifically, the verbal abuse is best described as passive-aggressive versus more outward “yelling, swearing, insulting, or humiliating behavior” (RWJF, 2013, p. 1).

“This kind of subtle abuse is less likely to be reported and more likely to be overlooked as a problem, which makes it all the more insidious and it is all the more important that hospital administrators work to confront and prevent it” (RWJF, 2013, p. 1).

As stated in the recent NurseAdvise-ERR, October 2013,

The results of our 2003 and 2013 surveys expose healthcare’s continued tolerance and indifference to disrespectful behavior. These behaviors are clearly learned, tolerated, and reinforced in the healthcare culture, and little improvement has been made during the last decade. The stressful healthcare environment, particularly in the presence of productivity demands, cost containment, and hierarchies that nurture a sense of status and autonomy, have likely been the most influential factors. This creates an environment in which victims may feel they have no choice but to become perpetrators and join in the practice...the deep sense of frustration threaded through many of the comments from survey respondents suggests that now is the time for action (p. 4).

“The actual incidence and prevalence of horizontal violence in nursing are relatively unknown, as HV often is unrecognized and underreported” (Becher & Visovsky, 2012, p. 211). This is particularly true with regards to the higher prevalence of

passive-aggressive and covert behaviors versus more openly aggressive or public behaviors. It is much more straightforward to take action in a bullying incident involving assault or public yelling of insults compared to the more typical HV covert behaviors of attitude, name calling, gossiping, unreasonable assignments, isolating, and making condescending remarks when asked a question. Johnson and Rea (2009), conducted a study to learn more about HV among nurses by asking the following research questions: (a) What is the experience of workplace bullying by RN members of the Washington State Emergency Nurses Association? (b) What is the relationship between bullying and intent to leave the organization or the nursing profession (p. 85)? The Negative Acts Questionnaire-Revised was the instrument used to measure workplace bullying. For clarity of the study, workplace bullying was defined as:

. . . a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation wherein the target of bullying has difficulty in defending himself or herself against these actions (p. 85).

Findings from this study indicated that 27.3% of the nurses had experienced workplace bullying, with 18 of the nurses reporting experiencing two negative acts daily or weekly and as many as 50 nurses experiencing three or more negative acts on a daily or weekly basis (p. 86). The respondents' manager/director was most often the bullying source (50%). Charge nurses were the bullying source for 25% of respondents and coworkers were the source for 38%, followed by physicians as the source for 29% of respondents (p. 87). "International studies support the concept that bullying is most prevalent against new nurse graduates during their first year of practice" (Fleateau-Lux & Gravel, 2013, p. 26). As

new graduate nurses are transitioning to become a professional nurse from being a student nurse, it is a time of questioning, doubt, learning, and development as the new nurse learns the culture of his or her new workplace. A study of nursing students in Australia (Curtis, Brown, & Reid, 2007) revealed the rather bleak finding that 57% of participant nursing students indicated that they had experienced or witnessed HV (p. 159). Furthermore, this study identified five major themes that were consistent with HV experiences. These themes are: humiliation and lack of respect, powerlessness and becoming invisible, the hierarchical nature of HV, coping strategies, and future employment choices (pp. 159-160). The relevance of HV towards nursing students cannot be overstated. This is where the familiar adage “nurses eat their young” is most applicable, during the schooling and new graduate phases, and where the presence of HV has the best chance to thwart the new nurse’s practice in its path and cause the new graduate to question whether he or she would even like to continue to practice as a nurse.

A study on new graduate New Zealand nurses by McKenna (2003) aimed to determine the prevalence and characteristics of different types of HV experienced by new graduate nurses and to assess the psychological impact on the nurses from these events (p. 91). Interpersonal conflict and horizontal violence were reported by new graduate nurses across all clinical settings including: medical wards, surgical wards, critical care/emergency wards, and mental health services. Covert interpersonal violence most often manifested as the following in the participants’ survey responses: being undervalued (31%), blocked learning opportunities (17%), emotional neglect (16%), and being given too much responsibility without enough support (23%) (McKenna et al. 2003, p. 93).

Psychological effects of the distressing events included: reduced self- esteem and confidence, fear, anxiety, sadness, depression, frustration, mistrust and nervousness (p. 95).

People must feel safe to report the occurrence of horizontal violence. Yet in this study, nearly a half of the distressing events described were not reported. This underreporting may be because of a fear of retaliation, cynicism concerning the outcome of processes in which the senior person to be reported to may be the very person responsible for the behavior, or it may reflect a general trend of under-reporting of incidents by nurses. Effective incident reporting processes and analysis of the reports may increase awareness of how to avoid further incidents of horizontal violence (pp. 95-96).

Retention and Job Satisfaction

Despite the recent surges in nurses entering the workforce, with the aging of the current nursing population, it is predicted that there will be an estimated nursing shortage in the United States of 260,000 RNs by 2025 (Buerhaus, Auerbach, & Staigar, 2009, p. 663). This will be “twice as large as any nurse shortage experienced since introduction of Medicare and Medicaid in the mid-1960’s” (Buerhaus et al., 2009, p. 664). This directly points to the significance of retention of current nurses and new graduate nurses. It is imperative to maintain a healthy work environment in which bullying and HV are not tolerated in order to retain the older nurses in the workforce to pass on knowledge (Longo, 2013, p. 954).

Recent findings from a Robert Wood Johnson Foundation analysis of national survey data from early career registered nurses support the idea that “Intimidating and disruptive aggressive behaviors in the nursing workplace such as bullying, harassment,

and verbal abuse contribute to medical errors, poor patient outcomes, and nurse turnover”(Budin, Brewer, Chao, & Kovner, 2013, p.1). This study included the actions of yelling, swearing, insulting, obscene comments, speaking condescendingly, making humiliating comments disguised as a joke, and ignoring in its definition of verbally abusive behaviors. The most common aggressive actions were found to be speaking condescendingly or ignoring. Almost 50% of the early career nurse respondents had experienced at least one episode of verbal abuse, with 5% experiencing at least five episodes of verbal abuse over the past 3 months. “Nurses experiencing verbal abuse were most often white females, married, without children younger than six years old, worked in a hospital but not a magnet hospital, and provided direct care on 12-hour day shifts”(Budin et al., 2013, p.1).

Bullying is one of the most significant reasons behind nurse retention and high turnover rates.

“In the United States, the annual non-retention (turnover) rate for clinical practicing nurses is 33% to 37%, for newly registered nurses it ranged from 55% to 61%, and approximately 60% of newly registered nurses leave their first position within 6 months because of some form of lateral violence perpetrated against them” (Griffin, 2004, p. 258).

This is an extremely expensive statistic, as well as a detrimental one in light of the current and looming nursing shortage that is facing the United States in the next decade. “It is not surprising that the costs of workplace bullying are estimated to be anywhere from \$3 billion to \$36 billion annually” (Olender-Russo, 2009, p. 77). “Bullying another nurse adversely affects patient care and outcomes, job satisfaction and absenteeism” (Dellasega, 2012, p. 35).

The impact of HV is of extreme importance related to retention among new graduate and experienced nurses alike although most of the research has examined retention statistics related to new graduate nurses. Evidence supports the idea that the phenomenon of NH [nurse hostility] experienced by newly graduated nurses similar to the precept of oppression remains present in the profession.[and] the profession has been endangered through the collective failures of nursing leaders, educators, and nursing colleagues who have ignored the impact of NH (Hickson, 2013, p. 300).

As Luparell (2011) stated, “we need to critically examine how students are socialized into the profession, not only within the formal educational environment, but also as they interact with practicing nurses during clinical experiences” (p. 95). Perpetuating the idea that bullying is the norm or acceptable behavior in any way must not be permitted in any arena, no matter how good a student or a professional nurse’s clinical skills may be.

Along with the concern towards new graduate nurses with regard to HV and the phenomenon referred to as ‘nurses eating their young,’ it is important to also consider the plight of the older nurse. Nurses who have worked for many years in a variety of departments and positions and through a variety of health care transitions (i.e. technology advances, computer charting, HMO’s, Affordable Care Act) have a tremendous amount of wisdom to pass on to newer nurses. While older nurses can fill the role of the bully, they can also be the ones who are bullied. In addressing the need to change the culture of work from a hierarchical, power-driven model to one in which each nurse is respected and appreciated, there are many opportunities for the older nurse to fill the needed role of

teacher, mentor, preceptor, and leader. “By offering appropriate ways to attain recognition, covert mechanisms such as bullying may be avoided” (Longo, 2013, p. 953).

In a study by Johnson and Rea (2009), “nurses who were bullied were almost twice as likely to report that they were “very likely” or “definitely” intending to leave their current position in the next 2 years compared with those who had not been bullied” (p. 87). This same study found that respondents who had been bullied were three times more likely to report that they were “somewhat likely” to consider leaving the profession of nursing in the next 2 years compared to those who did not report being bullied (p. 88).

The findings from another study attest to the findings that new graduate nurses exhibit the impact of HV in the forms of absenteeism from work, consideration of leaving the nursing profession, and symptoms of post-traumatic stress disorder (McKenna et al., 2003, p. 95)

Health and Well-being of the Nurse

Being bullied or disrespected is difficult and destructive for anyone. If this behavior is ongoing and the nurse finds him or herself as a frequent target, or is unable to find an answer despite following reporting protocols, it is likely that the nurse will develop certain health problems, either physically, psychologically, or both. “This repeated conflict makes HV overwhelming, leading to symptoms of depression and even post-traumatic stress syndrome in the victim” (Becher & Visovsky, 2012, p. 211).

The psychological effects of HV can be severe and impact both the victim’s personal and professional life. Even with policies in place to deal with a situation when it

arises, it may not be possible for the individual to turn to that process if the perpetrator is his or her nurse manager or the charge nurse who is in charge every shift that the nurse works. The psychological toll of taking action, particularly if it is not a clear path or the norm for an institution, can be so intimidating that many nurses will choose to resign or find a new job rather than try to follow the policy recommendations.

When positive, respectful relationships are promoted among team members so every individual feels needed and important, the team will coalesce. Each person must matter in order to have the team matter, and everyone's goals must be focused on patient care (Dellasega, 2012, p. 37).

This observation coincides directly with the American Nurse Association's Code of Ethics. The Code of Ethics serves as a moral sounding board for professional nursing. This document stands at the very core of what it means to be a nurse. From the most recent publication of the American Nurses Association's Code of Ethics (2015):

- Nurses consider the needs and respect the values of each person in every professional relationship and setting...Provision 1.1, p. 17
- Respect for persons extends to all individuals with whom the nurse interacts. Nurses maintain professional, respectful, and caring relationships with colleagues...Provision 1.5, p. 20
- The nurse creates an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect...Provision 1.5, p. 20
- Disregard for the effects of one's actions on others, bullying, harassment, intimidation, manipulation, threats, or violence are always morally unacceptable behaviors...Provision 1.5, p. 20.

“The financial cost of HV has been estimated to be \$30,000-\$100,000 per year for each individual” (Becher & Visovsky, 2012). The costs are calculated in relation to the costs of absenteeism, decreased work performance, retention and turnover, training new employees to cover turnover rates, and medical treatments for associated medical conditions. As well as feeling isolated and facing the fear of going to work, nurses may

suffer from stress-related illnesses or consider/commit suicide (Rocker, 2014, p.3). Some of the stress-related illnesses include: nausea, headache, weight loss, insomnia, anxiety, depression, alcoholism, irritability, PTSD and self-doubt. In addition to illness, the bullied nurse is likely to have a fractured work record from leaving jobs or poor performance evaluations following him or her because of the effects of being bullied and trying to continue to work while combating the above-mentioned conditions.

Relationship to Patient Safety

Poor communication is a key component in sentinel events affecting patient safety (Joint Commission, 2008). “When essential information related to patient care is omitted as an act of HV, the victimized nurse is in a poor position to care for the patient and patient safety is compromised” (Becher & Visovsky, 2012, p. 211). If a nurse is feeling bullied and has stopped asking key questions, particularly related to proper technique of a procedure or medication administration, it is more likely that he or she will proceed with the action rather than checking in with a colleague.

The Institute for Safe Medication Practices (ISMP) conducted national surveys in 2003 and 2013. The 2003 survey measured intimidation and disrespectful behavior in the healthcare workplace. Results revealed both interdisciplinary and peer-to-peer violence patterns. The 2013 survey measured ten years of progress. “Sadly, the results paint a grim picture of a hostile work environment in which disrespectful behaviors continue to erode professional communication, which is essential to patient safety” (p. 1).

There are reasons to be concerned about the impact of HV on patient safety as evidenced by the following numbers from the ISMP studies (2013, p. 3):

- 49% of respondents in 2003 and 44% in 2013 reported that past experiences with intimidation had altered the way they handle order clarifications or questions about medication orders.
- 39% of respondents in 2003 and 33% in 2013 had concerns about a medication order but assumed it was correct rather than interact with an intimidating prescriber.
- 39% of respondents in 2003 and 38% in 2013 would ask another colleague to talk to a provider with a reputation for being disrespectful.
- No reduction was found between 2003 and 2013 in the percent of respondents who were aware of a medication error in which bullying played a role (11% both years).

Although some of these examples indicate more of a prescriber-nurse bullying relationship, the initial statistics related to order clarification and asking a colleague a question without hesitation are directly related to HV.

Role of Policy to Professional Nursing

Policies serve to guide professional nurses towards best practices in a variety of situations and settings. They serve as guideposts in the vast world of health care. Nurses are educated to look towards their employer's policies when confronted with a specific procedure, benchmark, or situation in the clinical setting. How policies are constructed is

a critical matter for the ultimate effectiveness of the policy, and the institution itself. It is essential for all parties involved in the issue to be present for the making of policy. This may include hospital administration, nursing management, staff nurses, physicians, pharmacists, and many other possible players. “If a policy development process consistently failed to be representative of affected parties, then one might question how just either the policy making process or the content of a policy really is” (Dirksen & Brown-Saltzman, 2012, p. 21).

Involving nurses in policy development gives them the opportunity to take ownership and responsibility for the environment in which they work...Such a policy should target positive behavior and work towards creating a working climate that treats nurses with dignity, respect, and fairness (Rocker, 2008, p. 6).

It seems reasonable that nurses would be included with the development of policy that serves to guide nursing-specific clinical and professional practice. With the goal for zero tolerance for bullying policies by the AACN and the Joint Commission, it is important to take a close look at policy specifics for certain essential criteria. Tehrani (2005) cites the following criteria as aims for anti-bullying policy in the Chartered Institute of Personnel and Development Bullying Guide (p. 30):

- Ensure the dignity at work of all nurses
- Respect and value differences among nurses
- Make full use of the talents of all the nurses
- Prevent acts of discrimination, exclusion, unfair treatment, and other demeaning behaviors
- Demonstrate a commitment to equal opportunities for all nurses

- Display open and constructive communication
- Handle conflict with creativity
- Show fair and just behavior when dealing with other nurses
- Become educated about nurse and employer responsibilities
- Develop positive behaviors

With regard to the implementation of zero tolerance policies, it is imperative to involve the nurses at the bedside, along with management, to get the most realistic picture of what is happening and how to deal with it. “While there is no consistent evidence regarding the most effective implementation of these policies, it is evident that strategies implemented need to be collaboratively prepared by administration, management, nurses, and other staff, and initiated as soon as an incident occurs”(Christie & Jones, 2013, p. 7).

Theoretical Framework

Nurses interact with other health professions in a variety of settings. Hospital nurses answer to managers and administrators, who may or may not be nursing professionals, as well as physicians, who direct patient care across disciplines. “Nurses may perceive a sense of powerlessness because of the influence of both physicians and administration” (Weaver, 2013, p. 140). Nursing has a traditional professional hierarchy with more experienced nurses on the top rungs, new graduate nurses on the bottom rungs, and students well below both of these groups in the hierarchy.

“Researchers have theorized that interpersonal conflict among nurses is not based in naked aggression or hatred as one might imagine” (Weaver, 2013, p. 140). Therefore, it

is appropriate to examine the concept of nurse bullying through the lens of Friere's (1971) theoretical framework of oppression. The reason that this theory is applicable to the study of HV is that it lays the groundwork for understanding the hostile actions that nurses take towards each other while feeling powerless over many other factors. Friere stated that oppression requires both a 'dominant' (physicians and administration) and 'inferior' (nurse) group. However, with HV, the dominant and inferior become enmeshed within the peer or colleague group, and both the dominant and inferior groups are nurses. Weaver (2013) further explains that "if a group was oppressed and had perceptions of powerlessness and low self-esteem, that group would respond by internalizing the conflict and oppress others in that group" (p. 140). Traditionally, nursing has operated within a patriarchal hierarchy where men were the physicians and nurses were women who served them in a subordinate role.

Sociological literature shows that oppressed group members tend to act out against one another because they lack control over their situation. They can't verbalize frustrations or concerns to higher-ups for fear of punishment. Inability to express feelings and concerns diminishes their self-esteem. Powerlessness further lowers their self-esteem and triggers the cycle of oppressed group behavior undertaken to boost self-esteem which in turn causes more frustration, lack of coworker support, and conflict (Townsend, 2012, p. 12).

"Oppression theory suggests that powerlessness, lack of control over the working environment, and subsequent low self-esteem contribute to the development of HV within the nursing profession" (Becher & Visovsky, 2012, p. 210). Examples of this actual or perceived lack of control can be a lack of breaks or meals, poor staffing ratios, limited supplies, and little acknowledgement of nurses' critical thinking skills (Townsend, 2012, pp. 12-13). When oppressed group members feel that they do not have a voice to make

any kind of change, then the internalized anger and hostility can be directed laterally, with the result of HV.

New graduate nurses have an inherently difficult time adjusting to shift work, primary patient responsibility, and a full patient load, without having to deal with the added stressors of fitting in, making the ‘queen bee’ happy, and ‘not rocking the boat.’ Many hospitals have addressed the degree of change for the new graduate nurse with specific new graduate orientation programs, ones which must be applied for and, usually, require some kind of work commitment. These programs offer the possibility of mentoring the new graduate into the culture of professional nursing, and giving them the abilities and confidence to stand up for themselves when faced with bullying behaviors.

Summary of the Review of Literature

As evidenced by the numerous references citing the impact of HV in nursing, particularly in the realms of retention, nurse health, and job satisfaction, this is a relevant topic to investigate further through the lens of policy implications. As supported by the literature, the prevalence of HV has continued despite efforts by national organizations to enforce zero tolerance approaches to this issue. The role of policy lends a potential vehicle for clearly addressing this issue if it is evidence-based, if nurses are involved in the creation of policy, and if the policy defines HV, both overt and covert actions. It is also essential to include a clear path of action in the policy for the nurse to use if there is a problem.

CHAPTER 3

METHODS

Introduction

The purposes of this project were to (a) examine established policies regarding bullying in the healthcare environment and (b) identify available evidence to support the policy across various sizes and types of hospitals in Montana including Critical Access Hospitals and non-Critical Access Hospitals as defined in the “operational definitions” section of chapter 1. This project was approved as “exempt” by the Montana State University (MSU) Institutional Review Board (IRB) after it was determined that anonymity and de-identification of all individual contacts and specific organizations would be assured.

Policy Retrieval Process

The method used to collect information from each institution included internet research on the hospital’s web page, phone calls to the Human Resource (HR) department and Nurse Managers/Administration, and, possibly, face-to-face conversations with appropriate personnel from hospitals. Face-to-face conversations did not occur in collection of policy data. The type of facilities assessed in this project included CAHs and non-CAHs in Montana. The goal was to examine the policies of five CAHs and five non-CAHs in Montana.

The assessment of each hospital began with the following question: Does your hospital have a formal policy addressing HV in the nursing workplace? If yes, the policy was requested for review. If unknown, the author was transferred to another department or contact often within HR or Nursing Administration. Multiple phone calls or email attempts were made to determine the availability and existence of a policy. If no, then that information was recorded as a significant finding. If the policy was obtained, it was then assessed via an evidence-based rubric created by the author and based on the literature.

Evidence-Based Rubric Design and Rationale

The evidence-based rubric used for policy analysis in this study was created by the author after a thorough review of the current literature. The themes present throughout the literature review, as well as the clear recommendations of national organizations and the theoretical context for this project, helped create the framework for the rubric. In organizing this study to conduct a systematic policy analysis, it became apparent that having a standard framework, such as this rubric, would allow each policy to be objectively assessed based on the current literature.

Rubric 1: Was the policy able to be obtained? Yes/No

**If not, what was the obstacle to obtaining the policy?*

Rubric 2: Does the policy have a zero tolerance approach to managing HV, including the use of “zero tolerance” language? Yes/No

**Rationale: The evidence clearly supports the need for a zero tolerance policy based on the AACN (2004) “Zero Tolerance for Abuse” Position Statement, the ANA (2011) “Zero Tolerance for Abuse” Position Statement, and the Joint Commission (2008) Sentinel Event Alert “Behaviors that undermine a culture of safety.”*

Rubric 3: Were nurses involved in the development of the policy? Yes/No

**Rubric 4: Rationale: “If a policy development process consistently failed to be representative of affected parties, then one might question how just either the policymaking process or the content of a policy really is” (Dirksen & Brown-Saltzman, 2012, p. 21). “Involving nurses in policy development gives them the opportunity to take ownership and responsibility for the environment in which they work” (Rocker, 2008, p.*

6). “While there is no consistent evidence regarding the most effective implementation of these policies, it is evident that strategies implemented need to be collaboratively prepared by administration, management, nurses, and other staff, and initiated as soon as an incident occurs” (Christie & Jones, 2013, p. 7).

Rubric 4: When was the policy last updated?

**Rationale: Due to the increase in literature during the past decade concerning HV in nursing, as well as the zero tolerance position statements since 2004, it seems that any policy that has not been updated since 2004 may not be up-to-date with the national and most recent evidence-based recommendations.*

Rubric 5: Is there a clear path of action for reporting a concern described clearly in the policy? Yes/No

**Rationale: “People must feel safe to report the occurrence of horizontal violence. Yet in this study, nearly half of the distressing events described were not reported...Effective incident reporting processes and analysis of the reports may increase awareness of how to avoid further incidents of horizontal violence” (McKenna et al., 2003, pp. 95-96).*

Rubric 6: Does the policy define Horizontal Violence? Yes/No

**Rationale: “Tolerance for NH [nurse hostility] has been viewed as a rite of passage, whereas new nurses often endure an underground hazing process” (Hickson, 2013, p. 293). With knowledge of both the overt and covert behaviors of HV in nursing (please refer to HV in operational terms definition section of this paper), it is essential to define what the term HV means in the policy, rather than assuming that people will know that non-verbal, common behaviors such as eye-rolling, withholding information, and not being available, are legitimate HV actions with known negative effects.*

Summary

The first step for developing a best-practice recommendation was to understand what is currently being done to address the issue of HV in the workplace by examining the literature. The next step involved collecting and documenting policies or lack of policies for each institution. Finally, existing policies were assessed in light of current evidence-based recommendations based on the literature findings.

CHAPTER 4

RESULTS/CONCLUSION

ResultsDemographics

A total of ten Montana hospitals were contacted for participation in this project. These agencies were chosen based on the fact that they all exist within one region of Montana and consist of different size hospitals. As well, they were all within a reasonable driving distance if a face-to-face encounter was deemed necessary. This cohort of hospitals concentrate on only one geographic area, thereby initiating consistency for data collection and possible future studies across a larger regional area. Five of the hospitals were CAHs and five of the hospitals were non-CAHs. All hospitals had Human Resource and Nursing Administration departments. The non-CAH hospitals included hospitals with Magnet designation, aspiring-Magnet designation, and both Levels 2 and 3 trauma certifications. None of the hospitals contacted received a letter of introduction to the project prior to initial phone contact by this author.

Findings

The findings from this investigator's review of current HV policy among hospitals of varying sizes across Montana suggested a variety of policy scenarios. Out of the ten hospitals contacted, only five hospitals responded. None of the five hospitals that responded in the study were found to have a specific HV nursing policy. Upon asking the first question, "Does your hospital have a policy on horizontal violence in nursing?" each

hospital contact person answered “No”. In follow up, this investigator asked if the hospital had a policy on any of the following: bullying, workplace violence, harassment, or any other applicable topics such as a code of conduct or job performance expectations. Out of the five CAHs contacted, two had workplace violence/harassment policies, one had no policy concerning workplace violence, and two were unresponsive to repeated contact attempts. Out of the five non-CAHs contacted, one had a workplace violence/harassment policy, one had no policy concerning workplace violence, two were trying to get permission to release their policy to this investigator, and one was unresponsive to repeated contact attempts. In Table 2, hospitals numbered 1-5 were CAH and those numbered 6-10 were non-CAH. There was a 50% response rate in this small sample of hospitals for this project with “waiting” (see Rubric 1) classified as a positive return.

Table 2. Evidence-Based Horizontal Violence Policy Rubric.

Hospital ID	Rubric 1 Policy able to be obtained	Rubric 2 Zero tolerance language	Rubric 3 Did nurse help author?	Rubric 4 Last update	Rubric 5 Is there a clear path of action?	Rubric 6 Does the policy define HV?
1	Yes	Yes “unacceptable”	No data available on the policy	2005	Yes Including alternative contact persons/paths	No
2	No No policy available	-	-	-	-	-
3	Yes	Yes “will not tolerate” “prohibit X behaviors”	No data available on the policy	2008	Yes Including alternative contact persons/paths	No
4	No No Response	-	-	-	-	-
5	No No Response	-	-	-	-	-
6	Yes	Yes “does not tolerate” “prohibited from X”	No data available on the policy. Signed by COO/CEO and VP HR/Ed only.	04/2006	Yes Including alternative contact persons/paths	No
7	No No policy available	-	-	-	-	-
8	No No Response	-	-	-	-	-
9	No No Response	-	-	-	-	-
10	No No Response	-	-	-	-	-

Critique of Data Collection Process

The process of requesting and collecting policies from hospitals was difficult and time-consuming, with poorer-than-expected return results. It seemed that the subject of the policy request, horizontal violence in nursing, would trigger a question with the first contact person in HR, and that person would then transfer the investigator to another person, sometimes in HR and sometimes in Nursing. The return rate on these transferred calls, and subsequent messages, was poor, at only 50% return rate.

In preparation for future research, it would be prudent to send a letter of introduction to both the supervisor of HR and the CNO of the hospital explaining the project and goals of the policy request. In this letter it would be important to note that each institution would remain anonymous within the policy review process based on the criteria for “exempt status” established in the Institutional Review Board application. Assurance of anonymity was stated during the phone calls that were made by the author, but a statement in writing would possibly be more effective. In addition, having a contact person in the hospitals to facilitate entre’ and policy acquisition m have improved the number of collected policies. Due to the nursing component of the policy, the most likely contact person would be the CNO of the hospital.

Limitations

A significant obstacle was that often the contact person did not know where to find the policy, whether under HR or Nursing on the hospital’s intranet system, and it can only be imagined that a nurse trying to find and use the policy to file a complaint might have the same difficulty. The location of the policies might vary based on how the

intranet of an institution listed keywords or utilized a search criteria. This author did not have access to each hospital's intranet, so relied on the contact person to use their subjective search criteria to find the requested policy information.

Recommendations

Future research with this focus could expand the contact person questions to explore additional information. Where is the policy located? Can a nurse find the policy? These question would help determine the availability of the policy to nurses. Who created the policy? This information was not apparent on any of the policies evaluated. An additional question for the future might explore policy usage rates and nurse retention at hospitals.

There is certainly room for future studies in this arena, as well as evidence- based policy development directly related to HV in nursing. It is likely that we may need to study administrators, nursing leadership, and staff nurses to discover their awareness and views on HV and how it affects the organization in order to more fully comprehend this issue. In particular, this study did not look at the compliance of policy based on Joint Commission accredited versus non-Joint Commission accredited hospitals. This would be an important point to study to determine the range of distribution that a strong practice recommendation, such as the zero tolerance policy recommendation, has among hospitals that are not Joint Commission certified. The results of this project will be published, including the rubric with interpretative statements and references to the evidence-based literature, so hospitals have access to the information generated by this inquiry.

Discussion

The findings from the evidence-based rubric assessment of the available policies from both CAH and non-CAH hospitals in Montana revealed a stark need to increase the presence of specific HV policies either within existing policies or introduced as stand-alone HV policies. Most of the policies examined were found under the general heading of Human Resources Workplace Violence, or Sexual/Workplace Harassment. It was not possible to determine whether or not the policy was available only under the HR section of the hospital's intranet system or also available under Nursing. A larger study sample including various rural and urban hospitals throughout the United States is necessary to follow up on the interesting findings of this very small sample size.

Although the policies examined did show comparable language to 'zero tolerance,' none of policies actually stated 'zero tolerance.' The inclusion of language consistent with national recommendations would be one suggestion for improvement. The policies all included definitions of what actions constituted unwelcomed or unwanted behaviors; but, most of the descriptions focused more on physical threats, sexual harassment, unwanted touching, or damage to person or property either with or without a weapon. These actions do not cover the nuances of the covert behaviors that lie at the core of HV which are often the most difficult to detect and decipher in the first place and are often the most damaging. Descriptions of these behaviors in the existing policies would also serve to improve the applicability to HV problems in the nursing workplace. All the policies had a clear path of action with a variety of people who the victim could report to with a complaint. This policy detail is essential because if the nurse manager is

the perpetrator then the nurse can proceed directly to HR or another manager to resolve an issue without fear of retaliation.

The lack of HV policy presence among the hospitals in this study is a subtle and symbolic reminder that the actions of an oppressed group often operate under the peril of powerlessness. Without a specific HV policy present, or even a general workplace violence/harassment policy present, a nurse who has an issue or feels bullied does not have a place of power from which to act. With the backing of a policy, the nurse has a framework with which to take action and feel more control in a difficult situation. It is difficult to know from such a small sample size in this project whether Montana hospitals are particularly out of touch with what is going on in health care and national organization recommendations, or whether this is a national problem. In order to address this question, a larger sample size across a larger regional area would be necessary.

Inherent challenges to the study and analysis of bullying and hostile behaviors, particularly covert behaviors, include the subjectivity of the action. People are different. What one person may perceive as hostile may not offend another person. This point speaks to the great necessity to explore existing policy language and content to assess how organizations choose to work towards the ANA's goal of zero tolerance bullying policies.

Ultimately, the goal of policy development would be to increase awareness on the continued prevalence of HV as well as the negative influences of HV on nurse health, retention, and patient safety. It is doubtful that policy alone can make this difference. Along with policy development and consistent implementation, hospitals need to use all

educational and awareness trainings possible to influence the culture of respect among workers. Using the recommendation of Tehrani's Anti-Bullying Guide (2008),

Tackling a difficult and complex issue like bullying at work is about much more than having a policy in the staff handbook. It's not just about an absence of negatives, but about actively defining and promoting positive working relationships. The focus needs to be moved from the destructive stance of punishing and isolating bullies to a more explicit presentation of positive options. Building a culture of dignity and respect at work means creating a workplace where appropriate ways of behaving are clearly communicated, promoted and supported. It also means individuals being supported in accepting responsibility for their behavior and actions, and working towards solutions when problems occur (p. 45).

Starting with new graduate nurses, new hires, and extending to all nurses within an organization this author recommends a combination approach of having a clear HV policy that is easily accessible to all nurses, as well as a dedicated approach towards respect in the workplace as cited above. All of these efforts could serve to change the culture of nursing by putting a nail in the old adage "nurses eat their young" and establishing a new adage-- "nurses care for the most vulnerable including their young."

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